

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	<b>PART II: TECHNICAL APPROACH</b>	Total Possible Points	Score	DHH Comments
		<b>Section Q: Claims Management (Section § 17 of RFP)</b>	<b>80</b>		
Q-1	A, B, and C	<p><b>Q.1</b> Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.</p>	<b>30</b>		
Q-13	A, B, and C	<p><b>Q.2</b> Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:</p> <ul style="list-style-type: none"> <li>• The process for auditing a sample of claims as described in Key Claims Management Standards Section;</li> <li>• The sampling methodology itself;</li> <li>• Documentation of the results of these audits; and</li> <li>• The processes for implementing any necessary corrective actions resulting from an audit.</li> </ul>	<b>25</b>		
Q-20	A, B, and C	<p><b>Q.3</b> Describe your methodology for ensuring that the requirements for claims processing, including adherence to all service authorization procedures, are met.</p>	<b>25</b>		

Question Q.1  
Claims Management Systems  
Capabilities

## Section Q: Claims Management

Q.1 Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.

### Demonstrable Dedication and Experience With Focus On Medicaid

Centene Corporation (Centene) will manage the claims processing function for Louisiana Healthcare Connections (LHC) and will bring 27 years of experience processing claims for public sector health care programs to LHC, DHH, and the Louisiana Medicaid Coordinated Care Network Program (CCN-P). In 2010, we processed approximately 20 million managed public sector program claims across 11 states in the service of 1.6 million members. Our claims management system, described below, is one component in our Management Information System (MIS): Centene's nationwide platform incorporating not only core claims functionality, but all the indirect yet critical information functions needed for claims processing:

- Member and provider data and service management
- Clinical care and utilization management
- Decision support and reporting analytics
- Interfaces for self-service functionality on the web and through Interactive Voice Response (IVR)

Through this *integrated*, enterprise-wide MIS, designed specifically for programs such as CCN-P, we continue to deliver superior operational claims service across all claims performance areas, including administrative and financial adjudication accuracy; clean claims payment turnaround; cost avoidance and third party recovery; systematic detection of fraud, waste, and abuse; and accurate, timely, and complete encounter submissions. In addition, our MIS is completely configurable for LHC and all affiliate health plans, through table driven parameters and customizable edit rules. The claims system capabilities we describe below and that we propose for LHC are in production today in all of our markets, including our three largest health plans in Texas, Georgia, and Indiana, where we have met or exceeded Louisiana performance requirements as stipulated in Section 17 of the RFP. Please see the discussion below for more information.

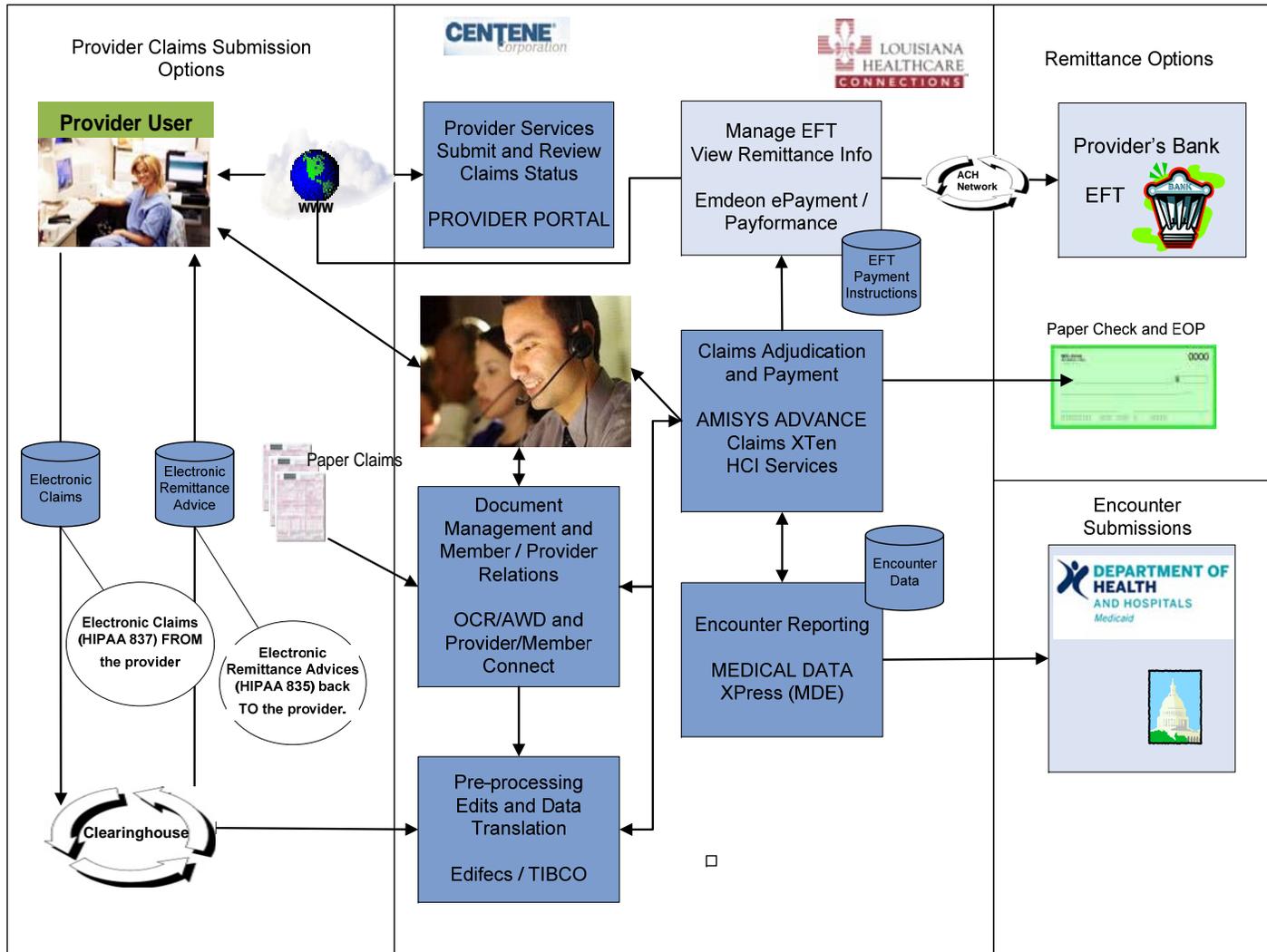
### Electronic Claims Management Functionality

Centene's state of the art HIPAA and DHH compliant claims adjudication process, from provider claim submission to provider payment, and integrated claims processing system are outlined below. See **Figure Q.1.A: Claim Processing Workflow** for a flowchart that illustrates this end-to-end process. For information on our HIPAA and DHH compliant claims processing and encounter processing and submission systems and methods, please see our response to R.2, (integrity of data supplied to DHH), R.5, (providing encounter data to DHH), and R.6 (ability to exchange data with DHH).

We will configure our systems for the specific DHH rules and will modify our configuration as required to ensure we remain consistent with DHH and federal requirements.

We have reviewed in detail all claims requirements stipulated in Section 17 of the RFP and also requirements indirectly impacting claims processing such as those found in Section 16 (general Information Technology capabilities, security and encouraging Electronic Data Interchange - EDI); Section 9 (provider preventable conditions and provider payments); Section 5 (Third Party Liability processing); Section 18 (reporting); and finally the CCN-P Systems Companion Guide (encounter processing). We support similar requirements in *all of our health plans today*, and our systems and processes are *fully* capable of honoring all CCN claims requirements.

Figure Q.1.A. Claims Processing Workflow



**Flexible Claim Submission Methods.** Centene has the ability to receive LHC claims in several ways to meet the various processing capabilities and requirements of our providers:

**1. HIPAA 837 Professional and Institutional EDI Claims from Multiple Clearinghouses.** Today we receive claims from over 60 trading partners across 11 states and will accept claims from any clearinghouse that meets our performance and service quality standards, and which can implement our HIPAA companion guides. LHC providers will also be able to submit HIPAA EDI 837 batch files *directly* to us through our secure Provider Portal.

When a provider submits batch claims directly to us via our Provider Portal, we will acknowledge receipt of that batch and return a response to the provider, in near real time, indicating whether we successfully received the transaction as a valid HIPAA file. Similarly, when we receive a file through a clearinghouse, we also send an ANSI standard 997 Functional Acknowledgement (FA) response to the clearinghouse, who in turn, submits a response to the provider regarding the successful receipt or rejection of their submitted claim file.

In our experience, the most common reasons we must reject a claims batch file in its entirety include situations where we cannot identify the submitter; we cannot validate the billing provider in any of the claims in the batch; there are invalid organization names included in all claims; or there is a problem in the batch header record or other structurally fundamental problems with the submitted file, including situations where the entire batch file is unreadable. To help with these types of issues or other EDI questions from providers, our EDI Support Desk is available to help providers resolve any issues with their batch submissions so that they can be reprocessed in a timely manner. The EDI Support Desk will be an option on our provider services call line and is available from 7:00 am to 5:00 pm CST.

**2. HIPAA Compliant Direct Data Entry (DDE) Facility on our Provider Portal.** This functionality is especially convenient for our smaller provider offices, yet it offers the same EDI validation as our batch claim submission processes. When a provider submits a *professional* claim via our online DDE facility, we will adjudicate that claim and post the final disposition of the claim on our Provider Portal within **two business days** of receipt, and we will pay the claim on the next check run. If, for any reason, we are unable to meet this service level (e.g. claim is flagged for fraud investigation or medical necessity review), our **Automated Work Distributor (AWD)** claim workflow system will alert our LHC Claims Center staff to contact the provider and help them understand the status of their claim. This service level is made possible through the integration of our **Provider Portal, EDIFECS EDI** system, **AWD**, and **AMISYS Advance**, our core claims processing system. See below for more information on these *integrated* systems supporting our claims processes.

**3. On paper.** We also accept CMS 1500 and UB04 paper claims. Paper claims are delivered from the US Postal Service on a daily basis. Within one business day, these claims are scanned and converted to data using our integrated combination of Kodak high volume scanners and **MACESS Formworks** Optical Character Recognition (OCR) system.

**Enabling Claims EDI and EFT.** In the best interests of our providers, state clients, and our own internal operations, our preferred mechanism for claim submission will be through EDI. Centene has found through our historical data, that when providers prepare claims electronically, the time from patient service to Centene receipt is less than half the time compared to claims submitted on paper. Claims data is more complete and clean because technology validates much of the data submitted at the earliest possible stage in the process. Centene aggressively educates and supports providers on the benefits and methods of EDI claim submission with excellent results. Between March 1, 2010, and March 1, 2011, more than 85% percent of all medical claims and more than 87% of all behavioral claims were submitted electronically to Centene for all affiliates.

