Response to the Request for Proposals

BUSINESS AND TECHNICAL PROPOSAL, INCLUDING ATTACHMENTS AND APPENDICES

RFP #: 3000011953
FOR LOUISIANA MEDICAID
MANAGED CARE ORGANIZATIONS

PROPOSAL DUE DATE/TIME:
April 29, 2019, 3 PM CT

SUBMITTED BY:
Louisiana Healthcare Connections
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

TO:
Teresa Bravo
Louisiana Department of Health
Bureau of Health Services Financing
628 N. 4th Street, 6th Floor
Baton Rouge, LA 70802
(225) 342-1862
Teresa.Bravo@la.gov

louisiana healthcare connections™

Transforming Louisiana's health, one person at a time.

REDACTED ELECTRONIC COPY

Confidential Legend:
It is the Proposer's position that the data contained in pages indicated in the below table of the proposal has been submitted in confidence and contains trade secrets and/or privileged or confidential information and such data shall only be disclosed for evaluation purposes, provided that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use or disclose the data therein to the extent provided in the contract. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions.

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SECTION 2.2.1
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Operationally, Louisiana Healthcare Connections works closely with us to ensure that we have access to the tools and resources necessary to identify and address care gaps. In addition to providing us with streamlined administrative processes, we value the quick, responsive access to the executive leadership at Louisiana Healthcare Connections. This executive-to-executive relationship enables a truly collaborative partnership to improve our patients' health.

Louisiana Healthcare Connections has been committed at every level to partnering with us to achieve greater outcomes and quality for the Medicaid patients we serve. We strongly urge the Louisiana Department of Health to re-contract with Louisiana Healthcare Connections; to not do so would be disruptive to our patients, our practice and to the strong operational and care coordination relationship we currently have in place.

—Michael G. Griffin
President and CEO
Daughters of Charity Health Centers

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SECTION 2.2.2

Cover Letter

I must admit that I was not initially a supporter of the concept of having private companies involved with Medicaid in Louisiana. I did not expect the changes to benefit my practice or my patients. I have been pleasantly surprised by the experience. The relationship with some plans, especially Louisiana Healthcare Connections, has been much more collaborative than I ever expected.

We have worked with Louisiana Healthcare Connections to develop services and improve quality of care. Because of a grant from Louisiana Healthcare Connections, we were able to hire a Licensed Clinical Social Worker to provide counseling services for our patients. I believe this has improved our overall behavioral health services to the point that we are now looking to hire a second LCSW.

The incentive and reward programs have been vitally important to this experience. These programs have made it possible to provide high quality pediatric care to Medicaid patients and still have a successful business.

—Dr. Albert W. Richert, Jr.
The Pediatric Center of SWLA

April 29, 2019

Teresa Bravo
Louisiana Department of Health
Bureau of Health Services Financing
628 N 4th Street, 6th Floor
Baton Rouge, LA 70802
(225) 342-1862
Teresa.Bravo@la.gov

Dear Ms. Bravo:

Louisiana Healthcare Connections, Inc. (LHCC) is pleased to submit its response to the Louisiana Department of Health –Request for Proposals for Louisiana Medicaid Managed Care Organizations RFP #:3000011953. LHCC acknowledges receipt of all addenda.

2.2.2.1 Location of administrative office with full time personnel;

Main Headquarters:
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809
Satellite Offices:
Baton Rouge
3854 American Way, Suite B
Baton Rouge, LA 70816
Covington
144 New Camellia Blvd.
Covington, LA 70433

Lafayette
825 Kaliste Saloom Rd
Brandywine 1, Ste. 200
Lafayette, LA 70508
New Orleans
4640 South Carrollton Ave.
Ste. 100
New Orleans, LA 70119

2.2.2.2 Name and address of corporate principal office registered with the Louisiana Secretary of State, email address, website URL, and telephone number;

Principal Office:
7700 Forsyth Boulevard, Suite 800
St. Louis, MO 63105
jschlottman@centene.com
https://www.louisianahealthconnect.com/
225-201-8477

Domicile Office:
Louisiana Healthcare Connections, Inc.
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

2.2.2.3 Name and address for the purpose of issuing checks and/or drafts;

James Schlottman, Plan President and CEO
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

2.2.2.4 Any other name(s) under which the Proposer does, or has done within the last ten (10) years, business;

The Proposer has not done business under any other name in the last 10 years.

2.2.2.5 Ownership status (whether the bidding organization is publicly traded or privately held). If privately held, a statement listing name(s) and address(es) of principal owners who hold five percent (5%) interest or more in the organization;
LHCC is not a publicly traded corporation. LHCC is a wholly-owned subsidiary of Centene Corporation, which is a publicly-traded corporation.

2.2.2.6 The type of legal entity (for example, corporation (profit or not for profit), limited partnership, general partnership, or trust), and the state where the entity is organized, including any parent organization;
LHCC is a for-profit, Louisiana domestic business corporation, and is 100% wholly owned by Centene Corporation, a publicly traded corporation organized in the state of Delaware.

