

SECTION N – UTILIZATION MANAGEMENT

N.1 Provide a detailed description of your utilization management (UM) policies and procedures including but not limited to:

Louisiana Health Care Connections (LHCC) combines our Louisiana experience managing utilization of Bayou Health covered services with the nationally proven UM approaches, innovative programs, and sophisticated technology resources of Centene Corporation. Centene manages and oversees utilization for more than 3.1 million Medicaid-eligible members nationally. Currently, LHCC manages utilization for more than 149,000 Medicaid members. Our combination of local and national experience allows us to offer a powerful set of strategies that include the following:

- Locally recruited and locally-based staff (including, but not limited to Utilization Management (UM), Case Management, Network Development, Member Services, and MemberConnections® outreach staff) ensure members and providers always have access to support from someone in their own community who understands local needs, local delivery systems, and patterns of care.
- We use sophisticated data management and analytics capabilities for data collection, indicator measurement, analysis, and improvement activities. We gather, analyze, and report data through our Quality Assurance and Performance Improvement Committee (QAPI Committee) and use UM data to identify and monitor under-utilization, over-utilization, and inappropriate utilization of services, aberrant provider practice patterns, and quality of service concerns.
- Support for providers and a reduction in the “hassle” of managed care, by asking for the lowest level of required authorizations possible, providing a simple web-based resource so providers can easily find out which services require prior authorization, accepting out-of-network care episodes, and offering a suite of technology resources to enhance provider ability to monitor and coordinate their patients’ care.
- Network Provider involvement in developing and approving UM criteria and policies.

We maximize health outcomes by ensuring our members receive consistent, unduplicated, high quality care according to nationally-recognized, evidence-based clinical decision criteria, such as InterQual®.

Our approach to UM is based on our philosophy of continuously improving the member’s experience and quality of care, improving outcomes of populations, and reducing per capita cost of health care. Our UM, Case Management, and Chronic Care Management programs (CCMPs) work together to promote a lifetime of healthy behaviors and outcomes. We monitor our trends of approvals, denials, terminations, reductions, and suspensions as a means to identify opportunities to refine our processes and target provider training.

UM Program Overview

Our UM Program adheres to 2014 NCQA Health Plan Accreditation Requirements for UM; federal regulations, including, but not limited to applicable parts of 42 CFR 422, 431, 438, 455, and 456; relevant Louisiana State requirements, such as LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations; and all related RFP and contract requirements. Our UM Program Description is reviewed annually and updated periodically as appropriate. We provide DHH with all required UM reports, and any additional reports requested by DHH.

Program Scope and Goals. The scope of our UM Program is comprehensive and applies to all eligible members across age categories, range of diagnoses and care settings.

Program Description. LHCC maintains a written UM Program Description (Description) that fully complies with State and federal requirements, as well as all Contract requirements for what the Description must include. We submit the Description to the Louisiana Department of Health and Hospitals (DHH) for written approval within 30 days of execution of a contract between LHCC and DHH, annually thereafter, and prior to any material revisions. The Description outlines our UM Program structure and processes, including assignment of responsibility to appropriate individuals, in order to promote medically necessary, fair, impartial, and consistent utilization decisions. The Description provides evidence of physical health (PH) and behavioral health (BH) service and Case Management coordination in our UM Program design, development, implementation, and review.

Program Structure and Authority. Oversight and operating authority of UM activities is delegated to the Medical Management Committee (MMC), which serves as LHCC's Utilization Management Committee (UMC). In the 1st quarter of 2014, the QAPI Committee renamed the Utilization Management Committee the "Medical Management Committee" to reflect the expansion of the committee's oversight to Case Management and Utilization Management in order to more closely integrate all medical management functions.

The MMC complies with all requirements of a UMC, reporting to the QAPI Committee and ultimately to the LHCC Board of Directors. The MMC meets at least quarterly, and makes meeting minutes available to DHH upon request. The MMC reviews and approves medical necessity criteria and protocols, clinical practice guidelines, and UM policies and procedures, which are then adopted in consultation with contracting health professionals. The MMC coordinates annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation.

The MMC monitors and analyzes relevant utilization data to detect and correct patterns of potential or actual inappropriate under- or over-utilization, which may impact health care services, coordination of care, appropriate use of services and resources, and member and provider satisfaction with the UM process. The MMC also monitors performance metrics, including phone access, adverse determinations and appeals volume, outcomes of inter-rater reliability and medical record audits, and timeliness of decision making. The MMC reports UM and performance data, including any corrective action plans, to the QAPI Committee

LHCC's UM Program Goals

1. *Optimize member health status, sense of well-being, productivity, and access to quality health care, while actively managing cost trends.*
2. *Ensure we provide medically necessary Covered Services appropriate to the member's condition, in the appropriate setting, and that meet professionally recognized standards of care.*

Program Linkages. Our UM, Pharmacy, Quality Assessment and Performance Improvement (QAPI), Credentialing, and Fraud and Abuse Programs are closely linked in function and process. UM staff track utilization trends to monitor for possible under- or over-utilization of services. In addition, as review nurses perform UM functions, they screen for quality and other indicators (such as those prescribed by the Patient Safety Plan and the Fraud and Abuse Program) and forward identified issues to the QI Department for review. Our Chief Medical Director (CMD) also reviews to determine if the information warrants additional review by our Provider Advisory or Credentialing Committees. If not, the information is filed for review during the recredentialing process.

To ensure a link between the Complaint, Grievance, and Appeal processes and our QAPI and UM Programs, our Grievance and Appeal Coordinator and Clinical Appeals Coordinator (positions within our QI Department) review and report Complaint, Grievance, and Appeal data to our cross-functional, inter-departmental Performance Improvement Team (PIT) monthly, and to the MMC quarterly. The Medical Management Department works closely with the Program Integrity Officer, LHCC's Fraud Investigators, and Centene's Special Investigations Unit to resolve any potential Fraud, Waste, or Abuse issues.

We analyze utilization of services in conjunction with the quality and outcome of the services delivered. Once a pattern of under- or over-utilization is identified, the Vice President, Medical Management (VPMM), Senior Director of UM, and Senior Director of Quality collaborate in developing interventions and monitoring outcomes in response to interventions.

At the individual member level, Case Managers work closely with UM staff to ensure that Medical Necessity reviews are conducted and authorizations are in place to support timely access to needed care and services. For example, our onsite concurrent review nurses (CCRs) communicate discharge planning needs to the Case Manager, who then prioritizes authorization of medically necessary post-discharge equipment and services to prevent readmissions.

UM Policies and Procedures

Our UM policies and procedures ensure Covered Services are medically necessary and are not arbitrarily or inappropriately approved, denied, or reduced in amount, duration, or scope. Staff use our evidence-based guidelines, review criteria, established procedures for processing requests for initial and continuing authorizations, and sound clinical judgment to determine medical necessity of requested services requiring prior authorization and concurrent review. Staff also take into account professionally-recognized standards of care, local variances in delivery systems, provider practice patterns, and any special circumstances that may require deviation such as disability, acute condition, co-morbidities, life-threatening illness, or risk of institutionalization.

Availability of UM Staff. LHCC's Louisiana-based staff (levels and qualifications of staff described below) conduct our UM in house. Our integrated technology platform allows us to easily share data with our affiliate subcontractors, which ensures a high level of coordination and collaboration. Practitioners may contact us via phone, fax, or through the Provider Portal. UM staff are available through a toll-free number during normal business hours (Monday-Friday, 8:00 a.m. to 5:00 p.m., Central Standard Time). After normal business hours and on holidays, calls to the UM department are answered by NurseWise, our 24/7 nurse advice line affiliate. NurseWise is not a delegated UM entity and does not make UM

LHCC in Action...

Linking our programs to support member outcomes

Data analysis indicated that delays in obtaining apnea monitors were a frequent cause of extended NICU length of stay (LOS). Our Concurrent Review staff collaborated with our Case Management and Provider Relations Departments to improve timeliness of review, authorization and delivery of apnea monitors. As a result, NICU Average LOS dropped from 33.32 days in December of 2013 to 31.37 days in June of 2014.

decisions. However, NurseWise has immediate access, when needed, to LHCC's Medical Management staff, including our Chief Medical Director, through an after hours on-call assignment roster. At the end of each shift, NurseWise sends an Activity Report to LHCC's Medical Management Department, including inquiries requiring follow-up no later than the next business day. LHCC ensures that a Louisiana licensed registered nurse or physician is available 24/7 to accept and process urgent requests for authorization.

Prior Authorization (PA) Process. Our written PA policies and procedures (P&Ps) comply with all applicable regulatory, accreditation, and Contract requirements. We submit all PA criteria and P&Ps containing any material revisions, to DHH for approval prior to implementation. LHCC does not require service authorization for emergency services or post-stabilization services, whether provided by an in-network or out-of-network (OON) provider. LHCC does not require prior authorization of progesterone for eligible women with a history of pre-term labor or a short cervix found in a current pregnancy; treatment of STIs; or the use of long acting reversible contraceptives. LHCC does not require PA of normal newborn deliveries, EPSDT services, or medically necessary covered services of a new member for the first 30 days, regardless of whether or not the provider is in the LHCC network. LHCC will honor any prior authorization for durable medical equipment, prosthetics, orthotics and certain supplies issued while a member was enrolled in another MCO or the Medicaid FFS program for ninety (90) calendar days from the date of enrollment and we will give special consideration to continuity of care in cases where new members have existing authorizations for scheduled surgeries, post-surgical follow up visits, ongoing therapies to be provided after transition or out-of-area specialty services.

LHCC has dedicated staff who enhance our ability to quickly obtain and share information necessary for continuity of services in place at the time of enrollment. Our Transition Coordinators outreach to previous Managed Care Organization (MCO) or FFS Program representatives and providers to ensure we are able to obtain complete information about each member's needs and services and to provide prompt authorization information to providers to ensure continuation of existing services, particularly for those members with Special Health Care Needs. Section I.1 provides a detailed description of how LHCC transitions members with SHCN. LHCC does not require a referral for in-network women's health specialists, EPSDT screening services, or for eye care or vision services. Services for which we require PA include, but are not limited to, chiropractic services, durable medical equipment, enteral and parenteral nutrition for home use, home health care services, hyperbaric oxygen therapy, hysterectomy, and pain management services. In accordance with DHH requirements, we also require prior authorization for induction of labor prior to forty-one (41) weeks gestational age.

The MMC reviews and revises our PA List annually to ensure the list includes only those services for which the PA process can favorably influence quality of care. During this review, we remove services that we consistently approve, or that are frequently requested and approved. Our UM staff submit any services that meet this criteria to the MMC with a recommendation that they be removed from the PA list. The MMC reviews the recommendations and supporting information and makes a final decision. For example, after a thorough review of utilization and clinical data, and feedback from our OB/GYN providers, we have recently removed the PA requirement for pregnancy ultrasounds. Previously, we waived the PA requirement for high-risk obstetricians, but required general practice OBs to obtain PA beyond the baseline assessments. Review of our UM data indicated an extremely low rate of denials for OB ultrasounds. After consulting with our network providers and evaluating the potential benefit of early diagnosis of prenatal complications, we decided to remove the PA requirement for all OB providers.

Submitting PA Requests. Members may submit a service authorization request either verbally or in writing. We describe this process in the Member Handbook and incorporate it into our Grievance procedures.

Providers may submit PA requests and supporting information via phone, fax, and our web-based PA request system on our Provider Portal. We do not require paper requests, and accept expedited requests by

phone. Our web-based PA system allows providers to submit requests by using a HIPAA 278 transaction with a unique tracking number for each request that the Provider can use to view the status of requests (e.g., approved, denied, pending).

We are enhancing our Provider Portal with *InterQual Smart Sheets* for adult and pediatric procedures, durable medical equipment (DME), and imaging. *Smart Sheets* offer providers a “smart checklist” customized for each service, including the appropriate procedure code, which allows us to efficiently share key aspects of our criteria with providers and reduce denials due to incorrect or missing information. Additionally, through our pharmacy benefit manager and affiliate US Script, Inc., we offer “smart PA” algorithms to authorize claims in real time, as well as automatically convert faxed PA requests to data so that we may apply auto-determination logic, obviating the need for some PA and ensures appropriate utilization.

Providers may also submit PA requests through our UM Call Center. Our PA staff are local and staff our Call Center Monday-Friday from 8:00 a.m. to 5:00 p.m., Central Standard Time (excluding State-declared holidays). After hours the UM Call Center is answered by NurseWise and a Louisiana licensed registered nurse or physician is available 24/7 to accept and process urgent PA requests.

UM staff enter all requests for authorization into **TruCare**, our member-centric health services management platform for collaborative care coordination and Case, Disease, and Utilization Management. TruCare captures, stores, and reports the time and date all service authorization requests are received; decisions made regarding the requests; clinical data to support the decision; and time frames for notifying providers and members of the determination. Among other core functionality, TruCare houses and displays a member’s Care Plan, including identified health issues, treatment goals and objectives, milestone dates, and progress in a well-organized online format. It is available to providers and members via the secure Provider and Member Portals.

PA Review Process. Our Referral Specialists receive and complete the authorization process for PA requests for Covered Services that do not require clinical review. The Referral Specialist forwards clinical requests electronically through TruCare to a UM clinician. Within two business days of receiving the request, unless additional information is needed from the provider, a UM clinician conducts a Level I medical necessity review (as described below) using appropriate criteria, guidelines, and available information about the member’s condition and circumstances.

Requests That Meet Criteria. If the request meets criteria, the UM clinician notifies the provider and issues an authorization number as expeditiously as the member’s condition requires, not to exceed the timeframes noted below. If the provider submits the request by phone, the UM clinician conducts the level I review in real time while interacting with the provider, and issues an authorization number during the call.

Requests That Do Not Appear To Meet Criteria. If the request does not meet criteria, the UM clinician may request additional information or refer the case to a Medical Director who may authorize, deny, or pend requests awaiting additional information needed to apply criteria. The Medical Director reviews the case and consults with the requesting provider, as appropriate, to gather additional clinical information and discuss alternatives to the requested services. As applicable, the Medical Director consults with a board-certified physician in an appropriate specialty and with appropriate clinical expertise in the member’s condition or disease, prior to issuing a denial or authorizing a service in amount, duration, or scope that is less than requested.

Requests With Insufficient Information To Make a Determination. If clinical information needed to make a determination is not provided at the time of the request, the UM clinician contacts the provider to inform them of the information needed and the deadline for submission. If needed clinical information is not received within two business days of the PA request, the UM clinician again outreaches to the provider to request sufficient information for medical necessity review. If we do not receive the

information after two attempts within the 14 day review period, the UM clinician issues a denial for lack of sufficient clinical information necessary to render a determination, no later than the 14th day of the review period. If we receive information but it is insufficient to meet criteria, the UM clinician refers the case through TruCare to the Medical Director for review.

When a member's condition is not addressed by our UM guidelines, review criteria, or internally developed clinical policies (or adhering to them is not in the best interest of our members), our CMD makes the determination after researching available and current literature, obtaining guidance from Centene's Chief Medical Officer, and/or consulting with the LHCC Chief Medical Officer, medical directors and local physicians with expertise in the member's condition.

Expedited PA. We provide an expedited PA process when the provider indicates or LHCC determines that following the standard authorization decision time frame could seriously jeopardize the Member's life, health, or ability to attain, maintain, or regain maximum function. UM staff and the CMD (as applicable) follow the same process as described above for standard PA reviews to obtain information from the provider and determine whether the request meets criteria, but ensure the determination is made within 72 hours of request. If the determination results in a denial, reduction or termination, the Medical Director or designee notifies the provider orally within one business day of the determination, and issues a written or electronic notice of the decision to the treating physician, PCP, and Member within two business days of making the determination. The notice includes the reason, right to a peer-to-peer discussion, right to appeal and the appeal process.

Pharmacy PA Process. US Script, our pharmacy benefit manager affiliate, manages pharmacy utilization for over 2.4 million low-income individuals and Medicaid/CHIP members as a full-service PBM, and supports Centene affiliate plans in 13 states. In 2008, US Script was one of the first PBMs to receive Pharmacy Benefit Management accreditation from URAC.

LHCC and US Script comply with PA requirements established by DHH, including DHH prohibitions against PA of selected drugs, such as HIV drugs. Our PA process takes into consideration prescription refills related to the prescriptions written prior to enrollment in LHCC and includes policies to support transition into LHCC from another plan.

Our pharmacy PA review identifies opportunities to understand the challenges faced by prescribers and work with them to determine the most appropriate regimen. Within 24 hours after receiving a PA request and all necessary and requested information, a US Script pharmacist reviews the request and notifies the prescriber's office of approval or denial based on our established criteria. If US Script cannot make a determination within 24 hours, we permit and reimburse pharmacists to provide a 72-hour emergency supply of the medication, and require pharmacists to make a good faith effort to contact prescribers for prescriptions that could jeopardize health and safety.

In the event of a denial, US Script notifies the prescriber by fax, and either requests prescribing of PDL therapy or seeks additional information to support the use of non-PDL therapy. Members and providers (on behalf of members) may appeal an adverse determination to our CMD, who reviews all pharmacy appeals. Providers also may request a peer-to-peer review.

Once an appeal is requested, LHCC may approve non-preferred drugs (outside of the Preferred Drug List [PDL]) when additional clinical information is provided by the physician to support the non-PDL drug. One of the following PA criteria must be satisfied.

- Current prescription for a non-PDL drug at the time of enrollment with LHCC (we authorize new members' existing physical health medications for 60 days, and BH medications for 90 days)
- Members who received a prescription drug that was on our PDL but was subsequently removed or changed can continue to receive the drug for at least 60 days.

Review Timeframes. LHCC conducts reviews in a timely manner, in compliance with all State and federal laws and Contract requirements. A UM clinician reviews each request to determine the severity of the member’s condition and urgency of need based on information provided. Our Medical Directors and UM Supervisors are available telephonically 24/7 to provide consultation to UM, Case Management, nurse advice line staff, and providers for complex or expedited requests. LHCC adheres to the following review timeframes.

<p>Standard Review</p>	<p>As expeditiously as possible, as indicated by the member’s condition, but not to exceed 14 calendar days from receipt of the request for service. 80% of standard service authorization determinations are made within 2 business days of obtaining the appropriate medical information required. 95% of concurrent review determinations are made within 1 business day, and 99.5% of concurrent review decisions are made within 2 business days of obtaining the appropriate medical information that may be required. The provider is notified verbally within one business day of making the initial determination, and in writing within two business days of making the decision.</p>
<p>Expedited Review</p>	<p>As expeditiously as possible, as indicated by the member’s condition, but no later than 72 hours after receipt of the expedited authorization request. Expedited Requests may be extended by an additional 14 days if requested by the provider or member, or if LHCC determines that additional time is needed to obtain appropriate clinical information to determine medical necessity, and the extension is determined to be in the member’s interest.</p>
<p>Extensions</p>	<p>Service authorizations for an extended stay or additional services are provided to the member receiving the service and health care professional and/or facility, as expeditiously as the member’s health condition requires, but verbally within one business day of the determination to extend the service, and within two business days in writing.</p>
<p>Retrospective Review</p>	<p>Within 30 calendar days following receipt of all necessary information, not to exceed 180 days from the date of service. Authorization may not be retracted, and/or payment may not be reduced for an item or service furnished in reliance upon a previous approval, unless the approval was based upon a provider’s material omission or misrepresentation about the member’s health condition.</p>
<p>Urgent Concurrent, Expedited Continued Stay and/or Post Stabilization</p>	<p>Within one business day from receipt of the request for services. A request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of “urgent,” even if the earlier care was not approved by LHCC. If the request does not meet the definition of urgent care, the request may be handled as a new request with the timeframe appropriate for the type of decision (i.e. pre-service or post service).</p>

Notice of Authorization. The UM staff issue an authorization notice including the authorization number; the approved provider; approved service; date approved; and amount, duration, and scope of the approved services. When the timeframe is extended, our written notifications include the reason for the extension, and provide information about the member’s right to file a Grievance and how to do so if they disagree with the extension.

Notice of Action. Whenever a decision is made to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, we send a Notice of Action (NOA) to the member and provider. All notifications are written to be easily understood by the member and include

the member-specific reason/clinical rationale for the determination; specific criteria used and availability of the criteria; and the availability, process, and timeframes for appeal of the decision.

We also offer providers an opportunity to request an informal reconsideration/peer-to-peer discussion with our CMO/CMD or other appropriate specialty clinical reviewer who makes the adverse determination. We communicate this option to the provider at the time of verbal notification of the denial, and include it in the standard Notice of Action letter template.

The informal reconsideration is not a prerequisite, nor does it supercede the member's right to file an Appeal; and it does not extend the 30 day required timeframe for a Notice of Appeal Resolution. The LHCC physician who makes the adverse determination conducts the informal reconsideration with the provider rendering the service within one working day of receipt of the request, at the convenience of the requesting provider. If that LHCC physician is unavailable within one business day, the CMD designates an appropriate peer reviewer to conduct the reconsideration. We do not deny continuation of a higher level service (e.g., inpatient hospital) for failure to meet medical necessity criteria unless the appropriate lower level of care can be provided either in-network or out-of-network.

Specialist as a PCP and Access to Specialty Care Centers. We allow members to request ongoing care from a specialist as their PCP, or to request access to specialty care centers when they have a life-threatening condition or disease that requires specialized medical care over a prolonged period of time. The specialty provider must agree to serve as the PCP, and meet all requirements for access and preventive services as a primary care provider. Specialty Care Centers must be in network or be willing to enter into a single case agreement with LHCC.

Retrospective Review Process. We base retrospective reviews of services requiring PA solely on the information available to the provider at the time of care. In such cases, a UM clinician reviews the request for extenuating circumstances, such as inaccurate benefit information given to the provider. If exceptional circumstances do not exist, we issue an administrative denial. If exceptional circumstances exist and the service meets criteria, the UM clinician sends the provider an approval letter and tracking number. If the care does not meet criteria, the UM clinician refers the case to a Medical Director to make the final determination.

Clinical Criteria. LHCC uses clinical criteria to determine medical necessity and guide best practice medicine so our members receive high quality, cost effective care. We use Interqual in most cases, as described in more detail in the section below titled *Industry Products Used and How*.

Provider Access to Criteria. Treating providers may request UM criteria and CPGs related to a specific authorization request by contacting our Medical Management Department, or they may discuss a UM decision with one of our Medical Directors. Each contracted provider receives a Provider Manual, a Quick Reference Guide, and a comprehensive orientation that includes critical information about how to request services, how and when to contact the Medical Management Department, and availability of clinical criteria. When providing clinical criteria or a CPG, we identify the source of the criteria, including the vendor, professional association and/or society or government agency. If the criteria is based on the medical training, qualifications, and experience of the CMD or other trained and qualified professionals, we include the identity of the professional.

Inter-Rater Reliability. Within 30 days for new hires and annually thereafter, our CMD and VPMM conduct IRR testing to evaluate the consistency with which our clinical reviewers apply UM criteria. We use the McKesson IRR test that is applicable for InterQual®. The test evaluates the appropriateness of medical necessity criteria by comparing decision making among clinical reviewers against the standards provided by InterQual®. The MMC and QAPI Committee review these reports at least annually to identify potential trends or patterns that require corrective action or additional training as needed.

Second Opinions. LHCC maintains written procedures to ensure second opinions are conducted in a timely manner. A member, parent/guardian, provider, foster care caseworker, or other member of the

member's health care team may request a second opinion when there is a question concerning diagnosis, or options for surgery or other treatment of a health condition. LHCC authorizes OON second opinions when there is no in-network practitioner available. We cover the second opinion at no cost to the member.

Provider Training and Support. Our comprehensive provider education and training covers all aspects of our UM Program, including, but not limited to medical necessity criteria and guidelines; clinical practice guidelines; services requiring PA; PA requirements and processes, such as the requirement that a member may receive a three day emergency supply for drugs requiring PA until authorization is completed; forms and submittal instructions; determination timeframes; and Grievance, Appeal, and Fair Hearing processes.

Our Provider Relations staff provide training in provider offices and through webinars, and telephonically when we update UM processes, identify issues with the provider, and upon provider request. We provide a Quick Reference Guide that includes a summary of PA information. We also provide information in the Provider Manual, and provide all of the information listed above and more on our Provider Portal. The Portal also includes information about the inpatient notification and concurrent review process, including name and number of the UM department, and how to notify us of inpatient admissions after hours, on weekends, and on holidays.

Evaluation of UM Process. We conduct an annual evaluation of member and provider satisfaction with our UM process. Data collection and analysis includes member satisfaction survey results (CAHPS), member and provider complaints and Appeals that are specifically related to UM, provider satisfaction surveys containing specific questions about the UM process, and feedback from providers who have been involved in Appeals related to UM decisions. We assess the responses and develop action plans or interventions to address areas of dissatisfaction.

Provider dissatisfaction was a key factor in our decision to review our policy regarding OB ultrasounds requested by general practice obstetricians. Previously, we waived the PA requirement for high-risk obstetricians, but required general practice OBs to obtain PA beyond the baseline assessments. Review of our UM data indicated an extremely low rate of denials for OB ultrasounds. By listening to our providers and evaluating the potential benefit of early diagnosis of prenatal complications, we decided to remove the PA requirement.

The VPMM and CMD will continue to monitor for potential over-utilization, and promptly report negative trends to the MMC.

- *Specific levels and qualifications required for UM staff;*

Our Highly Skilled Team

The CMD and VPMM are the senior executives responsible for implementing the UM Program including medical necessity decision making; cost effectiveness; medical quality improvement; medical review activities related to UM; complex, controversial, or experimental services; and successful operation of the MMC. The Behavioral Health (BH) Medical Director is responsible for implementing, directing, and monitoring the behavioral health aspects of the UM program. In addition to the CMD, LHCC has a Chief Medical Officer, and may have additional Medical Directors to support the UM Program.

Under the direction of our CMD, our UM staff facilitate the provision of medically necessary care by authorizing Covered Services that are appropriate for the member's condition in amount, duration, and scope; that are provided in the appropriate setting; and that meet nationally-recognized, evidence-based standards of care. We hire local, appropriately licensed personnel to ensure our review process considers the regional and cultural characteristics of our members, the local delivery system, and practice patterns of our providers. A physician or other appropriately licensed health care professional with appropriate

clinical expertise in treating the member’s condition or disease makes all decisions to deny an authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.

LHCC does not structure compensation to individuals or utilization management entities that would provide inappropriate incentives for the individual or entity to deny, limit, or discontinue Medically Necessary Services to any member. We require all medical management staff to sign an annual Affirmative Statement regarding confidentiality and compensation. The statement represents the employees’ understanding that LHCC does not employ incentives to create barriers to care and services, does not incentivize providers or other UM staff to deny coverage of care or service, and does not provide incentives for UM decision makers that result in under-utilization.

Chief Medical Director. LHCC’s CMD is a physician with a current, unencumbered license through the Louisiana State Board of Medical Examiners. Neither our CMD nor our Medical Directors can have a history of disciplinary action or sanctions (including loss of staff privileges or participation restrictions) that have been taken—or are pending—by any hospital, governmental agency or unit, or regulatory body that raise a substantial question regarding the clinical peer reviewer’s physical or mental ability, or professional or moral character. The CMD must have at least three years of training in a medical specialty.

The CMD devotes full time (minimum 32 hours weekly) to LHCC operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the CMD is not available, LHCC has physician staff to provide competent medical direction. The Chief Medical Director is actively involved in all major clinical and quality management components of LHCC, including, but not limited to those in the table below.

Chief Medical Director Responsibilities
Develop, implement, and interpret medical policies and procedures, including, but not limited to service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the Grievance System
Provide clinical support to the UM staff
Assure that reviews of cases that do not meet Medical Necessity criteria are conducted by appropriate physicians in a manner that meets all pertinent statutes, regulations, accreditation standards, and contractual requirements, and takes into consideration the health status and needs of the individual member
Serve as director of the Utilization Management Committee, and chairman or co-chairman of the QAPI Committee
Collaborate with the Behavioral Health Medical Director in assuring appropriate integration of physical and behavioral health services
Educate and monitor provider performance related to UM activities, reports, and requirements

Vice President, Medical Management. Our VPMM must be a Louisiana-licensed registered nurse, physician, or physician's assistant if required to make medical necessity determinations. If not required to make medical necessity decisions, the VPMM must have a Master’s degree in health services, health care administration, or business administration in order to manage all required medical management requirements under DHH policies, rules, and the Contract. The primary functions of the VPMM are to:

- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria

- Ensure appropriate concurrent review and discharge planning of inpatient stays
- Develop, implement, and monitor the provision of care coordination, disease management, and case management functions
- Monitor, analyze, and implement appropriate interventions based on utilization data, including identifying and correcting over- or under-utilization of services
- Monitor PA functions and assure that decisions are made in a consistent manner.

Senior Director, Utilization Management. A Louisiana-licensed registered nurse, physician, or physician's assistant with a minimum of three years of clinical experience. The Senior Director of UM oversees operations of the referral management, telephonic utilization review, prior authorization, and concurrent review functions.

Pharmacy Director. A Louisiana-licensed Pharmacist with at least three years of clinical experience. The Pharmacy Director and their staff are responsible for oversight of the PBM subcontractor, and for developing and implementing the pharmacy benefit management (PBM) program.

Board-Certified Clinical Consultants. Louisiana-licensed specialty physicians who provide clinical guidance and clarification of information to the CMD when a medical necessity decision requires the knowledge and expertise of a particular medical specialty.

Prior Authorization Case Managers. Louisiana-licensed health care personnel with a minimum of three years of clinical experience. PA Case Managers are trained in the consistent application of evidence-based, nationally recognized clinical support criteria to ensure that services provided are a covered benefit, and are medically necessary, appropriate to the member's condition, and rendered in the most appropriate setting. Prior Authorization staff communicate closely with Case Management staff to ensure coordination among Utilization Management, Case Management, Care Coordination, and Disease Management functions.

Concurrent Review Case Managers (CCR). Louisiana-licensed nurses or physician's assistants with at least three years of recent clinical nursing experience in an acute care setting, and who conduct inpatient and telephonic concurrent review. LHCC currently has 10 Concurrent Review staff working onsite at 17 of our high-volume hospitals. CCR staff collaborate with hospital staff to effectively coordinate discharge planning activities and post-acute care authorizations, including the use of alternative settings when clinically appropriate. Our CCR staff have access to an extensive network of alternate care facilities and community-based services, ensuring that our members receive the right care, at the right time, and in the right setting. Our CCR staff's comprehensive knowledge of network facilities and community-based services enhances their ability to provide services at the most clinically appropriate and cost effective level of care.

Referral Specialists (RS). Our Referral Specialists have three or more years of experience working in a medical-related setting, and support the operations of the UM department. Referral Specialists collect demographic information necessary for prior authorization, but cannot make clinical determinations.

Program Specialists (PS). College graduates with experience in Social Services or a related health care field. PS staff support Case Managers in coordination of psychosocial and community resources for members.