LHC will *actively* provide multiple electronic claim submission options and education and encourage providers to *submit claims electronically*. For example, large providers capable of managing a direct EDI connection to Centene will be invited to use our **EDIFECS Ramp Manager**, for the same kind of EDI

on-boarding applications that DHH's fiscal intermediary (FI) offers today, using the same EDIFECs product. Beyond claim and remittance transactions, providers connecting directly with LHC will receive direct assistance from our EDI Help Desk to implement the broader HIPAA transaction set, including 270/271, 276/277, 278, and HL7 transactions such as Continuity of Care Document (CCD) exchanges and Scheduling Information Unsolicited (SIU) for appointment scheduling. Please see our response to R.2, R.6, and R.7 for more information on our EDI capabilities; R.13 for how we promote and encourage EDI/EFT; and R.15 for CCD exchanges.

**HIPAA EDI Compliance.** HIPAA format adherence is verified real-time using our **EDIFECs X-Engine** compliance software which improves our claim auto-adjudication rate and the quality of the downstream encounter data we process and submit to our state clients, such as DHH. X-Engine validates data against X12 syntax and rules for data structure; tests to ensure conditional rules requiring secondary fields are completed accurately and completely; and ensures all data is in compliance with our HIPAA Transaction Companion Guides. These upfront edits not only ensure that transactions are compliant with federal mandates and DHH rules, but they improve processing efficiency by recognizing and rejecting problematic transactions in the earliest stage of the process and sending notification to our trading partners and providers through the ANSI TA1/997 Functional Acknowledgment (FA). This rapid turnaround allows providers to correct and resubmit non HIPAA compliant claims as quickly as possible for adjudication and payment.

**Pre-adjudication Edits.** EDI and paper claims data are processed through our EDIFECs and **TIBCO middleware** to map, translate, and validate the data, ensuring that common edits are consistently applied. We configure TIBCO to validate certain claim data elements, including member; billing and rendering provider; and other data elements against data we currently have in AMISYS Advance. Refer to R.4 for a discussion of the safeguards and systems we use for the master data management and interoperability of member and provider data. If a transaction is rejected for any of the specific reasons configured in TIBCO, an ANSI 277 Unsolicited (277U) notification is systematically sent to the EDI trading partner or submitting provider, conveying the specific DHH-approved edit that did not pass our upfront validation processing. Examples of pre-adjudication edits include:

- **Member Validation** – confirms presence of member record in our systems
- **Validate Dates of Service** – confirms that the claim date of service is valid and does not contain future date or a date outside of the member's eligibility span
- **Diagnosis Code Validation/ICD9 Tables** – confirms the presence and accuracy of ICD9 and procedure codes, and all HIPAA codesets.

In the case of electronic claims, we first check, via our EDIFECs EDI subsystem, for HIPAA compliance and ANSI EDI syntax as described above. If the claim is structurally unsound from an ANSI EDI perspective, or does not pass our enforced level of HIPAA compliance, we immediately issue an ANSI standard 997 FA back to the submitting clearinghouse or provider. Please note, that, beginning January 1, 2012, and in line with our production support of the HIPAA 5010 transaction set, we will also begin issuing ANSI 999 FAs.

If EDIFECs determines that the claim is HIPAA compliant, our TIBCO middleware then instantaneously proceeds with a series of pre-adjudication edit functions, as described above; including member and provider validation. If the claim fails this level of processing, we will issue a detailed HIPAA 277 Unsolicited (277U) to the claim submitter, within one business day of claim receipt.

Finally, if the claim passes the above pre-adjudication edits, the claim is automatically loaded into AMISYS Advance. There are relatively few situations where an "unclean claim" is loaded into AMISYS Advance, such as specific scenarios where it is impossible to determine whether a claim is totally "clean" without applying adjudication logic in AMISYS Advance. These situations include claims where supplementary documentation is needed, such as signed consent forms, or where we need third party payer documentation for claims with known "other insurance" (OI). We will configure AMISYS Advance

and our integrated AWD to prioritize all pend types related to "supplementary documentation needed" situations so that these pends are immediately routed to a claims analyst specialized to handle these cases. If the analyst determines (using our MACCESS document management system, integrated with AWD) that we have not received the requisite supporting claim documents, we will immediately deny the claim, and the provider is notified within five business days via detailed information, including the reason for the denial in the HIPAA 835 Remittance Advice, online Explanation of Payment (EOP), and/or paper EOP (depending on the provider's preference).

### **Six Steps of Adjudication**

All claims that successfully pass the pre-processing edits are loaded for adjudication into AMISYS Advance, our core claims processing system. AMISYS Advance accepts the Julian time stamps, for both paper and electronic claims, indicating when the claim was received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim and to track our adherence to claims processing timeliness standards. AMISYS Advance's audit trails retain snapshots of all transactions for current and historic activity. This audit function includes date span logic, historical claims tracking, operator ID stamping, and accommodates the setting of different audit parameters.

AMISYS Advance performs *six primary steps of adjudication* that a claim must successfully pass through in logical succession to reach a paid, denied, or internally pended status. These steps are listed below along with a brief description of each and specific examples of edits that will be configured within each step for DHH claims.

**Step 1: Field and General Edits.** AMISYS Advance determines the presence and validity of required claim data such as CPT/ICD9 codes and whether the fields are consistent with the business rules outlined by DHH and federal regulations, as well as age, gender, duplicate, and timely filing edits. Example edits include:

- Procedure Code/ICD9: code inconsistent with member gender
- Procedure diagnosis code deleted, incomplete, or invalid
- Invalid type of bill.

**Step 2: Member Eligibility.** The system verifies eligibility for service dates and coverage type, and existence of Other Insurance (OI).

- Verifies that a member is eligible during the dates of service indicated on the claim
- Confirms that we have received premium payments from the state for the member for the coverage period corresponding to the claim dates of service.

**Step 3: Provider Eligibility and Status.** The system checks the submitting provider's eligibility to see members and receive payment from us, as well as the provider's network participation status for the dates of service. Edits include:

- Participating or nonparticipating status is verified
- The provider's financial affiliation is determined
- Pend edits will apply if:
  - The provider TIN or NPI is not on file
  - There are multiple affiliations to choose from under one TIN and/or NPI.

Note: In the event a pend occurs for either of the above reasons, Centene has an established process to quickly review and resolve the pends. We have specialists that work specific pend types and the pends are routed automatically by our AWD claim workflow system, integrated with AMISYS Advance, to the appropriate pend specialist queue. See our discussion below on claims workflow management for more information.

**Step 4: Prior-authorization.** AMISYS Advance is integrated with **TruCare**, LHC’s integrated, member centric health services management platform where primary authorization data is held. AMISYS Advance is configured to determine if an authorization is required for a specific service, then if applicable, verifies the presence of a prior authorization, and confirms that the dates of service are within authorization date spans, limits etc. Examples of prior authorization edits AMISYS Advance applies include:

- Authorization is or is not on file
- Procedure does or does not match authorization
- Service has or has not exceeded the authorized limit.

**Step 5: Covered Services.** To define exactly which services are covered and at what levels, the system determines covered services by applying configured eligibility, provider, and benefit management rules, along with tables of valid procedure codes and ranges; diagnosis codes (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range; provider type; service location; and benefit limitations. This step determines if a member is eligible for the services rendered, if the service date falls within the effective date of the benefit and meets all the criteria established by DHH for payment. Examples of edits related to covered services include:

- Denial edit will apply if:
  - A service is not covered
  - A service has exceeded the benefit limit
- Pend edits will apply if a service has exceeded a benefit amount.

**Step 6: Pricing.** AMISYS Advance prices the claim by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and provider specific contractual and financial agreements. This step also applies DHH reimbursement rules, such as limiting payment for non contracted in-state and out-of-state providers for emergency services to no more than the DHH rate. Please see our response to Section P.1, Third Party Liability (TPL), for more information about TPL. Pricing edits may include:

- AMISYS Advance applies appropriate COB and TPL rules for the specific health plan (e.g. CCN-P), to compute final provider payment
- If the provider is out-of-network, the appropriate fee schedule is applied
- When appropriate, pend queues are set up to review claims (by senior claims staff) to determine appropriate pricing, for example:
  - First time claim submission from non-participating providers
  - Claims that exceed high dollar billing thresholds.

**Present on Admission and Hospital Acquired Conditions.** AMISYS Advance fully supports flexible processing of adjudication rules as they pertain to Present on Admission (POA) indicators and policies. In addition, we have implemented two levels of clinical editing to detect potential situations where the patient has experienced Hospital Acquired Conditions (HAC). These two integrated approaches include our ClaimsXten® (CXT) clinical editing software from McKesson, and our integrated workflow HealthCare Insight (HCI) which includes HCI’s clinical editing software (augmenting CXT) to detect HAC potential. Please refer below to our discussion of CXT and HCI edits and to J.2 for more details on our approach to detecting and reducing HAC with our members.

### **Claims Workflow Management**

Our AWD software will manage LHC’s workflow of any pended claim in AMISYS Advance in *real time*. If a claim pends in AMISYS Advance, AWD will immediately route an electronic work item to a claims processor skilled to address that type of claim pend. The claim processor can then address the pend issue within AWD and the appropriate claim change is immediately made in AMISYS Advance, with a full

audit trail of the change and all other financial transaction activity. By “pushing” claims in real time to trained processors who possess a particular area of expertise, such as our licensed medical review clinicians, we are able to ensure more rapid pend resolution. AWD also provides processors with immediate access to claim images (including attachments) and supports the communication and routing between departments to resolve a claim pend. When the “pend issue” is addressed, we re-adjudicate the claim using the six-step process described above.

We will configure AWD to identify and escalate any pended claim that is approaching 15 days to a claims supervisor to ensure visibility and timely resolution. This intentional awareness of aging pends will allow immediate realignment of resources to work areas of concern and will ensure we maintain claims processing timeliness standards. In addition, this awareness drives research for additional auto adjudication opportunities.