2.2.2.7 If out-of-state Proposer, name and address of local representative; if none, so state;
LHCC is not an out-of-state Proposer.

2.2.2.8 If any of the planned personnel is a current Louisiana state employee, or was employed by the State of Louisiana within the past two (2) years, provide a listing to include the employee name, state agency, and termination date, if applicable;

Employee Name	State Agency	Termination Date
Glenda LeBlanc	Louisiana Legislative Auditor's Office	9/18
Kameshia Netter	Louisiana Dept. of Health	6/17
Nichole Tate	Louisiana Office of State Uniform Payroll	7/17
Li Liu	Louisiana Dept. of Education	3/18
Che'Vandrea Johnson	Louisiana Dept. of Health	4/18
Traci Gremillion	Louisiana Dept. of Corrections	9/18
Lisa Tropez-Arceneaux	Louisiana Dept. of Public Health	11/18
Toya Pierce	Louisiana Office of Juvenile Justice	3/17
James Roig	SE Louisiana War Veterans Home - Louisiana Dept. of Veterans Affairs	6/17
Magean Lecompte-Garner	Louisiana Dept. of Children and Family Services	1/19

2.2.2.9 Proposer's state and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number, if available;
[redacted] [redacted]

2.2.2.10 A graphical summary of whether Proposer meets mandatory and preferred qualifications to propose, as identified in Sections 2.9.1, 2.10.2.1.2, and 2.10.2.5.1;

Qualification Requirements	Mandatory Qualifications		Preferred Qualifications	
	Yes	No	Yes	No
2.9.1 In order to be considered for award, the Proposer must demonstrate that it has met the following mandatory requirements prior to the deadline of receipt of proposals:				
2.9.1.1 Meet the federal definition of an MCO, as defined in 42 C.F.R. §438.2;	X			
2.9.1.2 Have the capacity and willingness to perform all functions in this RFP and in the Model Contract;	X			

Qualification Requirements	Mandatory Qualifications		Preferred Qualifications	
	Yes	No	Yes	No
2.9.1.3 Not be an excluded individual or entity as described in 42 C.F.R. §438.808(b);	X			
2.9.1.4 Have a license or certificate of authority issued by the Louisiana Department of Insurance (LDI) to operate as a Medicaid risk bearing "prepaid entity" pursuant to La. R.S. 22:1016 and submit with the proposal response;	X			
2.9.1.5 Comply with all Louisiana Department of Insurance applicable standards. Information can be found at LDI's website: www.ldi.louisiana.gov. The MCO must meet solvency standards as specified in 42 C.F.R. §438.116 and Title 22 of the Louisiana Revised Statutes;	X			
2.9.1.6 Have a minimum of five (5) years of experience as an MCO for a Medicaid managed care program prior to the deadline for receipt of proposals;	X			
2.9.1.7 Have, within the last thirty-six (36) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana;	X			
2.9.1.8 Have its principal place of business be located inside the continental United States; and	X			
2.9.1.9 Have not had a contract terminated, withdrawn in lieu of termination, or not renewed for non-performance or poor performance within the past ten (10) years.	X			
2.10.2.1.2 It is preferred, though not mandatory, that Proposers meet the following qualifications prior to the deadline for receipt of proposals:				
2.10.2.1.2.1 Have a minimum of seven (7) years of experience in providing health care services for a Medicaid managed care program prior to the deadline for receipt of proposals; and			X	
2.10.2.1.2.2 Have, within the last twelve (12) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana.			X	
2.10.2.5.1*The Proposer should provide a copy of its certificate of accreditation by the National Committee for Quality Assurance (NCQA) for each of its Medicaid managed care contracts. If the Proposer is not accredited in Louisiana, the Proposer should provide a specific timeline outlining the Proposer's plan to achieve full accreditation in Louisiana as soon as possible after the execution of a contract. It is preferred, though not mandatory, that Proposers be accredited by NCQA as a Medicaid managed care organization in Louisiana or in another state prior to the deadline for receipt of proposals. It is preferred, though not mandatory, that Proposers be accredited by NCQA as a Medicaid managed care organization in Louisiana or in another state prior to the deadline for receipt of proposals. ***LHCC has provided the required information in its Technical Proposal response, Section 2.10.2.5 NCQA Accreditation.***			X	

2.2.2.11 A brief statement of the Proposer's involvement in litigation related to the delivery of Medicaid benefits in the last ten (10) years;

The following table details LHCC's involvement in litigation related to the delivery of Medicaid benefits in the last 10 years:

OPEN LITIGATION

NONE

2.2.2.12 A brief statement of the Proposer having had within the last ten (10) years a Medicaid managed care contract(1) terminated or not renewed for non-performance or poor performance and/or (2) terminated on a voluntary basis prior to the contract end date. The Proposer must provide the name and contact information of the lead program manager of the contracting entity;

LHCC has never had a contract terminated or not renewed for non-performance or poor performance nor terminated a contract on a voluntary basis prior to the contract end date.