Program Coordinators (PC). Highly trained non-clinical staff with significant experience in a health care setting. PC staff assist Case Managers with administrative duties such as follow-up calls, data collection for screening assessments, obtaining test results, and coordinating home care services and transportation.

o **Training you provide your UM staff;**

UM Staff Training and Monitoring

Staff Training. LHCC Human Resources (HR) and our Medical Management Training Team (MMT Team) collaborate in providing both general training and UM-specific training to support our UM staff in making appropriate decisions. General training provides an understanding of the Bayou Health Program, population, and providers; the context in which UM decisions are made. UM-specific training familiarizes staff with health management/clinical information systems, the appropriate application of criteria, and LHCC’s UM policies and processes. Additional details related to UM staff training can be found in N.2

General Orientation and Training. LHCC’s Human Resources staff provide all employees with general classroom training, including orientation to Bayou Health; our parent company, Centene Corporation; and LHCC, including structure, Mission, Vision, Values, and ethics, compliance, and professionalism. All employees receive Cultural Competency training in accordance with nationally-recognized CLAS Standards, along with disability awareness training; and training on fraud, waste, and abuse; HIPAA requirements; customer service skills; and telephone etiquette.

UM Training. Our Medical Management Training Team (MM Training Team) maintains and implements a robust and comprehensive role-based training program that includes Medical Management Trainers, Clinical Educators, Preceptors, and dedicated Systems Trainers. The MM Training Team uses classroom training, an established training curricula, online courses, and case studies to train new employees on job-related skills and situations. Preceptors encourage dialogue regarding roles and responsibilities, monitor skills development, and conduct role-playing exercises to prepare UM staff for various scenarios.

Clinical Staff Training. UM clinical staff responsible for medical necessity decision making receive training on InterQual® criteria/clinical guidelines; TruCare and the Avaya Call Management System; UM policies and procedures, including DHH issued practice guidelines; regulatory, accreditation, and contractual requirements; the QAPI Program; the Grievance System; fraud, waste, and abuse; and performance standards. They also receive training on LHCC’s Case and Chronic Care Management Programs, including referral triggers and regional issues. We train non-clinical UM staff on Avaya, TruCare, and UM policies and procedures related to their specific job requirements. Core topics for UM clinical staff training include:

Core Topics for UM Clinical Staff Training	
<ul style="list-style-type: none"> • Authorizing services 	<ul style="list-style-type: none"> • Case and Chronic Care Management Programs, including referral triggers and regional issues
<ul style="list-style-type: none"> • InterQual Criteria including severity of illness, intensity of service, and discharge criteria 	<ul style="list-style-type: none"> • Quality Improvement, including quality of care concerns and current initiatives
<ul style="list-style-type: none"> • Clinical policies and DHH policies 	<ul style="list-style-type: none"> • Performance standards, productivity goals, inter-rater reliability testing, case reviews, and quality.
<ul style="list-style-type: none"> • PA timelines, including when to send to the Medical Director; and timeframes for authorizations, adverse determinations, and medical necessity appeals 	<ul style="list-style-type: none"> • Complaints and Grievances
<ul style="list-style-type: none"> • Concurrent review and discharge planning, including how and when to coordinate with the Case Manager 	

All UM staff participate in ongoing training, at least quarterly, and whenever changes to UM criteria/guidelines and policies occur. UM clinical review staff receive weekly updates regarding service coverage, process changes, and medical necessity guidance. Managers review annual updates to LHCC's clinical policies during staff meetings and one-on-one sessions and we also post updates on the LHCC intranet. Clinical Lunch and Learns, general staff meetings, and seminars provide additional knowledge and skills-based training opportunities. We use results of monthly case audits, Inter-rater Reliability Audits, and individual supervisory sessions to evaluate the effectiveness of our UM training and to identify individual and department-wide training needs.

Non-Clinical Staff Training. Non-clinical staff in Medical Management, such as Referral Specialists and Program Specialists, receive general staff training, call center training and role based training including medical terminology, how to use the TruCare clinical system, timeframes for UM decision making, all relevant UM policies and procedures and documentation skills.

Methods and Evaluation. Our MM Training Team maintains and implements a robust and comprehensive training program that provides ongoing, on-the-job training throughout the individual's employment at LHCC. The Training Team offers formal training sessions at least quarterly, and whenever a change in UM criteria, guidelines, and policies occur. Weekly meetings with all UM staff include feedback from providers, service coverage updates, process changes, and updates to medical necessity guidance. The MM Training Team also provides monthly staff inservice sessions, one-on-one supervisory sessions, and clinical education Lunch and Learn sessions. Medical Management leadership uses a variety of methods for evaluating performance, including direct observation, live and retrospective telephone monitoring, performance reports, case reviews, and Inter-Rater Reliability Audits.

○ **Industry products (Milliman, Interqual, etc.) used and how**

InterQual®. Our clinical decision criteria aligns the interests of the member, the provider, and LHCC with nationally-recognized and internally developed evidence-based standards of care developed with input from medical experts. In most cases, we use McKesson's InterQual® guidelines to determine medical necessity and appropriateness of physical health care. InterQual® is a recognized leader in the development of clinical decision support tools, and is used by more than 3,000 organizations and agencies to assist in managing health care for over 100 million people. InterQual® provides a clear, consistent, evidence-based platform for care decisions that promotes appropriate use of services, enhances quality, and improves outcomes.

LHCC uses InterQual's Level of Care and Care Planning criteria for Pediatric Acute, Adult Acute, Home Care, Durable Medical Equipment, Sub-Acute/Skilled Nursing, and Procedures to review requests for medical necessity determinations.

Clinical Policy Committee (CPC). Centene, LHCC's parent company, has chartered a Clinical Policy Committee, comprised of Medical Directors from each affiliate health plan. The CPC is responsible for developing corporate Clinical Policy Statements. These statements are typically developed when there is no InterQual® guideline for a specific service, or a local practice does not align with InterQual®.

The CPC reviews sources including, but not limited to scientific literature; studies and guidelines published by government agencies (Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, National Institutes of Health, Healthy People 2020, etc.); specialty associations and societies (American College of Obstetrics and Gynecology, American Pediatric Association, American Diabetes Association); and input from relevant specialists with expertise in the service, procedure, or technology.

Our Chief Medical Director (CMD) participates in the CPC, and may submit guideline development requests to the Committee while consulting with the Louisiana Department of Health and Hospitals to ensure guidelines address Louisiana requirements and the needs of our members. For example, InterQual® criteria did not provide sufficient guidelines for nutritional supplements and hyperbaric treatment. Our Chief Medical Director brought the issue to the CPC, which developed, reviewed, and approved relevant Clinical Policy Statements.

New Technology Review. Our CMD consults Centene’s available Clinical Policy Statements when a request is made for authorization of new and emerging technologies, new application of existing technologies, or application of technologies for which there are no InterQual® criteria. Centene’s Clinical Policy Committee (CPC) is responsible for developing Clinical Policy Statements after evaluating new technologies or new applications of existing technologies for inclusion in our medical necessity criteria. The CPC develops, disseminates, and annually updates medical policies related to medical procedures, behavioral health procedures, pharmaceuticals, and devices. The CPC relies upon Hayes Technology Assessments, published scientific evidence, applicable government regulatory body information, CMS’s National Coverage Decisions database, and input from clinical specialists and professionals with expertise in the topic under review. LHCC notifies providers of any new standards or updates in writing through the Provider Newsletters and our Provider Portal.

Clinical Practice Guidelines (CPG). Clinical Practice Guidelines are not clinical guidelines for medical necessity reviews but are used to guide best practices for Adult and Child Preventive Health, Asthma, Prenatal Care, Diabetes, Lead Screening, Sickle Cell, Immunizations, and ADHD/ADD Guidelines for both adults and children. Our UM staff might reference a CPG when engaging with a member and/or provider in discharge planning and follow up care, strategies for avoiding readmission and health education and prevention. We adopt CPGs from nationally recognized associations or societies and we list them on our public website. Internally developed guidelines are reviewed and approved by Centene’s CPC with representation from appropriate board-certified specialists. We also coordinate the development of CPGs with other DHH MCOs to avoid providers receiving conflicting practice guidelines from different MCOs. LHCC disseminates practice guidelines to all affected providers and, upon request, to members and potential members.

- *Describe any differences between your UM phone line and your member services line with respect to bullets (2) through (7) in item J.1 of this part;*

Member Services Line. LHCC has adopted an integrated health plan approach by providing one toll-free number that our members and providers can call to ask questions about benefits, get help to obtain needed services, file a Grievance or complaint, or request PA of services. Our Louisiana-based Member Services call center staff provide high quality services Monday-Friday from 7:00 a.m. to 7:00 p.m., Central Time (excluding State declared holidays), with after-hours support from NurseWise, our URAC accredited 24/7 nurse advice line. NurseWise staff, including 58 Louisiana licensed Registered Nurses, are located in the United States and, as a Centene affiliate, share the same communications technology, software systems, and parallel LHCC staff training and call response protocols.

Avaya, our Automatic Call Distribution (ACD) system, provides seamless call answering, reporting, monitoring, and transfers. In complete compliance with the contract standards in Section 12.16.1-13 (ACD System), Avaya provides historic data for analysis and reporting, and additionally provides real-time data for continuous monitoring via our integrated IEX Workforce Management application (described below).

Our Interactive Voice Recognition (IVR) self-service features allow members to verify eligibility, obtain a PCP’s name and phone number, request a replacement ID card, or check the status of a claim, or check

their CentAccount balance 24/7 using voice or push button prompts. For convenience, our IVR connects callers directly to NurseWise for 24/7 nurse advice, our Case and Chronic Care Management staff for advice and support, and to the Statewide Management Organization for behavioral health, Magellan®. Customer Service Representatives (CSRs) can also provide warm transfers to all subcontractors and internal departments, including our Case and Chronic Care Management staff, as needed.

CSRs document all calls in Member Relationship Management (MRM), our innovative Member Services inquiry, tracking, workflow, and data management system. Expanding on the latest in Customer Relationship Management technology, MRM is the “system of truth” for all member information and provides, for example, demographics, special needs status, language spoken, current and previous Case Managers, Care Gaps, and wellness messages tailored to the member. MRM also supports Unified Member View, which links together all enrolled family members across multiple enrollment spans with LHCC allowing, for instance, the CSR to confirm all family member telephone numbers and email addresses, and identify needs across family members. When a member requests information regarding the status of a PA request, referral, or other UM request, the CSR may obtain the information for the member. However, members may request the CSR to transfer them to their assigned Case Manager, without having to enter the UM queue.

UM Line. LHCC’s UM line, located in Baton Rouge and Lafayette, operating 8a.m. to 5p.m. Central Time, Monday through Friday (excepting State declared holidays) only handles calls for Louisiana members and providers. Dedicated UM Referral Specialists who are trained to appropriately respond to UM requests and issues answer the UM line, employing the same technology, procedures and call quality assurance program as our member services line. Providers may access the UM line via a prompt in the IVR or by requesting UM from a call center CSR. Our UM RS staff document contacts in TruCare.

Training for Outstanding, Personal Service Delivery. *Member Services and UM Line.* LHCC’s new hire training program for CSRs and Referral Specialists, conducted in our Baton Rouge and Lafayette offices, employs adult learning principles to accommodate all learning and thinking styles, and includes classroom, computer, online, and hands-on training with interactive modules, videos, and role-playing. It also incorporates participation from experts throughout LHCC, such as Pharmacy and Case Management staff, and quizzes to test knowledge.

A core goal of our Customer Service training is to develop staff understanding and sensitivity about the cultural, social, and other challenges many of our members face. All CSR and Medical Management trainees must successfully complete our Cultural Competency Training Program upon hire, and semi-annually thereafter. The program, based on all 15 of the enhanced National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), reviews the challenges facing many of our members, such as low literacy; limited mobility; behavioral health issues; disabilities; Limited English Proficiency; and lack of shelter, food, and social supports. We also require disability sensitivity training, including topics on People First Language, the Americans with Disabilities Act, misconceptions about persons with physical and behavioral disabilities, and the impact of poverty on our membership. This training is especially important since our Customer Service staff are often called upon to help identify community resources and supports for members.

We use Role-Based Access Controls to define the level of access and type of information an individual may see. For example, a non-clinical staff member in Medical Management can access member demographics, but not the clinical data related to UM, Case Management, claims, pharmacy, lab results, or assessments. CSRs do not have access to clinical information in TruCare, but are able to view demographic information and authorization status in MRM. Referral Specialists are able to enter demographic information and referral and prior authorization requests into TruCare and may have access to referral and prior authorization clinical information, to the extent necessary for their role.

UM Line. In addition to core customer service training, Referral Specialists who staff the UM line receive training that includes processes for handling urgent and emergent calls, using an escalation matrix based on call type. UM staff have immediate access to all LHCC UM policies and procedures and clinical practice guidelines, as well as member assessment, Care Plan, and other information through TruCare.

Call Routing Process. *Member Services Line.* When a CSR receives a call from a member regarding a PA request, referral, or other UM request, the CSR obtains information from the appropriate UM staff and relays it to the member during the call, providing first call resolution. CSRs also warm-transfer members to assigned Case Managers or to the Case Management staff upon request and for calls requiring clinical escalation, such as urgent requests.

UM Line. In most cases, calls to the UM line come from providers via the IVR with push-button or voice prompts requesting PA, or from facilities notifying us of an admission or providing clinical information needed for concurrent review. If at any time during the IVR the provider says “agent,” a CSR answers the call and warm-transfers the provider to a Referral Specialist for assistance.

Information Available at the Desktop. See Section R.1 for a detailed description of the information available to CSRs and Referral Specialists.

Handling Calls from Members with Limited English Proficiency or Hearing Impairment. *Member Services and UM Lines.* Our IVR provides a Spanish option for both members and providers. If a member or provider selects the Spanish prompt, the call is routed to a bilingual English/Spanish staff member whenever possible. If a bilingual staff member is not available, the staff member who receives the call utilizes Voiance, our language interpretation subcontractor, with professional translators available for more than 200 languages meeting all CMS, HIPAA and ACA regulatory requirements. Although the majority of calls to the UM line come from providers or provider staff, we will ensure that appropriate accommodations are made for non-English speaking members who are calling to speak to their Case Manager or Care Coordinator.

For members who are deaf or hard of hearing, or have other communication disorders, both lines use LHCC’s TTY/TTD line through Louisiana Relay. If a member needs a face-to-face interpreter, our Referral Specialist initiates a three-way call with the interpreter service vendor, provides the vendor with pertinent information regarding the member’s needs, and assists in scheduling a time and place for an interpreter to meet with the member. Our staff do not use children in the member’s household as translators.

Monitoring Quality and Accuracy of Information Provided to Members and Providers. *Member Services and UM Lines.* To ensure the delivery of accurate information and exceptional service, we monitor CSRs, Referral Specialists and Prior Authorization staff through our *Call Quality Assurance (QA) Program*, customized for each department. Each department audits staff using our Call Witness audit tool, which is integrated with Avaya. Call Witness records each phone interaction and either the Quality Specialists (for CSRs) or the UM Manager (for Referral Specialists and Prior Authorization staff) audit a pre-determined number of calls for every staff member each month against a QA Report Card. For more detail on the QA Program for CSRs, please see Section R.1

UM Line. In order to maintain the highest quality of service and accuracy of information, the UM Managers audit one to two live or recorded member and provider calls per staff person per month to evaluate the staff person’s ability to appropriately, effectively, and accurately communicate with the member or provider and assess their level of competency. If the Manager notes any incorrect information or poor customer service during the review, the Manager promptly corrects the information for the member/provider. If inaccurate information is identified during monitoring of a recorded session, the Manager promptly notifies the staff person who contacts the member/provider to provide the correct information. In all cases, staff are retrained on wrongly delivered information and provided with resource material for review, as appropriate.

Calls are scored using LHCC's Call Quality Audit Form. Each category on the audit form has a series of contact skill requirements and an associated point value based on the level of importance of a specific skill. Call quality data is shared with each staff person at least monthly, and a Manager may increase the frequency of monitoring if a staff person has not met performance standards, and has a corrective action plan. Referral Specialists met or exceeded standards for quality and accuracy of information provided in the audits conducted during the 2nd quarter of 2014.

The UM Manager uses the audit results to identify opportunities for improvement in verifying eligibility at the time of each call, and provides training to staff. Ongoing monitoring is used to verify successful training. Medical Management call center performance metrics, including the results of quality audits, are reported to the Performance Improvement Team, which analyzes these metrics against performance of all their call center queues.

Monitoring Adherence to Performance Standards. *Member Services and UM Lines.* Our Workforce Coordinator (WF Coordinator) monitors real-time call center activity, and works with management to initiate necessary staffing and schedule changes to ensure sufficient coverage for all inbound callers. The WF Coordinator analyzes call volumes, call trends, and staff productivity and provides management with call center reports and recommendations to enhance forecasting models. Two Quality Specialists administer our Call Quality Assurance Program, evaluate staff performance to ensure accuracy, provide immediate and ongoing coaching, and make recommendations for new skill development based on quality audit trends. Our Health Plan Trainer (Trainer) develops the content and methods used to deliver the initial training curriculum, provides management with reports to assess staff development of required skills, and drives ongoing training content directed by trend analysis and cross-organizational need. Our Customer Service Department reports overall call center performance to the PIT and the QAPI Committee, and the Medical Management Department reports performance to the MMC, the PIT, and the QAPI Committee C.

How Customer Service Line Interacts with External Customer Service Lines. *Member Services and UM Lines.* LHCC offers to CSRs and UM line staff ongoing training related to available community resources, and provides resource materials that describe the services offered and contact information. Staff access community resources guides and information on the desktop about local and state-based services provided, for example, by non-profit, faith-based, and government agencies. LHCC provides our *Community Connections* resource directory to Medical Management staff that includes a broad range of community agencies, community supports, and advocacy organizations. All Medical Management staff are conversant with the directory, and are trained in how to initiate a warm transfer to the appropriate resource. If the member needs immediate or more intensive assistance, such as when a member needs housing assistance, food, or formula, both CSRs and UM phone line staff warm transfer the member to Case Management staff to assist with resolution. For complex issues requiring direct outreach to the member, the Case Management staff assisting the member collaborate with in-field MemberConnections™ staff and Case Managers to provide in-person assistance.

After Hours Procedures. *Member Services and UM Lines.* After normal business hours and on weekends and State declared holidays, calls to both lines are answered by NurseWise, our 24/7 nurse advice line affiliate. NurseWise is not a delegated UM entity and does not make UM decisions. However, NurseWise has immediate access, when needed, to LHCC's Medical Management staff, including our Medical Director, through an after hours on-call assignment roster. At the end of each shift, NurseWise sends an Activity Report to LHCC's Medical Management Department, including inquiries requiring follow-up no later than the next business day. We provide NurseWise with contact information and an escalation matrix that describes the appropriate steps to be taken for urgent or emergent situations.

- *If your UM phone line will handle both Louisiana MCO and non-Louisiana MCO calls,*
- *explain how you will track Louisiana MCO calls separately; and*

A Louisiana Team Providing Service to Louisianans. LHCC’s UM call center is dedicated to Louisiana calls. LHCC’s experience as an incumbent shows that understanding local geography, patterns of care, and issues of local importance is critical to creating a comfortable experience for members and providers who call our Medical Management Team. To provide the best service, our Referral Specialists, PA Specialists, nurses, management and support staff, located throughout the state, mirror the culture and diversity of our State and membership. The majority of our Medical Management staff were born in or are long-time residents of Louisiana. Our VPMM, a life-long resident of Louisiana, received her undergraduate and graduate degrees in nursing from Loyola University, New Orleans and attended Baton Rouge General School of Nursing. When recruiting new employees, we outreach locally and will use, as appropriate, the Louisiana Workforce Commission as a valuable resource for referral to available local and in-state talent.

o how you will ensure that applicable DHH timeframes for prior authorization decisions are met.

Ensuring Compliance with DHH Timeframes for Decision Making

Our Medical Management staff is trained on DHH timeframes for decision making and notice and use TruCare tracking and alerts to ensure real time monitoring of elapsed time from receipt of request for authorization. Referral Specialists log the date and time of receipt of all PA requests into TruCare. The PA or Concurrent Review (CCR) nurse is then able to see the time available to make a decision, depending on the request type and the associated timeframes for completion. Our staff also apply clinical judgment as they prioritize requests, ensuring the medical condition of the member is always given consideration and decisions are not only compliant with regulatory requirements but are in the best interest of the individual member. For example, if our UM staff determines that a member’s health status requires a prompt response, but the initial request does not contain sufficient information, they will outreach to the requesting provider to obtain the missing information as quickly as possible, regardless of whether or not the provider indicated the request to be urgent.

UM Managers monitor turnaround time for UM decision making daily, and immediately address non-compliance in logging, routing and/or tracking requests, as well as delays in obtaining all necessary information, forwarding requests that didn’t meet guidelines to a physician reviewer and/or completing the request after receiving the physician decision. UM Managers provide feedback and retraining as needed to ensure timely decision making on an individual staff person level and address system issues through process improvement initiatives. The UM Department reports turnaround times compared to required timeframes to the VPMM and Performance Improvement Team (PIT) monthly, and to the MMC quarterly for identification of any opportunities for improvement. For example in monitoring turnaround time for UM requests, we identified that PA staff were devoting significant time to generating Notice of Action letters that included all required information. Since this meant they had less time available to outreach to providers for missing clinical information, we created a unit of nurses with responsibility for generating medical management correspondence. This relieved PA staff from having to generate correspondence which enabled them to complete UM requests more quickly. This performance improvement initiative improved turnaround times for initial clinical review, while also improving accuracy of content and timing of Notices of Action.

Concurrently, our UM data analysis indicated that adverse determinations were largely overturned during peer-to-peer reconsideration due to a lack of all necessary clinical information being provided at the time of the initial decision. As a result, focusing our UM staff on outreaching to providers when a request does

not meet clinical guidelines before referring it to a Medical Director for a determination has also supported timely decision making. Our goal is to collect sufficient clinical information to render an accurate and timely medical necessity determination during the first level review. This will reduce the burden on our network providers, improve turnaround times for decision making, reduce the volume of peer-to-peer reconsiderations, and provide members with more timely access to authorized care. The table below shows recent UM turnaround times since implementing this process improvement.

Authorization Type 2 nd Quarter 2014	TAT Goal	TAT Actual
Concurrent Review – 1 business day	95%	96.8%
Concurrent Review – 2 business days	100%	99.3%
Retrospective Review – 30 calendar days	100%	98.7%
Standard – 2 business days	80%	93.3%
Standard – 14 business days	100%	99.5%
Urgent	100%	100%
DME – 25 days	100%	99.8%

N.2 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

Overview

Louisiana Health Care Connections’ (LHCC) approach to utilization management (UM) is based on the Triple Aim of continuously improving the member’s experience and quality of care, improving outcomes, and reducing per capita cost of health care.

Through our UM Program and associated policies and procedures, we ensure Covered Services are medically necessary and are not arbitrarily or inappropriately approved, denied, or reduced in amount, duration, or scope, and that amount, duration, or scope of a required service is not denied or reduced because of diagnosis, type of illness, or condition of the member. We accomplish this through:

- Use of nationally recognized, evidence-based clinical guidelines for determining medical necessity
- Rigorous initial and ongoing UM staff training and monitoring
- Data analysis and trending to monitor appropriate application of clinical criteria/guidelines, timeliness of decision making, and opportunities for improvement within the UM policies and processes.

Oversight and operating authority of UM activities is delegated to the Medical Management Committee (MMC), which serves as LHCC's Utilization Management Committee (UMC). In the 1st quarter of 2014, the Quality Assessment and Performance Improvement Committee (QAPI Committee) renamed the Utilization Management Committee the “Medical Management Committee” to reflect the expansion of the committee's oversight to Case Management, Chronic Care Management, and utilization management in order to more closely integrate all medical management functions. The MMC complies with all requirements of a Utilization Management Committee, and reports to the QAPI Committee and ultimately to the LHCC Board of Directors.

LHCC understands and will comply with all DHH requirements for Utilization Management, including, but not limited to Section 2.2.4.1.MCO Project Overview; Section 4.2.3 Medical Director/Chief Medical

Officer; Section 4.2.4 Behavioral Health Medical Director; Section 4.2.14 Medical Management Coordinator; Section 6.19 Medical Services for Special Populations; Section 8.0 Utilization Management; Section 8.1.20 Fraud, Waste and Abuse; Section 8.2 Utilization Management Committee; and Section 14.0 Quality Management; Section 15 Fraud, Waste and Abuse and all other relevant contractual, State, and federal requirements.

Clinical Guidelines For Determining Medical Necessity

UM staff use our evidence-based guidelines and review criteria as guidelines to determine medical necessity of requested services requiring prior authorization. The UM leadership team train and monitor staff to use sound clinical judgment, and to take into account professionally-recognized standards of care, local variances in delivery systems, provider practice patterns, and any special circumstances that may require deviation, such as disability, acute condition, co-morbidities, life-threatening illness, or risk of institutionalization. Below, we describe the clinical guidelines and criteria we use.

InterQual®. LHCC's Medical Management Committee has reviewed, approved, and adopted McKesson's InterQual® clinical decision support guidelines for adult and pediatric care and service. We use Acute, Home Care, Procedures, Durable Medical Equipment (DME), Sub-acute, and Skilled Nursing Facility guidelines in determining medical necessity of those covered services requiring prior authorization. These InterQual guidelines are imbedded and fully integrated into TruCare, our member-centric health management platform for collaborative case, chronic care, and utilization management. InterQual provides a consistent, evidence-based platform for care decisions that support our Triple Aim goals. InterQual delivers clinical content that is a synthesis of evidence-based standards of care, current practices, and consensus from primary care physicians, specialty physicians, and other medical professionals, as appropriate. Annual updates to InterQual criteria are reviewed and approved by the MMC. We train UM staff on the appropriate application of new and revised criteria.

Clinical Policy Committee (CPC). Centene, LHCC's parent company, has chartered a Clinical Policy Committee comprised of Medical Directors from each affiliated health plan. The CPC is responsible for developing corporate Clinical Policy Statements. These statements are typically developed when there is no InterQual® guideline for a specific service, or when a local practice does not align with InterQual®. For example, we requested development of a clinical policy on enteral , which the CPC developed and our Medical Management Committee approved because InterQual's policy was not exhaustive and UM staff required additional guidance.

The CPC reviews sources, including, but not limited to scientific literature, studies, and guidelines published by government agencies (Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, National Institutes of Health, Healthy People 2020, etc.); specialty associations and societies (American College of Obstetrics and Gynecology, American Pediatric Association, American Diabetes Association); and input from relevant specialists with expertise in the service, procedure, or technology. Our Chief Medical Director (CMD) participates in the CPC, and may submit guideline development requests to the Committee while consulting with the Louisiana Department of Health and Hospitals to ensure guidelines address Louisiana requirements and the needs of our members. For example, our UM staff requested more in-depth clinical policies related to nutritional supplements and hyperbaric treatment of wounds. Our Chief Medical Director brought the issue to the CPC, which reviewed relevant evidence-based scientific literature and nationally-recognized clinical guidelines, and developed a Clinical Policy Statement that met the needs of LHCC's UM program while ensuring compliance with DHH requirements.

Clinical Practice Guidelines (CPG). While we do not use CPGs as criteria for medical necessity determinations, we do use them to support our goals of quality health care and improved member outcomes. We adopt CPGs from recognized sources, such as the American Academy of Pediatrics, the

American Diabetes Association, and the American College of Obstetrics and Gynecology. Our MMC, which recommends CPGs for adoption, includes contracted providers from a variety of specialties, which ensures that CPGs are consistent with local provider practice standards and delivery system capabilities.

The MMC may recommend CPGs in response to changes in practice standards, preventive health recommendations, health outcomes data, and/or prevalence of a specific disease or condition within the state or LHCC membership. The MMC sends recommended guidelines to the Quality Assessment and Performance Improvement Committee (QAPI Committee), which reviews, approves, and adopts guidelines for distribution to our provider network. The MMC and QAPI Committee review all CPGs at least annually. We currently have CPGs for the provision of acute, chronic, and preventive services, including Adult and Child Preventive Health, Asthma, Cardiac Disease, Depression, Hemophilia, HIV, Prenatal Care, and Sick Cell. LHCC collaborates with other Bayou Health Plans to ensure consistency of CPGs so that Bayou Health providers do not receive conflicting guidelines from different MCOs.

New Technologies. The Clinical Policy Committee evaluates new procedures and technology, and provides expertise in the development of guidelines for new procedures and technologies, or new uses for existing technologies. The CPC uses Hayes Technology Assessments, CMS National and Local Coverage Determinations, scientific literature, specialty society recommendations, DHH coverage policies, and input from relevant specialists with expertise in the procedure or technology to develop or revise criteria. Our CMD participates in the Committee, which ensures that guidelines address Louisiana requirements and the needs of our members. Our MMC conducts a comparative review of all LHCC UM criteria and CPGs to ensure consistency among criteria and guidelines.

UM Staff Training and Monitoring

Staff Training. LHCC Human Resources (HR) and our Medical Management Training Team (MMT Team) collaborate in providing both general training and UM-specific training to support our UM staff in making appropriate decisions. General training provides an understanding of the Bayou Health Program, population, and providers; the context in which UM decisions are made. UM-specific training familiarizes staff with health management/clinical information systems, the appropriate application of criteria, and LHCC's UM policies and processes.

General Orientation and Training. Our Human Resources (HR) staff provides all new employees with general orientation and training that includes an overview and history of Bayou Health; our parent company, Centene; and LHCC, including Mission, Vision, Values, and Policies. During the first two weeks of employment, our HR staff provides education and training in a classroom setting.

Content. Trainers conduct sessions on basic managed care principles, the Bayou Health Program, LHCC member characteristics, DHH priorities, and general information systems training. We cover LHCC's organizational structure, departments and functions, cultural competency (based on nationally recognized CLAS standards), HIPAA standards for confidentiality, compliance and ethics, disability awareness and sensitivity, customer service skills, telephone etiquette and call routing/warm transfers and fraud, waste and abuse prevention, monitoring, and reporting.

Methods and Evaluation. We use a variety of training methods, including classroom sessions, online training, and a Preceptor program. Trainers, Preceptors, and UM Managers use direct observation, audits, and supervisory sessions to evaluate the performance and learning needs of each individual staff person.

- **Classroom training** is offered to a group of employees by one trainer. All training rooms are equipped with computers, and classroom training applies adult learning principles that recognize the varied ways adults learn. We also employ a Train-the-Trainer model for smaller groups in order to engage participants in skills training.