**Coding Review.** Once claims pass adjudication in AMISYS Advance, they are further analyzed by CXT to determine **clinical appropriateness** of claim coding. CXT contains a comprehensive set of rules based on nationally recognized coding guidelines (cited below), which address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. These edit rules are based on generally accepted principles of coding medical services for reimbursement and are not based on medical necessity, nor are they designed to make reimbursement or payment decisions. Instead, CXT offers a recommendation that is applied to the claim when a provider’s coding pattern is unsupported by a coding principle. CXT’s flexible configuration tools will allow LHC to customize these edits by incorporating LHC provider coding/reimbursement policies and DHH benefit criteria into the applicability of these edits. Standard edits provided by CXT are based on nationally recognized guidelines, including but not limited to:

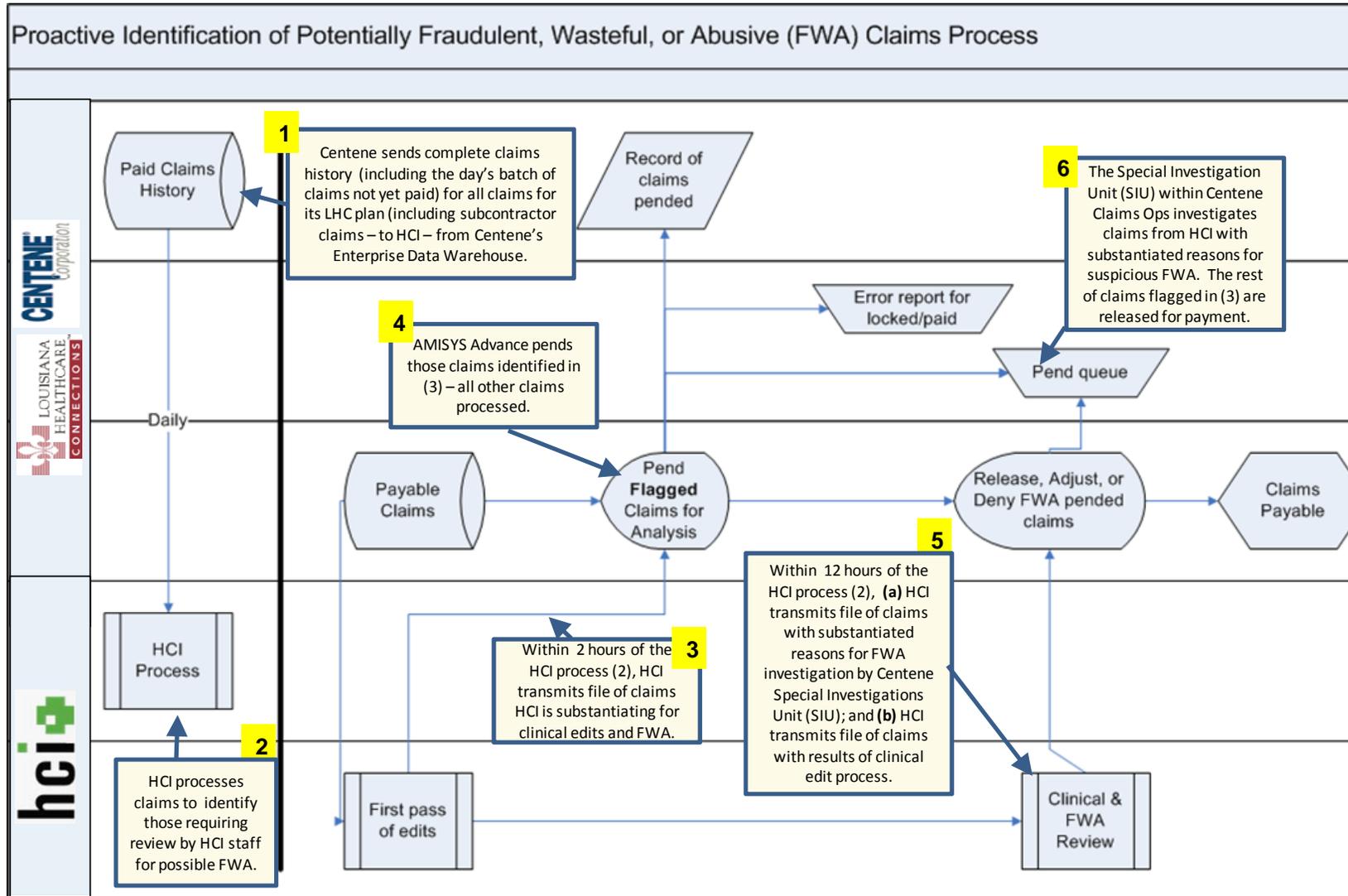
- *American Medical Association (AMA):* CXT utilizes the CPT Manuals, CPT Assistant, the AMA website, and other sources
- *Centers for Medicare & Medicaid Services’ (CMS):* In addition to using the AMA’s CPT manual, CMS offers a variety of edits including the National Correct Coding Initiative (NCCI) for professional and outpatient services
- *American Board of Anesthesiology:* CXT offers edits based on this and other specialty boards.

Below are a few examples of the edits that are performed with CXT:

- *Unbundling:* submission of a global CPT/HCPCS code along with other CPT/HCPCS codes that are considered included in the global code billed
- *Multiple Surgical Reductions:* submission of multiple surgical procedures performed on the same day during the same operative session, which requires price reduction of secondary procedures
- *Global Surgical Period:* addresses the payment/nonpayment of evaluation and management services billed during the global surgical period of another procedure.

**Fraud, Waste, and Abuse.** Centene has also entered into a strategic partnership with Verisk’s HealthCare Insight (HCI) subsidiary to further evaluate claims to detect clinical coding errors, inaccuracies, and potentially fraudulent behaviors in billing. Through HCI’s Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, LHC will be able to provide DHH with an additional screening of clinical billing discrepancies and proactive fraud, waste, and abuse detection/prevention services, without disrupting claims turnaround time. See **Figure Q.1.B: Proactive Identification of Potentially Fraudulent, Wasteful, or Abusive (FWA)**, for a diagram that illustrates this process.

Figure Q.1.B. Proactive Identification of Potentially Fraudulent, Wasteful, or Abusive (FWA) Claims Process



### Claims Payment

Once claims pass through all the above edits, AMISYS Advance then processes all claims with a status of paid or denied on the next claims payable cycle. AMISYS Advance captures the date of payment and the check or transaction number with the claim. The payable cycle determines claims timeliness penalties, if applicable, and applies interest payments in accordance with DHH rules (again, if applicable). At the provider's option, a check will be mailed along with an Explanation of Payment (EOP) or they will receive an Electronic Funds Transfer (EFT) into the provider's designated bank and a remittance advice. EOPs also will be available on our secure Provider Portal and we will offer providers the option of receiving the HIPAA 835 Electronic Remittance Advice (ERA) in lieu of paper EOPs. Our EOPs and ERAs are customizable by health plan and we will review the design of the EOP with DHH prior to go-live implementation. Please see **Figure Q.1.C. Example Explanation of Payment (EOP)** below for an LHC sample EOP, citing how the EOP meets RFP requirements.

If a claim is denied for any reason, the provider will still receive an EOP (or ERA) with an explanation of denial and resubmission address, if applicable. The EOP or ERA clearly outlines for the provider the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable.

LHC will process claims payment, with corresponding EOP (or ERA) production for providers *twice weekly*. This frequent payment processing further enhances our ability to notify providers of any issues with their claims within five business days, and allows us to decrease aged claims in our system, but most importantly demonstrates our desire to serve our providers with timely claims resolution and prompt payment.

Fee Schedule Changes. Our integrated Centelligence™ Negotiator system allows us to systematically and quickly implement complex changes in fee schedules for whatever portion of our network is impacted by those changes, enhancing our ability to apply the correct fee schedule to the correct services from the correct providers for the correct dates of service. This in turns enables us to rapidly respond to DHH or LHC mandated changes and react quickly to market conditions. For more information about Centelligence Negotiator, please see our response to R.3 and R.11.

We will also issue Explanation of Benefits (EOB) frequently to a sample of members as a further control on Medicaid fraud, waste, and abuse, per RFP requirements in Section 17.3. Please see our response to Q.2 for more information.



### Accuracy Standards

Centene’s claims accuracy performance metrics are summarized in the table below. These measurable objectives are informed by "best practices" industry benchmarks, and we regularly review these metrics to ensure they reflect the "state of the art" operationally.

	Acceptable	Good	Excellent
Processing Accuracy	90%	95%	98%
Payment Accuracy	95%	97%	99%
Financial Accuracy	99%	99%	99%

Centene has multiple processes in place to measure, audit, and improve our claims processing accuracy. Please see our response to Q.2, Claims Payment Accuracy, for a detailed description of these processes.

### Timeliness Standards

Our clean claims turnaround time (TAT) standards for electronic (EDI) claims are 95% clean EDI claims paid or denied within 15 business days, and 99% clean EDI claims paid or denied within 30 calendar days. We acknowledge DHH requirement of 90% of all clean claims to be paid in 15 days and 99% paid in 30 days.

We are confident that we will meet and exceed DHH requirements for claims processing and have met Louisiana’s timeliness standards in three of our largest markets: Texas, Indiana, and Georgia. In these markets we cover similar populations as those served by the CCN-P Program (TANF, CHIP, and ABD members), with a preponderance of children; with similar claims processing needs and requirements related to timeliness, COB, and TPL requirements; support for paper claims and electronic claims processing; and very similar requirements related to encounter processing and submission.

The chart below depicts our cumulative claims processing turn-around times for the past 15 months (since beginning of 2010).

Health Plan	Turn-Around Times	
	15 days	30 days
Superior Health Plan Texas	94.90%	99.20%
Peach State Health Plan Georgia	97.10%	99.60%
Managed Health Services Indiana	93.30%	99.00%

Internally, Centene sets high standards for all operations and continuously strives to improve all of our business processes in service of our members, providers, and state partners. As mentioned above, our ability to receive and process claims in a quick and efficient matter is a key factor in our ability to provide excellent service.

Centene works in a culture of continuous process improvement. For example: if during the month and for any reason, performance standards are not met, we immediately initiate root cause analysis, identify the issues, and correct the technology or process to return claims processing to the expected performance.

### Monitoring Performance

Powering the information needs for our claims department is our Centelligence™ Insight system with operational reports and executive dashboards measuring Key Performance Indicators (KPI) to monitor inbound claims volumes, inventory status, and submission patterns, among other operational metrics. Centelligence™ supports operational monitoring and reporting needs for our entire claims function including our Centene corporate staff and LHC local Claims Liaison, Compliance Officer, and Centene's independent Internal Audit Department. For more information on our monitoring and audit capability, please see our response to Q.2 and Q.3. For more information on Centelligence™, please refer to R.10.

### Addressing Claims Inquiries

LHC will provide a variety of systems-based methods through which providers can initiate a claims inquiry, including online or via telephone. These methods include the following:

**LHC's Provider Portal.** Our Provider Portal allows providers to view claims status and payment information online. Please see our responses to G.12, R.11 and R.15 for more information on our Provider Portal.

**Provider Relationship Management (PRM) System.** Our Provider Services Representatives (PSR), located in Baton Rouge, will be able to offer assistance to providers who call our Call Center with claims inquiries, claims submission (paper and EDI) processes, and timely claims resolution using our **PRM** system. PRM is our next generation *provider services inquiry and provider data management* application, powered by Microsoft Dynamics contact relationship management (CRM) software; our **Portico** enterprise provider data management system; our Emptoris enterprise contracting system; and our **Interactive Voice Response System (IVR)**, with voice activated IVR that will allow providers access 24/7 to information such as member eligibility and claim status, including paid date and amount. PRM is integrated with our Provider Portal, AMISYS Advance, our MACESS document image management system, and our AWD system. PRM contains all the information a PSR needs to answer most provider claim inquiries and allows the PSR to document the nature of the call and the resolution. We use the reporting feature of PRM to analyze the reason for provider calls and use this information to identify training and awareness opportunities. Please see G.14 for more information about our provider services function, as well as our responses to Q.3 and R.13.

**Provider Claims Disputes.** All Centene health plans have a claims dispute procedure in place and LHC will submit our claims dispute process, policies, and procedures to DHH for approval within 30 days of contract award. Typically the first request to adjust a claim is considered a *claim adjustment*. Claims Adjusters (CAs) will process, track, and resolve the provider's claim issue within DHH approved timeframes and requirements. If the provider is not satisfied with the findings, the provider may then appeal the decision. LHC will notify providers of our delivery/ mailing address for the receipt of claims disputes and/or appeals through the provider contract, during our provider orientation, on the Provider Portal, in the LHC Provider Manual (available on the Provider Portal), and on remittance advices (EOPs). When a claim for payment is denied in whole or in part, LHC will notify the provider in writing on the EOP of the right to file a claims dispute. Claims disputes from non-contracted providers will be handled in the same manner as those from contracted providers. All documentation received during the claims dispute resolution process will be date stamped upon receipt by the mail room staff, scanned, and routed for resolution by the CAs. LHC has the ability for us to capture all decisions around the dispute, as well as related documentation, within our PRM system.

### **Record Keeping**

Member, provider, and claim information is available for each claim, as well as real-time history of the actions taken on the claim. Whether the claim is pending, paid, or denied, AMISYS Advance assigns a transaction date and a code indicating the reason for any action taken. Centene and appropriate LHC personnel can view all of this information online. All claims loaded into AMISYS are maintained at the claim and line detail level. Once adjudicated, the AMISYS claim record is translated into a HIPAA compliant 837 format for encounter processing by our MDE XPress Encounter Pro system and submission as a clean encounter to our state clients. Please see our response to R.2 and R.5 for details on encounter processing.

### **Subcontractor Claims Processing Functions**

LHC will delegate claims payment operations for vision claims to OptiCare Managed Vision® (OptiCare), LHC's affiliated vision benefits subsidiary and subcontractor. Opticare will receive claims directly from providers and process them through their own internal proprietary systems in adherence to all DHH requirements, and according to the appropriate Louisiana Medicaid fee schedule or contractual rate. Opticare will provide LHC with claim encounter files and monthly operational claim reports, which will be reviewed as part of the LHC delegation oversight function.

Question Q.2  
Claims Payment Accuracy

Q.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:

- The process for auditing a sample of claims as described in Key Claims Management Standards Section;
- The sampling methodology itself;
- Documentation of the results of these audits; and
- The processes for implementing any necessary corrective actions resulting from an audit.

### **Complementary Audit Methodologies from Multiple Perspectives**

Centene Corporation (Centene) and Louisiana Healthcare Connections (LHC) will employ a number of *complementary* audit methodologies, conducted by our:

- Internal Audit and Compliance (IA&C) department: targeted specifically at financial and administrative claims processing and payment accuracy
- Claims Department: focused on continuous improvements in claim processor staff performance
- External Auditors: to ensure claim processing and payment controls are appropriate, effectively implemented, and compliant with best practices (via SAS/70 Type II auditing) and with Sarbanes Oxley (SOX) Section 404 Management Control regulations.

These methodologies ensure that limited Louisiana and federal Medicaid and CHIP matching funds are appropriately and accurately applied toward the health care of Coordinated Care Network Prepaid (CCN-P) members. In addition, we view our claim audit activities not only as a compliance and monitoring exercise, but also as an *opportunity* to identify system, staff, provider, or systemic process improvements, and to act on these opportunities to enhance payment accuracy and ensure all funds are targeted for appropriate member care.

### **Oversight and Audit**

**Overview.** Quality is monitored rigorously by Centene’s Internal Audit and Compliance (IA&C) Department, who reports directly to the CEO and Audit Committee of the Board of Directors (a reporting structure organizationally *independent* of the Claims Department). The Claims Audit Program reviews the accuracy of claims payment performance before and *after* claims have been adjudicated and paid. IA&C audits encompass all aspects of claim entry, adjudication, enrollment, benefit and payment determinations, *including* all attributes mentioned in section 17.5.3.2 of the Request for Proposal. IA&C reports audit *results* directly to the CEO and Audit Committee of the Board of Directors as well as to the Claims Management Team, and to applicable local plan and state clients – as we will for LHC Senior Management and DHH.

In addition to the *Standard Monthly Audits* conducted by IA&C, internal Claims Department Quality Review Analysts (QRA) conduct *Staff Audits* to evaluate the performance of all staff involved in claims processing *before and after* claims are paid, and staff adherence to job specific guidelines. As a best practice, LHC will further supplement the IA&C and QRA staff audits with a local claims expert, our *LHC Claims Liaison*, who will work closely with DHH to thoroughly understand and implement all DHH requirements. The combined team of the QRA, the IA&C staff and the LHC Claims Liaison will conduct *Targeted Audits* to evaluate specific areas, such as claims paid with high financial impacts, high rates of denials for individual Claim Processors and key provider claims review.

All our audit teams use supporting information from AMISYS Advance, our core claims processing system and related, integrated systems to evaluate claims processes and produce audit reports. Our management team uses these reports to *monitor* and, in conjunction with QRAs and IA&C staff, take appropriate corrective *action*, if needed. Finally, Centene’s external auditors conduct *SOX* and *SAS/70*

**Type II Audits** to validate the effectiveness of internal claims controls. We continue to receive unqualified opinions from these audits.

**IA&C Standard Monthly Audit.** Independent from the claims department, IA&C staff will perform a comprehensive audit monthly of a statistically valid sample of all processed claims; including paid, denied, appealed and adjusted claims. This statistically valid sample size is informed by industry experts such as KPMG, and Ik-Whan Kwon, Ph.D (author of *Statistical Decision Theory with Applications to Business and Economics – Bayesian Approach*) and in literature, such as in *Essentials of Managed Health Care Fifth Edition* by Peter R. Kongstvedt, and provides a 99% confidence level with a quarterly average precision of +/- 2.5%

**Sampling Methodology.** For every weekly payment cycle, an AMISYS Advance utility will produce a standard file extract with records of all LHC finalized claims (paid, appealed, denied and adjusted claims), through the applicable check payment date in order to capture the most recent claims processed. A second, automated software utility will then randomly select claims from this extract. The resulting claims selection will be audited by IA&C on a monthly basis for the attributes described below.

**Financially Stratified Claims Audit.** In addition to the above *Standard Monthly Audit* IA&C performs, IA&C will *also* perform a monthly audit on an annual minimum of 250 claims, submitted over the course of a year, according to DHH requirements in Section 17.5.3.1. On a monthly basis, we will produce another file extract with all finalized claims processed through to final status (paid/denied) upon initial submission. The claims will be stratified into quartiles to help isolate different systemic factors that might arise in an audit. For example, higher dollar claims are processed by more experienced staff, and are generally more complex in terms of coding and general claim type. Any issues with a claim in a higher quartile range are generally different from those in lower quartiles. From each quartile, the randomizing utility described above will be used to select six claims from each quartile, for a total of 24 claims per month (a total of 288 claims per year). These claims will be audited for the same criteria used for IA&C's Standard Monthly Audit, described below.

**Attributes Audited by IA&C.** Claims will be audited for procedural and financial accuracy as well as compliance to contract obligations. The IA&C audit will include all the attributes in section 17.5.3.2 listed below. Claim dollars in the audit sample will be traced to the *specific* underlying provider contract or fee schedule. When an error is found, the specific error reason and if applicable, dollar amount incorrectly processed, will be documented. These errors will be communicated back to the responsible department (i.e. Claims, Health Plan or Configuration teams) and through the IA&C tracking process. IA&C will track the error through final resolution, documenting the reason for the error and the solution that was implemented to correct the error.

For LHC, when reviewing the claims sample, IA&C staff will review at minimum the following (as IA&C does for our existing plans today):

- Claims were accurately data-entered into the system, including diagnosis, charges, provider, claimant, and procedure codes (*claim data entered correctly*)
- Benefits were paid to the correct party (*claim associated with correct provider*)
- Authorizations were on file for all claims, when appropriate (*proper authorization obtained for service*)
- The claimant was eligible for benefits at the time the services were provided (*member eligibility correctly applied*)
- Contracted providers were paid in accordance with contractual rates (*allowed payment agrees with contracted rate*)
- Non-contracted providers were paid in accordance with Medicaid rates and DHH requirements (*in accordance with requirement 9.3 Reimbursement to non-contracted providers.*)

- Duplicate claim submissions were identified and denied (*duplicate payment of the same claim has not occurred*)
- Claims were processed in accordance with utilization review/case management decisions made about those services and if the reason for payment was applied appropriately (*denial reason applied appropriately*)
- Non-covered services were appropriately identified and denied, and the reason for payment was applied appropriately (*denial reason applied appropriately*)
- Other insurance was investigated for coordination of benefits, and when appropriate, liability was reduced (*Co-payment application considered and applied*)
- The processed claim was supported by adequate documentation
- Effect of modifier codes correctly were applied
- Proper coding was consistent with provider credentials.

**Claims Staff Audits.** Although frequency, function, and methods of individual staff audits differ along each step in the claims life cycle, our approach to staff audits will focus on determining if staff have successfully completed applicable training; know the performance benchmarks for their position and the role audit plays in performance achievements; understand their job function; and know how their job as Claims Processor impacts the entire claim life cycle.

QRAs are Claims Subject Matter Experts (SME's) with extensive claims administration experience, and many have held operational positions in the functional areas they now audit. The QRA staff audit each processor with a frequency and sample size appropriate to that processor's experience level and recent quality performance, with no less than 25 claims audited per processor, per month. QRAs randomly select claims for audit using AMISYS Advance and a Data Analysis Tool, configured with processor specific thresholds. QRAs review all processor adjudication actions to confirm whether they adhere to Centene policies and procedures, and whether the processor is correctly using and maximizing the use of workflow tools. When the QRA completes the audit report, they and/or the processor's supervisor meet with the processor to discuss audit results and review each error in depth to determine if additional training is required. If necessary, the QRA or supervisor may implement a follow up, targeted audit to confirm whether the processor has a clear understanding of the proper handling of the erred claim situation.

**Accuracy Audit Results:** The chart below provides Claims Department internal accuracy performance benchmarks. Over the most recent rolling 12 month reporting period (through 03/31/2011), Centene Claims Processors maintained *excellent* performance achieving 99.1% payment accuracy, and 99.3% financial accuracy against benchmarks.