- Online training is available on the intranet, allowing staff the option of self-paced learning and providing access to CME/CEU modules necessary for licensure.
- Preceptors use case studies to train new employees on job-related situations, and build problem-solving skills before the employee faces such situations on the job. Preceptors also use group discussion, subject matter review, and quizzes to measure learning and readiness. Preceptors work with new employees for at least six weeks, and provide consistent and timely feedback, support growth potential, and skill development and reduce error rate for new staff as they assume their role and responsibilities. Our Preceptor training program allows us to identify and train seasoned staff to serve as instructors and mentors for new staff.

UM Training. We engage our UM staff in a targeted, interactive, role-based orientation and ongoing training program that is focused on consistent interpretation and application of UM criteria.

Content. The UM Preceptor guides the new employee through a rigorous curriculum covering fundamental UM knowledge and skills, covered benefits and services, and specific UM policies, procedures, processes, and systems. The table below provides examples of training topics we provide.

TOPIC	UM TRAINING CONTENT EXAMPLES
Fundamentals	Overview of LHCC and Subcontractors; Active listening; TruCare and other common tools, techniques, and available resources; Care Management and Care Coordination, including integrated care training; Disease Management; Interpreter services, sometimes provided through Three-way calls; Member and Provider Portals; HIPAA and confidentiality; Cultural Competency; Fraud, Waste and Abuse; members with special health care needs; Medical Transportation; Pharmacy Department; Emergency Management Protocols
Covered benefits and services	An in-depth review of covered services, including, but not limited to limitations and exclusions, basic versus specialty behavioral health services, and carved-out services.
Utilization Management Processes	<ul style="list-style-type: none"> • LHCC and clinical and DHH coverage policies • Authorizing services • InterQual Guidelines including severity of illness, intensity of service, and discharge criteria • Prior Authorization timelines, including when to send to the Medical Director, and timeframes for authorizations, adverse determinations, and medical necessity appeals • Concurrent review and discharge planning, and how and when to coordinate with the Case Manager • Case and Disease Management, including referral triggers and regional issues • Quality improvement, including quality of care concerns and current initiatives • Complaints and grievances • Performance standards, productivity goals, inter-rater reliability testing, case reviews, and quality

In addition, we train and require all UM staff rendering adverse determinations to sign an attestation that no adverse determinations will be made regarding any medical procedure or service outside of the scope of their expertise.

Methods and Evaluation. Our MMT Team maintains and implements a robust and comprehensive training program that provides ongoing, on-the-job training throughout the individual’s employment at LHCC. The MMT Team offers formal training sessions at least quarterly, and whenever a change in UM criteria, guidelines, and policies occurs. Weekly meetings with all UM staff include feedback from

providers, service coverage updates, process changes, and updates to medical necessity guidance. The MMT Team also provides monthly staff in-service sessions, one-on-one supervisory sessions, and clinical education Lunch-and-Learn sessions. We reimburse our UM staff for certain CEUs related to maintaining licensure, and offer seminar opportunities. Medical Management leadership uses a variety of methods for evaluating performance, including direct observation, live and retrospective telephone monitoring, performance reports, case reviews, and inter-rater reliability audits.

Monitoring. LHCC conducts inter-rater reliability testing and Case Reviews on all clinical staff who make authorization decisions to ensure fair, impartial, and consistent decision-making. Our tools measure and evaluate each reviewer's comprehension, competency, and consistency.

Inter-rater Reliability Testing. Within 30 days for new hires, and annually thereafter, our Chief Medical Director (CMD) and Vice President, Medical Management (VPMM) conduct IRR testing to evaluate the consistency with which our clinical reviewers apply UM criteria. We use the McKesson IRR test that is applicable for InterQual®. The test evaluates the appropriateness of medical necessity criteria by comparing decision making among clinical reviewers and against the standards provided by InterQual. The MMC and QAPI Committee review these reports at least annually to identify potential trends or patterns that require corrective action or additional training, as needed.

Physician Peer Reviews. At least annually, Centene's Medical Management Audit (MMA) Department reviews the decision-making of our medical directors to determine accuracy in terminating, suspending, reducing, or denying requests. Medical directors review decisions made by their peers across Centene plans, assess the medical necessity of those decisions, and provide a rationale for their evaluation. MMA staff review and score responses, which must demonstrate decision-making competency based on our UM guidelines and criteria. If improvement opportunities are identified, MMA staff develop and oversee corrective actions.

Centene Corporate Clinical Rounds. Clinical leadership from all Centene affiliate health plans participate in monthly clinical rounds to discuss cases involving members with Sickle Cell Disease, transplants, or NICU admissions. Cases are selected from affiliates on a rotating basis and are reviewed against current research, industry best practices, and emerging successful practices of affiliates. These rounds allow clinical leadership to share experiences, discuss regional variances in practice standards, and educate affiliate clinical staff (including UM and Case Management staff).

Performance Standards. UM Managers monitor UM performance standards related to call center access, turn-around time for service authorizations and appeals, content and timeliness of notice to providers and members, denials and appeals, and consistent application of clinical guidelines. The UM Department aggregates findings and reports quarterly to the MMC. UM Managers address deficiencies at the individual level through one-on-one discussion, and corrective action based on the scope and urgency of the deficiency. The MMC develops and monitors department-wide corrective action plans, and quality and/or process improvement projects, as appropriate, to ensure consistent compliance with performance standards within the Medical Management Department. The MMC reports results to the QAPI Committee quarterly.

Case Review. The UM Manager reviews 5%, or at least 30 cases, per non-physician reviewer annually, including prior authorizations and concurrent reviews. The first review is conducted during the three-month probationary period for each new employee. The UM Manager provides feedback to each reviewer, and the results are included in the annual employee performance review. Cases are selected randomly from TruCare, and hard copies are blinded before being reviewed.

Initial and Ongoing Case Reviews. We conduct case reviews to ensure appropriate application of criteria consistent with all LHCC and other applicable standards. UM Managers conduct case reviews on 100% of cases for new UM staff until competency is demonstrated. Quarterly, and more frequently as needed, UM Managers conduct six case reviews per reviewer. UM Managers use our UM Management Audit Tool in

conjunction with InterQual® criteria to determine whether staff applied UM criteria appropriately and complied with all LHCC and NCQA UM standards. The Managers score results against the benchmarks, and take the actions, described below. Managers discuss results with each reviewer immediately following the review, and consider quarterly case reviews as part of the annual employee performance review. Failure to improve can result in actions ranging from a formal performance improvement plan to termination.

Simulated or Actual Care Review. The CMD and UM Manager prepare at least five cases for review based on previous authorization requests or fictional case studies, which form a combination of narrative and blinded attachments. Cases are distributed to each non-physician reviewer for review. Each reviewer documents their review and decisions on a Case Review Form. Reviewers describe the review process, and how the appropriate criteria and protocols were applied. The CMD meets with all participants for group discussions and a review of decision-making processes and results. This allows staff to discuss various approaches, including how member-specific information was considered, and helps ensure consistency in future clinical reviews for medical necessity. The MMC and QIC review summary reports quarterly. The CMD retains copies of all IRR and Case Review documents and group session summaries to use in the development of future training programs and educational materials.

Case Review Score	Action
90-100%	Continue quarterly case reviews. No action required.
75-89%	Notify employee in writing; review 6 cases monthly until accuracy is =90%. Corrective action includes remedial training. Reviewer must improve to 90% by the next quarter.
<75%	Notify the reviewer in writing and review cases daily until accuracy reaches 90%.

Monitoring Quality and Accuracy of Information Provided on UM Phone Line. To ensure the delivery of accurate information and exceptional service, we monitor Referral Specialists and Prior Authorization staff through our *Call Quality Assurance (QA) Program*. The UM Manager audits staff using our Call Witness audit tool, which is integrated with Avaya. Call Witness records each phone interaction and the UM Manager audits a pre-determined number of calls for every staff member each month against a QA Report Card.

In order to maintain the highest quality of service and accuracy of information, the UM Managers audit one to two live or recorded member and provider calls per staff person per month to evaluate the staff person’s ability to appropriately, effectively, and accurately communicate with the member or provider and assess their level of competency. If the Manager notes any incorrect information or poor customer service during the review, the Manager promptly corrects the information for the member/provider. If inaccurate information is identified during monitoring of a recorded session, the Manager promptly notifies the staff person who contacts the member/provider to provide the correct information. In all cases, staff are retrained on wrongly delivered information and provided with resource material for review, as appropriate.

Louisiana Health Care Connections Utilization Management Staff consistently exceed the goal of 90% for Prior Authorization and Concurrent Case reviews

Call Witness also allows the Manager to target specific types of calls, expand quality assurance by recording calls for later review (such as during high volume periods), and incorporate call examples in the training curricula role-play library. Elements that are monitored include, but are not limited to HIPAA compliance, cultural appropriateness, and accuracy and effectiveness of PA interactions. The Manager also evaluates monitored and recorded interactions to determine if the UM staff person is consistently

following UM criteria and guidelines, and requesting and documenting the appropriate information needed for decision-making.

Calls are scored using LHCC’s Call Quality Audit Form. Each category on the audit form has a series of contact skill requirements and an associated point value based on the level of importance of a specific skill. Call quality data is shared with each staff person at least monthly, and a Manager may increase the frequency of monitoring if a staff person has not met performance standards, and has a corrective action plan. Referral Specialists met or exceeded standards for quality and accuracy of information provided in the audits conducted during the 2nd quarter of 2014.

The UM Manager uses the audit results to identify opportunities for improvement in verifying eligibility at the time of each call, and provides training to staff. Ongoing monitoring is used to verify successful training. Medical Management call center performance metrics, including the results of quality audits, are reported to the Performance Improvement Team, which analyzes these metrics against performance of all their call center queues.

Monitoring UM Line Adherence to Performance Standards. Our Workforce Coordinator (WF Coordinator) monitors real-time UM line activity, and works with management to initiate necessary staffing and schedule changes to ensure sufficient coverage for all inbound callers. The WF Coordinator analyzes call volumes, call trends, and staff productivity and provides management with call center reports and recommendations to enhance forecasting models.

Our Health Plan Trainers (Trainers) develops the content and methods used to deliver the initial training curriculum, provides management with reports to assess staff development of required skills, and drives ongoing training content directed by trend analysis and cross-organizational need. Our Medical Management Department reports performance to the MMC, the PIT, and the QAPI Committee.

The UM Manager documents individual results in the employee’s file and compares it to predefined performance goals, including measures for time to answer, abandonment, average talk time, time on hold, number of calls handled, and documentation compared to content of the call. The Manager meets with the staff person monthly to discuss strengths, deficiencies, and specific training needs. Follow-up activities may include informal coaching, retraining, or a performance improvement or corrective action plan. UM Managers address trends across multiple staff at departmental staff meetings or training sessions, and display reminders in the department as appropriate.

The performance standards for our UM line staff are listed in the table below along with their quality scores during the three months reflected.

TYPE	TARGET PERCENTILE	APR	MAY	JUN	QTR 2 TOTALS
Greetings: Louisiana Healthcare Connections during the greeting, Provided name, Informed caller the call is being monitored for quality assurance	90-100%	100%	100%	100%	100%
Tone: Willingness to assist caller, respond appropriately (How may I help you)	90-100%	100%	100%	100%	100%
Followed Member identification process: Name and DOB	90-100%	100%	100%	100%	100%
Checked Member's eligibility: Start and Term Date	90-100%	83.3%	83.3%	83.3%	83.3%
Followed correct protocol and obtained information needed : Provider ID obtained (NPI/TIN), Call Back number	90-100%	100%	91.7%	100%	97.23%

Utilized Hold appropriately?	90-100%	91.7%	100%	100%	97.23%
Provided Resolution for caller.	90-100%	100%	100%	100%	100%
Thanked the caller for calling Health Plan.	90-100%	100%	100%	100%	100%

To ensure compliance with timeliness performance standards, and that providers and members have timely access to UM decision-making, the call center Supervisor monitors call center performance in real time using Avaya’s on-screen call queue monitoring tool. This allows them to immediately adjust staffing to ensure timely handling of all calls in accordance with DHH standards. If call volume increases unexpectedly, local Supervisors help handle calls or arrange for cross trained staff, such as Case Managers, to assist.

The Avaya CMS system also produces historical reports so the UM management team can analyze trends that require adjustments in order to maintain service levels. For example, we analyze and trend historical phone statistics in half-hour increments by queue, which allows for changes in work distribution among queues or adjustment in staffing levels.

Performance Standard	Medical Management Call Center Performance 2014
ACD Calls	17776
Abandoned Calls < 5%	.11%
ASA < 30 seconds	0 seconds
Service Level > 90%	99.86%
Average Hold Time < 3 minutes	56 seconds

UM Data Analysis and Performance Improvement

The CMD and VPMM, in collaboration with the QI department, conduct ongoing data analysis and trending to monitor effectiveness, accuracy, and consistency in application of clinical guidelines in order to ensure that our members are not inappropriately denied access to medically necessary care. These staff also analyze data to identify under- and over-utilization, provider outliers and opportunities for improvement, including, but not limited to improvement in the appropriateness of UM decisions and PA criteria. The CMD, VPMM, and Quality Improvement Departments collaborate on the analysis of denial and appeal data to identify trends that might indicate the need for a performance improvement project or corrective action plan.

The MMC reviews the overall effectiveness of our UM policies, procedures, and processes and makes changes as needed to meet the goals of the department and the Plan, as well as comply with regulatory and contractual requirements. The MMC also uses this data to evaluate clinical guidelines for clarity and level of understanding, as well as appropriateness when applied within the context of Louisiana practice patterns, delivery system, and member demographics.

The MMC monitors trended data on service utilization, denials and appeals, clinical outcomes, inter-rater reliability, compliance with performance standards, case review results, and provider and member satisfaction with UM processes. At least quarterly, Committee members use data on the PA and concurrent review medical necessity processes and outcomes and their impact on appeals and grievances, along with trended utilization reports and provider satisfaction with UM processes to make recommendations for improvement. For example, UM data indicated an extremely low denial rate for obstetrical ultrasounds, while provider feedback showed significant dissatisfaction with having to obtain PA. The MMC reviewed the approval data and decided to remove the PA requirement. The goal was to

improve provider satisfaction while also improving member access to OB ultrasounds, and potentially improve detection rates of complications of pregnancy. The MMC will continue to monitor utilization of ultrasounds by general OB/GYN providers to ensure that removal of the PA requirement does not result in over-utilization.

The MMC is also responsible for monitoring provider requests for service authorizations, and medical appropriateness and medical necessity of requested services. The MMC uses provider quality and utilization profiling, denial trends, and provider feedback to evaluate the UM program from the provider perspective. Provider profiling includes monitoring of under- and over-utilization, outliers, and compliance with CPGs. Medical record reviews are conducted at all PCP sites with 50 or more linked members, and practice sites which include both individual offices and large group facilities, at least once during each two year period. A reasonable number of records are reviewed at each site with the results reported to the MMC, the QIC, and to DHH quarterly with an annual summary.

Performance Improvement Example: Accuracy and Turnaround Time. In 2013, our VPMM and Senior Director of UM used UM performance data to identify a quality of service issue. Turnaround times for requests for service were not meeting internal goals because UM Case Managers were writing and generating their own medical management correspondence for PA and concurrent reviews. This reduced their available time on the phone queue. We created a Medical Management Correspondence Unit with nurses specially trained to write medical necessity determination letters that are understandable to the member, and meet all regulatory requirements for timeliness and content. The UM Case Managers document all necessary information in the case record so the nurses in the Correspondence Unit can produce accurate, complete, and compliant communications to the member and provider. Once the letter is written, the Supervisor of the Correspondence Unit provides an additional quality review before the letter is sent to a member or provider. The result has been improved turnaround times for UM reviews and improved quality and timeliness of medical necessity and appeal determination letters.

N.3 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider or a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

LHCC understands and will comply with all DHH requirements for utilization management data collection, analysis, and reporting, including, but not limited to NCQA Standards for Utilization Management; Section 8.0 Utilization Management; LAC 50:1.1101 (Louisiana Register, Volume 37, Number 1); Section 14 Quality Management; and all other relevant contractual, State, and federal requirements.

Identifying, Gathering, and Reporting Utilization Data

Louisiana Healthcare Connections' (LHCC) Utilization Management (UM) Program is data-driven and closely integrated with our Quality, Case Management, and Chronic Care Management functions with a shared goal of improving quality of care, service, member experience, outcomes, and ensuring cost effectiveness. The Vice President of Medical Management (VPMM), Senior Director of Utilization Management, and Senior Director of Quality routinely collaborate to identify and analyze the data needed for effective management of UM functions, and create meaningful reports of results for review by the Medical Management Committee (MMC). Oversight and operating authority of UM activities is delegated to the Medical Management Committee (MMC), which serves as LHCC's Utilization Management Committee (UMC). In the 1st quarter of 2014, the Quality Assessment and Performance Improvement Committee (QAPI Committee) renamed the Utilization Management Committee the

“Medical Management Committee” to reflect the expansion of the committee's oversight to Case Management, Chronic Care Management, and utilization management in order to more closely integrate all medical management functions. The MMC complies with all requirements of a Utilization Management Committee, and reports to the QAPI Committee and ultimately to the LHCC Board of Directors.

LHCC gathers, analyzes, and reports utilization data through the MMC to the QAPI Committee, the review and decision-making body of our Quality Assurance and Performance Improvement (QAPI Committee) Program. These committees use UM data to identify under- and over-utilization, aberrant practice patterns, quality of care and service concerns, and opportunities for UM process improvement.

The LHCC Board of Directors oversees the development, implementation, and evaluation of the UM Program and approves the Annual UM Program Description, Annual Evaluation, and Work Plan. The Board delegates oversight and operating authority through the QAPI Committee to the MMC. The MMC oversees an integrated management system that is responsible for the assessment, planning, implementation, and evaluation of all UM activities, including, but not limited to review and approval of UM policies, procedures, protocols, criteria, and clinical guidelines. UM policies and procedures describe the process by which LHCC conducts prospective, concurrent, and retrospective utilization review for medical necessity, referral management, second opinions, and coordination of care through collaboration with Case Management and Chronic Care Management functions. The MMC reports to the QAPI Committee on all UM activities, including data analysis, outcomes, and corrective actions. The CMD has oversight of the MMC, which includes the VPMM, Senior Director of UM, and network providers.

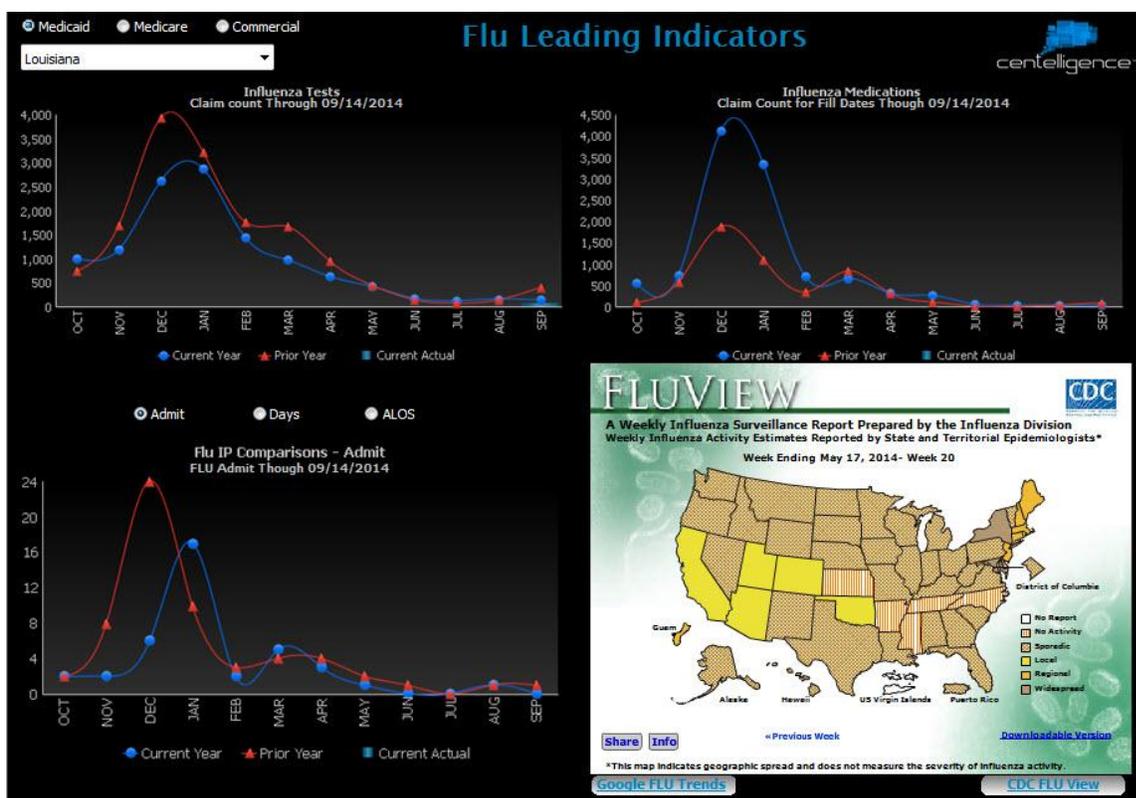
The VPMM, Senior Director of Quality, and Senior Director of UM analyze UM data for completeness, accuracy, and consistency with particular attention to identifying trends in under- and over-utilization. All utilization data is reported to the MMC quarterly unless significant variances are identified requiring immediate interventions. In such cases, the CMD and VPMM assess the variance, and recommend an appropriate action plan. Routine reports provide a comprehensive analysis of data, including identification of variance or trends, review of outcomes, and recommended interventions based on the findings. The MMC makes recommendations that may include additional data analysis, continued monitoring of a process or provider, and/or corrective action. Recommended actions may be multi-departmental, and may include new or revised UM, Case Management (CM), or Chronic Care Management (CCM) programs; revisions to prior authorization requirements; new or revised clinical practice guidelines (CPG) or medical necessity criteria; additional network development activities; improvements in UM data collection and monitoring; staff and/or provider re-training; or addressing the practice patterns of a particular provider or the utilization patterns of an individual member.

Gathering Utilization Data. Centene Corporation (Centene), LHCC's parent company, supports our UM program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and reporting. Centelligence™ is Centene's award winning family of integrated decision support and healthcare informatics solutions. Centelligence™ provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with “drill down” capability.

LHCC captures UM data from internal and external sources and houses the data in Centene's Enterprise Data Warehouse (EDW), which is powered by high-performance Teradata technology. The EDW systematically receives, integrates, and transmits internal and external administrative and clinical data, including medical, behavioral and pharmacy claims data, lab test results, and subcontractors (i.e. vision), along with health assessment information. Claims/encounter data, authorizations, referrals, CM, CCM activities, and member and provider demographics are all collected and refreshed nightly. Housing all information in the EDW allows the Senior Director of Quality and the VPMM to generate reports from a single data repository.

Analyzing and Reporting Utilization Data. Centelligence™ powers the analysis of the data described above, including under- and over-utilization, provider practice patterns, provider clinical quality, and cost reporting information. Standard and ad hoc reports provide a system-wide view, as well as a window into member and provider level data needed for investigation of suspected under- or over-utilization. Centelligence™ also contains “best of breed” predictive modeling solutions that incorporate evidence-based, proprietary Care Gap/Health Risk identification applications that identify and report significant health risks at population, provider, and member levels. This enables us to not only assess appropriateness of delivered services against evidence-based guidelines, but also against the average risk of members or subgroups of members receiving the services. Reports help us to determine whether the members receiving specific programs or services are the ones who can receive the most value from them. Finally, the Care Gaps and Health Risk ‘alerts’ power our Online Care Gaps, which allows our members and providers secure access to actionable health information via our Member and Provider Portals.

Centelligence™ provides an information technology infrastructure that allows LHCC to generate an array of regular, consistent UM reports that can be used to trend utilization, identify variances, and inform process and quality improvement initiatives. It also allows us to compare our experience against both industry benchmarks and our Centene affiliate health plans. For example, the graphic below demonstrates one way we monitor trends to identify potential utilization issues, such as utilization of influenza tests or medications in the context of inpatient admissions for influenza.



In order to fully understand the utilization trends of our members and providers, and to conduct root cause analysis in support of quality and process improvement, we monitor and analyze data at the aggregate and detail level, including by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and by comparing services authorized to services received. Routine monthly

trend reports monitor key utilization measures, such as inpatient admissions and length of stay, ED visits, and specific preventive care services.

Each report described above includes a drill-down capability to more specific areas of interest. For example, when analyzing ED visits or inpatient utilization, we can look at not only the total number of visits or days, but also at the utilization by member demographics and provider/facility in relationship to the presence or absence of physician office visits, frequent ED utilization, and readmissions. We can identify patterns of under- or over-utilization by member, provider, facility, Region, and Parish. Utilization patterns are compared to benchmarks established by the MMC and based on industry standards, national HEDIS Medicaid averages, or DHH mandated thresholds. Internal UM benchmarks are based on historical data that reflect variances in population demographics, seasonal variations, cultural disparities, and regional characteristics of our members. We also consider delivery system variances and regional provider practice patterns. For example, our Concurrent Review nurses (CCRs) reported delays in hospital discharges due to insufficient home health care resources in New Orleans and Shreveport. The CCRs referred the issue to Provider Relations staff who conducted a network analysis, which confirmed insufficient provider resources. PR staff recruited additional home health care agencies, adding capacity and improving outcomes by improving availability of needed post-discharge care.

Monitoring and Evaluation When A Variance Is Identified

Variances in Provider Utilization Patterns. LHCC's QI and MMC staff may identify patterns of under- or over-utilization by individual providers by reviewing the provider's performance on profile measures, or by comparing them to utilization benchmarks, as well as to the practice patterns of their peers.

Provider pattern of under-utilization. Our QI staff review provider's performance on quality measures related to primary and secondary prevention services, such as preventive health visits or diabetes care. Performance is compared to national benchmarks, when available, and average network performance. Once we identify a provider as an outlier, QI staff, Provider Relations staff, or the CMD meet one on one with the provider to discuss performance, provide education, and establish an action plan for improvement. QI staff monitor performance monthly or quarterly, depending on the measure, and report outcomes to the MMC and to the provider. The Senior Director of Quality continues to monitor performance until the issue has been corrected and maintained at an acceptable level for at least six months.

Provider pattern of over-utilization. Our QAPI Committee and/or UM staff monitors for patterns of over-utilization by a specific provider by reviewing quarterly profile reports, including inpatient, ED, and other services. Our concurrent review nurses may note a trend of unplanned admissions for a specific hospital. In each case, QAPI or UM staff compare utilization to national benchmarks or average network performance. Network Management staff or the CMD meet with the facility staff to discuss performance, provide education, determine if there are any underlying causes that need to be addressed, and develop an action plan. If we identify a pattern of over-utilization at the provider level, Provider Relations or the CMD meet with the provider to discuss performance, provide education, and establish an action plan for improvement. The Senior Director of Quality continues to monitor performance until the issue has been resolved and maintained for at least six months.

In certain cases, the VPMM refers a provider with high rates of over-utilization to the Program Integrity Officer for investigation of possible fraud, waste, or abuse. A screening algorithm in our claims system may also generate such referrals. The Program Integrity Officer may review clinical records and other original documentation, claims data, utilization data, and any relevant reports or correspondence, and follows regulatory and contractual requirements for prevention; identification; and reporting of fraud, waste, or abuse as appropriate. Outcomes of the investigation are reported to the MMC and QAPI Committee along with any corrective action plan. Oversight of corrective action plans is the responsibility

of the Program Integrity Officer. In some cases, information is forwarded to the Credentialing Department for inclusion in the provider file.

Variations in Member Utilization Patterns. Case Management or UM staff may identify patterns of under- or over-utilization by individual members through monitoring progress on, and adherence to, the care plan and provider treatment plans, and by reviewing claims, utilization, predictive modeling, and other data.

Under-utilization by Members. Our UM, Case Management, and Chronic Care Management staff routinely monitor for patterns of under-utilization by specific members, such as monitoring reports that identify members in need of preventive services. For example, we generate care gap reports through Centelligence™ to identify members who have not obtained recommended adult/child preventive services, including EPSDT, HIV/STI screening, cervical cancer screening, mammograms, and routine screening related to chronic conditions, such as Hemoglobin A1c and cholesterol screening for adults with diabetes. These reports also identify members who do not adhere to medications, do not attend the recommended number of prenatal visits, or do not use preventive treatments, such as controller medications for asthma.

We outreach to, and assess, members with under-utilization of primary care and preventive services and concurrent over-utilization of urgent, ED, or inpatient services for Case Management, Chronic Care Management, and behavioral health needs. QI staff initiate targeted reminders in the form of postcards, automated telephonic reminders, and outbound Text4Baby messages to pregnant members. Our MemberConnections™ staff conduct in-person outreach when a member is not engaged in Case Management or cannot be reached by phone. If a member is engaged in Case Management, QI staff notifies the assigned Case Manager who reviews the member's care plan; conducts a partial or full reassessment of member needs, barriers, and planned services; revises the care plan as indicated; and monitors to ensure the member accesses appropriate care. The Case Manager continues to monitor monthly UM reports to identify members with persistent care gaps. The Case Manager prioritizes outreach to members who have an increased risk of acute care utilization due to under-utilization of primary and preventive care.

The Director of Pharmacy monitors under-utilization of acute, maintenance, and preventive medications and reports findings to the assigned Case Manager. If the member is not engaged in Case Management, the Director of Pharmacy may refer the member for assessment. The Case Manager or a MemberConnections™ Representative outreaches to the member to educate them about the importance of medication adherence, and to identify and address barriers to filling prescriptions. For example, staff may assist the member to locate a pharmacy near their home, help them arrange transportation to pick up prescriptions, or discuss techniques for remembering to take medications as prescribed.

Over-utilization by Members. UM staff

LHCC in Action...

A 59-year old male member with a history of frequent ED visits for unspecified back pain was his wife's sole caretaker. She was severely disabled and had been in a nursing home for a short time. The member described being consumed by guilt at placing his wife in a facility, so he brought her home, but subsequently injured his back while transferring her from the bed to a chair. He refused home care because he didn't believe anyone could care for his wife the way he could. He admitted feeling overwhelmed and depressed, but was unwilling to relinquish control of the situation. The Case Manager referred the member to the SMO for BH services. Through BH counseling and support from our Case Manager, he learned to accept help from his family in taking care of his wife so he could begin to take better care of his own health. The Case Manager provided assistance with scheduling primary care appointments, transportation to physical therapy, and engaging in effective pain management techniques, which successfully transitioned him from ED utilization for his back pain to more proactive and preventive health management.

may identify a pattern of over-utilization by a member during prospective, concurrent, or retrospective clinical reviews, or by reviewing daily call center reports of members referred to, or accessing the ED who have previous ED visits. They may also identify patterns of over-utilization using standard and ad hoc UM reports generated through Centelligence™. Our Concurrent Review staff routinely assess members with readmissions and unplanned admissions, and refer them to Case Management. Once a member is determined to have a pattern of over-utilization, we offer to enroll them in Case Management if they are not already enrolled.

The assigned Case Manager contacts the member to assess/reassess their needs, barriers, and planned services, including care managed by the Statewide Management Organization (SMO) for specialty behavioral health services. The Case Manager assesses the full scope of member needs and is sensitive to underlying issues, such as potential abuse or neglect that leads to high ED utilization. The Case Manager might engage the Director of Pharmacy or their designee in a medication review and reconciliation, if appropriate. In those cases, the Pharmacy Director/designee uses pharmacy reports to review for duplication of therapy, gaps in therapy using medication possession ratio over time, potential drug interactions, and the potential abuse of controlled substances. The Case Manager maintains frequent contact with the member, caregiver, or other responsible party to encourage adherence to the care plan, including adherence to a medication regimen and preventive care, and assist in addressing any barriers to primary or preventive care, such as transportation or help in making appointments. If the Case Manager suspects neglect or abuse, they initiate a referral to Adult or Child Protective Services to evaluate the safety of the home environment.

In May of 2013, the cervical cancer screening (CCS) rate for LHCC members was 43.33%.

Understanding the importance of cervical cancer screening to reducing future costs and saving women's lives, our Quality, Medical Management, and Provider Relations Departments collaborated on an initiative to increase member compliance and provider accountability. Our HEDIS 2014 reported rate was 57.31%, an improvement of 13.98 percentage points. We have continued to focus on improving our CCS rate throughout 2014.

Provider-Focused Interventions. As part of provider profiling, QI staff identified the top 55 providers with non-compliant patients, which presented a total of 1,741 members who needed CCS. QI staff contacted these providers and gave them the names of non-compliant members, along with education on our CCS Performance Improvement Project (PIP) to enhance awareness of LHCC's commitment to increasing CCSs. In addition, QI staff encouraged the providers to participate in assisting with outreach efforts. Other interventions included:

- The QAPI and Provider Relations (PR) Departments conducted visits to providers with large member panels to promote the program, establish productive, working relationships, and offer support and resources in reaching their patients.
- PR staff educated network providers about our Pay for Performance (P4P) Program, including incentives available for increasing CSS rate.
- We oriented other providers and public health nurses about the CCS PIP program.
- Provider Relations staff educated providers and administrators about proper claims and billing procedures related to CSS.

Member-Focused Interventions. Through our Proactive Outreach Manager (POM) program, QI staff analyzed care gap data to identify all non-complaint members for the CCS measure, yielding a total of 11,176 members. We used an automated outbound outreach campaign to reach members via voice, e-mail, or text. Messaging stressed the importance of CCS, and reminded/encouraged members to make appointments for CCSs. Other interventions included:

- The QI and MemberConnections™ Departments worked together to identify CCS appointment “no-show” members, and provided them with additional education about the member incentive program CentAccount, which compensates members for completing certain screenings, such as Pap smears.
- QI staff sent letters targeted to members noncompliant for CCS.
- Case Management and MemberConnections™ staff assisted with transportation, and referred members to support groups to address fear and misconceptions about CCS.
- MemberConnections™ Representatives conducted home visits to members who could not be reached by phone or mail.
- QI staff distributed care gaps reports to clinical and Member Services staff to emphasize the need for reminders when members contacted the Plan.

N.4 Describe your plan to provide care in the most appropriate and cost-effective setting. The plan should specifically address non-emergent use of hospital Emergency Departments. Strategies of interest to DHH include but are not limited to access to primary care services through medical homes, urgent care and retail clinics; and, interventions targeted to super-utilizers, such as patients with sickle cell disease, chronic pain, dental, and/or behavioral health conditions.

Providing Care in the Most Appropriate and Cost-Effective Setting

LHCC’s goal is to provide our members with the right care, in the right setting, at the right time. We provide care in the most appropriate and cost-effective setting and reduce inappropriate and duplicative use of health care services through a multi-dimensional plan that incorporates:

- Early identification of physical and behavioral health (BH) conditions as well as psychosocial issues through initial and ongoing member screening and assessment, data mining, review of monthly reports, and predictive modeling through Centelligence™, our award-winning family of integrated decision support and health care informatics solutions.
- Risk stratification and targeted interventions to maximize the impact of care coordination resources
- Best-in-class chronic care and disease management programs that improve health outcomes through individualized treatment plans, referrals and assistance to ensure timely access to providers, and identifying and overcoming barriers to primary and preventive care.
- Resources and support for members/caregivers to avoid non-emergent ED visits and avoidable inpatient admissions, including but not limited to in-person assistance through our MemberConnections™ community outreach program, and non-emergency transportation to and from both covered and non-covered state plan services such as dental and behavioral health (BH) services.
- Care coordination and referrals, telephonically or in-person depending on member acuity, to facilitate access to all needed services and supports. This includes, but is not limited to scheduling assistance, monitoring, and follow-up for members requiring medical services and coordination. It also includes appropriate methods of assessment, referral, and coordination with the Statewide Management Organization (SMO) for members requiring both medical and BH services, and with programs such as the state’s 1915 (c) waiver programs for those in the voluntary opt-in population.

LHCC may authorize services beyond the benefit limit to ensure care in appropriate, cost-effective settings. For example, a high risk adult member exhausted home health hours. We authorized above the benefit limit in order to prevent a readmission.

- Effective care transition planning and post-discharge follow-up to reduce readmission to inpatient facilities and avoidable ED visits

LHCC understands and will comply with all DHH requirements relating to providing care in the most appropriate and cost-effective settings, including, but not limited to, Sections 6.8.1 Emergency Medical Services; 6.19 Medical Services for Special Populations; and 6.37 Case Management; and all other relevant contractual and regulatory requirements.

Non-Emergent Use of the Emergency Department (ED)

We prevent and reduce non-emergent ED use through multiple strategies, such as promoting primary care through the medical home, ensuring availability of appropriate urgent care settings, interventions targeted to super-utilizers, and other strategies described in the relevant sections below. In addition, we educate members and providers regarding appropriate utilization of ED services, including behavioral health emergencies, and monitor emergency services utilization by provider and member. We address inappropriate ED utilization through our **ED Diversion Program**, which builds upon and expands our 2013 Ambulatory-ED Visits Performance Improvement Project (PIP). Average ED visits per member in this project fell from 5.83 at the beginning of Q3 2013 to 2.8 by the end of the quarter.

Ambulatory-ED Visits PIP. In Q4 2012, we identified 1254 high ED utilizers (members with three or more ED visits in the previous 90 days), and our MemberConnections™ Representatives (MCRs) attempted to contact each of these high ED utilizers to provide education and offer case management services. Our MCRs educated members about the importance of a medical home and how to access it, appropriate options for non-emergent health care needs, and alternatives to utilizing the ED, such as the availability of after-hours appointments and urgent care clinics in the member's area. MCRs also educated members about how to contact NurseWise, our 24/7 nurse advice line, for questions; and the availability of scheduling and transportation assistance. Members who agreed to participate in our Case Management Program were assigned a Case Manager to complete a comprehensive assessment and care plan that addressed the member's full range of needs, including but not limited to BH needs requiring a referral to the Statewide Management Organization (SMO) for specialty BH services. Case Managers conducted additional education and provided scheduling and transportation assistance as needed.

Our Provider Relations Specialists (PR Specialists) contacted the 75 practices with the highest ED utilization each quarter, along with our network FQHCs, Medical Home eligible providers, and other providers. PR staff provided each with information on their ED rates; and encouraged them to contact

Our 2012-13 ED Visits Performance Improvement Project achieved a 52 % reduction in the ED rate for targeted members in Q3 2013.

their patients on the ED list to provide education, offer preventive and primary care appointments, and ensure their office schedules could accommodate our members. PR Specialists also discussed the member's barriers that contributed to their high utilization rates to help the provider tailor their own outreach to the member.

ED Diversion Program We have capitalized on the success of our Ambulatory-ED Visits PIP by allocating additional staff resources to focus on identifying and addressing high and non-emergent ED utilization. In 2014, our ED Diversion Program is targeting our top 2400 ED utilizers in addition to the 75 practices each quarter whose assigned members have the highest ED utilization. We will continue the member and provider outreach strategies described above, and increase in-person outreach by MCRs for members who cannot be reached by phone and those who need more intensive assistance. We will also track the names of members who visit the ED whom we share coordination with the SMO. QI staff will generate and distribute monthly reports to the SMO that include the names of these members and dates of service. Case Managers will discuss identified ED utilization during bi-weekly rounds with the SMO for

co-managed members, and facilitate development of outreach, education, and other strategies to address the utilization collaboratively with the SMO.

Primary Care Through Medical Homes

LHCC ensures that each member has an ongoing source of primary care appropriate to his or her needs, and a person or entity formally designated as primarily responsible for coordinating their medical care and Medicaid covered services. We accomplish this through the following activities.

Educating and Assisting Members to Select A PCP. LHCC provides outreach and education to guide Members through the process of selecting a PCP and establishing a Medical Home. Staff from NurseWise, our 24/7 nurse advice line affiliate, conduct Welcome Calls to all new members within 14 days of enrollment. During this contact, we verify that they received their New Member Welcome Packet, and help them, as necessary, to choose a PCP using our online “Find a Provider” web-based search tool and/or our Provider Directory. NurseWise staff also provide education during the Welcome Call including:

- Information about the Member’s assigned PCP and the importance of making their own selection
- The member’s right to change their PCP at any time and how to do so
- Rights and responsibilities in scheduling and keeping appointments
- Scheduling and transportation assistance available through LHCC.

As needed, we offer to help Members schedule an initial appointment, and arranging any needed transportation services to ensure the Member keeps the appointment. For members enrolled in Case Management, Case Management staff also follow up with the member to make sure they kept the appointment, and help with rescheduling and further assistance if they did not.

Tools. In addition to this initial education, we provide Members with tools to support timely appointment scheduling. Our web-based searchable Provider Directory allows Members to search for doctors by zip code, specialty, gender, language, and includes medical group and hospital affiliations. Members also can access LHCC’s website for a “one stop” center of resources such as information on benefits; a Provider Directory; the Member Handbook; and instructions for contacting us for assistance. In addition, our secure Member Portal allows Members to modify personal information and change their assigned PCP.

Members with Special Needs. Case Management staff assist Members to identify PCPs with expertise that matches their special needs. We allow Members with disabling conditions and/or chronic illnesses, and children with special health care needs, to select a specialist as a PCP. Within three days of a request, Case Management staff request clinical information from the current PCP and/or specialist to support the request. Our Medical Director reviews the information and approves the request after verifying the special health care need, and the specialist agrees to execute and fulfill requirements of a PCP Agreement.

Newborns. Our dedicated Start Smart For Your Baby® Program Case Managers or MCRs outreach immediately upon learning that a Member is pregnant to encourage and assist expectant mothers to choose a PCP for their baby. Staff also contact new mothers within 30 days of receiving notification of a delivery to encourage them to select a PCP, if they have not yet done so. We also verify claims paid and Kick Payment reports against the enrollment file to ensure every newborn is assigned a medical home.

Assigning a PCP. If a member does not select a PCP within 10 days of enrollment, LHCC assigns one. Our PCP assignment logic considers historical claims and other enrollment data indicating previous PCP, LHCC data on prior PCP of new members who were previously enrolled with LHCC, as well as geographical proximity, physical accessibility to the Provider, and family provider assignments. For new members in foster care with an existing relationship with a PCP, we make every effort to assign the child

to that PCP, to maintain continuity of care. If the PCP is not contracted with LHCC, we will make every attempt to contract with them while maintaining continuity of care for the member.

Identifying and Addressing Barriers. Our Customer Services Representatives (CSRs) are trained to provide scheduling assistance; search our online Provider Directory for a PCP that meets the Member’s needs; mail helpful resources (such as the Provider Directory); and call PCPs directly to assist with scheduling appointments. In addition, Case Managers provide assistance to members who have ongoing service needs with choosing a PCP, scheduling appointments, and securing transportation to the appointments. For example, if CM staff conducting assessments identify that a new Member is due for a preventive visit with the PCP, they immediately assist in scheduling the appointment. As needed and appropriate, CM field staff or MCRs will attend PCP appointments with high risk Members to help address barriers related to fears or concerns about seeing a doctor. CM staff also outreach to assigned Members with reminders, and to identify and address any barriers, such as finding a PCP near their residence who meets cultural and language needs.

Supporting The Medical Home. LHCC educates and contractually requires PCPs to manage and coordinate medical and health care needs of members to assure that all medically necessary services are made available in a timely manner. This includes, but is not limited to developing treatment plans to address risks and medical needs, and coordinating the members care, as needed, with other providers, such as those contracted through the SMO. We educate and require PCPs to meet DHH-required appointment scheduling standards to ensure members have access to the appropriate setting for preventive and primary care services to prevent use of inappropriate settings. We also educate and require that PCPs provide after-hours availability to members who need medical advice. At minimum, we require the PCP office to have a return call system staffed and monitored in order to assure that the member is connected to a designated medical provider within 30 minutes of the call. We provide education on these requirements via our provider orientation process, the Provider Handbook, written and online materials, ongoing trainings, and targeted education when we identify non-compliance or inappropriate utilization. To proactively encourage the expansion of appointment availability, reducing wait times and increasing access to care, thereby reducing inappropriate ED utilization, we instituted three important value added incentives and supports for our providers:

- **ED Reduction.** LHCC offers all PCPs additional ppm related to managing emergency utilization (as described in more detail in Section Z.1.) In addition, LHCC offers key medical groups and health systems the opportunity to participate in “gain share” compensation models. Through these gain share models, LHCC shares savings resulting from offsetting reduction to ER or Urgent Care services with providers participating with the program. This model supports the expansion of appointment availability as a deterrent to inappropriate ER and urgent care visits.
- **Extended Hours.** To further encourage access to care and appointment access, and to offset the expenses of providing services after normal business hours, LHCC offers enhanced reimbursement to PCPs who offer extended appointment hours.
- **Missed Appointments Follow Up.** LHCC requests that PCPs inform our Provider and Customer Service Department when an LHCC member misses an appointment so we can monitor these events in our system and provide outreach and education to the member on the importance of keeping appointments. This also will assist our providers in reducing their missed appointments and help to reduce the inappropriate use of ED services by members who do not access care (such as preventive services) appropriately.

We offer financial incentives for providers to encourage expanded after hours availability, performance on preventive care measures, and Patient Centered Medical Home activities.

In addition, Case and Disease Management staff outreach to PCPs to involve them in care planning, share monitoring and adherence information as well as gaps in recommended care, and solicit PCP input on strategies to influence member behavior. Our Provider Portal offers tools PCPs can use to track Members who are overdue for recommended services:

- Our comprehensive **Online Member Health Record (MHR)** provides PCPs with a well-organized view of a member's care gaps as well as a cursory clinical "face sheet" and detailed clinical tabs for each member for whom we have supporting data. The MHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in Centene's Enterprise Data Warehouse.
- Our **Online Care Gap Alerts** feature pushes alerts to the provider when a member's record is presented as a result of an eligibility inquiry and will show if a member is due for or missing a service recommended by evidence-based guidelines. PCPs can view clinical quality and cost utilization drill down reports generated by our Centelligence™ system that encompasses data for all services delivered to the member by that provider, when we have sufficient claims data from that provider to display meaningful information.

In addition, we provide a variety of resources to enhance PCP capability to detect and, as appropriate, treat BH conditions in the primary care setting. For example, we will provide a toolkit to PCPs on evidence-based treatment of ADHD. We also notify PCPs of ED utilization through an ED "flag" on the Portal when the provider checks member eligibility. This improves PCP awareness of members who may not be appropriately accessing primary and preventive services, thereby supporting the PCP's own outreach and education efforts.

Urgent Care and Retail Clinics

Availability of urgent care and other easily-accessible locations for non-emergent care, such as retail clinics, can reduce unnecessary use of the ED. While DHH does not establish a specific access standard for urgent care, our urgent care network currently offers access based the 90 mile standard to 95% of our membership. We are expanding availability of urgent care through our recent contract with the 15 Take Care Clinic locations operated by Children's Hospital of New Orleans. In addition, after hours primary care, an appropriate setting for many urgent care needs, is available to 96.9% of members within 60 miles and 100% of members within 90 miles.

We educate members about the role and availability of urgent care providers in a variety of ways, such as:

- Through our new member Welcome Packet, Welcome Call, Provider Directory, and Member Handbook and website
- When Case Managers work with members to complete assessments and care plans, as part of their education of the member about appropriate access
- When members contact the Member Call Center or NurseWise, with urgent care questions or needs.

Interventions Targeted to Super-Utilizers

LHCC has developed targeted interventions for high utilizers and members with chronic and complex conditions that put them at high risk for high utilization. We identify 'super-utilizers' and those at risk for high utilization through ongoing review of enrollment, predictive modeling, utilization and other data. The criteria we use includes but is not limited to those in the table below.

Selected Criteria for Identifying Super-Utilizers and High Risk Members	
<ul style="list-style-type: none"> • Impact Pro risk score of >7 • 3+ inpatient admissions within the last 6 months for same/similar diagnosis • 3+ ED visits in the last 3 months • Chronic or non-healing wounds/Stage 3 burns requiring extensive wound care or skin grafts • Requires life sustaining device such as ventilator, tracheostomy, oxygen, CPAP/BIPAP, tracheostomy care or suctioning • TPN or continuous tube feedings • Recent functional decline within 90 days • Private Duty Nursing • Multiple co-morbidities that require 3 or more specialists 	<ul style="list-style-type: none"> • Diabetes with Lower Extremity episode/complication or HgbA1c >7 • High risk pregnancy (including those who need 17-P) • Post-transplant within 6 months • NICU with LOS >7 days • Catastrophic illness or injury, e.g. transplants, HIV/AIDS, sickle cell disease, cancer, serious motor vehicle accidents • End Stage Renal Disease • Dual diagnosis (members with serious, chronic behavioral health and physical health diagnoses)

Below we describe interventions we have developed to target selected groups of super-utilizers and high risk members.

Sickle Cell Disease. To improve outcomes and reduce ED and inpatient visits across all affiliate health plans, we use a comprehensive, evidence-based approach to the management of members with sickle cell disease (SCD). Our Sickle Cell Program provides educational materials, offers Case Management and Care Coordination services, and promotes use of, and adherence to, hydroxyurea. Once a member is identified, a Case Manager outreaches to the member to describe the program and conduct an in-depth assessment. Using the results of the assessment, the Case Manager stratifies the member as low, medium or high risk, and either determines if they meet the criteria for Hydroxyurea or assesses their level of adherence to their Hydroxyurea regimen, whichever is applicable. The Case Manager maintains contact with the member using the following guide for frequency of intervention.

Acuity Summary	Contact Frequency
High Risk	
Unstable Hospitalized Symptomatic and at risk for inpatient Admission or ED visit	At least every other week but can be as often as daily until the member is stable
Medium Risk	
Complex but stable Numerous health care needs and services	At least every other month but as often as necessary to address complex needs
Low Risk	
Stable Member/family managing illness well Follow-up with DM or BH	Quarterly Determined from communication with BH care manager or DM coach

Education and Disease Management. We provide all members with SCD with educational materials and disease management resources, including a Member Welcome Letter, Understanding Sickle Cell Booklet, Living Well With Sickle Cell book, and instructions on how to access podcasts and the health education library that contains materials approved by DHH. We may provide some high-risk members with a ConnectionsPlus phone that may be preloaded with our Living Well with Sickle Cell audio book and

several podcasts that have been approved by DHH. We send two health tips a week to the phone via text and preload the phone with all numbers the member may need to call to access care and services.

Case Management and Care Coordination. Our Case Management staff understand that coordinating multiple subspecialty referrals is only a small part of the overall needs of a member with SCD and their family.

Our Case Managers offer comprehensive care for these members including, but not limited to, helping them manage the daily needs of living with a chronic illness, medication adherence, preventive and primary care, pain management, member education, and coordination of health care providers. Program Coordinators assist the member with social needs while Case Managers address the clinical aspects of the member's condition, and conduct

provider outreach and education regarding Hydroxyurea use and adherence. We follow up with a Hydroxyurea Reference Guide for the PCP to educate them on the appropriate use of the drug.

Individual Sickle Cell Pain Plan. Episodes of acute pain are the most common reason for members with SCD to seek medical attention. Stress, weather conditions, dehydration, infection and alcohol consumption can trigger an acute episode of pain, but most episodes have no identifiable cause. Members with SCD experience pain that ranges from mild to excruciating and it isn't unusual for them to also have fever, swelling, tenderness, hypertension, nausea and vomiting during an acute pain episode. Education and self-management skills are critical tools in avoiding or reducing the severity of an acute episode.

Our Case Managers work with the member and provider to ensure they develop a pain plan tailored to the member's needs. The plan outlines how the member can appropriately manage their pain at home and includes pre-defined thresholds for the use of opioids and guidelines for when they should contact their health care provider. Case Managers prioritize members with SCD who have had five or more ED visits in the prior year for a chief complaint of pain, outreaching to the member and treating physician to encourage prompt development of a pain management plan. In addition to the pain management plan, the Case Manager develops an overall care plan that addresses physical, psychological, social, and environmental needs, goals, and interventions. In the event that a member is admitted to the hospital, our UM staff follow InterQual® Sickle Cell Crisis criteria to determine level of care, including sickle cell day hospital/observation or acute inpatient facility.

Chronic Pain. To address chronic pain, which may cause avoidable ED visits, LHCC currently offers a Low Back Pain Chronic Care Management Program (CCMP) through our Centene affiliate and subcontractor Nurtur. In CY 2013, across Centene affiliate plans that use Nurtur's Low Back Pain management program, 14% of those engaged were able to participate in an exercise program appropriate for their condition, and 100% of eligible participants reported a reduction of 20% or more on the pain scale index. An Exercise Physiologist conducts a baseline assessment call and based on the assessment, the Exercise Physiologist provides physical health coaching to members supplemented by psychosocial coaching by a Behavioral Health Coach as appropriate. The Exercise Physiologist works with the member and their physician to develop a Care Plan that focuses on promoting recovery from low back pain and preventing future back pain episodes. Interventions may include instruction for the development of core muscle endurance, strength and flexibility; review of workstation ergonomics; optimization of body

Sample Care Plan Elements Addressing Management of Acute Pain Episodes from SCD

- Follow pain plan for acute pain management
- Take extra vitamins – folic acid
- Take anti-inflammatory medications
- Increase fluid intake
- Contact PCP or treating physician at onset of crisis
- Contact 24/7 Nurse line if PCP or treating physician is not available
- Warm baths for comfort
- Place a heating pad on low or warm water compress on the painful area
- Massage the area and then rest

mechanics and posture; and a maintenance exercise program. The Behavioral Health Coach provides recommendations for Care Plan strategies addressing medication understanding and adherence; and managing pain and stress.

We will expand this program under the new contract to address other types of chronic pain. The expanded

Pain Management Program Goals

- 50% of active participants will reduce or eliminate 1+ lifestyle risk factor or disease within a 12 month period
- Improvement in Oswestry Disability Index to < 20
- Adherence to treatment guidelines and improve self-management skills
- Reduced health care utilization related to back pain
- Reduced pain medication usage
- Improved body mechanics
- Increased exercise tolerance
- Improved functional ability
- Improved pain management
- Decreased ED visits for pain

Pain Management Program will use Nurtur Health Coaches as well as our RN Case Managers and Social Workers who will be trained and certified in pain management, in addition to the existing staff who focus on low back pain. The Program will also incorporate guidelines for appropriate ED prescription of pain medications currently being finalized by DHH’s ED Reform Committee. Our Chief Medical Director participates on this committee and has assisted with development of the guidelines. We will notify our ED providers of the new

guidelines once they are final via the Provider newsletter, fax blast, and Provider Relations and Case Management staff as well as our concurrent review nurses, which are onsite at 17 network hospitals. We will also post the guidelines on our Provider Portal.

Dental Needs. LHCC is working with the Dental Benefits Manager (DBM) to develop a Memorandum of Understanding (MOU) that will incorporate joint education efforts, our reciprocal referral process, coordination protocols for shared members. We are discussing coordination for shared members who are high utilizers of ED or inpatient services due to dental issues, as well as for members at high risk of poor outcomes due to dental issues. For example, we are discussing joint efforts to identify and assess members aged 18-20 with an ED visit for dental pain, which may indicate drug-seeking behavior rather than a need for treatment. We are also discussing coordinated education and outreach, such as efforts to educate pregnant members about, and ensure services to address, the higher risk pregnant women have for gingivitis, gum disease, and related “pregnancy tumors” (growths on gums caused by plaque) that are linked to a higher risk of preterm birth and low birth weight.

Additionally, LHCC plans to provide value-added dental services for adult members through our network FQHCs. Because oral health and general health are linked, we anticipate that increasing access to dental services will improve health status of our adult members over time, including but not limited to those with chronic conditions who may experience exacerbations due to poor oral health.

BH Conditions. For members with high utilization of inpatient and/or ED services related to a BH condition, we coordinate with the SMO to develop, implement and monitor an integrated care plan that addresses the full range of Bayou Health, specialty BH, and other services the member needs; and to provide education and support for appropriate access to prevent unnecessary hospital and ED utilization.

Our Case Managers (including our BH clinician Case Managers) conduct joint rounds with the SMO care management team at least bi-monthly via phone or in person to discuss shared members. Our BH Medical Director will also participate under the new contract. During joint rounds, we discuss the progress and utilization for shared members, including all medications they are using, to identify potential interactions and member compliance. We identify and develop solutions for addressing any barriers to appropriate access. LHCC’s Pharmacist participates in joint case rounds to assist in identifying member medication adherence issues, drug interactions, and over- or inappropriate prescribing, for both medical and BH medications. Joint rounds participants also discuss pending discharges for members who are in the

hospital or psychiatric facility to identify needed post-discharge services and follow up to prevent a readmission or ED visit.

Our Quality Improvement (QI) Department reviews a monthly report from the SMO for shared members with ED visits. QI staff compare this list to our ED utilization report to accurately determine overall ED utilization for the member. Case Management staff and SMO staff discuss and develop strategies to address members with high utilization during joint rounds. Under the new contract, QI staff will also generate a report monthly that includes the names of shared members with ED visits and dates of service and distribute it to the SMO. ED Diversion Program or Case Management staff also notify SMO staff when we identify an ED visit for a co-managed member, and collaborate on follow up actions including member outreach and education, provider follow up appointments, and needed care plan revisions. For members with an inpatient admission who have potential BH issues requiring a referral for BH services, our onsite concurrent review nurses (CRNs) work with hospital staff and attending physicians to arrange any SMO care management services and BH provider consultation that may be necessary during the inpatient stay. If the member has an existing relationship with an outpatient BH provider, we attempt to involve that provider to ensure continuity of care.

CRNs also work with a member being discharged from inpatient care and providers to ensure necessary follow-up appointments are scheduled prior to discharge. For example, for a member with an inpatient BH stay, CRNs coordinate with hospital discharge planning staff and SMO staff to schedule the seven day follow-up appointment prior to discharge. After discharge of high and moderate risk members, our Transition of Care (TOC) Team assists with referrals and scheduling any additional post-transition visits or services that are not yet scheduled, such as visits with other specialists recommended during a post-discharge follow-up appointment.

In addition, TOC Team staff ask the member about any changes in their medications and if they are having any trouble filling the prescriptions. We provide education about medication management, assist the member in connecting with the provider and/or pharmacy to obtain refills as needed, and/or work with the SMO in identifying medication needs as appropriate. LHCC continues medication prescribed to a member in a state mental health treatment facility for at least 60 days after the

From 2012 to 2013, our Start Smart For Your Baby® Program achieved a 31% decrease in our NICU rate, a 37.9% reduction in NICU days/1000 births, and an 8.6% decrease in the rate of preterm (<37 weeks) births.

discharge, unless our pharmacist and the facility's prescribing physician determine that the medications are not medically necessary or potentially harmful to the member.

High Risk Pregnancy/NICU. We ensure access to appropriate service settings for members needing medically high-risk perinatal care, including both prenatal and neonatal care, through our Start Smart For Your Baby® Program. Centene's award-winning, multi-faceted approach to prenatal and postpartum care, which LHCC has adapted to the unique characteristics and needs of our Louisiana members, includes extensive member outreach and incentives, wellness materials, provider incentives, and intensive case management. Start Smart reinforces the appropriate use of medical resources to extend the gestational period and reduce the risks of pregnancy complications, premature delivery, and infant disease. Program components for high-risk pregnant members and neonates include but are not limited to those highlighted below.

High Risk OB Case Management. We provide our high and medium risk pregnant members at risk for poor pregnancy/birth outcomes with best practice case management interventions to increase access to appropriate prenatal care, education, and needed community resources, while decreasing admissions to the Neonatal Intensive Care Unit (NICU), as well as infant and maternal morbidity and mortality. In addition to regular phone contact with the Case Manager for education, support, and monitoring for complications and adherence to prenatal care and any provider treatment plan, our field Case

Management staff and MCRs are available to meet in-person with the member. For example, a Case Manager may accompany the member to an OB appointment to ensure clear communication between the member and provider.

17-Hydroxyprogesterone (17P). To reduce preterm births for pregnant members with a history of a preterm delivery, we identify and outreach to members with previous preterm births to educate them about and offer 17P. We identify 17P candidates through data mining, historical claims, telephonic outreach, screenings, and Case Manager encounters. Start Smart staff educate identified members who agree to participate about the importance of early and consistent prenatal and postpartum care. We also review the 17P benefit coverage guidelines and encourage appropriate use of 17P with providers, including those serving members identified as 17P candidates.

NICU Management. For our dedicated Start Smart NICU Team, we recruit nurses who have experience working in NICU units. These nurses work directly with the hospital NICU nurses, participate in NICU rounds, and assist with discharge planning for NICU members. They also serve as a bridge between hospital NICU staff and the mom, sharing the knowledge our Start Smart Case Managers have about the mother's social issues and obstacles. This bridge helps to ensure hospital staff have full information and that the discharge plan will effectively address all issues that are critical to the infant's success.

Perinatal Substance Use Disorder (SUD) Management. LHCC is expanding our Start Smart Program to enhance our management of pregnant members with SUD with the goal of reducing maternal inpatient and ED admissions, and NICU admissions. We will add BH Case Managers to promote member recovery, improve perinatal outcomes, and improve appropriateness and cost-effectiveness of care settings for these members and their infants. Case Managers will use Motivational Interviewing and other best practice engagement techniques to involve members in their care. They also will collaborate with the member and treating Bayou Health and SMO providers to develop a care plan that includes treatment referrals, self-management tools, such as workbooks designed to better understand their triggers, and use of local support groups and resources.

Per RFP Section 22.13. Proprietary and/or Confidential Information, this information is confidential and has been redacted from this copy.

In addition, our Text4Baby and SSFB Texting Programs offer texts with prenatal education and an email that promotes breastfeeding initiation. After delivery, breastfeeding moms are encouraged to enter the survey arm of the SSFB texting program, which contains additional breastfeeding information and support and a survey component that tracks breastfeeding duration and exclusivity. This data (not available elsewhere) will help us understand the current state of breastfeeding among our members and develop effective breastfeeding support strategies. The program also tracks maternal weight and encourages timely postpartum and well child visits. Members can earn \$5 on their CentAccount pre-paid reward card for taking the SS4B survey.