*Industry standards for claim quality are based on Essentials of Managed Health Care*

	Acceptable	Good	Excellent
Payment Accuracy	95%	97%	99%
Financial Accuracy	99%	99%	99%

QRAs also regularly review all Mail Production Specialists (MPS) tasks to confirm the accuracy of the claim form sort and preparation for scanning into our MACESS Formworks imaging and optical character recognition (OCR) system. This includes: *Scanning* – to confirm the accuracy of the MPS' image capture and reimaging procedures, if applicable; and *Claim Data Capture* – to confirm the accuracy of OCR interpretation and entry ("vertexing"), or data entry for Key From Image (KFI) paper claims (for claims that cannot be processed by OCR).

**Targeted Audits.** QRAs conduct *targeted audits* to confirm that a processor understands a specific process. For example, should a processor's production reflect a high rate of claim denials, the QRA may conduct an audit to confirm the appropriateness and accuracy of their actions. QRAs also conduct high dollar threshold audits of professional claims in excess of \$5,000 and facility claims in excess of \$10,000 on a *daily basis* to review any high dollar payments prior to the check cycle.

The Claims Team uses pricing and benefit audit tools to review paid and denied claims for accuracy. If the Claims Team detects a claim error, the claim will be suspended and the correct outcome noted and communicated to the Claims Department, who manually reprocesses these flagged claims. Finally, LHC's local claims staff will conduct an audit of each check cycle before granting final approval to Centene for payment release. This review targets areas of *contractual compliance* rather than processing accuracy.

**External Audits.** In addition to our internal audit functions, annually Centene undergoes regular external audits, and completed the following reviews in 2010:

**SOX Management Report on Internal Controls over Financial Reporting.** Centene's management is responsible for establishing and maintaining adequate internal controls over financial reporting and supporting MIS controls, including those related to security. Each year, management conducts evaluations of the effectiveness of internal controls over financial reporting according to Sarbanes-Oxley Section 404 (SOX) regulations. Our Internal Audit Department and Ernst & Young, LLP conducted our most recent audit of these controls for the period ending December 31, 2010, and concluded that Centene's internal controls over financial reporting were effective. Centene's assessment of the effectiveness of internal controls for the period ending December 31, 2010 was audited by KPMG, LLP, another public accounting firm. *No significant deficiencies or material weaknesses were identified.*

**SAS 70 Type II.** KPMG, LLP performs this annual audit for Centene to test the design of controls over Claims Processing and Datacenter Operations and the operating effectiveness of such controls, including those related to MIS availability, security and data integrity. In its most recent SAS 70 Type II audit (2010), *Centene received an unqualified opinion from KPMG, LLP* (that is: KPMG did not discover any material adverse findings).

**HIPAA Audit.** In 2010, Centene engaged Ernst & Young for our annual IT HIPAA risk profile to ensure that we had identified appropriate risks (including those related to claims processing) along with potential severity, likelihood of occurrence, and impact. Ernst & Young reported no material findings in that audit.

**Implementation Audits.** In addition to the package of routine audits that are conducted as described above, the Configuration Quality Team audits the quality of benefit, authorization and pricing configuration, and Configuration Quality Review Analysts audit 100% of all configuration for new business for accuracy of configuration. If an audit issue arises, it is documented and a change request is initiated to remedy the problem. Additionally, IA&C performs a 100% audit of all new business configuration against current state statutes and regulations. IA&C along with Configuration, Claims and Contract Implementation Teams hold daily tag meetings to ensure that all parties stay synchronized in terms of ensuring the quality of claims payment to providers.

**Member Engagement.** LHV and Centene will engage members to help identify cases where billed services may not have been performed, or may have been improperly billed. Monthly, we will use our Centelligence™ platform to identify up to 1% of members for whom a claim was paid in the previous 45 day period for follow up. These claims will be selected by one of three methods:

- A targeted selection based on unusual patterns of care (e.g. rare, high-cost services or neighbors receiving the same service on the same day)
- A random selection of claims from high-abuse categories (e.g. DME, radiology)
- A broad random sample across all claims for statistical sampling.

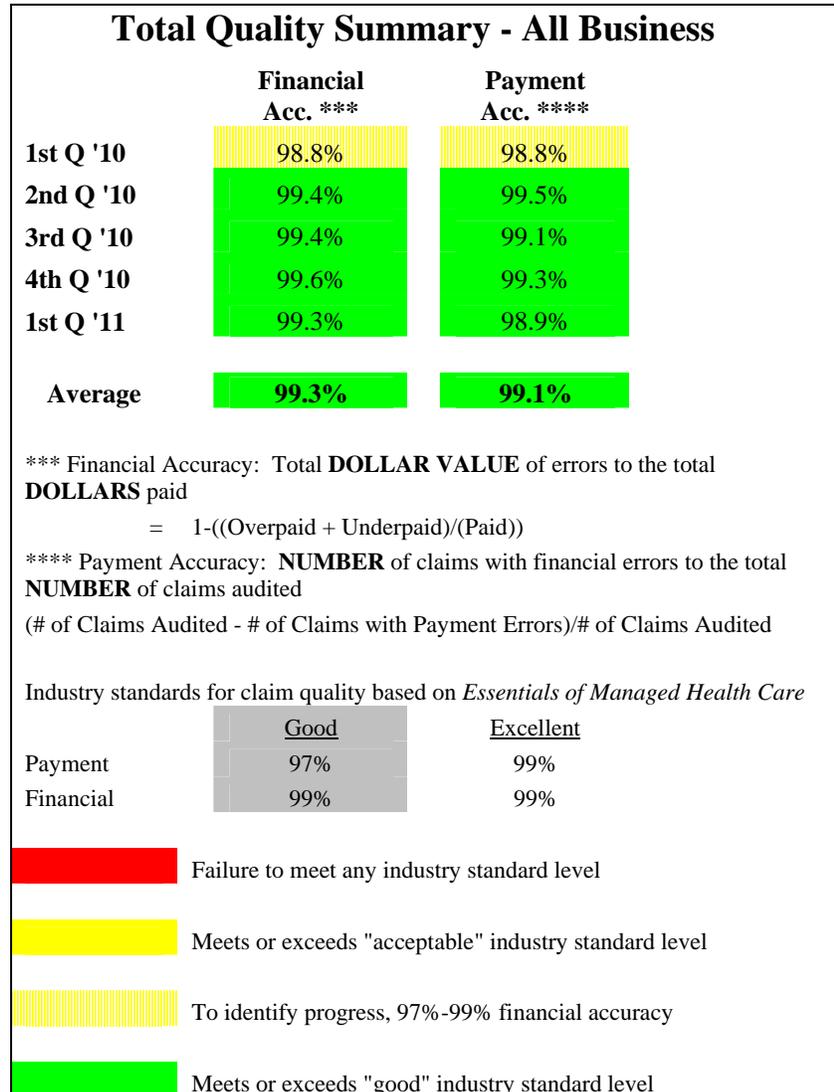
Member Services staff will then follow up with members. The EOB will request that the member validate the services on the sheet, and send back a signed affidavit that the services were rendered as described. Otherwise, the member may indicate services that they question, either calling the LHC Member Call Center, or sending in a note on the prepaid response envelope enclosed for that purpose.

### **Reporting Results of Testing**

As mentioned above, all our Audit Teams produce reports using the Claims Audit Report Database and supporting information from AMISYS Advance and related systems and will work with DHH to define a

suitable format for these reports. This report would also include number of claims audited, number of errors including the individual results for each attribute tested, and the dollars of overpayment or underpayment associated with those errors. Below is a sample report we use for other health plans.

**Figure Q.2-A Sample Report - Accuracy Statistics**



**Correction Methods**

**Education and Retraining.** Claims processing issues related to claims staff performance or provider billing errors are typically remediated through education and retraining. QRAs or IA&C communicate all staff deficiencies to the immediate Supervisor who establishes a retraining plan. Upon completion of training, the QRA or Supervisor may implement a targeted audit to confirm that additional training or action is not warranted. QRAs will communicate all provider billing problems to LHC’s Provider Services Department where outreach and education can be arranged and conducted by their Provider Relations Specialist. Please see our response to question Q.3 for more information on claims training processes to ensure DHH requirements are met.

**Change Request (CR).** If an audit finds that the error is due to configuration, our LHC Claims Liaison and our Configuration team will review the logic causing the error to determine where the issue lies and will put in a CR to have the configuration changed accordingly. All CRs go through testing, validation that the correct outcome was achieved, and User Acceptance Testing, and are then promoted to production when these steps are completed.

**Process Modification.** Upon identification of a potential systemic process deficiency, our QRA or IA&C staff notify Centene's Process Quality Department, who will employ tools such as Lean Six Sigma to determine root cause. Through analysis and cross-functional dialogue with all affected departments, this team evaluates and recommends process improvement plans.

#### **Provider Specific Monitoring and Audits**

Centene and LHC are committed to ensuring that providers have the tools and support systems in place to ensure claim timeliness, accuracy, and completeness of data submitted. We conduct a number of claim audits on submitted claims and, where necessary, root cause analyses to identify system or coding problems, and initiate outreach and education to targeted provider billing staff to provide guidance and instruction as necessary. For LHC, this outreach will be conducted in person, via email or telephonically. Our LHC Claims Liaison and Provider Claims Educator (LHC Claims Team) will also attend large group orientations, training sessions and workshops to provide the claims expertise necessary to respond to specific questions raised by providers and their billing staff.

Outlined below are several of the monitoring and audit activities that will be conducted by or in conjunction with LHC Claims Team. These are best practices gleaned from our experience with our affiliate Medicaid/CHIP managed health plans:

**Quarterly Key Provider Claim Reviews.** The local LHC Claims Liaison will review the top twenty claim submitting providers or *key provider group* claims quarterly and provide scoreboard results to LHC's Contracting and Network staff. LHC's Provider Relations staff will also evaluate top denials and intervene with providers if billing patterns reveal potential errors.

**EDI Claims Submission Analysis.** In conjunction with Centene's Electronic Data Interchange (EDI) Help Desk, the local LHC Claims Team will collaborate to identify and educate providers who submit paper claims and attempt to encourage electronic submissions via our Provider Portal or EDI clearinghouses. Please refer to R.13 for more information on our efforts to encourage the use of EDI and Electronic Fund Transfer (EFT) by our providers.

**90 day Implementation Claim Audits.** We will conduct claim audits for 90 days for all new providers to assist in identifying any configuration or billing issues. Early outreach and education promotes good relationships with providers and fosters long standing business relationships.

**Program Modification Audits.** With the introduction of any program changes, such as a change in state reimbursement rates, our LHC Claims Team will review claim outcomes to ensure complete compliance with state, federal and DHH compliance requirements. Even before those changes are put into effect, Centene and LHC Finance Team uses Centelligence™ Negotiator system to simulate the impact of rate changes, in terms of which providers are impacted by the change and the overall likely effect on provider payments based on historical claims history. We can then implement those rate changes automatically in our AMISYS Advance claims processing system; allowing us to deploy rate changes smoothly, quickly - and accurately. Please refer to Section R.10 for more information.