Other Strategies To Ensure Appropriate, Cost-Effective Care

Transition of Care Program. Our Transition of Care (TOC) Program provides proactive transition planning and intensive support to engage members in their care after discharge, preventing and reducing readmissions for high-risk members. Our dedicated TOC Team consists of RNs and social workers, supported by a BH clinician when needed, as well as CRNs (including those onsite at 17 network hospitals). CRNs and TOC staff work to reduce admissions/readmissions and improve appropriate, cost-effective utilization by ensuring coordinated development and timely implementation of a transition plan; promoting medication adherence and compliance; increasing PCP visits (including accompanying the member to the first post-discharge visit if necessary to support member compliance and understanding); and improving self-management skills and self-efficacy. TOC staff follow the member up to 30 days post-discharge, with a well-coordinated hand off to an assigned CM if ongoing Case Management is required.

Ensuring Appropriate Pharmacy Utilization. To improve appropriateness of care and reduce costs, LHCC will continuously monitor and manage provider prescribing patterns and member utilization of prescription drugs. When we identify high-utilizers and indicators of inappropriate utilization, we will take one or more of the following steps:

- Stratify and assign members to the appropriate level of Case Management or CCMP interventions.
- Educate members about appropriate prescription drug utilization, including Case Management and CCMP staff outreach, and information in the Member Handbook, on the Member Portal, and in at least two quarterly member newsletters annually.
- Educate providers with outlier prescribing trends about compliance with the preferred drug list (PDL) and appropriate prescribing practices. We may also invite prescribers to a Peer-to-Peer consultation of their prescribing practices.
- Intervene with providers whose prescribing practices are found to be outside of industry standards or peer norms, are non-compliant with adherence to the PDL and/or generic prescribing practices, or who may not be adhering to prior authorization policies or procedures.

Pharmacy Lock-In Program. Our Pharmacy Lock-In Program will use DHH approved policies and procedures to ensure appropriate use of Medicaid benefits and serve as an educational and monitoring parameter. Pharmacy staff will monitor claims data to identify signs of a consistent pattern of misuse or overuse. Our Pharmacy Director and/or Medical Director will validate inappropriate use and determine whether to enroll the member in the Program. If the determination is positive, pharmacy staff will contact the member via certified letter to explain the decision and details about the program, including:

- The restriction to a designated pharmacy and/or prescriber(s).
- Sharing a list of at least three pharmacies from which the member may choose one for the Lock In program.

- The availability to obtain necessary drugs in an emergency, and to obtain a 72-hour emergency supply from a different pharmacy.
- The member's right to appeal the decision and the process for doing so.

The Pharmacy Department will send a copy of the letter to the designated pharmacy, prescriber(s), and PCP. A Case Manager will attempt to contact the member to provide education about appropriate pharmacy utilization. If the member is pregnant, we will attempt to enroll her in our Perinatal SUD Management program, through which we will provide a BH Case Manager to coordinate care and support her recovery.

Pharmacy staff will review the member's pharmacy claims at least annually from the original lock-in effective date to determine

compliance and appropriate pharmacy utilization. Once the member is compliant for a period of four consecutive quarters, the Pharmacy Department will notify the member, PCP, and pharmacy via letter that the lock-in is being removed and the member is free to access any network pharmacy.

Psychotropic Medication Utilization Review. We are implementing a Psychotropic Medication Utilization Review (PMUR) Program to address overutilization of ADHD medication. LHCC has contracted with another Centene affiliate, Cenpatico® Behavioral Health (Cenpatico), to assist us in administering the program. Cenpatico, URAC accredited since 2007, created its PMUR program in 2008 to improve oversight and monitoring of psychotropic medication use in children in the Texas foster care system. The subsequent policy and health care delivery model changes reduced psychotropic medication use by almost 23%, class polypharmacy by 44% and use of more than five psychotropic medications by Texas children in foster care by almost 43% between 2008-2013.

The goal of the PMUR Program is to ensure that pharmacological treatment is benefiting the child and that all members of the treatment team are working together to accomplish this outcome. The PMUR process incorporates claims review, medical record review, and peer-to-peer consultation and education. PMUR is a proven means of assuring appropriate utilization of psychotropic drugs, which often do not have FDA-approved use for children. PMUR will help PCPs in their oversight and treatment of members requiring this medication and reduce the incidence of polypharmacy and of adverse drug effects (including obesity). It will also reduce unnecessary drug costs, and identify where psychosocial interventions may be more effective or needed to complement drug therapy.

CRITERIA FOR IDENTIFYING PHARMACY MISUSE OR OVERUSE

- Prescriptions written on a stolen, forged or altered prescription blank issued by a licensed prescriber
- Prescribed medications do not correlate with the member's medical condition
- Member receives more than five therapeutic agents or three controlled substances per month
- Member receives duplicative therapy from different providers
- Member has filled prescriptions at more than two pharmacies per month or more than five pharmacies per year
- Member receives prescriptions from more than two prescribers per month
- Member has been seen in hospital Emergency Room more than two times per year
- Member has diagnosis of narcotic poisoning or drug abuse on file
- Number of prescriptions for controlled substance exceeds 10% of total number of prescriptions

PDL Drugs. PMUR is applied to the prescribing of both preferred and non-preferred psychotropic drugs of all classes. For example, the review may be applied to LHCC’s current PDL, as well to the common

Cenpatico PMUR Experience	
State	Population
Texas	Foster Care TANF (all ages) SSI (all ages)
Mississippi	Foster Care
Florida	Foster Care TANF Children under 5
Washington	TANF (all children under 5)
Kansas	Foster Care SSI (all ages) Long Term Care Intellectual/Development Disabilities (all ages)
New Hampshire	Foster Care

PDL that Bayou Health MCOs will soon develop as required by this RFP.

PA Requirements. Centene affiliate plans and their P&T Committees use as a base the Texas parameters, and adjust them as needed to meet the specific needs of each state. For example, LHCC will adjust the parameters and reviews, as needed, to account for the common PDL and its criteria as well as for prescribing by network PCPs and other prescribers who are not behavioral health specialists in the SMO network.

DUR. Centene’s PMUR program identifies psychotropic medication use that exceeds parameters using both concurrent and

retrospective information. We screen using data from our initial and comprehensive health risk screenings and assessments of newly enrolled members, and monthly pharmacy claims reports. Each plan’s Behavioral Health (BH) Medical Director (or in some plans, their Medical Director) reviews members identified by the screenings/assessments and monthly reports against medical, pharmacy and other clinical histories as shown in TruCare, Centene’s/LHCC’s health services management platform. The BH Medical Director directs specialized PMUR Team clinicians (licensed therapists with training related to psychotropic medications) to contact providers if more information is warranted.

PMUR Team clinicians fax a provider-friendly form to help providers submit required additional information, such as lab results and notes from previous visits. Upon review of the provider’s submitted information, the BH Medical Director determines whether provider outreach is needed and documents the determination in TruCare.

Our PMUR processes also include reviews of a provider’s prescribing when requested by caregivers and, in the case of children in foster care, caseworkers, Court Appointed Special Advocate (CASA) staff, medical consenters and judges.

Provider and Member Education and Support. When the member’s drug use falls outside of parameters and is not supported by medical histories, the BH Medical Director contacts the provider and explains the purpose of the review and current psychotropic medication prescribing standards. The BH Medical Director will collaboratively formulate a plan of treatment with the provider, document the plan in TruCare, and send copies of the treatment plan to the provider and in some affiliate plans, to the caregiver. For children in foster care, we also send copies of the treatment plan to the member’s Caseworker/Medical Consenter. LHCC’s provider education efforts will include reaching out to nurse practitioners as needed, because of their significant role in treating children with ADHD and other disorders.

A PMUR Team clinician will monitor the member’s drug claims data and is authorized to discontinue provider monitoring when there is documented evidence that the treatment plan is successfully followed, for example, when claims show a medication has been discontinued. The clinician will refer to the BH Medical Director cases in which additional provider outreach may be necessary.

The PMUR Team will report any provider who persistently refuses to follow the plan of treatment to Quality Improvement (QI) staff as a Quality of Care concern. We will use standard QI processes to

address providers who fail to adhere to PMUR guidance, and take appropriate steps including referral to the Credentialing Committee for consideration of continued network status. Throughout the process, the Behavioral Health Medical Director will immediately contact appropriate state officials finding evidence or risk of a member's safety or serious side effects, such as the Medical Director at the agency responsible for the state's foster care program.

Coordination with BH Statewide Management Organization (SMO) providers. For members for whom we have claims data from the SMO showing psychotropic drug use, that alone or in combination with LHCC pharmacy claims data, falls outside of parameters, the BH Medical Director or PMUR Team will reach out as needed to the SMO providers. They will verify the drug therapy the member is currently using as prescribed by the SMO provider. They also will share with the SMO provider the psychotropic prescribing as shown by LHCC claims, clinical histories of services received by our network providers, and clinical recommendations based on clinical parameters. They also will develop as needed treatment plan goals and adjustments in collaboration with the SMO providers. This sharing of information will help reduce the incidence of over-prescribing and fragmentation of services with members receiving multiple services for the same presenting problem. LHCC's outreach also will foster coordination among LHCC and SMO providers for members with complex BH conditions by focusing on an integrated care approach through communication and collaboration

Community Paramedicine Program. LHCC worked with Acadian Ambulance to implement a Community Paramedicine Program for members with asthma who are 21 years old and under and live in the New Orleans area. The program provides real time support from a community paramedic, including triage, home assessment, and appropriate redirection for this targeted group of members, with a goal of decreasing unnecessary emergency department visits and inpatient stays. If the program is successful in decreasing unnecessary ED visits and inpatient admissions/readmissions for the target population, we will evaluate the feasibility of expanding the program as part of our strategy to monitor post-discharge care in remote areas.

Telemedicine. LHCC is working on a collaborative telemedicine solution to improve access to specialist providers in rural and underserved parts of the state. This program will allow us to ensure closer monitoring of members with post-discharge home health needs who also require specialty care, through increased member interaction with specialists from whom TOC and Case Management staff will solicit feedback on member progress.

We are actively engaged in discussions with Louisiana State University (LSU) Hospital Services Division (HCSD), LSU Health Science Center New Orleans, and LSU Health Care Network Clinics to develop a partnership for a telemedicine program across the state. This partnership may also include LCMC Integrated Health System (including Children's Hospital, Interim LSU Hospital [ILH], Touro, and the future University Medical Center).

Telemedicine programs traditionally consist of three components:

- The member (patient) in a remote area who travels to a clinical setting to receive the session
- The providing physician on the other end of the video feed in a different geographic location
- The technical and administrative team at both sites that facilitate the sessions

For our proposed Telemedicine Program, LHCC will be the lead on engaging the member for the telemedicine session. LSU Health Science Center, under the leadership of Dr. Ali, Chief Medical Officer at LSU Health Clinic, will be the lead on finding willing specialist providers from different academic departments to participate as providing physicians. LSU HCSD, under the direction of Dr. Ali, will be the lead for the technical and administrative services needed to execute the program, as the current equipment and hardware belong to them.

Phase I of program implementation will be traditional telemedicine. We will use existing LSU telemedicine infrastructure, with some additions by LHCC where needed. Members in certain geographic areas will access a local medical clinic or hospital for a telemedicine visit with a specialist. In Phase 2, we will be developing an innovative in-home telemedicine approach. During this phase, we will evaluate LSU's current telemedicine platform to determine the feasibility of using it on mobile devices. If feasible, this will allow our Case Management staff to serve as the receiving end of a telemedicine visit in the member's home. In addition, to enhancing the member's specialty care access, this will facilitate our monitoring of the member's post-discharge home care services, the member's progress, and any unmet needs.

Home-Based Primary Care. Through our Centene affiliate and national leader in physician house call medicine, US Medical Management (USMM), we will provide home-based primary care services to selected members. USMM delivers a physician-led services model that serves over 50,000 individuals in 11 states using proprietary, evidence-based treatment protocols and a patient centered, physician-driven EMR with complete continuum of care integrated reporting and scheduling. USMM provides over 400,000 physician house calls, 39,000 podiatric house calls, 139,000 home health visits, and 380,000 hospice patient days annually.

**Members Eligible To Receive
Home-Based Primary Care**

- **2+ admits and one or more chronic conditions**
 - **5+ different chronic conditions**
 - **4+ ED visits and 3+ different chronic conditions**
 - **Personal Care Services cost of \$1,750 PMPM or higher.**
-

Environmental and psychosocial factors driving inappropriate utilization may be difficult to identify in an office setting, but become evident the moment a USMM provider steps into the member's home. Medication bottles, food, durable medical equipment, level of structural upkeep or disrepair, standards of cleanliness, personal hygiene, pets, family members, social support systems or isolation are all readily apparent and add significantly to the provider's understanding of factors that might represent barriers to treatment adherence and health outcomes. This contributes to the provider's capacity to accurately identify and meet home health care needs, and mobilize other supportive services locally available, in order to improve clinical stability.

Eligible members who choose to participate will receive an Annual Wellness Visit, which includes a Personalized Prevention Plan with realistic treatment goals and necessary referrals to specialty care and community resources. A 'Risk versus Benefit' discussion factors heavily into the development of the Personalized Prevention Plan, as does the member's expressed beliefs and goals. This person-centered approach to medical management allows individualized, personalized, and diversity-directed considerations around the member's psycho-social and medical needs.

Frequency of well and sick visits will occur according to each member's medical necessity. For members who choose to use USMM's physician as their PCP, rather than as supplemental primary care, the physician will schedule visits in compliance with DHH appointment availability standards. All members will have telephone access to USMM's on-call physician during the evening and weekend hours for acute concerns, in addition to LHCC's Member call center and 24/7 access to a nurse through NurseWise. Follow-up for chronic conditions will occur at variable intervals depending on medical necessity, and may range from one week or less for a member experiencing decompensation, to two months for a member with more physiologic resilience and fewer medications. The physician will reconcile electronic and bedside medication lists at each visit, visually inspecting medication bottles within the member's home to verify medications. The physician will follow HEDIS guidelines and address HEDIS gaps at each visit, including coordination of appropriate referrals and changes in medication.

For members who choose to remain with the existing PCP and use USMM for supplemental primary care services, the physician will communicate with the PCP and treating providers during Personalized

Prevention Plan development and monitoring to ensure coordination of all services, and will participate as appropriate in rounds on the member's care with Case Managers, the Medical Director, and other clinical staff. The assigned Case Manager will also coordinate with the physician and other providers to integrate care.

By providing this high-touch, convenient service to address non-emergent needs, we expect to reduce inappropriate ED and hospital utilization and improve use of the medical home and urgent care services.

Long Term Acute Care and Rehabilitation Hospitals. We authorize care in Long Term Acute Care (LTAC) and rehabilitation hospitals when appropriate for members who require complex care for an extended period of time. For example, hospitalized members weaning from a ventilator or those with significant wound care needs may need a lower level of care for a relatively long period of time prior to returning home safely. LTAC and rehabilitation hospitals are designed for longer stays, and also have specialized expertise in treating these complex issues. LHCC authorizes these services when medically necessary as an appropriate, cost-effective alternative to lengthy acute care hospital stays. In addition, providing this specialized focus in an environment geared toward longer stays supports member satisfaction, as members seldom desire to remain in the acute care hospital for long periods when an appropriate alternative is available.

Palliative Care and Hospice Program. We are developing a Palliative Care and Hospice Program to serve members with cancer and other advanced chronic and debilitating illnesses with indicators of persistent challenges with pain and symptom management, as identified by such factors as pharmacy and ED use. The program will support members (such as those with Alzheimer's, advanced cancer, or cystic fibrosis) and their families maintaining the member in the home rather than admitting the member to a facility or institution. Our Integrated Care Team for this program will include an RN Case Manager who is certified through the **National Board for Certification of Hospice and Palliative Nurses, as well as a Program Specialist and Program Coordinator to assist with non-medical and non-clinical needs.** IC Team staff will work with the member and treating providers (and family/guardian as appropriate) to develop and monitor a care plan that meets the member's health and psychosocial needs, recognizing the critical role of family/caregivers in supporting the member's psychosocial wellness. Through our Centene affiliate and national leader in physician house call medicine, US Medical Management, we will provide home-based physician services when appropriate, such as evaluation and management of the medical condition and pain and the discussion of treatment goals, including advance care planning or hospice. We will also provide and educate providers about guidelines from the National Hospice and Palliative Care Organization in the Provider Manual and on our Provider Portal. Program staff will inform providers of the guidelines when coordinating the provider in developing and monitoring the member's care plan. LHCC will become a member of the Louisiana-Mississippi Hospice and Palliative Care Organization to leverage resources for staff training and member education, as well as to stay current on recommended practices and local support resources for members.

Palliative Care and Hospice Program staff will leverage the expertise of our BH Medical Director and BH Case Managers in addressing behavioral health issues, such as when the receipt of stressful and difficult information or the need for end-of-life decision making triggers challenging family dynamics.

N.5 Discuss approach you will use to address high STI prevalence by incentivizing providers to conduct screening, prevention education, and early detection, including targeted outreach to at risk populations.

Approach to Addressing High STI Prevalence

LHCC will use a multi-dimensional approach to address high STI prevalence, including, but not limited to HIV prevalence. This approach includes the following components:

- Provider incentives for STI screening to promote early detection
- Prevention education and early detection through our Start Smart For Your Baby® pregnancy and perinatal management program for pregnant members, and through partnering with the Office of Public Health for non-pregnant members
- Targeted outreach to at-risk populations
- A best-in-class Chronic Care Management program that promotes sexual health and ensures access to screening, counseling, and treatment in order to reduce new HIV and STI infections.

LHCC has adopted the CDC recommendations for screening and testing for HIV/STI. We will educate providers on the benefits of screening and testing for HIV/STI during new provider orientation and subsequent office visits, through Provider Newsletters, and contacts from Case Management, Chronic Care Management, and MemberConnections™ staff who assist members to coordinate and/or access services. We will educate members through educational materials in the Member Handbook, on the website, and in the member newsletter, and targeted outreach to high-risk members (described below). We also partner with community organizations in community outreach and education events, such as staffing a table with screening information at World HIV/AIDS Day conferences with LSU in 2013 and 2014.

Incentivizing Providers To Conduct STI Screening

LHCC has a two-tiered incentive program for HIV/STI screening, testing, prevention education, and early detection. We will provide an incentive for OB/GYN providers to conduct screening as early in a woman's pregnancy as possible, and then to retest as necessary throughout the pregnancy in order to reduce the risk to both mother and child and improve health outcomes. We will also incentivize PCPs to comply with CDC guidelines for screening and testing for HIV and STIs.

OB/GYN Incentives. LHCC will incentivize OB/GYN providers to improve HIV and STI screening, counseling and education of pregnant members with the goals of reducing the risk of transmission to the newborn and improving maternal and child outcomes. Pregnant women are more likely to get tested for HIV/STI if their providers strongly recommend testing and educate the woman on the risks to herself and her unborn child. In a study of 1,362 pregnant women conducted as part of the Center for Disease Control and Prevention's "One Test. Two Lives." campaign, 93% of women who felt their providers strongly recommended an HIV test decided to get tested.¹ Counseling and screening for HIV at any point in a woman's pregnancy benefits both mothers and babies, while early detection and treatment can dramatically decrease the risk of mother to child transmission. According to the CDC, women with HIV who take antiretroviral medication during pregnancy as recommended, can reduce the risk of transmitting HIV to their babies to less than 1%.² Even if a woman was not tested and treated earlier in her pregnancy, rapid HIV tests allow women who arrive at delivery rooms with unknown HIV status to receive preventive medications during labor, and for the baby to be treated immediately after birth, which reduces the risk of transmission by about 10%.³

We will offer OB/GYNs up to a \$70 incentive (\$10 per screen) for a full panel of HIV and STI screening (HIV-1 and HIV-2, chlamydia, syphilis, herpes type 1 and 2, hepatitis B surface antigens, and Neisseria gonorrhoea), and counseling and prevention/treatment education of a pregnant woman. We will educate our providers on the importance of repeat screening of high-risk women, preferably before 36 weeks

¹ Centers for Disease Control and Prevention, One Test. Two Lives. <http://www.cdc.gov/features/1test2lives>

² Centers for Disease Control and Prevention. HIV Among Pregnant Women, Infants and Children. <http://www.cdc.gov/hiv/risk/gender/pregnantwomen/facts/index.html>

³ Centers for Disease Control and Prevention, One Test. Two Lives. <http://www.cdc.gov/features/1test2lives>

gestation. We will also pay the individual screen incentive for the HIV/STI panel for any follow-up screening of pregnant women. In addition, LHCC will offer an HIV screening incentive to OB/GYNs that perform a Rapid HIV test on women who arrive in the delivery room with no prenatal HIV/STI testing and unknown HIV status.

PCP Incentives. LHCC will launch a campaign in February of 2015 that will include a PCP incentive for providing education, counseling, and HIV/STI screening of any man or woman, regardless of age. The PCP incentive will be available for individual tests, as well as for the full screening panel described above. Our Chief Medical Director will work closely with Provider Relations to ensure that all PCPs are educated on CDC recommendations for HIV/STI screenings, and are aware of our primary care HIV/STI screening campaign and incentives.

Prevention Education and Early Detection

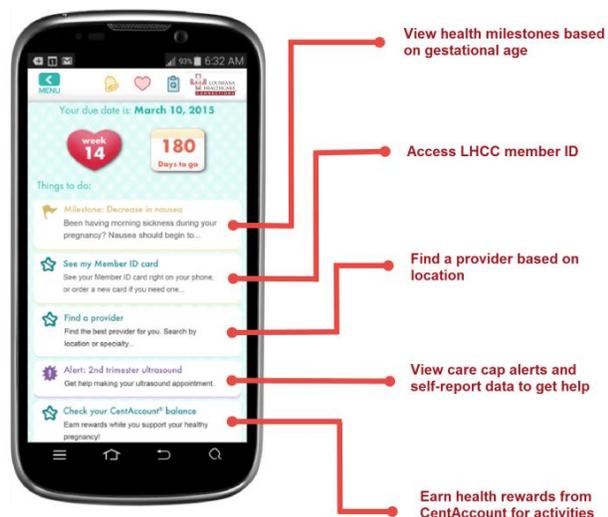
We will address prevention education and early detection of pregnant members through our Start Smart For Your Baby® program, and the OB incentive described above. For other members (in addition to general member education on screening guidelines, as well as the PCP incentive described above), we will address prevention education and early detection through collaboration with OPH.

Pregnant Members. Our Start Smart for Your Baby® Program (Start Smart) offers a range of education, Case Management, and care coordination interventions that help extend the gestational period and reduce the risk of pregnancy complications, premature delivery, and low birth weight infants, and improve maternal and infant health outcomes. Specially trained registered nurses (Start Smart Case Managers) offer comprehensive Case Management for high and moderate risk pregnant women, including education and referral to appropriate resources needed to ensure a healthy pregnancy. (See our response to Question N.6 Prematurity Prevention and Perinatal Outcomes for more general program details). For all members, our Start Smart Welcome Packet includes information on HIV/STI and the importance of screening as early in the pregnancy as possible.

In addition, our Start Smart Case Managers target members with high risk conditions and/or behaviors, encourage screening for HIV/STI, and educate on prevention of HIV/STI and the benefits of early detection and treatment by using our established education and discussion guide. The Case Manager introduces the topic by educating the member about the risk of not knowing if they have an STI, and explaining what might happen if an STI is left untreated during pregnancy.

We provide links and resources for the Case Manager to use in educating the member about the special risks STIs pose for pregnant women and their babies, including, but not limited to information developed by the March of Dimes related to miscarriage, ectopic pregnancy, preterm delivery, stillbirth, and birth defects and other prevention education topics. The Case Manager defines what an STI is, describes common symptoms, and ensures the member understands that many infected individuals do not know they have an STI as some STIs cause no symptoms. In addition, they discuss the fact that a baby most frequently becomes infected with the STI during delivery while passing through an infected birth canal, but that a few STIs can cross the placenta and infect the fetus. The key message is that the best way to keep the baby healthy is through testing early in the pregnancy, but that it is never too late to be tested and treated to protect the baby's health.

Using LHCC's Mobile StartSmart for Baby, expectant mothers can securely:



LHCC's Start Smart for Your Baby® for Bayou Health Mobile App. On 2/1/2015, we will launch the Start Smart for your Baby® for Bayou Health mobile app ("Start Smart Mobile") for expectant members. Start Smart Mobile will be among our growing, free suite of programs available through the LHCC Mobile app.

Start Smart Mobile combines LHCC's operating experience working with Louisiana members, Centene's 30 years' experience in Managed Medicaid systems development, and the technology leadership of our partner Wildflower Health, a mobile health technology company focused on women's health throughout their pregnancy, with apps supporting over 50,000 women today. Start Smart Mobile features a broad range of integrated interactive tracking tools, self-service functions, alerts, communication, and accessible resources.

Through Start Smart Mobile, our expectant mothers will have access to information on more than 50 risk factors for pregnancy complications, including HIV and STI.

Non-Pregnant Members. In order to improve prevention education about, and early detection of, HIV/STI and to address Louisiana's public health priority to reduce HIV/STI rates, we will coordinate and collaborate with the Office of Public Health (OPH) and OPH-certified School-Based Health Centers (SBHCs) to improve awareness of, access to, and rates of HIV/STI screening for LHCC members. We currently include every OPH Parish Health Unit (PHU) in our provider network. In addition, many SBHCs are in our network, and we will continue to engage those that are not to encourage them to join LHCC.

LHCC will coordinate our public health-related activities related to HIV/STI education, counseling, and testing with OPH via one or more Memoranda of Understanding as per RFP Appendix RR. We currently share and report data in coordination with our OPH network PHUs and SBHCs. In doing so, we have identified strategies that could potentially improve data collection and reporting of HIV/STI screening, as well as leverage and expand resources for providing education, counseling, and testing.

Facilitating Education and Screening By Reimbursing Any Medicaid-Eligible Provider. We have learned that members, particularly adolescents, are sometimes uncomfortable going to their PCPs for services and screenings related to sexually transmitted diseases. Because of the importance of these screenings, we pay claims from any Medicaid-eligible providers and urge members to complete testing at any location, though we prefer, encourage, and support access to care through the member's medical home. We also understand that adolescents may be more likely to seek HIV/STI counseling and education through a Parish Health Unit or SBHC. Our statewide contract with OPH includes school-based services in 64 locations throughout Louisiana, while the OPH clinics provide an additional 55 Full-Time Sites and 9 Part-Time Sites. We are also contracted with Access Health and two other FQHCs that provide School Based services (RKM and St. Gabriel Community Health Center).

Case Management To Support Prevention Education and Adherence to Treatment. Through our MOU with OPH, we will recommend establishing a referral protocol for PHUs and SBHCs to notify us when a member tests positive for HIV/STI. If appropriate authorizations and consents are obtained, our Case

Managers will collaborate with PHUs and SBHCs to offer to enroll students with a positive test in our Case Management program. This will allow us to monitor treatment adherence, provide ongoing education, and encourage healthy behaviors that reduce the risk of HIV/STI and teen pregnancy. If a member accesses care from a PHU or SBHC that is not their designated PCP, we will outreach to them to remind them that they can change PCPs at any time and can select a PHU/SBHC that is part of the LHCC network for their primary care.

Targeted Outreach to At-Risk Populations

We will develop strategies for outreach to high-risk members, and provide culturally competent education related to screening and early detection. For members who have already tested positive, we will provide a best-in-class HIV management program that promotes sexual health, ensures access to screening, counseling and treatment, helps to reduce new HIV and STI infections, and addresses health disparities.

Outreach to Address Health Disparities that Predict Risk. Some groups of people are affected by HIV/AIDS and STIs more than other groups of people. Differences may occur by gender, race or ethnicity, education, income, disability, geographic location, and sexual orientation, among others. Social determinants of health, like poverty, unequal access to health care, lack of education, stigma, and racism are also linked to health disparities.

We target outreach to member populations at high risk due to factors such as race/ethnicity. For example, African-Americans are the racial/ethnic group most affected by HIV. Gay and bisexual men account for most new infections among African-Americans, and young men between the ages of 13 and 24 are the most likely to be affected in this group. Stigma, fear, discrimination, homophobia, and negative perceptions of STIs and HIV often result in diagnosis late in the course of HIV infection, which increases the incidence of transmission to others.

We use our Proactive Outreach Management (POM) campaigns to conduct automated outbound messaging to identified member populations. Using POM, we can develop and deploy a targeted message for different groups of members, such as an AIDS Awareness Month message that targets African-American men between 18 and 25, or an STI screening reminder message for pregnant members. We already use POM to conduct outbound messaging calls for chlamydia as part of our HEDIS efforts.

We also target outreach through collaboration with community organizations and other entities that serve specific sub-populations with increased risk. For example, because of the prevalence of HIV infection among young African-American men in Louisiana, we participated in an event organized in part by the Office of Public Health and the Baton Rouge AIDS Society (an OPH-contracted HIV/STD Program community organization) that targeted young men. We will continue to work with providers and community organizations involved with the OPH HIV/STD program to leverage their experience in addressing this sensitive issue.

Screening and Treating STI to Reduce Risk of HIV Transmission. Strong STI prevention, testing, and treatment efforts can play a vital role in preventing sexual transmission of HIV. Individuals who are infected with STIs are at least two to five times more likely than uninfected individuals to acquire HIV infection if they are exposed to the virus through sexual contact. In addition, if an HIV-infected individual is infected with another STI, that person is more likely to transmit HIV through sexual contact than other HIV-infected persons (Wasserheit, 1992)⁴. The inclusion of bisexual men in the highest tier of HIV and STI prevalence means outreach efforts must include women who have bisexual partners.

⁴ Fleming DT, Wasserheit JN. 1999. From epidemiological synergy to public health policy and practice: The contribution of other sexually transmitted diseases to sexual transmission of HIV infection. *Sexually Transmitted Infections* 75:3-17.

To target these populations, we will promote and participate in outreach and education events, such as National Black HIV/AIDS Awareness Day (February 7th), National Women and Girls HIV/AIDS Awareness Day (March 10th), and National HIV Testing Day (June 27th). Our Utilization Management, Case Management, and Chronic Care Management staff, along with our MemberConnections™ Representatives, will reinforce the importance of preventive screening during member contacts. To increase staff expertise in this targeted outreach and education, we will have the majority of our MemberConnections™ Representatives certified in HIV Prevention Counseling and Rapid Testing by the end of 2014.

HIV Management Program. We will offer a comprehensive HIV Management program that will help providers address the needs of members who test positive for HIV/AIDS, and provide supports that will enable them to employ best practices in the care and treatment of our members with HIV/AIDS. LHCC is in discussion with the AIDS Healthcare Foundation (AHF) for its NCQA accredited Positive Healthcare HIV/AIDS Disease Management Program services (PHC-DM). AHF's extensive expertise in working with HIV disease, associated co-morbidities, and the psycho-social needs of individuals with HIV uniquely positions the program to serve the disease management needs of LHCC's Bayou Health members. AHF implemented the nation's first and only HIV/AIDS Disease Management program for the Florida Medicaid Agency for Health Care Administration in 1999. In 2005, NCQA awarded AHF the first HIV/AIDS Disease Management accreditation in the nation. Today AHF's PHC-DM remains one of only three such specifically accredited programs in the country.

Most of our MemberConnections™ Representatives will be certified in HIV Prevention Counseling and Rapid Testing by the end of 2014.

This successful model provides member education, provider education and support, and an evidence-based approach to actively managing, monitoring, and intervening to improve member and provider practices that impede the best health outcomes.

Member Education. We will develop individualized education plans (medical, psychosocial and antiretroviral-specific educational materials), as well as quarterly member newsletters to increase member and family/significant other knowledge, and promote member-centered care that focuses on self-management. Materials will also address interventions to promote health, safer sex, prevention for positives, and healthy life style habits. Program staff will compare individual baseline knowledge assessments contained in the HRA to the HRA follow up assessments to monitor the effectiveness of the education provided to each member.

Provider Education and Support. Each Primary Care Physician (PCP)/HIV Specialist caring for an LHCC member will have access to an array of support services and tools, including, but not limited to evidence-based guidelines and access to ACCME-accredited continuing medical education at no cost to the provider, and to HIV expert physicians for case conferencing. Program staff will work with the PCP and other practitioners participating in the member's care in order to coordinate services, provide monitoring information (such as inpatient admissions, ED use, and prescription fill information), and promote member adherence to medical appointments and understanding of the medical home. Program staff will also provide feedback to providers on quality measures, and supply provider and member educational materials and notices of upcoming AHF, PHC-DM, and other HIV-related continuing medical education opportunities.

Because medication adherence is essential to achieve durable viral suppression, increase immune function, combat drug resistance, and control disease progression, we will provide Medication Therapy Monitoring, education, and feedback as needed with each member to assure adherence to the prescribed antiretroviral regimen, as well as any co-morbid medication management. Program staff will provide PCPs feedback reports based upon the care plan and provider preference. If the PCP has not specified

their preference, feedback loop reports on medication adherence, health system utilization (e.g., emergency room visits, hospitalizations, etc.) will be available via our Provider Portal.

Evidence-Based Standards. PHC's clinical staff, lead by AHF's Medical Director, will assist our Chief Medical Director and Behavioral Health Medical Director in developing program content for members and practitioners, as well as policies, procedures, and standards of care. They will also assist LHCC to review, adopt, and assure consistency with best practices and evidence-based standards related to HIV and care for co-morbid conditions, which we will disseminate to our provider network for review and input prior to implementation.

Case Management. The program provides evidence-based chronic Care Management, support, monitoring, and feedback on goals and outcomes to assure members gain knowledge and achieve the optimal level of health and independence. Registered Nurse (RN)-led teams focus on direct contact with members to complete a comprehensive, evidence-based health and psychosocial health risk assessment that includes factors such as clinical status, social/lifestyle issues, knowledge of HIV, ability to comply with medication regimens, and member sense of health and well being.

Case Managers (CM) use results to develop personalized care plans that incorporate evidence-based protocols, with the input of the PCP, member, member-designated family/significant other, and other relevant health care providers/community based agencies. The care plan will account for co-morbidities, potential complications (based on the member's stage of HIV disease), the need for prophylaxis of opportunistic conditions, and the member's goals for healthy living. Program staff will assess the needs of family and caregivers, and address them to the extent that they impact care. Through the assessment and interactive contact of the CM with the family/caregiver, the CM will identify issues; provide education, emotional support, advocacy, and resource referrals relevant to the psycho/social needs of the family/caregiver and/or the member.

CMs treat each member by utilizing a holistic approach, and understand the unique medical and psychosocial impact of HIV disease and the treatment protocols regarding other co-morbid conditions, including, but not limited to hepatitis B and C, tuberculosis, hypertension, diabetes, asthma, congestive heart failure, and cancer. CM ensure that co-morbid conditions are addressed according to evidence-based protocols, with treatment for all conditions integrated through medical home oversight and coordination among all treating providers.

The CM will reconcile pre-inpatient admission medications and post-discharge medications after any inpatient care to ensure their regimen is appropriate and complete, and that they understand the purpose, frequency, side effects, and interactions of each medication. Any issues such as incompatibility, duplication of therapy, or inappropriate dose will be brought to the attention of the PCP/prescribing provider and the attending inpatient medical provider in order to modify the discharge medication profile prior to discharge. The CM will follow up with the member in their home and/or telephonically post-discharge to ensure the medication education has been effective, and to reconcile the discharge plan with the member home medications

Medication Therapy Management. Antiretroviral (ARV) therapy advances over the past twenty years has significantly contributed to bending the mortality curve of HIV disease through viral suppression, improved immune function, and quality of life, however, issues of long term adherence to therapy, ARV drug resistance (that carries with it cross resistance among members of the same class of ARV), drug-drug interactions, and tolerability of the ARVs remain significant barriers to long term effective and durable viral suppression success. We will assist our members to understand that the way to achieve long-term treatment success is through a strict adherence to a specific regimen of three or more ARV medications taken in combination. The combination regimen must be taken exactly as it has been prescribed without missing doses, if they are to exert the life saving suppression of the HIV virus, which can be very challenging for members.

Our **Medication Therapy Monitoring Program (MTMP)** will integrate with PHC-DM interventions. The MTMP is a system of planned interventions to assist the member with adherence to their ARV and other co-morbid condition medication treatment regimens, as needed. The CM and Chronic Care Team (CCT) will perform an MTMP assessment, including comprehensive medication review, upon program enrollment. The nurse and member discuss all medications that the member is taking, including over the counter medication, the reason, frequency, and potential side effects and interactions of each drug. Any issues identified during this exchange will be raised to the PCP, pharmacist, and/or the medical director. The CM will follow up with the member on a quarterly basis to continually assess member medication non-adherence risk, and incorporate interventions to mitigate or eliminate identified risks. Examples of such issues and possible actions to mitigate non-adherence include:

Problem/Issue	Interventions
Failure to fill or refill a prescription	Pharmacy auto-refill, mail order, or home delivery
Missing dose(s) of medication	Pill box or reminder device; if necessary, weekly visits for pillbox fills are conducted until the member is confident in his/her ability to take the medication appropriately.
Taking more medication than prescribed	Work with local pharmacy to dispense medication in bubble packs
Discontinuing medications without the knowledge or advice of the medical provider	Education and counseling on the risks and dangers of unplanned discontinuance of medication, and the importance of adherence to medication regimen
Taking a medication at the wrong time, in the wrong dose; not following other administration instructions	Pill box or bubble pack prescription fill; reminder system

N.6 Describe your plan to address prematurity prevention and improved perinatal outcomes. The plan may include but not be limited to the following:

Plan To Address Prematurity Prevention and Perinatal Outcomes

From 2012 to 2013, Louisiana Health Care Connections (LHCC) achieved a 32.9% decrease in our NICU admission rate, a 35.2% reduction in NICU days/1000 births, and an 7.9% decrease in the preterm (<37 weeks) rate of births. Our plan to address prematurity prevention and improved perinatal outcomes under the new contract incorporates:

- Our proven **Start Smart For Your Baby® pregnancy and postpartum management program** to improve prenatal care and ensure post partum follow-up to achieve better birth and maternal/infant health outcomes. LHCC has used the Start Smart Program since Bayou Health inception as our key vehicle to promote education and communication among pregnant members, case managers, and physicians to ensure a healthy pregnancy and first year of life for babies. The program is modeled on our parent company Centene’s award-winning program, which received the 2010 URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, Start Smart was named an NCQA Best Practice.
- A **Preterm Birth Prevention program** to improve routine cervical length assessments and provision of 17P for all eligible pregnant members with a history of preterm labor or short cervix in the current pregnancy.

- Interventions and incentives to improve other perinatal outcomes such as the VBAC rate and the c-section rate, and increase use of effective contraceptives to support healthy birth spacing and improve outcomes in subsequent pregnancies.

To ensure identification and appropriate treatment for pregnant members with risk factors for prematurity or other suboptimal perinatal outcomes, we contractually require providers to perform a risk assessment on all pregnant members, including a screen for tobacco, alcohol, and substance use. If indicated, we require providers to refer the member to an appropriate fetal medicine specialist (or to contact LHCC for assistance with a referral) for further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists (ACOG).

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We offer all providers comprehensive information and support to help improve services for pregnant Members. Provider education covers the role and importance of our NOP process, our Start Smart program, and clinical topics such as use of 17P, prevalence and risk of cesarean section deliveries, and our adopted clinical practice guidelines related to perinatal care. We emphasize the importance of providers accessing information in DHH's data systems to provide appropriate services to the highest-risk women (such as providing 17P to women with a prior pre-term birth, and tobacco cessation services to women who smoke during pregnancy). We offer this information in the Provider Manual, on our Provider Portal, and in initial and ongoing Provider trainings. We describe additional provider education below. We will also collaborate with DHH and providers in creation of DHH's Report Card for maternity and NICU care, and work with DHH and birthing hospitals to create Centers of Birthing Excellence.

In addition, to promote DHH priorities related to prenatal care and perinatal outcomes, we are implementing an annual OB Excellence Award. We will honor the top three OB providers in our network based on their performance on specific metrics that reflect excellence in care and outcomes among their LHCC patients. These metrics will include well woman screenings, STI panel, administration of 17P, submission of NOPs, compliance with prenatal and postpartum visits, c-section rate, risk-adjusted VBAC rate and long-acting reversible contraception (LARC) rate. Each awardee will receive a \$5000 grant in addition to recognition through our provider newsletter and Provider Portal, and press releases to local media in each awardee's community.

Start Smart For Your Baby® Program

Start Smart incorporates case management, care coordination, and disease/population health management strategies to improve birth outcomes and infant health. Key program objectives are to extend the gestational period and reduce low birth weight; reduce the risks of pregnancy complications, premature delivery, and infant disease; and ensure a healthy first year of life for the newborn. Below we discuss some of the key components of our Start Smart Program.

Identifying and Assessing Pregnant Members. Case and Utilization Management staff review enrollment data from DHH to identify pregnant members. Staff review for eligibility status on the 834 file indicating pregnancy as well as indicators in the two years of historical claims data, such as recent prescriptions for prenatal vitamins or claims for OB ultrasound. We also identify pregnant members through our Welcome Calls to all new members, Customer Service Representative contact with members calling LHCC, Case Management staff assessing members with identified needs or providing care coordination, and MemberConnections staff outreach.

A key way we identify pregnant members early, as well as identify those who may have risk factors, is our **Notification of Pregnancy (NOP) process**. Physicians may complete the NOP via phone or securely online on the Provider Portal. We offer providers an incentive of \$75 for each submitted NOP. Members may complete it via the hard copy we send in our new member Welcome Packet, by phone during the Welcome Call or any other phone contact with LHCC staff, or online on the Member Portal. To improve the percentage of pregnancies for which we receive an NOP prior to delivery, we initiated focused member and provider outreach and education in 2012. This included increased outreach to educate members on the role and importance of the NOP via newsletters and community events such as our Baby Showers, and Provider Relations staff outreach to educate providers on NOP submission requirements and process. As a result, we achieved an 83.1 % improvement in NOPs received from CY 2012 to CY 2013.

We automatically enroll all identified pregnant members into the Start Smart Program. A Start Smart Case Manager attempts to contact high and medium risk members (as indicated by information such as predictive modeling or information on the NOP) to provide education and assistance to access prenatal care, and to complete a full OB Assessment, which assesses pregnancy-related risk factors. The Case Manager also assesses overall health and needs for non-covered services including behavioral health, dental, and social services.

The assessment incorporates information from the member, family/caregiver as applicable, OB and other treating providers, as well as any claims, utilization, and other information we have about the member, to develop a holistic picture of the member's conditions and needs. We use results to stratify members by risk level for appropriate intervention. All pregnant members receive education and assistance (described below) to empower them to access prenatal care appropriately and take actions to promote a healthy pregnancy. Members stratified as medium or high risk receive interventions (described below) to address identified risks and needs.

Member Outreach and Education. Start Smart staff generate a weekly report of new pregnant members and those newly identified as pregnant from TruCare information on new members, HRS and assessment results, NOP receipt, and provider and member referrals. The report triggers the mailing of our Start Smart educational packet. In addition, we send regular periodic educational mailings throughout pregnancy that encourage a healthy lifestyle for pregnancy and beyond and answers to questions about fetal development. For example, we educate members on the benefits of exercise during pregnancy, and provide information on how to set up a safe walking program before and after delivery, a log for tracking steps, and a pedometer. The mailings also encourage appropriate prenatal visits during the pregnancy and provide suggestions related to pediatrician selection.

We invite pregnant members to Start Smart events focused on prenatal visits, breastfeeding, stages of birth, oral hygiene and care, mental health, family planning, and newborn care. Start Smart Case Managers and our MemberConnections Representatives (MCRs) partner with providers and community-based organizations such as schools and community centers to present educational workshops and other events. These events provide a venue for expectant moms to ask questions and share concerns, as well as for LHC to identify and outreach to potential high or moderate risk pregnant members and provide education about WIC and other community resources. For example, our Baby Shower events educate pregnant members about prenatal and postpartum care for themselves and their newborn.

Held in rotating locations across the state, the quarterly classes cover the basics of prenatal care, including nutrition; the risk of smoking and benefits of smoking cessation; the progress

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of a fetus throughout pregnancy; the importance of regular follow-up with medical providers; common health issues that occur during pregnancy; and a review of the Start Smart and MemberConnections Programs. Partnering with community health centers and local health and human services organizations, we provide educational materials, including our March of Dimes endorsed Start Smart Pregnancy Book, information about infant care, lead poisoning, child safety and the importance of scheduling well visits. We invite all new and expectant mothers by region and provide refreshments and DHH-approved baby gift items, such as sippy cups, bibs, and baby books as an incentive to participate. When our baby showers are part of an event hosted by a local service organization, MCRs set up a booth to provide educational materials and baby gifts. Our Start Smart CMs often attend the baby showers to provide in-person education and answer member questions.

Our **Diaper Days** are targeted to the families of newborns. We focus on postpartum care, infant care, EPSDT services and issues related to being new parents. We host Diaper Days monthly, and we engage new mothers and fathers and support them in being active in their baby’s development and health and wellness care. We provide baby gifts and child wellness literature, as well as our “Dad: Little Word, Big Deal” book for new fathers. We have hosted events in collaboration with organizations such as Healthy Start in New Orleans. In June 2014, we co-hosted a “**Diaper Days for Dads,**” exclusively for young new fathers, in conjunction with Family Services of Greater New Orleans’ NOLA Dads program, which provides support, mentoring, and education.

Member Incentives. We provide incentives of nominal value, such as a Start Smart digital thermometer or onesie, to encourage completion of NOPs and participation in events. LHC encourages completion of our Baby Shower Program by offering incentives such as a raffle for an infant car seat. Through our CentAccount Member Incentive Program, members can earn financial rewards up to \$90 for accessing specific services. We offer individually-payable services and a bonus if three payable services are accessed or completed.

Incentives for Accessing Recommended Perinatal Care	
Prenatal visits (\$10 for each group of 3 visits, with a maximum of 9 visits)	\$10 per 3 visits
Postpartum visit within 30 days of delivery	\$10 per visit
Annual Chlamydia & STI (including HIV) Screening	\$20
Infant well-child visits	\$30 per 6 visits
Bonus for achieving all of the following: 9 prenatal visits, 1 post-partum visit, Start Smart for Baby text survey	\$100

We load earned rewards onto a CentAccount Pre-Paid Rewards Card which members can use to purchase approved health care items such as over the counter medications.

Member Engagement and Support Tools. LHCC offers patient engagement tools to engage pregnant members, educate them about needed health screenings throughout pregnancy, increase identification and triage of high-risk pregnancies to evidence-based action including connection to Start Smart Case Managers and other public health resources, and improve health decisions of pregnant members. We are developing additional tools, which we will implement by Q2 2015. Our patient engagement tools specific to pregnancy and post-partum care are shown in the table below.

Engagement Tools for Pregnant/Post-Partum Members

ConnectionPlus®. Provides pre-programmed cell phones to selected high-risk members to support engagement in care. This program received URAC’s 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award; a 2009 and 2010 Medicaid Health Plans of America (MHPA) Best Practices Compendium Honoree; and a 2011 MHPA Best Practice Award in the Technology Division. ConnectionsPlus enables members to make or receive calls from their providers or plan staff, for example, when they require motivational CM contact or have questions about their pregnancy or other health condition. We program the phones with numbers such as for the PCP, OBGYN, NurseWise, and 911. CMs can contact members for outreach and assessments, to provide assistance such as reminders about prenatal appointments, or provide useful health information via verbal or text messages. Especially in rural areas, increased telephonic communication helps members overcome the barrier to care that travel distances sometimes pose. This program contributes to improved perinatal outcomes through improved access to CMs, health care information, and treating providers.

The StartSmart for your Baby® for Bayou Health Mobile Application (Start Smart Mobile). StartSmart Mobile will provide a broad range of integrated interactive tracking tools, self-service functions, alerts, communication, and accessible resources for pregnant and post-partum members. Powered by our partner Wildflower Health, a leading mobile health technology company focused on women’s health throughout their pregnancy with apps serving over 50,000 women, Start Smart Mobile will allow our pregnant Members to:

Engage with Self Service Tools

- View information on the time and place of next medical visit
- Access the Baby Name Picker feature and see the current list of top baby names
- Track pregnancy milestones
- Access the Baby Gift Registry
- View and earn CentAccount™ Rewards
- Enter information from OB/GYN visits such as weight, blood pressure, blood sugar, fetal heart rate
- Use tools and trackers such as setting custom reminders for appointments



Communicate Quickly and Efficiently with a Nurse

- A call pop-up phone number for immediate telephone call to NurseWise, our 24/7 nurse advice line
- A short, pre-populated, “contact me” form for NurseWise call-backs
- Common Questions and Answers from Nurseline for expectant moms in mobile format
- Reach local public health resources

Access Information on Demand

- Personalized health advice
- Information on more than 50 risk factors for pregnancy complications
- Gestational risks and considerations
- Informative photos and ultrasounds by weekly pregnancy stage
- Daily advice to help get ready for baby
- Related topics and podcasts in our Health Library

StartSmart Mobile through the LHCC app will be available via the Mobile App Resources section of our public website, as well as the Apple iTunes Store (for iPhone), and Google Play Store (for Android devices.).

SS4Baby Texting Program. A component of our Start Smart program that offers texts with prenatal education and an email that promote breastfeeding initiation. After delivery, breastfeeding moms are encouraged to enter the survey arm of the texting program, which contains additional breastfeeding information and support and a survey component that tracks breastfeeding duration and exclusivity. This data will help us understand the current state of breastfeeding among our members and develop effective breastfeeding support strategies. The program also tracks maternal weight and encourages timely post partum and well child visits.

Member Notification of Care Gaps. Starting in Q1 2015, members may choose to receive care gap notifications regarding prenatal and post-partum appointments via their Member Portal account. An email notification will

Engagement Tools for Pregnant/Post-Partum Members
indicate that they have an important message about their health care waiting, and provide a link to sign into the Portal. Once signed in, they will see information about the care gap and how to receive assistance, if needed, to address it, such as assistance scheduling a preventive care visit.
CentAccount Mobile. Allows members to track their CentAccount status using their phones. This portable reminder can encourage members to keep appointments for reward-eligible services. The app will be available via the Mobile App Resources section of our public website.
Enhanced Interactive Capabilities. In 2015, we are enhancing our website through the incorporation of LiveLook technology, allowing members to click, enter their phone number, and get an immediate call from our Customer Service Representatives. LiveLook also enhances our co-browsing capabilities to mobile devices, allows site visitors to allow our CSRs to take control of their web or mobile screen.

High Risk OB Management. Members at medium to high risk of pregnancy complications and poor birth outcomes, including but not limited to those with preterm labor history, receive integrated prenatal and postpartum case management by a Case Manager with obstetrical nursing expertise. For moderate and high risk Members, the Case Manager facilitates access to prenatal care, educates the member on health care needs, assists with social needs, and coordinates any specialty referrals. The Case Manager contacts high risk Members by telephone at least every two weeks and moderate risk Members at least monthly to monitor their condition, and ensure access to needed services and community resources.

High risk Members also receive a home visit if an assessment indicates the need for closer monitoring. For example, we may provide in-home monitoring through Alere (formerly Matria) such as for 17P administration and management of hypertension and gestational diabetes. Start Smart staff work with providers to contact members who miss prenatal appointments and reschedule or problem solve to address barriers.

Post-Partum Follow-Up. We mail all members our Start Smart Newborn educational packet within three weeks of delivery. It includes information about infant care, breastfeeding, signs of infection following delivery, wound care for cesarean delivery, and post-partum information such as the warning signs and a screening tool for post-partum depression. We also provide postpartum case management services to women identified as high risk during the pregnancy and those with an adverse pregnancy outcome including preterm birth less than 37 weeks. The Case Manager provides one-on-one education covering topics in the packet, verifies that the Member has scheduled a post-partum visit, and provides scheduling and transportation assistance as needed to ensure access. The Case Manager also discusses and refers the member to safety net services for inter-pregnancy care and breastfeeding support if indicated.

Specialized Management of Behavioral Health Issues in Pregnancy. We are implementing a Perinatal Substance Use Disorder (SUD) Chronic Care Management Program (CCMP) to promote recovery and improve perinatal outcomes. A BH Case Manager will refer the member to the Statewide Management Organization (SMO) for specialty BH assessment and treatment as needed, and to coordinate with the SMO case manager to develop and coordinate a care plan with input from the OBGYN and BH provider.

The care plan will include treatment referrals, self-management tools, such as workbooks to help members better understand their triggers, and coordination with the SMO to connect the member to local SUD-related support groups and resources. We will also refer Start Smart members with depression to our Depression CCM program. We already include the Edinburgh Depression Scales in our Start Smart welcome packet and the newborn packet sent to all newly pregnant and post-partum Members, with instructions for the Member to complete and return the screening via a prepaid, addressed envelope. A Case Manager also completes the Edinburgh screening during prenatal and post-partum outreach calls, if not already completed by the Member. A Case Manager scores the completed tool and analyzes results to stratify the Member and determine future interventions.

For Members with positive screening results, the Case Manager coordinates access to basic BH services through the network, and refers the member to the SMO for specialty BH assessment and treatment as needed. We are adding our Depression CCMP for these members. A BH Case Manager will coordinate with the Start Smart Case Manager to work with the OBGYN and network and any SMO providers treating the member to share monitoring information and treatment plans and facilitate an integrated approach to care. A Health Coach will also support the member through education on the condition, development of a care plan that incorporates self-management education and support as well as provider treatment plans, and reminders for appointments.

Routine cervical length assessments for pregnant women;

Preterm Birth Prevention Program

A short cervix in the second trimester is the most powerful predictor of preterm birth risk. The American College of Obstetricians and Gynecologists (ACOG), the Society for Maternal Fetal Medicine (SMFM), and the American College of Nurse-Midwives (ACNM) each published practice guidelines in 2012 supporting the addition of universal cervical length screening to routine prenatal care to diagnose prematurely short cervix. Intervention with vaginal progesterone, an inexpensive generic drug, is also recommended by these professional societies as an evidence-based strategy with significant potential to reduce preterm birth and infant mortality. Our Preterm Birth Prevention Program, designed to decrease preterm birth rate and improve neonatal morbidity and mortality, incorporates use of these recommended strategies.

- Phased-in implementation of universal cervical length screening
- Identification of all pregnancies with cervical length <20mm at 18-22 weeks gestation and initiation of preterm birth treatment (vaginal progesterone)
- Increasing 17P usage among members with preterm birth history

Cervical Length Screening. We plan to phase-in implementation of universal cervical length screening. We are currently negotiating with three of our high-volume clinics to begin piloting this screening in January 2015. The pilot will allow us to analyze, evaluate, and improve processes and preliminary outcomes prior to implementing network-wide. These providers will complete cervical length screening for all singleton pregnancies between 18-22 weeks gestation regardless of preterm birth history. For each site, we will conduct provider education onsite on the practice guidelines noted above, and the resources available for providers and members through LHCC such as for assistance scheduling appointments. We will provide sites with preterm birth screening algorithms, coding guidance, and options for prescribing progesterone (vaginal and intramuscular).

QI staff will review claims and pharmacy data monthly, using codes for cervical length screening with cervicometer or transvaginal ultrasound, to determine rates for cervical length screening rate, 17P, and preterm birth. They will also evaluate the NOP rate to determine whether each site is submitting NOPs as requested to facilitate early LHCC identification and support for the member through our Start Smart program. QI staff will work with each site to identify and resolve barriers, such as assisting the site with correct coding Provider Relations, Case Management, and MemberConnections staff will also collaborate to identify any emerging best practices from the sites and identify and address barriers. If the program is successful at reducing preterm births, we plan to begin network-wide implementation in Q1 2016.

• Provision of injectable or vaginal progesterone for every eligible pregnant woman with a history of preterm labor or a short cervix found in the current pregnancy.

Providing Progesterone for Those with Preterm Labor History or Short Cervix

In addition to piloting cervical length screening and appropriate follow up with 17P at these three sites, we will continue our successful 17P Program already in place, which provides injectable or vaginal progesterone for every eligible pregnant member with a history of pre-term labor or a short cervix found in the current pregnancy. Our program is based on Centene's 17P program, named a finalist in the 2010 Case in Point Platinum Awards for innovative case management programs. We educate OBGYN providers about the availability and importance of 17P at initial orientation, in the Provider Manual, on the Provider Portal, and through outreach from Start Smart Case Managers when we identify pregnant members with a history of pre-term labor. We will not require prior authorization of progesterone unless we request and receive DHH approval. To encourage improved utilization, we will offer providers an incentive of \$10 per injection of 17P or administration of other antenatal progesterone for eligible members. Start Smart Case Managers educate identified members about the importance of 17P, and provide assistance for accessing appointments for 17P as well as other needed prenatal care. In addition, we offer home administration of 17P through Alere nurses, and educate OBGYN providers about this resource and how to contact us to access it for their patients.

In 2013, we implemented a Performance Improvement Project to increase appropriate 17P utilization. We identified barriers including lack of member knowledge about the use and benefit of 17P, lack of provider knowledge regarding coverage of 17P, and difficulty in obtaining regional home health coverage for home administration of 17P. These interventions included:

- Conducted data mining for potential 17P candidates to improve early identification and outreach to these members.
- Provided case management and coordination for these members by a nurse with experience working with pregnant women with preterm labor history .
- Implemented education by Start Smart staff and Alere nurses about 17P for all members identified with preterm labor.
- Developed additional education material and a presentation for Provider Relations Representatives (PRRs) to use in educating providers on 17P. Start Smart Case Managers accompanied our PRRs to large OB practices throughout the state to assist with education. We also sent a fax blast on 17P to all OBGYNs.
- Worked with Alere to increase state coverage of nurses to administer 17P in the home.

As a result of our interventions, we met our goal for percentage of identified members receiving 17P. We are maintaining these enhanced processes to prevent prematurity.

• Incentives for vaginal birth after cesarean (VBAC); and
• Interventions to reduce Cesarean section rates including but not limited to prior authorization for induction of labor prior to forty-one (41) weeks gestational age.

Increasing Vaginal Birth After Cesarean and Reducing the C-Section Rate

To reduce unnecessary C-sections, we will require prior authorization for induction of labor prior to forty-one weeks gestational age. We educate members and providers (using staff and methods previously

described for providing education) about the risks of unnecessary C-sections and how to avoid them, including but not limited to healthy pregnancy behaviors such as accessing prenatal care, identifying and addressing risks such as gestational diabetes or other chronic condition requiring specialized management of the pregnancy, and avoiding elective C-sections. Our PR Representatives also outreach to providers with claims for elective c-sections to educate them on ACOG criteria for appropriate use of C-sections. LHCC will implement additional interventions to reduce the C-section rate, including but not limited to interventions to increase our VBAC rate. We already educate these providers about the ACOG criteria during initial orientation, the Provider Manual, Provider Portal, newsletters, and ongoing training sessions. Our Provider Relations Representatives will also provide one-on-one education to providers identified through profiling as being outliers for C-sections as well as those with elective deliveries prior to 39 weeks gestation.

Beginning in September 2014, LHCC will no longer reimburse OBGYNs and hospitals for C-sections that do not meet ACOG criteria. We have notified all providers of the reimbursement change. In addition, we will require prior authorization for c-sections prior to 39 weeks gestation, and educate providers about the ACOG guideline for VBAC. As described above, our new OB Excellence Award will also incorporate a component for the provider's C-section rate and risk-adjusted VBAC rate. Start Smart Case Managers will educate members with a previous C-section on the option for VBAC, and encourage the member to discuss VBAC with their provider.

• Provider or patient incentives for post-partum visit provision within recommended guidelines of 21-56 days post-delivery;

Increasing Post-Partum Visits

We educate OBGYN providers about the importance of a post-partum visit within 21-56 days post-delivery, and the assistance LHCC can provide members with scheduling appointments and transportation. We monitor the post-partum visit rate as part of our profiling program, and follow up with providers identified as outliers to provide additional education and support to increase their rate. For example, PR Representatives discuss the availability of our Start Smart and MemberConnections staff to help the provider remind members of scheduled visits. We will offer a \$50 incentive to providers for each member with a completed postpartum visit within 21-56 days post-delivery.

As described above, we also educate members about the importance of the post-partum visit and provide assistance with scheduling and transportation as needed to ensure access. Start Smart Case Managers discuss recommended post-partum care with medium and high risk members prior to delivery, and remind and help them schedule an appointment as needed following delivery. We provide a \$10 CentAccount reward for completion of the visit. In addition, we have dedicated two Case Managers to conduct outreach on post partum visits. For example, new pregnant members usually have a very short period of eligibility for Bayou Health. These staff resources allow us to quickly outreach to and educate a greater number of these new pregnant members about the importance of both prenatal care and the post-partum visit.

• Incentives for use of long acting reversible contraceptives, which are to be provided to the member without prior authorization; and

Long-Acting Reversible Contraceptives

We contractually require OBGYNs and other providers of routine gynecological care to annually discuss plans for future pregnancy with all fertile members of reproductive age, and provide special counseling on pregnancy prevention options for adolescent patients. We also require these providers to provide

appropriate family planning and/or health services based on the member's desire for future pregnancy and to assist the member in achieving her plan with optimization of health status in the interim. We will develop codes for providers to use that will allow us to reimburse for and track these activities.