**Claims Xten® Reviews.** The LHC claims team will review the results of the Claims Xten® edits to determine if a provider is consistently billing with unbundled, incidental or retired codes. If identified, the Provider Claims Educator will outreach to and educate the provider's office. See section Q.1 for a more detailed discussion on Claims Xten process.

**Addressing Provider Non Compliance.** Our routine audit activities allow for the early identification of possible billing or coding issues. When issues are identified, LHC staff will work with providers to

educate them via new provider orientations; phone calls to the provider's office; and during onsite visits. If trend analysis identifies a provider who is failing to adhere to billing and coding requirements, the Provider Services Representative or local Claims Team member will refer their findings to LHC's Provider Network Team for further action. A Provider Relations Specialist from the Provider Network Team will immediately contact the provider, provide education on contractual requirements and administrative requirements, and offer the local LHC Claims Team, our EDI specialists or other relevant department to conduct retraining in person if necessary. The LHC staff will document all activities and trend follow up behaviors to determine if issues have been corrected. For continued billing or coding issues, the Provider Network Team may refer the provider to the Credentialing Committee and Clinical and Service Quality Improvement Committee (CASQIC) for consideration of additional action, including sanctions and possible consideration of continued network status.

Should any LHC staff member suspect a provider of potentially fraudulent billing, they will immediately engage Centene's Billing, Errors, Abuse, and Fraud (BEAF) department who provides oversight and guidance for the prevention, detection, and resolution of billing misconduct including inappropriate billing and coding.

**Subcontractor Audits.** OptiCare Managed Vision® (OptiCare), LHC's affiliated vision benefits subcontractor, employs a claims payment accuracy audit process that is independent of the claims payment function. LHC will submit a claims payment accuracy percentage report as stipulated in the Request for Proposal (RFP) for Opticare, using a similar methodology, as described above.

Question Q.3  
Meeting Claims Processing  
Requirements

Q.3 Describe your methodology for ensuring that the requirement for claims processing, including adherence to all service authorization procedures, are met.

Centene Corporation (Centene) and Louisiana Healthcare Connections (LHC) will provide local and enterprise level, claims processing expertise to ensure the successful implementation and ongoing operation of all claims processing functions for the Louisiana Medicaid Coordinated Care Network-Prepaid (CCN-P) Program. Centene brings 27 years of claims processing experience for full-risk Medicaid managed care and the results of ongoing process improvements from operating our 11 health plans, including the recent implementations of our Magnolia Health Plan in Mississippi and our coordinated care plan for older adults and persons with disabilities, IlliniCare, in Illinois.

Under the guidance of our Enterprise Business Implementation (EBI) team, we will follow our implementation model, leveraging the workflow, tools, and templates, as well as control methods we have developed and refined to ensure that we exceed the requirements of DHH for claims processing and service authorization. Centene's EBI approach, with its suite of tools and processes, allows Centene to implement new products and new health plans that are operationally excellent on day one. Please also reference our response in Section Q.1 Claims Management Capabilities and Q.2 Claims Accuracy and Audit. Both responses include additional information about how we will ensure our ongoing ability to meet and exceed the requirements of DHH.

Overall, there are three general factors that we bring together for ensuring that we meet claims processing requirements:

- **People** – LHC will have a *dedicated* claims processing and system configuration **implementation team** focused strictly on the successful implementation of LHC's claims processing function until pre-established goals are met operationally; for example, claims turn-around time (TAT) requirements are met, payment accuracy is at a consistently high level, and EDI receipt rate is near or at our goal of 85%. After these goals are achieved, the claims configuration functions will smoothly transition to our corporate configuration team and claims processing operations will move to an LHC dedicated claims operations team in our Claims Department based in Farmington, MO. In addition to the dedicated claims and configuration implementation team, a designated Contract Implementation Manager (CIM) will be assigned to the team who is specifically tasked to ensure that the requirements for DHH are understood and implemented correctly. We also see DHH as a critical member of our team and look forward to establishing a strong working relationship with DHH as a partner in our effort to achieve continuous quality improvement.
- **Processes**– Centene uses a health plan implementation project management approach called the **Enterprise Business Implementation (EBI) Model**. The EBI Model uses reliable business principles; a proven set of tools and techniques; defined levels of authority; and carefully defined procedures and methodologies that will assist the implementation team in launching LHC from initiation, through deployment, to full health plan operations. EBI has established standards for, and delivers excellence around, how projects are organized including the highly integrated component of claims processing. The EBI tools and pre-populated templates will give the claims and configuration implementation team a jump-start on the implementation process. The use of the tools and templates allow for rapid customization that is needed for Medicaid managed care products, all of which have both programmatic differences and operational nuances that must be accounted for and implemented.
- **Technology** - Our integrated software applications are functionally rich and our skilled business analysts and Information Technology (IT) professionals are able to configure our system components to meet the specific rules and processing needs of each of our state partners, such as DHH. Our *HIPAA EDI infrastructure*, our integrated front-end eligibility and claims processing systems (**Member Relationship Management (MRM)** and **AMISYS Advance**); our claims pend workflow system **Automated Work Distributor (AWD)**; our clinical case management system (*TruCare*); our Centelligence™ Negotiator automated provider fee schedule configurator; and our secure **Provider Web Portal**, utilized in claims processing functions, are also tightly integrated via underlying

standards based transactions and file interfaces, which largely automates our claims processing functions and allowing us to exceed industry standards.

We deploy these three factors: *people*, *process*, and *technology*; in two complementary phases: **Implementation Planning and Execution** and **On-going Process Monitoring and Controls** to deliver claims processing services that meet or exceed our state clients' requirements.

### **Phase I – Implementation Planning and Execution**

**Update Work Plan and Schedule.** Upon contract award, the EBI Engagement Lead will review the work plan and schedule to ensure that the activities reflect all the required work, all work is properly sequenced, the durations are reasonable for the nature of the work, and the correct people are assigned to oversee the performance of each activity. The claims and configuration functional area work plan is a component of the master EBI work plan and so will tie to that "master plan" for overall project status, time tracking, and dependency completion. Each Integrated Team Lead is responsible for tracking his or her team's progress and reporting back to the EBI Project Lead. The claims and configuration processing section has interdependencies with Information Technology teams, Clinical Management and Provider Services, and Contract Compliance. Project Analysts carefully review the work plan and work with the EBI Lead to ensure the plan includes all the necessary cross functional steps and will make the appropriate changes to the work plan as needed. Project Analysts will also define the critical success factors and timeline to ensure that we meet the requirements of DHH for readiness and go-live. The work plan will be posted and maintained on a shared LHC project site.

**Assign Resources.** In addition to the dedicated claims and configuration implementation team described above, the implementation team works closely with the following teams throughout the implementation: Provider Network Management, Medical Management (for clinical authorization requirements), Finance, Internal Audit, and our Compliance Department. All teams are supported by the Information Technology team. Led by a dedicated IT Implementation Project Lead, each functional area within IT will also have a functional team lead including our Electronic Data Interchange (EDI) team; our MRM team for enrollment and eligibility processing; our AMISYS Advance team for claims processing set-up; our Provider Relationship Management team and our Medical Management Team. After contract award, we will assign specific people to serve as the functional lead for each of the above areas. We will also have project contacts at OptiCare Managed Vision® (OptiCare), our affiliated vision subcontractor, and at HealthCare Insight (HCI) our strategic partner for claims fraud, waste, and abuse detection. Both of these relationships are well established and we will leverage the existing technology interfaces and working relationships that we have built for our other state contracts, in service to DHH.

**The Initiate Phase of Claims Processing and Operations - Capture and Document Business Requirements.** We utilize a Business Requirements and Solutions Approach (BRSA) standard template to capture and document business requirements. This method of capturing and documenting requirements and business processes has proven to be very successful for our previous implementations and we will apply this same methodology, templates, and prior experience with DHH in support of our implementation of the CCN-P Program. Each Integrated Lead creates BRSA documents with assistance from the functional analysts and other stakeholders to document requirements and tailor those requirements as mandated by DHH. The BRSA also includes a dependency section, which identifies links across other functional areas. These BRSA documents are then used to conduct functional and cross-functional walk-through with all functional areas to confirm accuracy of dependencies upstream from, and downstream to, other processes. The BRSA is broken down into the following components:

#### ***Business Requirements.***

- Identify critical success factors.
- Identify performance requirements, such as TAT, EDI goals, etc.
- Identify business and operational process and system dependencies, if different than standard.
- Develop high-level use case/ test scenarios supporting documentation.

- Identify potential training needs.
- Identify key terminology.

**Solutions Approach.** The Solutions Approach is created along with the business requirements and includes specific information about how those requirements will be achieved. It describes the behavior of the system as seen by an external observer and contains the necessary technical and business processes.

- Define “how” the Business Requirements will be supported.
- Provide overview of processes/flows/ architecture, e.g. for claims workflow management.
- Identify detailed IT requirements/configuration, authorizations, benefits grid, etc.
- Identify dependencies, including downstream dependencies.
- Identify assumptions/risks.
- Identify training needs.
- Identify and define key terminology.

Exit criteria for each stage in the process provide a control for project milestone completion. Exit criteria are statements to confirm if the required tasks and steps were satisfactorily completed; the required deliverables completed, reviewed, and received sign-off before the stage is considered complete; and ready for transition. Completing the transition and acceptance of transitioned deliverables becomes the entry criteria for the next stage of work. Careful review of the exit criteria helps ensure that the appropriate requirements are being met. Special attention is paid to each functional area, with particular emphasis on service authorization and claims processing, due to these processes’ financial impact, and impact to our members and providers.

**Designing The Solution To Meet DHH Requirements.** Technical configuration design documents are developed by the IT Systems and Business Analysts to identify how the applications will meet business requirements contained in the BRSA. These include the detailed specifications, or Configuration Requests (CR), and authorization grid needed to configure our core claims processing system, AMISYS Advance. Several project stakeholders and subject matter experts review the technical design to validate against the requested functionality. The document is then finalized after the design walk through (similar to the BRSA walk through) and is signed-off by senior management in each functional area.

**Configuration of DHH Specific Rules and Edits.** Once the design documents have been completed, each of the following systems will be configured for the specific requirements of DHH and the CCN-P Program:

**Electronic Data Interchange.** The focus of the EDI Inbound Claims effort is to configure our EDI Translation software, which includes EDIFECS and TIBCO BusinessWorks. These integrated systems allow us to accept and process the HIPAA 837 Professional (837P) and HIPAA 837 Institutional (837I) files quickly and accurately; achieve the highest level of HIPAA 5010 compliance for handling of electronic claim transactions; and ensure file transfer protocols are secure, protecting the privacy and integrity of claims data. The tasks listed below allow us to implement a full cycle electronic claim process, which includes:

- Our receipt of the HIPAA 5010 837P or 837I
- Acknowledging the claim receipt back to the submitter with an ANSI 999 (the HIPAA 5010 functional acknowledgement)
- Sending a HIPAA 5010 277U (unsolicited claim status response) back to the provider with initial claim status. If a provider or trading partner is unable to receive a 277u, we also supply a proprietary audit file on the status of the claim as it was received.
- Completing the full cycle by issuing a HIPAA 5010 835 with remittance information.

Each of the functions below is prioritized and managed by an EDI Lead who has overall responsibility of ensuring the execution of these functions. The scope of this team’s focused effort includes:

- Configuration of our HIPAA EDI infrastructure, including our EDIFECS and TIBCO Business Works applications for HIPAA 5010 compliance and for all DHH pre-adjudication edits to ensure the

integrity of data. For more information on these edits, please reference Section Q.1. For more information on our EDI infrastructure, please see our response to Section R.2 and R.5.

- Configuration of our EDIFECs Ramp Manager Trading Partner EDI on-boarding system for the specific business rules of DHH and LHC
- Web Portal configuration for medical claims submissions/claims inquiry, including rules for HIPAA 837 I and 837 P templates, as well as batch file submission and error messages
- Transformation of paper and EDI claims data into standardized format for loading into AMISYS Advance
- Creating the directory structure for file transfers
- Ensuring processing schedules are configured according to the requirements of LHC and DHH
- Ensuring our Optical Character Recognition software is configured for the specific needs of DHH and LHC
- Creating EDI response messages
- Creating our Internal Provider Audit Report and 999 Response report and 277u Claim Status
- Configuring Electronic Claim Adjustments for LHC
- Modifying our EDI 837 Companion Guides specifically for LHC and DHH requirements
- Configuration of our HIPAA 837 Claims Data Repository
- Configuration of IVR Claims Inquiry Response

The EDI team is also tasked with setting up clearinghouses for claims transfers including:

- Clearinghouse selection
- Trading Partner Agreement (Payor ID defined, etc.)
- Creating HIPAA 837 I and P Companion Guides
- Modifying EDI jobs to include LHC EDI reports
- Testing files with any new clearinghouses for connectivity, HIPAA compliance, etc.
- Ensure clearinghouse set-up is complete to send reports to providers

**Claims Processing.** Our dedicated **Claims Configuration** implementation team will focus on the activities below. They will work closely with the Contract Implementation Manager (CIM) and cross functionally with all teams involved in the claims processing function, including Provider Network Management, Medical Management, and our Finance Department. Critical to our success is our pricing summit, which we conduct early in the implementation process. This “best practice” session brings together Claims Configuration, Contracting, and our CIM to ensure that all key individuals are at the table when defining and documenting the pricing rules that must be configured in our AMISYS Advance system so that claims will be processed timely and correctly. Additionally, we work with our senior executives and, when possible, a representative from the state to facilitate the finalization of business decisions around areas of ambiguity in pricing. The Claims Configuration team remains connected through daily tag meetings and a weekly reprioritization meeting throughout the implementation and post-implementation phases. The activities for this team focus on setup of our AMISYS Advance for EDI and paper claim processing rules; setup of MACESS EXP Formworks for receipt of paper claims; and TIBCO pre-adjudication edits, as well establishing appropriate work processes for claims processors. Below are the critical path objectives:

- **Basic AMISYS Advance Set-Up:** The basic code sets, procedure code detail, age/gender edits, and other relevant information are configured as first priority. Any plan specific variances will be configured upon approval of the Integrated Lead Team, and as appropriate.
- **Creating Payclass Shells:** The objective here is to insure that pay class shells are set up and available for attachment to the providers as the contracts are received. This information is passed on to the Portico application to insure adequate and timely processes to meet provider setup needs. This step assists us in our ability to meet network adequacy needs and to produce directories.
- **Loading of Fee Schedules:** Based on the guidelines in the contract, the appropriate fee schedules will be identified by our CIM and then downloaded, formatted, and loaded into AMISYS Advance.

- **Configuration of Benefits:** LHC will have a Benefit Lead who will create a detailed benefit grid. Upon completion of the Benefit Grid, the benefits will be configured in AMISYS Advance.
- **Configuration of Authorizations:** Our Medical Management team is responsible for the detailed analysis and creation of an authorizations grid, which details the exact specifications for authorizations. Upon completion of benefit configuration and upon receipt of the authorization grid, authorizations are configured within AMISYS Advance so that in most cases, AMISYS Advance will be able to systematically match the authorization decision from TruCare with the claim.
- **AMISYS Advance Six Steps of Adjudication:** the six steps of adjudication within AMISYS Advance are configured for the specific business rules of DHH and LHC. Please refer to Section Q.1 for more information on these six steps.
- **Third Party Liability:** Compliance coding for the specific TPL rules and exceptions needed for the CCN-P Program are specifically configured for the processing rules of DHH and LHC.

***Automated Work Distributor (AWD).*** We will configure our AWD software for the specific workflow rules required by LHC, such that a claim that pends due to a Third Party Liability (TPL) issue, for example, would route to one of our claims analysts skilled in TPL processing and resolution. Likewise, in order to meet the TAT processing requirements, we will configure AWD to appropriately escalate pended claims to ensure visibility so they can be adjudicated within the required timelines.

***Claims Xten and HCI.*** These tools are delivered with industry standard claims edits based on nationally recognized guidelines, such as the National Correct Coding Initiative (CCI) for professional and outpatient services. However, we can customize the rules in our ClaimsXten software for the specific coding, reimbursement policies, and benefit criteria for the CCN Program. Finally, we will communicate any specific coding requirements to HCI for fraud, waste, and abuse detection.

***Configuration of Payment Arrangements (pay classes):*** As provider contracts are received, the Contract Implementation Manager will create payment guides, which will guide the configuration of the payment arrangements in Centelligence™ Negotiator and AMISYS Advance. Centelligence™ Negotiator (Negotiator) has both contract simulation capabilities and allows us to configure and systematically load complex contract fee schedules directly into AMISYS Advance. The simulation capabilities of Negotiator will allow our provider network professionals to refine and predict the effect of the total reimbursement schedule (including payments for direct care service, as well as care coordination activities) we develop with our NCQA or JCAHO accredited Medical Home providers, as well as our other network providers. Negotiator will help us ensure that we compensate and incent our PCMHs to deliver coordinated, quality care, without exposing Medical Home providers to unacceptable levels of risk and that, as we progress through the contract and as we track quality and coordinated care measures, we are able to refine and adjust our reimbursement strategy for ever continuing quality of care delivered. In this latter scenario, Negotiator is indispensable to our Provider Network staff - again to help us ensure that any fee changes will lead to the desired incentives.

Our ability to implement new fee schedules with Negotiator will be particularly important with the reimbursement arrangements we have with our Medical Home providers, with the emphasis on care quality and coordinated care performance. That is, as we move through the contract, we will be tracking quality and coordination measures jointly with our Medical Home providers, and we will jointly be adjusting our total reimbursement program with these providers, with approval from DHH, so it will be critical to be able to implement new and complex fee arrangements to complement our quality incentives with our providers.

***Provider Relationship Management.*** We will configure our Provider Relationship Management system for all provider related data necessary to ensure accurate claims payment, including the provider's financial affiliation(s), license status, specialty/practice type, and pay class (which includes factors that represent the provider's contractual relationship with LHC).

**TruCare.** For service authorization, LHC will utilize TruCare, our care management and utilization software system. TruCare utilizes rule-based architecture, which allows customized clinical workflow related to clinical decision support criteria, prior authorization, and medical necessity review. TruCare's interface capabilities allow it to transmit authorizations in real time to our AMISYS Advance claims subsystem, and TruCare's data granularity allows authorizations to be issued at the procedure code level, enabling the highest level of specificity for subsequent claim adjudication, and enhancing claim payment turnaround times to our providers. TruCare is integrated with McKesson's InterQual medical necessity criteria software, which gives us evidence-based criteria providing a consistent guideline to help our staff determine the medical necessity and the appropriateness of covered services requiring prior authorization. TruCare is scalable and fully customizable to exceed DHH's requirements surrounding service authorization. TruCare's customizable capabilities empower our licensed clinical staff to reduce duplicative or unnecessary services. AMISYS Advance is configured to look for service authorizations, where required, will access the authorization file to obtain the authorization number for the service, and return it to the claim entry screen. If no authorization is found, or if the authorization does not match, the system assigns a deny code. For more information please reference our response to Section Q.1 Claims Management Capabilities.

**Testing.** All configuration and coding within our systems to meet the specific needs for the CCN-P Program go through a rigorous testing and promotion process. All new configuration is first built in our development environment and is unit tested to ensure accuracy. Once unit tests pass, configuration is promoted to our testing environment for integrated testing. This vigorous testing anticipates all significant processing scenarios. Any issues are immediately communicated to our configuration and/or development team and addressed. Once any issue has been resolved, the configuration moves back to integrated testing and is fully tested again. Upon successful passage through integrated testing, the configuration moves to user acceptance testing (UAT). In UAT, the tester will review the integrated testing results and run 'real life' scenarios through the system and review the results for accuracy. Upon passage of UAT, the configuration is moved to production. Our implementation scheduled is designed so that *at least 30 days pre go-live*, the claims operations and IT staff are able to jointly test hundreds of claim scenarios using mocked up claims, existing claims from another market converted with CCN-P "like data", as well as partner with our contracted providers in the Louisiana market. We share the results of these tests with these providers to ensure our reimbursement and denials are in line with their expectations. Throughout the process, we conduct joint meetings, which include staff from the claims implementation team, contracting, configuration, and provider data management. Extensive testing and broad review of the results, even with external parties, ensures that the final outcomes of service authorization and claims processing are correct. Partnering with providers helps to build confidence in the provider community that LHS is ready to process claims correctly and timely.

**Training.** All claims staff attend rigorous training to ensure understanding of the claims process and, where necessary, these training programs will be tailored for the specific requirements of DHH. LHC will hire a local Claims Liaison and a local Provider Claims Educator who will go through our comprehensive training program. Additionally, they will have hands-on training with the implementation team as they transition the plan to full operation. See **Part II Go –live and the Implementation Transition Process** below.

LHC will be assigned a *designated* team of highly trained claims analysts located in Farmington, Missouri, who will dedicate their efforts to understanding the requirements of LHC and DHH and who will work with the implementation team and local LHC Claims Liaison to ensure all DHH requirements are understood and implemented correctly.