In 2012, ACOG released practice guidelines advising that adolescents who are sexually active and at high risk of unintended pregnancy should be encouraged to consider of long-acting reversible contraceptives (LARC) as a contraceptive option. We encourage our providers to educate women on the benefits of LARC, particularly if the woman is deemed high-risk for contraceptive failure when using other methods. In order to improve LARC utilization, we have removed the prior authorization (PA) requirement for LARCs and have begun to educate our providers on the safety of inserting a LARC at the time of delivery.

In 2013, LHCC claims reports showed an average of 68.8 LARCs dispensed each month. Since January 2014, when we lifted the PA requirement for LARC, the average number of LARCs dispensed per month has risen to 94.5.

During the implementation of the pharmacy carve-in, LHCC required PA for IUD and implant drugs to protect against over-prescribing for very young girls and to minimize claims for LARC drugs that were never administered. In December 2013, the P&T Committee recommended the removal of the PA requirements to facilitate access to an important support to family planning and because claims histories showed that LHCC was

approving most PA requests for the IUDs and implants. This recommendation took effect on January 1, 2014.

The Pharmacy Director will enhance LARC utilization management by monthly monitoring pharmacy LARC claims, directing pharmacy staff to periodically outreach to a random sample of providers to determine whether the LARC devices were inserted, and work with LHCC Case Managers as needed regarding LARC administration at time of delivery.

We provide information about LARC in the Provider Manual and on the Provider Portal, as well as during initial orientation with OBGYN providers, and ongoing education available to all providers such as in our quarterly newsletters. We will also provide the ACOG guidelines on the Provider Portal. In addition, one component of the OB Excellence Award, described above, is the LARC utilization rate among the provider's LHCC members..

We also provide written and online information to members on contraceptive options in the Member Handbook and on the Member Portal, as well as in our Start Smart Welcome Packet we provide to all newly-identified pregnant members. Our Start Smart CMs provide information to pregnant women on post-delivery contraception options during the prenatal period and following delivery, along with reminders and assistance to access recommended post-partum visits. MemberConnections Representatives inform members during phone and in-person outreach. We will be including information on LARC in the Text4Babies messages for our pregnant members during the 3rd trimester. In addition, Start Smart Mobile will include information on contraceptive options, including LARC.

For members who are minors, we always involve the parent(s)/guardian in all aspects of case management. In the case of sexually active teens at risk of unwanted pregnancy, we understand the importance of balancing the need for parental consent for contraceptives with giving the teen a stronger role as the 'driver' of the process so they can begin to take responsibility for managing their own health. Our Case Managers work closely with the parent(s)/guardian to help them understand the risks of teen pregnancy and the need to encourage the child to take responsibility for their health, especially as the child nears transition into adulthood.

N.7 Explain how you will Identify and address underutilization of services in areas including, but not limited to HIV and Syphilis screening in pregnant women, use of long acting reversible contraceptives and appropriate pain management approaches in patients with sickle cell disease.

LHCC understands and will comply with all DHH requirements for addressing underutilization of HIV/STI screening, long acting reversible contraceptives, and sickle cell pain management, including, but not limited to Section 6.1.3 Core Benefits and Services, Section 6.8.1.7 Emergency Medical Services, Section 6.13 Perinatal Services, Section 6.26.6.6 Expanded Services/Benefits, Section 6.31 Preconception/Inter-conception Care, Sections 6.39 and 6.39.1.7 Chronic Care Management Program, Section 14.1.6 Quality Management, and all other relevant contractual, State and federal requirements.

Identifying Underutilization of Services

Louisiana Health Care Connections (LHCC) identifies patterns of underutilization by continually monitoring and analyzing utilization management (UM) data, such as claims and encounters, from clinical processes, activities, and programs including prospective, concurrent, and retrospective review; adverse determinations; Case and Chronic Care Management; preventive care; transition planning; and drug utilization review. These analyses allow us to identify opportunities for improvement, assess plan- and provider-level compliance with our UM guidelines, and monitor program integrity and authorization accuracy.

General Identification Processes. Our staff review and analyze a variety of utilization data reports on a regular basis (i.e., daily, weekly, monthly, quarterly, and ad hoc). We monitor and analyze data at aggregate and detail levels by member, individual provider or facility, provider specialty, type of service, diagnosis, place of service, and region; and we compare services authorized to services received.

In collaboration with our subcontractors with delegated UM, our analysis includes physical health, pharmacy, vision, and transportation utilization data. Each report includes a drill-down capability to more specific areas of interest. For example, when analyzing emergency department (ED) visits or inpatient utilization, we look not only at total number of visits or days, but also at the utilization in relationship to readmissions, frequent ED utilization, or presence or absence of physician office visits.

We review the following types of utilization reports to identify underutilization:

- Daily inpatient census, including admissions, length of stay, unplanned readmissions, top ED diagnoses, and frequent ED use
- Key outpatient measures, including ED visits/1000 members; recommended preventive care exams and screenings; Case Management activities; specialty provider referrals; laboratory, radiology, and other ancillary services; certain selected procedures (such as hysterectomies); and utilization related to ambulatory care-sensitive conditions
- Quality of service indicators, such as out-of-network care; adverse determinations that reduce or deny authorization of service, and the types of services impacted; and member and provider satisfaction, including grievances and appeals related to services delivered or denied, timeliness of decision-making, and telephone responsiveness data
- Key readmission indicators, such as three or more ED visits in the past six months, the top ED utilizers and physician practices with the highest ED utilization, two or more hospital admissions within 12 months, polypharmacy, and predictive modeling of members likely to be readmitted
- Pharmacy indicators that identify aberrant prescribing patterns, such as physicians whose members have a high use of inhalers and not enough maintenance medications, and physicians who prescribe maintenance drugs on a 30-day, rather than 90-day, basis; and,

- Targeted, case-mix adjusted reports, such as for routine well visits for children and adolescents; Psychotropic Medication Utilization Review (PMUR) that facilitates the appropriate utilization of psychotropic drugs; notice of pregnancy (NOP), such as a third ultrasound indicating a high-risk pregnancy; and pregnant women with substance use issues.

Examples of how we use these reports to identify patterns of underutilization include:

- QAPI staff identify patterns of underutilization by a specific provider by reviewing the provider’s performance on profile measures for primary and secondary preventive services, such as preventive health visits or diabetes care testing. The profile compares provider performance to their network peers (average network performance) as well national benchmarks, when available.
- QAPI or Case Management (CM) staff identify patterns of underutilization by a specific member by reviewing routine care gap reports of members in need of recommended preventive services (such as EPSDT services, annual cervical cancer screening, and routine hemoglobin A1c and cholesterol screenings for diabetics).

We also identify members who are underutilizing treatment services, such as low use of controller medications in members with asthma. CM staff monitor monthly predictive modeling reports to identify members persistently listed as having gaps in recommended care, and to identify those with the highest risk for future acute care utilization, and therefore the highest priority for outreach for preventive services.

We also identify potential underutilization of services through staff contact with members and providers. For example, Case Managers interacting with members and providers may identify potential utilization issues during care plan monitoring or other face-to-face or telephonic interactions. In each case, performance is compared to average network performance or national benchmarks to identify issues.

Identifying Underutilization of HIV/Syphilis Screening, LARC, and Sickle Cell Pain Management Services. We identify potential underutilization of these services through our Health Risk Screening process and member and provider referrals, as well as regular review by UM, CM, and QAPI staff of the following data sources, using the indicated criteria for potential underutilization.

Identifying Member Underutilization of Specified Services		
Service	Data Source and Monitoring Frequency	Criteria for Potential Underutilization
HIV/Syphilis screening	NOP, claims data; monitored monthly	Pregnant member without an NOP and claim for screening
LARC	Claims for women of reproductive age (15-45); monitored quarterly	Women of reproductive age with no OB/GYN or pharmacy claims related to contraception in the prior 12 months; postpartum women with no provider or pharmacy claims related to contraception within 90 days of delivery
Sickle Cell Pain Management	Claims data; monitored monthly ED Utilization and Inpatient Census reports; monitored daily	ED claim for pain associated with sickle cell Inpatient claim associated with sickle cell Pharmacy claims indicating non-adherence with hydroxyurea

In addition, Start Smart for Your Baby® (Start Smart) and MemberConnections™ staff may identify members underutilizing HIV/Syphilis screening and LARC through contact with pregnancy and post-partum members. Case Management staff may identify members underutilizing sickle cell pain management services through contact with members who receive Case Management and those enrolled in our Sickle Cell program (described below).

We identify potential underutilization by an individual provider's members through QAPI staff analysis of quarterly profiling reports. QAPI staff review Primary Care Provider (PCP) profiles to identify members with persistent care gaps, and members with multiple ED visits and/or an inpatient admission with no primary care follow up. Provider Relations staff contact providers with higher-than-average numbers of members with low primary care utilization to discuss possible reasons and interventions. Barriers, such as geographic location, transportation, and culture, are identified and potential solutions are explored. Our Case Managers and MemberConnections™ staff assist the provider with outreach to members, and help to schedule appointments, transportation, and educate the member on the importance of primary and preventive care.

In cases in which the members have PCP encounters, but the recommended preventive services were not provided (or the member continues to use the ED), Provider Relations or the CMD may educate the provider on clinical practice guidelines, strategies for engaging members in routine preventive care, and available Case Management and Chronic Care Management Programs that support member engagement and appropriate utilization. We also track providers with higher-than-average readmission rates and high rates of ED visits and/or inpatient admissions for ambulatory care sensitive conditions and other potentially preventable events (PPE). In those cases, the CMD meets with the provider to educate on clinical practice guidelines and problem solve contributing factors, such as lack of access to specialty providers in rural Parishes.

Addressing Underutilization of Services

When we identify potential underutilization, our Program Coordinators outreach to the member telephonically to discuss care gaps, provide assistance in locating appropriate providers, scheduling appointments, and arranging transportation, as needed. MemberConnections™ Representatives (MCRs) may conduct face-to-face visits to members who cannot be reached by phone to educate them on the importance of primary and preventive care, and help to engage them in Case Management, as appropriate.

MCRs may also refer the member to our Chronic Care Management programs, or educate the member on available community resources. For example, several of our MCRs are certified in HIV Prevention Counseling and Rapid Testing, and they provide education on the importance of screening for HIV and STIs, as well as available resources for accessing screening services. Case Managers engage members with special needs or complex conditions in care planning, assist with referrals, and coordinate with the PCP to ensure the member receives appropriate primary and preventive care, as well as medically necessary services.

We include care gaps on the provider portal, and Case Managers may notify providers of members with persistent care gaps. Our QAPI staff monitor provider patterns of underutilization through provider profiling. Providers with low utilization are contacted by QAPI, Provider Services staff, or the Chief Medical Director and are educated on primary and preventive care guidelines.

Addressing Underutilization of HIV/Syphilis Screening. LHCC takes a multi-dimensional approach to improving rates of HIV and STI screening during pregnancy, including our Start Smart for Your Baby® Program, High Risk OB Case Management, and provider incentives.

Start Smart for Your Baby® Program (Start Smart). Our perinatal management program emphasizes early identification of pregnant members to improve birth outcomes. By identifying pregnant members as

early in the pregnancy as possible, we help them gain access to prenatal care; offer education on health care needs, such as the importance of HIV and STI screening; assist with special needs and concerns; coordinate referrals to appropriate specialists, as well as to the High Risk OB Case Management Program (described below), as needed.

We risk stratify each pregnant member using available clinical information. We then mail each pregnant woman a packet that contains an introduction to the Start Smart program and educational materials that address the importance of prenatal care, staying healthy during pregnancy, signs of pre-term labor, and a prenatal depression survey. We also include a journey booklet for tracking prenatal and postpartum visits. Our Case Management and MemberConnections™ staff engage pregnant women in education through telephonic outreach, face-to-face interactions, and by providing information both in print and on the LHCC website.

LHCC's Start Smart for Your Baby® for Bayou Health Mobile Application (App). Our new app for expectant mothers called Start Smart for Your Baby® for Bayou Health mobile app ("Start Smart Mobile"), available beginning 2/1/2015, is a key component of our growing free suite of programs available through our LHCC mobile app. **Built on best of breed mobile technology**, Start Smart Mobile combines LHCC's experience with Louisiana members; Centene's 30 years' experience in Managed Medicaid systems development; and the technology leadership of our partner Wildflower Health, a mobile health technology company focused on women's health throughout their pregnancy, with apps supporting over 50,000 women today. The result is **Start Smart Mobile**, featuring a broad range of integrated interactive tracking tools, self-service functions, alerts, communication, and accessible resources. Using Start Smart Mobile, our expectant mothers will have access to information on more than 50 risk factors for pregnancy complications, including HIV and STI, and access to personalized health advice.

High Risk OB Case Management. Our Start Smart Case Managers offer medium to high-risk pregnant women the opportunity to enroll into the High Risk OB Case Management component of our Start Smart program. If the woman agrees to participate, the OB Case Manager collaborates with the member, family, and treating physician to develop a care plan that includes problems, goals, and interventions. The OB Case Manager monitors prenatal and preventive care throughout the pregnancy, provides education on the importance of HIV/STI screening, and maintaining positive behaviors to improve the member's health and the health of their infant.

If appropriate, we extend Start Smart services through the baby's first year (as long as they are plan eligible) so we can continue to help improve the health of the mother and child, and help the mother maintain positive behavior changes developed during pregnancy. We also extend enrollment beyond delivery to decrease risk for the member in subsequent pregnancies.

Provider Incentives. We incentivize our providers in two ways. First, we provide an incentive to them for completing the Notice of Pregnancy, which not only alerts us to a member who is in prenatal care, but captures medical, behavioral, and social information needed by our Case Management staff to screen for medium to high-risk members. We will also incentivize obstetrics/gynecology (OB/GYN) providers to improve HIV and STI screening, counseling, and education of pregnant members. The goals of our incentive are to reduce the risk of transmission to the newborn, and improve maternal and child outcomes.

Incentives for OB/GYN Providers. LHCC will incentivize OB/GYN providers to improve HIV and STI screening, counseling, and education of pregnant members with the goals of reducing the risk of transmission to the newborn and improving maternal and child outcomes. OB/GYNs will receive up to \$70 in incentives for a full panel of HIV and STI screening, and counseling and education of a pregnant woman. LHCC also will offer an HIV screening incentive to OB/GYNs who perform a Rapid HIV test on women who arrive in the delivery room with no prenatal HIV/STI testing and unknown HIV status.

The HIV/STI screening panel will include HIV-1 and HIV-2, chlamydia, syphilis, herpes type 1 and type 2, hepatitis B surface antigens, and Neisseria gonorrhoea. We also pay this incentive for any follow-up screening of pregnant women. Finally, we will educate our providers on the importance of repeat-screening of high-risk pregnant women, preferably before 36 weeks gestation, who meet the following criteria. Providers should repeat-screen:

- Women who use illicit drugs
- Women who have STDs during pregnancy
- Women who have multiple sex partners during pregnancy
- Women who live in areas with high HIV prevalence, have HIV-infected partners and/or report exposure to infected, or potentially HIV infected, bodily fluids
- Women with partners who have, or are believed to have, multiple partners
- Women with male partners who engage in sexual activity with other men
- Women who have a partner who uses illicit drugs.

Incentives for Primary Care Providers. LHCC will launch a campaign in February of 2015 that will include a PCP incentive for providing education, counseling, and HIV/STI screening for any man or woman, regardless of age. The PCP incentive will be available for individual tests, as well as for the full screening panel described above. Our Chief Medical Director will work closely with Provider Relations to ensure that all PCPs are educated on CDC recommendations for HIV/STI screenings, and are aware of our primary care HIV/STI screening campaign and incentives.

Supporting Our PCPs in Improving Rates of HIV/STI Screening. Using a comprehensive approach, we will provide general member educational materials on the website and in the Member Newsletter, automated outbound messaging, and targeted outreach to high-risk members. We will promote, at a minimum, National Black HIV/AIDS Awareness Day (February 7th), National Women and Girls HIV/AIDS Awareness Day (March 10th), and National HIV Testing Day (June 27th). Our UM, CM, and CCM staff, along with our MemberConnections™ Representatives, will reinforce the importance of preventive screening during member contacts, and we will have the majority of our MemberConnections™ Representatives certified as Community HIV Educators by the end of 2014.

Addressing Underutilization of Long Acting Reversible Contraceptives. Intrauterine devices and contraceptive implants (also referred to as long-acting reversible contraceptives, or LARCs) are effective for preventing unwanted pregnancies because they are considered safe for most women, are cost effective, and require little effort on the part of the woman once a clinician has inserted them. We educate our providers on the 2012 American College of Obstetrics and Gynecology's (ACOG) practice guidelines, which advised that adolescents who are sexually active and at a high risk of unintended pregnancy should be encouraged to consider LARCs as a contraceptive option. We also provide information on the World Health Organization's support of the use of LARCs for women of all ages.

In order to improve utilization, we have removed the prior authorization requirement for LARCs and have begun to educate our providers on the safety of inserting a LARC at the time of delivery. Our OB CMs and MCRs provide information to pregnant women on post-delivery contraception options, and we will include information on LARCs in the Text4Babies messages that are sent out to our pregnant members during their third trimester.

In addition, LHCC has contracted with all OPH Parish Health Units (PHU) and many of the OPH-certified School Based Health Centers (SBHC) statewide. Our MCRs and other staff have actively collaborated with these PHUs and SBHCs to encourage our members who are not engaged with a medical

home, or who are uncomfortable bringing certain concerns to their PCP, to obtain STI and HIV screening and family planning services from entities.

Recently, our QI staff worked with DHH and OPH staff to improve reporting of services delivered in many school-based health centers. These centers are staffed by registered nurses who are not Medicaid providers, and therefore do not bill for their services. Our objective has been to explore the option of these nurses becoming Medicaid providers so we can reimburse the SBHCs for their services and increase the accuracy of LHCC’s HEDIS, and other outcome, measures by receiving claims for services provided at the school-based programs.

For members who are minors, we always involve the parent(s)/guardian(s) in all aspects of Case Management. However, in the case of sexually active teens at risk of unwanted pregnancy, we understand the importance of giving them a stronger role as the ‘driver’ of the process so they can begin to take responsibility for managing their own health. Our Case Managers work closely with the parent(s)/guardian(s) to help them understand the risks of HIV/STIs and teen pregnancy, and the need to involve the child in decisions about their health care, especially as the child nears transition into adulthood.

Addressing Underutilization of Sickle Cell Pain Management. To improve outcomes and reduce ED and inpatient visits, LHCC is expanding the Sickle Cell Case Management program to incorporate population health components and transition to a formalized, evidence-based Chronic Care Management Program for members with sickle cell disease (SCD). The program provides educational materials, offers Case Management and Care Coordination services, and promotes use of, and adherence to, Hydroxyurea. Concurrent Review and Prior Authorization staff refer newly identified members with SCD to Case Management for assessment. We also use claims and pharmacy data to identify members with medications or a diagnosis related to SCD. Members/family may self-refer, and providers may refer a member to the Program.

Once a member is identified, a Case Manager outreaches to them to describe the Program and conduct an in-depth assessment. Using the results of the assessment, the Case Manager stratifies the member as low, medium, or high risk based on severity of illness and intensity of service. Case Managers use clinical guidelines to determine if the member meets the criteria for Hydroxyurea or, if they are already prescribed Hydroxyurea, assess their level of adherence to their medication regimen, whichever is applicable. The Case Manager will maintain contact with the member using the following guide for frequency of intervention.

Acuity Summary	Contact Frequency
High Risk	
<ul style="list-style-type: none"> • Unstable • Hospitalized • Symptomatic and at risk for inpatient • Admission or ED visit 	At least every other week, but can be as often as daily until the member is stable
Medium Risk	
<ul style="list-style-type: none"> • Complex but stable • Numerous health care needs and services 	At least every other month, but as often as necessary to address complex needs
Low Risk	
<ul style="list-style-type: none"> • Stable • Member/family managing illness well • Follow-up with DM or BH 	Quarterly, and determined from communication with BH Care Manager or DM coach

Education and Chronic Care Management. We provide all members with SCD with educational materials and Chronic Care Management resources, including a Member Welcome Letter, Understanding Sickle Cell Booklet, Living Well With Sickle Cell book, and instructions on how to access podcasts and our health education library that contains materials approved by DHH. We may provide some high-risk members with a ConnectionsPlus® cell phone that is preloaded with the Living Well with Sickle Cell audio book, and several podcasts that have been approved by DHH. We send two health tips a week to the phone via text, and preload the phone with all numbers the member may need to call in order to access care and services.

Case Management and Care Coordination. Our Case Management staff understand that coordinating multiple subspecialty referrals is only a small part of the overall needs of a member with SCD and their family. Our CMs offer comprehensive care for these members, including, but not limited to helping them manage the daily needs of living with a chronic illness, medication adherence, preventive and primary care, pain management, member education, and coordination of health care providers.

LHCC continually strives to improve access to pain management clinics, adult hematologists, and sickle cell day hospitals through network development efforts. We provide transportation whenever necessary to connect the member with the most appropriate provider and level of care. Program Coordinators assist the member with social needs while Case Managers address the clinical aspects of the member's condition, and conduct provider outreach and education regarding Hydroxyurea use and adherence. We follow up with a Hydroxyurea Reference Guide for the PCP to educate them on the appropriate use of the drug.

Individual Sickle Cell Pain Plan. Episodes of acute pain are the most common reason for members with SCD to seek medical attention. Stress, weather conditions, dehydration, infection, and alcohol consumption can trigger an acute episode of pain, but most episodes have no identifiable cause. Members with SCD experience pain that ranges from mild to excruciating, and it isn't unusual for them to also have a fever, swelling, tenderness, hypertension, nausea, and vomiting during an acute pain episode. Education and self-management skills are critical tools in avoiding or reducing the severity of an acute pain episode. Our Case Managers work with the member and provider to ensure they develop a pain plan tailored to the member's needs. The plan outlines how the member can appropriately manage their pain at home, and includes pre-defined thresholds for the use of opioids and guidelines for when they should contact their health care provider.

Case Managers prioritize members with SCD who have had five or more ED visits during the prior year for a chief complaint of pain, and outreach to the member and treating physician to encourage prompt development of a pain management plan. In addition to the pain management plan, the Case Manager develops an overall care plan that addresses physical, psychological, social, and environmental needs, goals, and interventions. The Case Management care plan that addresses pain management during acute pain episodes might include, but not be limited to the following elements:

- Follow pain plan for acute pain management

LHCC in Action...

A member in Thibodaux with Sickle Cell faced difficulty getting to her specialist in New Orleans for follow-up appointments and routine lab work. This led to 53 ED visits to obtain lab work to determine Sickle Cell Crisis (SCC). The member's Case Manager identified a local physician to help manage her Sickle Cell, decreasing her need for travel to New Orleans. In addition, the Case Manager educated the member and coordinated with the hospital lab director to prevent an ED visit simply for the purpose of drawing labs. Now, if the Member thinks a SCC is pending, she contacts her local PCP, obtains a physician's order, and goes to the hospital for outpatient lab work. Results are available within an hour, eliminating a trip to the ED.

- Take extra vitamins—folic acid
- Take anti-inflammatory medications
- Increase fluid intake
- Contact PCP or treating physician at onset of crisis
- Contact 24/7 Nurse line if PCP or treating physician is not available
- Take warm baths for comfort
- Place a heating pad on low, or warm water compress, on the painful area
- Massage the area, then rest.

Level of Care During a Sickle Cell Crisis. In the event that a member is admitted to the hospital, our UM staff follow InterQual® Sickle Cell Crisis criteria to determine level of care, including sickle cell day hospital/observation or admission to an acute inpatient facility. We will contract with available sickle cell day hospitals whenever possible, and our inpatient hospital contracts include an observation rate that allows for treatment of acute sickle cell pain without requiring an authorization.

EPSDT: Identifying and Connecting with Members. LHCC’s EPSDT Coordinators contact members due, or past due, for screenings to explain EPSDT benefits, why they are important, and assist members to address identified barriers to compliance. We also conduct follow-up calls and claims reviews to verify completed appointments. CM and Customer Service staff remind members during telephone contacts of due dates, and help them schedule appointments and transportation. All staff can view Care Gap alerts during members’ calls, so they can educate them about EPSDT benefits, assist with scheduling and transportation (if needed), and refer all clinical questions to appropriate staff.

Some of our members are more difficult to reach, or they face more barriers to compliance. In addition to telephonic and mail outreach, LHCC will use community outreach events and other point-of-service opportunities to educate members about EPSDT and help them access services. For example, we might reach members via a doctor’s office, pharmacy, mental health center, or during a home health visit. Our Case Management staff can leverage their relationships with providers to contact members.

MemberConnections™ Program (Connections). LHCC’s Connections Program is an intensive health outreach program that offers one-on-one and in-person assistance to members. Our MemberConnections™ Representatives (MCRs) are community health outreach workers we hire from within the communities we serve to ensure that our outreach is culturally competent, and conducted by people who know the unique characteristics and needs of each region. MCRs receive comprehensive training and become an integral part of our Customer Service and Case Management teams, and make home visits to high-risk members we cannot reach by phone to educate them about the importance of utilizing EPSDT services.

Baby Showers and Diaper Days. We use these events to educate members about the importance of EPSDT, as well as prenatal/post-partum visit utilization. MCRs host quarterly Baby Showers for our pregnant and recently-delivered members, and rotate the locations throughout LHCC’s service areas. Partnering with community health centers and local health and human services organizations, we provide educational materials, including our March of Dimes endorsed Start Smart Pregnancy Book, information about infant care, lead poisoning, child safety, and the importance of scheduling well visits.

We invite all new and expectant mothers by region, and provide refreshments and DHH-approved baby gift items, such as sippy cups, bibs, and baby books as an incentive to participate. When our Baby Showers are part of an event hosted by a local service organization, MCRs will set up a booth to provide educational materials and baby gifts. Our Start Smart Case Managers often attend the Baby Showers to provide in-person education and answer members’ questions.

Similar to Baby Showers, Diaper Days are more targeted to the families of newborns. We focus on postpartum care, infant care, EPSDT services, and issues related to first-time parents. We host Diaper Days monthly, and engage new mothers and fathers, and provide support and encourage them to be active in their baby’s development, health, and wellness care. We provide baby gifts and child wellness literature, as well as our Dad: Little Word, Big Deal book for new fathers. Based on a Diaper Days event we hosted in collaboration with Healthy Start in New Orleans, the Family Services of Greater New Orleans’ NOLA Dads program (that provides support, mentoring, and education) hosted with us a “Diaper Days for Dads” in the area on June 26, 2014, which was exclusively for young new fathers.

Newborn Underutilization. We will monitor for infants without any encounters or claims for a follow-up visit within three months after birth, and outreach to the parent(s)/guardian(s) to determine if they have not had any visits, or if they have accessed a Parish Health Unit or non-network provider. We will educate the parent(s)/guardian(s) on the importance of routine infant care and EPSDT, and attempt to resolve any barriers to obtaining care, including, but not limited to arranging transportation, identifying a network provider who is more easily accessible based on location or hours, referring them to an appropriate community resource, or referring them for behavioral health services. A Case Manager will be assigned to follow the member and infant, and will promptly escalate cases of potential neglect to the Chief Medical Director.

HEDIS Outreach. LHCC also uses HEDIS outcomes to identify areas of population-based underutilization. During the fourth quarter of 2013, we implemented a HEDIS call center to conduct telephonic outreach to members. In addition to addressing the State required HEDIS initiatives, the call center also includes reminder calls for HPV vaccines and CentAccount rewards for cervical cancer screening. Our Proactive Outreach Manager (POM) sends automated reminder calls to female members who meet the Cervical Cancer Screening (CCS) measure. Our QAPI staff continue to work with MemberConnections™ to contact targeted members and educate them on the importance of obtaining cervical cancer screenings and HPV vaccines. MCRs also address member fears and misconceptions regarding CCS during their monthly outreach events. Case Managers include HEDIS measures as part of their member health screening.

N.8 Explain how you will reduce overutilization of services and medications through policies such as, but not limited to, prior authorization for prescription of ADHD drugs to children younger than seven years of age.

Reducing Overutilization of Services and Medications Through UM Policies

Louisiana Healthcare Connections (LHCC) Medical Management policies support our goal of improving quality of care and member experience, improving population health outcomes and reducing per capita cost of care. We use a combination of evidence-based criteria and clinical guidelines: and Case Management, Chronic Care Management and medication utilization review to ensure that our members receive the most appropriate care, in the right setting, from the right provider, and at the right time.

Our Prior Authorization (PA) staff are available 24/7 and include Louisiana licensed registered nurses and physicians. We recruit our PA staff from across the State, ensuring they are conversant in the geography of Louisiana as well as the culture and correct pronunciation of cities, towns, and surnames. We train them in exceptional customer service skills, including how to explain prior authorization policies to members and providers and how to handle quality of care/service concerns. LHCC does not require prior authorization for emergency services, treatment of STIs or continuity of care for pregnant women who are transitioning into LHCC.

Customer Service Representatives (CSRs) are trained to answer member and provider questions related to prior authorization policies and information on PA policies is included in the Member Handbook. Our Provider Relations staff educates providers on prior authorization requirements and how to request prior

authorization during provider orientation and subsequent site visits. We include information on prior authorization policies in the Member and Provider Handbooks, and the Member and on the Provider Portals.

Developing UM Policies to Reduce Overutilization. Oversight and operating authority of UM activities is delegated to the Medical Management Committee (MMC), which reports to the Plan’s Quality Assessment and Performance Improvement Committee (QAPI Committee) and ultimately to the LHCC Board of Directors. The MMC serves as the Utilization Management Committee, meets at least quarterly and makes meeting minutes available to DHH upon request. The MMC reviews and approves medical necessity criteria and protocols, clinical practice guidelines and UM policies and procedures, including medication utilization review policies, which are then adopted in consultation with contracting health professionals. The MMC coordinates annual review and revision of the UM Program Description, Work Plan, and the Annual UM Program Evaluation.

The MMC monitors and analyzes relevant utilization data to detect and correct patterns of potential or actual inappropriate under- or –over utilization, which may impact health care services, coordination of care and appropriate use of services and resources, and member and practitioner satisfaction with the UM process. For example, in 2014, a review of PA of dental anesthesia indicated extremely low denial rates. Since the dental benefit is not managed by LHCC and requests for dental anesthesia were consistently appropriate, we removed the PA requirement, thereby reducing the administrative burden for providers and improving access for our members.

Examples of LHCC Policies Designed to Reduce Overutilization. Below we highlight some of the key LHCC UM policies and programs that we have designed to address potential overutilization.

ED Diversion Program. We have capitalized on the success of our Ambulatory-ED Visits PIP by allocating additional staff resources to focus on identifying and addressing high and non-emergent ED utilization. In 2014, our ED Diversion Program is targeting our top 2400 ED utilizers in addition to the 75 practices each quarter whose assigned members have the highest ED utilization. We will continue the member and provider outreach strategies described above, and increase in-person outreach by MCRs for members who cannot be reached by phone and those who need more intensive assistance.