All claims training programs are created and refined by Centene, leveraging our experience in claims processing activities. Each training module offers a variety of approaches and techniques to address all steps of claims processing. All training programs are conducted by Claims Trainers, and are supported by solid curriculum and evaluation tools to confirm attainment of skills and quality audits. Computer-based

training, lesson plans, e-learning, work processes, exercises/assessments, and workbooks are resources in all modules.

Our training programs provide a progressive curriculum that encompasses foundational learning that transitions into advanced level training for more complex claims processing functions. In total, an advanced adjuster generally receive a minimum of 14 weeks of classroom and hands-on training designed to span all aspects of claims processing from fundamental skills to specific elements related to health plan needs. The training encompasses: a review of the AMISYS Advance application including types of claim pends and related protocols for resolution; claims adjudication modules include review of benefits, pricing, and authorization requirements; and the workflow module addresses how to access and view claim images, route claims and correspondence to other internal departments, and follow-up mechanisms. Training modules for COB/TPL equip the processor with the skills to research and coordinate benefits to ensure accuracy in payment determination. The claim adjusters' curriculum provides them with a comprehensive understanding of the claims adjustment guidelines to effectively process resubmitted claims, identify, and report trends in processing deficiencies or errors for specific processors, providers, or technologies. All participants are audited throughout the training programs and must demonstrate proficiency to graduate from the programs and begin processing or adjusting claims.

Claims Training is dedicated to ensuring all students receive a comprehensive understanding of claims processing. This is achieved by use of instructional methods and tools to provide courses that are knowledge based, quality driven, and comprehensive of analytical functions that drive quality improvement and internal customer service. Training support continues beyond the formal classroom. The Claims Training team holds scheduled learning labs allowing processors to receive individual attention in areas for improvement. This environment provides an outlet for support beyond the operation floor and training classroom. The program allows all participants to schedule lab time during designated business hours to practice lessons learned. The focus is *participant driven* involving best practices, current work processes, process bulletins, and insight into system configuration for an improved understanding of how individual claims processors impact overall operations.

*It is through our comprehensive training process we ensure that all our claims staff are knowledgeable in claims processes, that there is on-going training, and succession planning in place. It is because of this training and our highly qualified and experienced staff, in combination with our claims processing system functionality, that we can assure DHH of our ability to meet and exceed their requirements.*

**Provider Training.** In addition to staff training, we will also design our provider training strategy and tools to ensure they are well prepared to file claims according to DHH and LHC rules as quickly as possible. Please reference our response in Section Q.1 Claims Management Capabilities.

**Policies and Procedures and Compliance Monitoring.** Again, concurrent to system configuration and training, we will be reviewing our standard policies and procedures, updating these according to DHH specifications and inputting them into our **Compliance 360** system for on-going contract monitoring. Our Compliance 360 system allows our Centene and LHC compliance professionals to systematically track our adherence to our state client's contracts, via auditable workflow tools.

**Sign off during Readiness Review with DHH (at appropriate point).** During readiness reviews, we will prepare all documentation, policies, and procedures as required by DHH. Further, we will demonstrate our ability to process all claims, including those with authorizations, to the satisfaction of our internal management as well as to DHH. We anticipate that DHH will “approve” or sign-off on our efforts at the appropriate time, allowing us, with all internal approvals, to move our configuration into production.

### **Implementation Focused on Operational Excellence**

Centene and LHC are committed to achieving *full operational excellence*. As such, before go-live, a local LHC Claims Liaison will be assigned to LHC. This individual will work closely with the CIM to evaluate all claims issues as they arise. This hands-on transition with the implementation team, and on-the-job

training, ensures that the local LHC Claims Liaison will be equipped to monitor claims processes and address claims issues moving forward into full operation. The CIM and the Claims Implementation Team will continue to manage claims configuration and pricing post go-live for approximately *six to nine months*, and will work with all areas affecting claims processing, including Provider Contracting and our Medical Management team, for service authorizations to ensure swift and accurate adjudication of claims. Once assured of successful operations, the implementation team transitions work to specific operational areas of expertise; claims configuration and maintenance of Centelligence™ Negotiator and AMISYS Advance will be transitioned to the configuration department of our Claims department in Farmington, Missouri; and maintenance of provider contracts and fee schedules will be transition to the Provider Network Management operational team. Specific disengagement metrics will be established that may include the following and more:

- Claims TAT meets or exceeds the requirements of DHH.
- Submitted configuration request (CR) volumes are consistently low.
- Auto-adjudication rate is at or above 85% and EDI submission rate reaches 80%.
- Claim accuracy percentage is at minimum an acceptable level. Reference our response in Section Q.2 on claims accuracy.

Wherever possible, members of the implementation team become a part of the ongoing operations staff. If we hire new staff for our LHC implementation, where it makes sense, we will attempt to bring them into the claims implementation portion of our overall implementation project plan. Either way, we have and will modify, as necessary, our detailed transition plan and timeline to ensure that the local LHC Claims Liaison is trained and equipped to resolve claims issues and lead on-going claims processing improvement efforts.

Our claims operations and configuration team continue to partner to identify ways to prevent manual intervention and increase the auto-adjudication rate. We continually monitor this process through our end-to-end claims processing oversight to ensure quality in each step of the process. Our target goal is to have an 85% auto-adjudication rate, or higher.

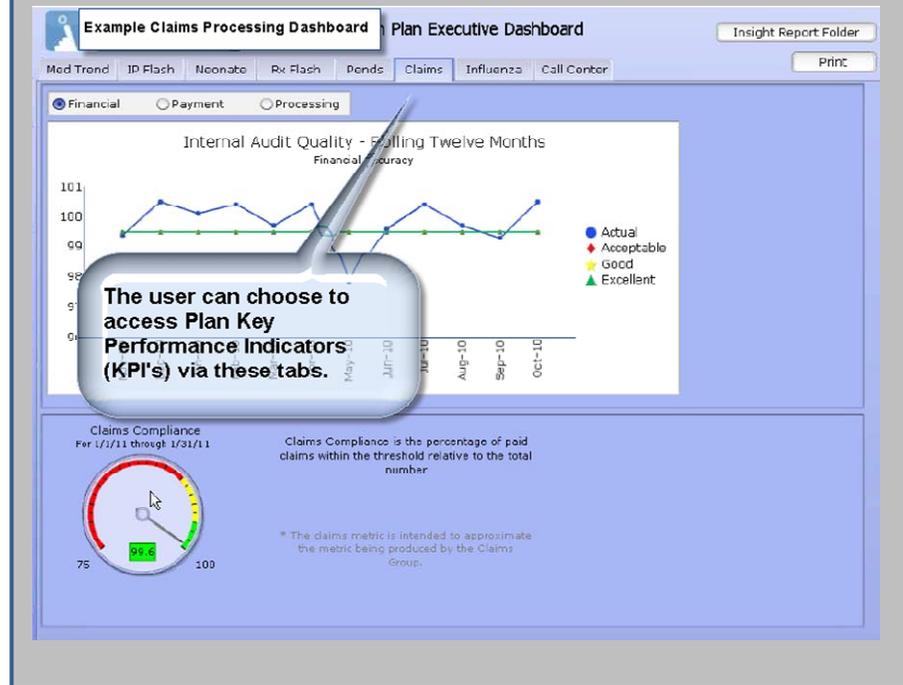
The EDI team is also engaged in the transition and monitors the receipt of claims through the EDI process and when they detect claim rejects in high volume, they bring these to the attention of the claims operations team to evaluate and address, either through a configuration change request or provider training. They also work with our trading partners to raise and address issues. In addition, they support our Encounters team, who identify areas where we can move edits required by DHH for encounters to the front end of the process, to ensure we receive quality data at the earliest possible stage. Please reference Section Q.1 Claims Processing Capabilities and Q.2 Claims Accuracy and Audit Functions, for more information.

### **Phase II – On-going Process Monitoring and Controls**

Centene employs multiple methods of controls and auditing to ensure we continuously meet and often exceed state requirements and federal mandates. These efforts include, but are not limited to the following:

**Continuous Quality Improvement and Claims Monitoring.** We continuously monitor claims volume, claims TAT, and electronic claims submission penetration via our Centelligence™ Insight Dashboards. Below is an example of our dashboard capability for claims Key Performance Indicators for financial, payment, and processing accuracy. These are monitored both at the plan level and by Centene corporate to identify areas of concern or for possible improvement.

## Example of Insight Dashboard: Claims KPI's



**Provider Satisfaction Surveys.** We will outreach to our providers through satisfaction surveys and in the course of relationship building to ensure that we are listening to their concerns and address any issues as they relate to claims processing. Through these outreach activities, we will determine the need to provide training, targeted outreach, etc., to assist our providers in understanding DHH and LHC rules for processing claims, the benefit of filing claims electronically, or other specific areas of concern.

**Provider Administrative Scorecard.** We are developing a provider scorecard that will compare a provider's pattern of paper versus electronic claims and reimbursements against all contracted providers. The report will be available via PRM to internal staff who work directly with providers, such as Network Managers, Claims Liaisons, Provider Service Representatives, and Case Managers. The data in this report will demonstrate the connection between a provider's claims submission practice and the impact on their business in terms of claims accuracy and reimbursement turnaround. By pulling the data together and presenting it in this format, LHC staff will be equipped with powerful and easy-to-understand information that will resonate with providers as we work together to improve EDI participation and claims accuracy and reduce administrative costs. See Section R.13 for how we will encourage and support electronic submissions of claims.

**Ongoing Claims Audits.** Our Quality Review team performs continuous quality improvement audits on our processes, people, and controls to ensure the highest level of claims accuracy. Please reference our response to Section Q.2 Claims Accuracy and Audit.

**Member Explanation of Benefits.** To identify potential fraud, waste, and abuse, we will engage members themselves to help identify cases where billed services may not have been performed, or may have been improperly billed. Please reference our response to Section Q.2 Claims Accuracy and Audit.

**Annual SAS 70 Type II Audit.** KPMG, LLP performs this annual audit for Centene to test the design of controls over Claims Processing and Datacenter Operations and the operating effectiveness of such

controls, including those related to MIS availability, security, and data integrity. In its most recent SAS 70 Type II audit (2010), *Centene received an unqualified opinion from KPMG, LLP* (that is: KPMG did not discover any material adverse findings).

**Sarbanes Oxley Management Report on Internal Controls over Financial Reporting.** Each year, management conducts evaluations of the effectiveness of internal controls over financial reporting according to Sarbanes-Oxley Section 404 (SOX) regulations. Our Internal Audit Department and Ernst & Young, LLP conducted our most recent audit of these controls for the period ending December 31, 2010, and concluded that Centene's internal controls over financial reporting were effective. Centene's **assessment** of the effectiveness of internal controls, which includes controls for claims processing, for the period ending December 31, 2010, was audited by KPMG, LLP, another public accounting firm. *No significant deficiencies or material weaknesses were identified.*