LHCC’s Chief Medical Director participates in the State’s Emergency Department Reform Committee, contributing to the development of measurement criteria and guidelines for ED utilization.

We will also track the names of members who visit the ED whom we share with the SMO. QI staff will generate and distribute monthly reports to the SMO that include the names of these members and dates of service. Case Managers will discuss identified ED utilization during bi-weekly rounds with the SMO for co-managed members, and facilitate development of outreach, education, and other strategies to address the utilization collaboratively with the SMO. In addition, once the State’s Emergency Department Reform Committee finalizes and approves guidelines for ED utilization, LHCC will disseminate them to network hospitals.

Urgent Care and Retail Clinics. Availability of urgent care and other easily-accessible locations for non-emergent care, such as retail clinics, can reduce unnecessary use of the ED. While DHH does not establish a specific access standard for urgent care, our urgent care network currently offers access based the 90 mile standard to 95% of our membership. We are expanding availability of urgent care through our recent contract with the 15 Take Care Clinic locations operated by Children’s Hospital of New Orleans. In addition, after hours primary care, an appropriate setting for many urgent care needs, is available to 96.9% of members within 60 miles and 100% of members within 90 miles.

We educate members about the role and availability of urgent care providers in a variety of ways, such as:

- Through our new member Welcome Packet, Welcome Call, Provider Directory, and Member Handbook and website
- When Case Managers work with members to complete assessments and care plans, as part of their education of the member about appropriate access
- When members contact the Member Call Center or NurseWise, with urgent care questions or needs.

Pharmacy. We tailor our Drug Utilization Review (DUR) activities to program characteristics and DHH requirements, and use the data US Script provides to us to support effective medication regimens and adherence, and to assess the progress of clinical initiatives such as ADHD medication management and assessment of polypharmacy. For example, we are currently implementing a Pharmacy Lock-In Program for members filling narcotics prescriptions at three or more pharmacies. Members who are identified through the lock-in program will be assessed to determine if the overutilization of medication is related to pain. In those cases, the lock-in program will serve as entry point for referral to a pain management program.

We have developed PA policies that are responsive to trends in overutilization and support the use of safe, appropriate, evidence-based pharmacological treatment as well as cost effectiveness. Our Pharmacy and Therapeutics (P&T) Committee guides the development and evaluation of our PA policies to identify and address trends in overutilization by using evidence-based guidelines, recommendations from our providers, feedback from our members, and results from our DUR program. Our BH Medical Director will serve as the clinical resource for developing behavioral health DUR and PA policies and analyzing utilization of psychotropics prescribed by non-behavioral health providers in the LHCC network.

We educate our providers on medication PA processes, including our Preferred Drug List (PDL) and how to submit a PA request. In addition, US Script, our pharmacy affiliate and a URAC accredited Pharmacy Benefit Manager, uses electronically transmitted point of sale messaging that informs pharmacists about what conditions need to be met to avoid a PA requirement. In the event US Script cannot make a PA determination within 24 hours, we require the pharmacist to dispense a 72 hour emergency supply of drugs. We also allow them to electronically override a claim stop when prescribers are unavailable to respond to a PA requirement, and the pharmacist determines that taking the drug will not jeopardize the health or safety of the member. We require the pharmacist to make a good faith effort to contact the prescriber and reimburse the pharmacist for the emergency supply.

Advanced Radiology Benefits. LHCC has a delegated radiology benefit management to NIA, a URAC and NCQA accredited program for non-emergent, advanced, outpatient radiology services. NIA uses evidence based guidelines to prior authorize CT, MRI and MRA studies, ensuring clinical appropriateness and cost effective, quality care. NIA's clinical guidelines are also designed to reduce unnecessary or redundant procedures and promote radiation safety.

Cesarean Sections. LHCC requires prior authorization for induction of labor prior to forty-one (41) weeks gestational age. Our clinical guidelines help providers understand the short- and long-term impact of choosing cesarean over vaginal delivery, as well as the safe and appropriate opportunities to prevent overutilization of cesarean sections.

Therapy and Rehabilitation Services. We have contracted with Cenpatico STRS to conduct UM for management of utilization of outpatient speech, physical, and occupational therapies. Offering discipline specific expertise, Cenpatico STRS implements utilization management policies; provides peer-to-peer consultation; and educates, trains and provides technical support to providers. Specialty therapy and rehabilitation services are therapeutic interventions intended to reduce the impact of developmental delay or acute impairment of an individual's general health and functional independence.

Each specialty service is unique in its purpose and application, so it is critical to have a strong clinical understanding of each discipline in order to determine appropriateness of service. Cenpatico STRS clinical guidelines are evidence-based and rely on national norms and therapeutic standards. They educate providers on clinical practice guidelines and offer training on discipline specific practice standards. Cenpatico STRS coordinates therapy services for members with special needs to promote greater effectiveness of therapy and rehabilitation services.

Home Health Care (HHC) and Durable Medical Equipment (DME). Home health agencies and durable medical equipment suppliers provide services and supplies that have been determined to be highly susceptible to fraud, waste and abuse. LHCC requires prior authorization of HHC and DME to ensure that our members receive medically necessary care and supplies while monitoring the appropriateness, quantity, frequency and duration of care and service to prevent over-utilization and also prevent, detect and report potential incidents of fraud, waste and abuse.

Managing ADHD Drugs Prescribed for Children Under Seven Years of Age

The Role of the LHCC Behavioral Health Medical Director. LHCC's BH Medical Director will be a Louisiana licensed physician with responsibility for oversight and coordination of behavioral health services and co-management of members with co-existing PH/BH conditions. The BH Medical Director will oversee, monitor, and assist with the management of psychopharmacology pharmacy benefit manager (PBM) activities, including the establishment of prior authorization, clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18. The BH Medical Director will provide clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) who are treating behavior health-related concerns not requiring referral to behavior health specialists.

Our BH Medical Director will also develop and provide training to staff and network providers on BH related Clinical Practice Guidelines related to the BH services being delivered in the primary care setting; and will be responsible for intervening with providers who display practice patterns outside of acceptable ranges for primary care based BH care and services. Our BH Medical Director will work with network providers to develop comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCP's, such as ADHD and depression; and develop targeted education and training for Bayou Health Plan PCP's related to commonly-encountered behavior health issues frequently treated in the primary care setting.

ADHD Medication Drug Utilization Review and Prior Authorization. LHCC monitors providers with higher than average volume of ADHD prescriptions, overutilization of brand name ADHD drugs when an equivalent generic drug is available, and providers who routinely order ADHD medications with a lower cost alternative. When a provider is identified with potential over-utilization, the CMD/BH Medical Director outreaches to the provider to discuss the reasons for their prescribing patterns and educate them on current clinical guidelines, as necessary. We use education, training and corrective actions, as needed, to reduce overutilization and ensure that our members are receiving quality care that is consistent with evidence based practice guidelines. Our Chief Medical Director currently performs peer-to-peer consultations with PCPs, providing them with the appropriate screening tools and educating them on clinical practice guidelines related to ADHD medication in children.

We recently identified higher than expected DME utilization in several categories, including wheelchairs, orthotics and prosthetics. As a result, we will require PA of 116 additional DME codes effective December 1, 2014. We will monitor results of PA during the first quarter of 2015 to determine the impact of this change and to review for potential fraud, waste, and abuse.

Psychotropic Medication Utilization Management Review Program (PMUR) Cenpatico® Behavioral Health (Cenpatico) LLS, LHCC’s behavioral health affiliate will assist us in managing the care, services and medications for our members with ADHD, including stimulant usage. Cenpatico, URAC accredited since 2007, has managed Medicaid and other public sector benefits since 1994 and currently serves over 2 million members across 17 states.

Louisiana Healthcare Connections and Cenpatico Behavioral Health will partner to ensure ADHD medication use in children represents acceptable practice, is used safely, and enhances the stability and functioning of the child

Some of Cenpatico’s specialized areas of expertise include, but are not limited to, behavioral health utilization management and case management, school-based services, specialty therapy and rehabilitation, community reentry, foster care and psychotropic medication utilization review.

In 2008, Cenpatico and our Texas affiliate (which holds a single statewide contract to serve Texas children in foster care) created its award-winning PMUR program to improve oversight and monitoring of psychotropic medication use in children in the Texas foster care system. The subsequent policy and health care delivery model changes have resulted in a **22% reduction in overall psychotropic medication use**, a class polypharmacy utilization decrease of 36% and a 42% decrease in the use of 5 or more medications for Texas children in foster care. The table below illustrates Cenpatico PMUR experience in other states.

Cenpatico PMUR Experience	
State	Population
Texas	Foster Care, TANF (all ages), SSI (all ages)
Mississippi	Foster Care
Florida	Foster Care, TANF Children under 5
Washington	TANF (all children under 5)
Kansas	Foster Care, SSI (all ages), Long Term Care Intellectual/Development Disabilities (all ages)
New Hampshire	Foster Care

PMUR Selection Criteria. PMUR may be triggered by information collected during the Health Risk Survey, by automated pharmacy claims screening, at the request of the assigned Case Manager, by provider referral, self-referral (including requests from parent(s) or guardian, or request by the court or foster care agency. We will also conduct PMUR for children who have received psychotropic medication(s) for 60 days or more; all children aged four and under receiving psychotropic medication; and all children whose medication regimen appears to have class polypharmacy: 2+ stimulants, 2+ alpha agonists, 2+ antidepressants, 2+ atypical antipsychotics, 3+ mood stabilizers, or 4+ psychotropics.

PMUR vs. Medication Review. There are times when Cenpatico’s Medical Director or LHCC’s BH Medical Director can answer questions about psychotropic medication usage and medication utilization parameters without the need for a full PMUR report. This includes instances where the PCP requests guidance on the standards of care and medication utilization parameters or the LHCC Chief Medical Director or Director of Pharmacy requests guidance in analyzing data collected through the Utilization Management program.

Clinical Review. The PMUR program uses evidence-based guidelines to determine appropriateness of psychotropic medications being prescribed for a child. Each month, US Script will generate a file containing psychotropic and ADHD-related prescription claims for children. Cenpatico applies clinical

edits to the file to identify children whose medication regimens fall outside of key clinical parameters. Cenpatico’s Medical Director will then review the file and verifies which children are receiving medications that fall outside of the parameters for 60 days or more, a timeframe we selected to ensure we factor in medications that may be in the process of titration as well as those that a child may have started but then discontinued.

The resulting list is then forwarded to the PMUR Service Management (PMUR SM) staff. The PMUR Service Management staff then obtain the child’s most current diagnoses, obtain a full list of medications, including dose and frequency of each, and gather clinical information regarding the clinical rationale for treatment. The PMUR staff will send a formal request to the prescribers via fax within 3 business days of receiving the list of children from the Medical Director. The request may include, but not be limited to, most recent primary care and/or psychiatric outpatient clinical records, most recent psychiatric evaluation, hospital discharge summaries, and most recent psychological evaluations.

The PMUR SM outreaches to the prescriber by phone if the records are not received within three business days of the request. The PMUR SM continues to follow up for a total of 9 days. If records are not received within nine days, the PMUR staff refers the case with all available clinical information to Cenpatico’s Medical Director for peer-to-peer review. The Medical Director, or an appropriately qualified physician designee will complete the PMUR report within no more than 10 days of receiving all necessary information, but as quickly as possible based on the health status of the member.

The PMUR Report will contain a formal determination of the appropriateness of the child’s medication regimen, as indicated in the table below.

Addressing Determinations of Appropriateness
The medication regimen meets clinical guidelines and is within parameters.
ACTION: PMUR staff will enter this information into the child’s record in TruCare, and forward the PMUR report to our Director of Pharmacy and the assigned Case Manager. PMUR will set a reminder in TruCare to follow up with the Case Manager 90 days after the review to identify any continued issues.
The medication regimen is outside of parameters but within the standard of care; is outside of parameters and an opportunity exists to reduce polypharmacy; or is outside of parameters and there is evidence of or potential for serious side effects from the medication regimen.
ACTION: Cenpatico’s Medical Director immediately notifies our Director of Pharmacy when the PMUR Report indicates that the medication regimen is outside of accepted clinical practice standards and/or there is evidence that the child is experiencing significant side effects. Cenpatico’s Medical Director will also immediately contact the prescribing provider to discuss the medication regimen and make recommendations based on evidence-based clinical guidelines. PMUR staff will monitor children with a PMUR at 90-day intervals after the initial review to identify any ongoing issues unless the PMUR indicates a need for more frequent monitoring. PMUR staff will review records and request physician notes for follow up PMUR when the medication regimen has not changed from the initial PMUR.

Quality of Care Concerns. Cenpatico’s Medical Director instructs the PMUR SM when to trigger a Quality of Care Concern in the event a prescriber continues to use medications outside parameters post-90 days, or when reports indicate the child appears to be experiencing side effects, is not benefiting from treatment, or the medication is inappropriate for the current diagnosis. Cenpatico’s Medical Director uses the Quality of Care process to intervene with providers. Possible interventions may include additional

provider education on clinical guidelines and medication parameters, collaboration with LHCC Quality and Pharmacy staff in the development of a corrective action plan, and/or referral to the LHCC Quality Assessment and Performance Improvement/Credentialing Committees.

Redirecting Requests for PMUR. The PMUR Program is not a substitute for medication pre-authorization or point-of-service drug utilization review. Cenpatico encourages caregivers to contact the treating physician directly with questions about why a specific medication or dosage was prescribed, side effects or requests to change or discontinue medications. The PMUR process can take 2-3 weeks to complete so waiting for a completed PMUR report can delay treatment or changes in medication.

Metabolic Monitoring. LHCC will use metabolic monitoring to monitor whether providers are ordering the appropriate lab work for certain medications. We will run a claims report for providers prescribing psychotropic medications for children and cross-reference the resulting list to claims for lab work. The Director of Pharmacy will identify those children without the appropriate corresponding lab work and refer them to the assigned Case Manager. The Case Manager will then notify the provider of the need to obtain lab work via fax and follow up within 30 days to ensure the lab work was ordered and obtained.

ADHD Chronic Care Management Program. Because drug utilization review is only a small part of preventing overutilization of ADHD medications and ensuring appropriate management of this condition, we will also implement an ADHD Chronic Care Management Program. Our BH Medical Director and Cenpatico's Medical Director will work together to provide clinical oversight of the Program.

The goal of LHCC's Choose Health program is to help members with ADHD achieve the highest possible levels of wellness, functioning, and quality of life. Cenpatico's ADHD program is based on the American Academy of Child Psychiatry clinical practice guidelines for the assessment and treatment of children and adolescents with ADHD, and includes evidence-based best practices developed by the American Academy of Pediatrics. Program objectives include:

- Increase member/family understanding of ADHD, its effects, and possible treatment options
- Increase appropriate self-management
- Increase appropriate use of medications
- Increase integrated treatment planning.

Identification and Stratification. We will identify children between the ages of 6-17 with a diagnosis of ADHD using information gathered during the Member Welcome Call and Health Risk Screening; predictive modeling using claims data; and referrals from members, families, providers, community agencies and LHCC Case Management staff. We will then stratify members enrolled in the ADHD DM program based on acuity as defined by the ADHD Symptom Scale. Members will be stratified into high/moderate/low risk levels.

Condition Specific Assessments. Cenpatico contacts all identified members within 30 days of identification to conduct condition specific assessments. By combining the results of the ADHD symptom scale and initial health assessment, Cenpatico DM staff determines the needed level of intervention and establish a baseline for clinical outcome measurement.

- **ADHD Symptom Assessment:** Assesses ADHD symptoms, functional impairment and response to treatment. The Choose Health Coach will complete an initial baseline scale score and then monitor, every 30 days thereafter, with parents/guardians to monitor signs/symptoms and response to treatment.
- **Initial Health Assessment:** Assesses current health status based on recent health care utilization and the presence of risk factors such as co-occurring physical health conditions, and caregiver availability, support and level of involvement.

By combining the results of the ADHD Symptom Assessment and Initial Health Assessment, we determine the needed level of intervention and establish a baseline for clinical outcome measurement.

Outreach and Education. LHCC will use multiple communication strategies, including written materials, telephonic outreach, web-based information, in-person outreach through MemberConnections™ staff, and Choose Health Coaches, as needed.

Motivational interviewing techniques are incorporated into a library of disease/age specific talking points designed to engage, destigmatize, educate and empower members to improve overall health and manage symptoms. Written information about the Program, diagnosis specific educational materials and instructions on how to contact their Choose Health Coaches.

Measuring Efficacy. UM staff with BH clinical expertise will review outcomes data, including utilization rates, and provide strategic and tactical direction to the Program with the goal of improving outcomes and the lives of individual members. Cenpatico and LHCC will collaborate in tracking the following measures:

- HEDIS: Follow up Care for Children Prescribed ADHD Medication
- ADHD symptom scale score improvement
- Functional improvement as evidence of increased understanding of the disease by member and parent(s)/guardian and ability to manage/self-manage the child’s condition.

N.9 Identify how you will assess the quality and appropriateness of care furnished to enrollees with special health care needs.

Overview

Louisiana Healthcare Connections (LHCC) routinely monitors and assesses the quality and appropriateness of care furnished to members with special health care needs (SHCN) through ongoing review and analysis of a wide range of data, at both the individual member level and at the plan level.

LHCC understands and will comply with all DHH requirements relating to quality and appropriateness of care furnished to members with special health care needs, including, but not limited to, Sections 6.19 Medical Services for Special Populations; 6.29 Care Coordination, Continuity of Care, and Care Transition; 6.37 Case Management; 14.1 Quality Assessment and Performance Improvement Program; and all other relevant contractual and regulatory requirements.

Data Management Capabilities for Assessing Quality and Appropriateness of Care.

Centelligence™ is our award-winning family of integrated decision support and health care informatics solutions. Centelligence™ receives, integrates, and continually analyzes an enormous amount of transactional data, such as medical and pharmacy claims, lab test results, health assessments, service authorizations, member

Centelligence™ produces business intelligence to deliver the right information:

- To the right person**
 - QAPI staff, state clients, Case Managers, Customer Service Representative, providers, members
- For the right task**
 - Clinical quality management, clinical intervention, internal workload adjustments, client reporting
- At the right time**
 - On schedule or in real time

information (current and historical eligibility, demographics, PCP assignment, and more); and provider information (participation status, specialty, demographics).

Centelligence™ provides expansive business intelligence support, including *flexible desktop reporting* and online *Key Performance Indicator (KPI) Dashboards* with "drill down" capability. Centelligence™ also powers our *provider practice patterns and clinical quality and cost reporting* information products. Through Centelligence™, we have the ability to report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, and other critical aspects of our operations.

Centelligence™ also includes a suite of best-of-breed *predictive modeling* solutions incorporating evidence-based, proprietary Care Gap/Health Risk identification applications that identify and report significant health risks at population, Provider, and Member levels. These Care Gaps and Health Risk "alerts" power our *On Line Care Gaps* feature, which allows our Providers and Members to securely access actionable health information via our Provider and Member Portals.

TruCare is our fully-integrated, state of the art clinical decision support criteria and health services management system that houses utilization and case management information; provides referral and authorization data; as well as care plan, clinical member contact, and other data. TruCare allows medical management staff to integrate utilization, case, care and population-based chronic care management efforts; proactively identify, stratify, and monitor high-risk members; consistently determine appropriate levels of care, and efficiently document the impact of our programs and targeted interventions. Please see our response to Question W.1 Information Systems for a full description of our MIS.

Assessing Quality and Appropriateness of Care Furnished to Members with Special Health Care Needs (SHCN)

Member-Level Assessment. Case Management staff work with members with SHCN, their families/caregivers, providers and others involved in their care to develop integrated Care Plans that address all identified needs and reflect the member's goals and preferences. We use the care plan as a living map toward reaching member goals and improved health status and utilization. We quickly modify the map when needed to adapt to changes in member health and support status to ensure the member remains on a forward path. Case Managers continuously evaluate member progress against Care Plan goals to determine whether services are appropriate and to identify issues with service quality.

Assessment Through Member Contact. Case Managers review the care plan during each Member interaction to assess progress on goals, reassess preferences and needs, and make any necessary modifications based on changes in the member's health, psychosocial or support status. Our Case Managers contact members to monitor progress and services at a frequency determined by risk level and member needs (shown below). We risk stratify each member using an algorithm that considers severity/complexity of illness(s), intensity of service, diagnoses, available services and supports and urgency of interventions. For members in the Voluntary Opt-In population who stratify as low risk, our Case Management staff will follow up no less than every six months to reassess risk level.

Acuity	Needs	Setting	Contact Frequency
High - Unstable	Episode of illness or injury needs, discharge planning and outpatient coordination of services.	Inpatient, Outpatient or Home	Weekly post-discharge until stable then either twice a month or monthly
	Complex or chronic condition, symptomatic and at risk for admission or readmission.	Outpatient or Home	Daily until stable, then weekly or twice a month as determined, then monthly
Moderate - Complex but Stable	Complex condition with many health care needs/services.	Outpatient or Home	Weekly to monthly
Low - Stable	No current unmet need for health care services but history of condition that places the Member at risk for potential problems or complications.	Outpatient or Home	One or two contacts and evaluation for care coordination discharge as appropriate; follow up screening every 6 months for Voluntary Opt-In population

Assessment Through Data Analysis. Case Managers monitor delivery of services and member condition and progress not only through direct contact with the member and caregiver/designated supports, but also through review of data such as:

- Utilization, claims, pharmacy, and predictive modeling data
- Telemonitoring (for certain high-risk members)
- Member complaints
- Provider referrals and input
- Referrals and input from the Statewide Management Organization (SMO) for members with BH conditions and from the Dental Benefits Manager (DBM)
- Critical incident reports.

Collaboration with Providers and Members. Case Management staff continuously monitor and collaborate with providers including the PCP to coordinate care, determine effectiveness of services, and identify new or changed needs that require a modification to the care plan. They also enlist members and their families/representatives as partners in monitoring by educating them on specific expectations for caregivers and other service providers, and how to report a critical gap in services. If a member/family member notifies us with a quality of care (QOC) concern, the Case Manager collects available information from the member and may schedule MemberConnections staff to make a home visit to obtain additional information. We follow up through our Quality Improvement (QI) staff for QOC issues.

Clinical Oversight and Coordination. Case Management staff conduct monthly rounds on high risk members to discuss monitoring results and member progress. Rounds include Case Management staff, Medical Director, and other clinical staff such as our Pharmacist and BH Medical Director. We also conduct integrated rounds twice a month, with SMO staff to discuss shared members.

Revising Care Plans To Ensure Appropriateness of Services. The Case Manager works with the member, family/caregiver, provider(s) and others (such as SMO staff for those receiving specialty BH care) to evaluate member progress and monitoring results and determine if Care Plan revisions are necessary. For example, action steps may need to change to reflect challenges with adherence; or additional services may be necessary to address new or changed needs. The Case Manager develops revisions using the same collaborative process described for initial Care Plan development, and

coordinates with UM staff to create, modify, or terminate authorizations to reflect the changes in the care plan and promptly notify providers.

Plan-Level Assessment. QI, Medical Management (MM), and Pharmacy staff analyze encounter and other data to identify potential areas for plan-wide improvement in clinical quality and appropriateness of care. Additional data sources include issues identified during Case Management and referrals from any source indicating potential problems or suspected fraud or abuse, including those identified by affiliated hospitals and contracted providers.

Data Analyzed To Identify Areas for Plan-Level Improvement in Quality and Appropriateness of Care
<ul style="list-style-type: none">• Demographic information relevant to health risks or indicative of health care disparities• Performance on standardized clinical measures, such as HEDIS• Utilization trends and other medical management data including pharmacy data• External data related to conditions or risks for similar populations• Member grievance and appeals• Provider complaint and appeal trends• Quality of care complaint data• Access and availability audits• Claims payment statistics• Member and provider satisfaction survey results.

Staff use these data sources to generate indicators for both standard and ad-hoc reports so that we can monitor the quality and appropriateness of care and drive improvements. We continuously monitor specific quality initiatives; adherence to adopted clinical practice guidelines; access and availability of care; member and provider satisfaction; continuity and coordination of care; over- and underutilization; compliance with new member medical home visits, annual physical exams, EPSDT services, prenatal care services; and chronic care and utilization management activities.

Our QI Department tracks results over time and analyzes them for trends or movement toward established goals. Identified trends may indicate a need for more in-depth evaluation and development of or revision to improvement strategies. The QAPI Committee reviews annual summary reports and makes recommendations for improvement actions. We regularly evaluate progress toward goals, using the QI Work Plan, and make adjustments or adds new interventions when indicated. Improvement activities and revisions to the QI Work Plan are approved by the QAPI Committee.

We monitor and will continue to monitor the following to evaluate the quality and appropriateness of care provided to members with SHCN.

Patient Safety. Our Medical Management staff (UM, CM and Chronic Care Management) review standard and ad hoc reports on potential or actual quality of care events, sentinel events, and adverse events. Staff use these reports to identify events over which providers could have exercised control and which were associated in whole or in part with medical intervention, rather than with the condition for which the intervention occurred. These reports include information from claims, LHCC staff referrals, member grievances, and external sources. We investigate the events, and the factors surrounding them, in order to make a determination of severity and need for corrective action, which may include review by the QAPI Committee. Quality of care and service issues are tracked by our QI staff, classified by severity, categorized by type and tracked by provider or practice. The Chief Medical Director reviews all quality of care issues, including adherence to evidence-based standards of care. The QAPI Committee reviews quality of care and service issue data quarterly, and may recommend corrective action for specific providers or improvement activities, if general trends are identified.

Adherence to Clinical Practice Guidelines. LHCC uses clinical practice guidelines (CPGs) to ensure provision of evidence-based care for routine preventive services and conditions including, but not limited to, those for which LHCC has a Chronic Care Management program or that are meaningful for the SHCN population. At least annually, QI staff measure compliance with two CPGs using HEDIS measures or, if an appropriate HEDIS measure does not exist, National Quality Forum or other nationally recognized performance measures. If necessary, we develop monitoring metrics (with input from a board certified specialist) to monitor compliance with these guidelines. Using standard, nationally recognized and accepted measures allow QI staff to compare results to national benchmarks of performance in these areas. If performance rates fall below LHCC or DHH goals, QI staff conduct further analyses to determine appropriate interventions for improvement. Outcomes and analyses are presented to the QAPI Committee at least annually.

Provider Performance Profiling. LHCC systematically profiles the quality of care delivered by individual providers and provider groups to measure and evaluate provider compliance with clinical performance indicators. Profiles include a multidimensional assessment of a provider's performance using clinical and administrative indicators of care that are accurate, measurable, and relevant to our enrolled population. Included in these profiles are quality of care indicators, specific utilization measures (such as ED utilization), pharmacy indicators, access and availability measures, and member grievance and appeal rates. Our provider profiling process uses national benchmarks whenever possible to compare and assess provider performance. QI, Medical Management, and Provider Relations staff analyze provider-level data to identify underperforming providers (defined as below the national Medicaid NCQA 75th percentile) and develop intervention strategies for them. QI staff monitor provider performance until compliance is maintained. Providers who meet or exceed established performance goals and demonstrate continued excellence or significant improvement over time are rewarded through our provider incentive program.

Monitoring Utilization Patterns. The Medical Management Committee (MMC) evaluates utilization data from health service encounters and pharmacy claims to evaluate for potential under- and over-utilization patterns, determine the need for clinical practice guidelines, and identify other utilization-related issues that may require intervention. Please see our responses to Question N.8 and N.9 for more details on our processes for identifying and addressing over- and under-utilization.

Member and Provider Satisfaction. We evaluate member and provider satisfaction against established benchmarks by monitoring member grievances, provider complaints, and satisfaction survey results at least annually. LHCC uses the CAHPS survey to annually measure member satisfaction with interactions with LHCC staff and providers, access to and availability of services, and overall satisfaction with LHCC. Our QI staff coordinates the CAHPS surveys and aggregates and analyzes findings using national benchmarks and report results. The QI staff reviews survey results and reports findings to the QAPI Committee with specific recommendations for performance improvement actions. These recommendations may include conducting ad-hoc focused studies or barrier analyses to further study a trend noted in the survey results.

QI staff tabulate this data monthly, trend it quarterly and distribute it to appropriate managers to assess program effectiveness and needs. LHCC assesses provider satisfaction annually using valid survey methodology and a standardized comprehensive survey tool administered by The Meyers Group. The survey tool measures provider satisfaction with network specialist availability, claims, quality, utilization management, and other administrative services. Our results are compared with the benchmark of The Meyers Group's book of business. For newly contracted providers, we monitor and evaluate their satisfaction through telephone and on site outreach by our Provider Relations staff and feedback gathered by Medical Management staff during routine interactions.

Member Grievances and Provider Complaints. The Manager of Grievances and Appeals (MGA) tracks member grievances and refers potential quality of care issues to the QI Department for investigation and

resolution. The MGA evaluates complaints and grievances by type, location, and region to identify trends that require further analysis and intervention. The Grievance and Appeals Department tracks and resolves all administrative member grievances and provider complaints. The Grievance and Appeals Committee analyzes grievance and appeals data quarterly to identify trends and provides recommendations for improvement.

Innovative Tools to Take Monitoring to the Next Level

Electronic Visit Verification (EVV). LHCC proposes to use electronic visit verification (EVV) as part of our monitoring of members with special health care needs receiving home health, hospice, and Personal Care Services. EVV will allow us to ensure that in-home services are delivered according to the timeframe and frequency specified on the Care Plan, through Case Management staff comparing actual visits to the established schedule.

In the absence of a State mandate for home health providers to use a specific DHH-designated EVV system for Bayou Health services, LHCC will offer home care providers access to and use of our Home Health Agency Management System, which incorporates integrated EVV functionality (AMS/EVV) and will be supplied by LHCC at no cost to the provider. Our AMS/EVV goes beyond EVV functionality by incorporating valuable process automation for home health agency providers. Scheduling, clinical documentation, compliance management, billing functions (including HIPAA compliant submission of EVV certified claims), payroll, and reporting are all in one consolidated system, eliminating manual and paper-based steps for our home health providers.

Transition of Care and Case Management staff and our home health providers will work off the same electronic scheduling page, alerting LHCC staff to any missed home care appointments in real time. Our affiliates operating in other have found that providers are significantly more likely to use EVV when the system offers the integrated functionality of our AMS/EVV system. In addition, we will pay a 5% per claim financial incentive for home health services (including Personal Care Services and Hospice care) for each such claim the provider files with us through our AMS/EVV system.

We will also offer our 5% per EVV claim incentive if the provider is using another EVV system (if that system meets LHCC's data interface and audit transparency standards). We reserve the right to inspect and test the provider's EVV system prior to including the provider in our 5% enhanced payment program, in order to ensure that LHCC clinical staff have appropriate online access to the EVV to monitor the home care delivered.