2.2.2.13 The stipulation that the proposal is valid for a period of at least ninety (90) calendar days from the date of submission; and

LHCC stipulates that its submitted proposal is valid for a period of at least 90 calendar days from the date of submission, April 29, 2019.

2.2.2.14 A positive statement of compliance with the contract terms defined in the Model Contract.
LHCC asserts that it will comply with the contract terms as defined in the Model Contract.

2.3.3 The original hard copy of the proposal shall contain original signatures of those company officials or agents duly authorized to sign proposals or contracts on behalf of the organization. A certified copy of a board resolution granting such authority should be submitted if the Proposer is a corporation. The proposal containing original signatures will be retained for incorporation into any contract resulting from this RFP.
The Certified Board Resolution can be found in the Attachments and Appendices Section of the proposal submission.

Sincerely,

James E. Schlottman
Plan President and CEO
Louisiana Healthcare Connections, Inc.

2.9 BUSINESS PROPOSAL REQUIREMENTS

As a pediatrician, ensuring an efficient, smooth experience for my patients is critically important; their attitudes toward health and experience with the healthcare system will impact our communities for decades to come. The incentive and reward programs and the way Louisiana Healthcare Connections conducts business enables providers to be successful while accepting Medicaid patients.

—Dr. Kenneth Cruse
The Center for Pediatric and Adolescent Medicine

SECTION 2.9.1

Mandatory Qualifications

During the past three years, Louisiana Healthcare Connections' management has provided Volunteers of America North Louisiana with open communication and direction in the form of monthly meetings. Our relationship has been reciprocal. Louisiana Healthcare Connections has called on us to provide input and feedback on specific policy proposals. We believe our relationship is built on professional trust and mutual respect.

VOA North Louisiana and our colleagues in the Baton Rouge and New Orleans affiliates support Louisiana Healthcare Connections, and we are appreciative of the comprehensive and essential health and care management programs it provides. Louisiana Healthcare Connections has recognized the excellent outcomes we have achieved with the high need populations we serve and has worked closely with us to ensure these members receive the intensive services they need to achieve their goals.

—Chuck Meehan
President and CEO
Volunteers of America North Louisiana

2.9 BUSINESS PROPOSAL REQUIREMENTS [5 PAGE LIMIT]

The Proposer shall meet all standards and must comply with all business proposal submission requirements in this section. The Proposer's business proposal should not exceed five (5) pages.

Louisiana Healthcare Connections (LHCC) asserts that it meets the mandatory requirements to respond to RFP #: 3000011953 as indicated in the following responses.

2.9.1 MANDATORY QUALIFICATIONS

In order to be considered for award, the Proposer must demonstrate that it has met the following mandatory requirements prior to the deadline of receipt of proposals:
2.9.1.1 Meet the federal definition of an MCO, as defined in 42 C.F.R. §438.2;

LHCC affirms that is meets the federal definition of an MCO as defined in 42 C.F.R. §438.2. A copy of our certificate of authority as a health maintenance organization in the State of Louisiana may be found in ***Attachment 2.9.1.4 Certificate of Authority***.

2.9.1.2 Have the capacity and willingness to perform all functions in this RFP and in the Model Contract;

LHCC has the capacity and willingness to perform all functions in this RFP and in the Model Contract as indicated in our response to 2.10 Technical Proposal Requirements.

2.9.1.3 Not be an excluded individual or entity as described in 42 C.F.R. §438.808(b);

LHCC confirms that it is not an excluded entity as described in 42 C.F.R. §438.808(b).

2.9.1.4 Have a license or certificate of authority issued by the Louisiana Department of Insurance (LDI) to operate as a Medicaid risk bearing "prepaid entity" pursuant to La. R.S. 22:1016 and submit with the proposal response;

LHCC has a certificate of authority from the Louisiana Department of Insurance (LDI). Please see ***Attachment 2.9.1.4 Certificate of Authority*** for documentation.

2.9.1.5 Comply with all Louisiana Department of Insurance applicable standards. Information can be found at LDI's website: www.ldi.louisiana.gov. The MCO must meet solvency standards as specified in 42 C.F.R. §438.116 and Title 22 of the Louisiana Revised Statutes. Documentation of compliance with these requirements may be included in separate attachments and will not count toward the business proposal and total page limits;

LHCC complies with all Louisiana Department of Insurance applicable standards and meets solvency standards as specified in 42 C.F.R. §438.116 and Title 22 of the Louisiana Revised Statutes. Demonstration of solvency may be found in ***Attachment 2.9.5.1.1.A LHCC Audited Financial Statements.***

2.9.1.6 Have a minimum of five (5) years of experience as an MCO for a Medicaid managed care program prior to the deadline for receipt of proposals*;

LHCC has seven years of experience serving Medicaid enrollees in the State of Louisiana, exceeding the minimum requirement of five years.

2.9.1.7 Have, within the last thirty-six (36) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana*; and

LHCC has been engaged in a Medicaid Contract in the State of Louisiana since 2012. Within the last 36 months, LHCC's parent company, Centene Corporation (Centene), has been engaged in contracts as a Medicaid MCO in multiple states with Medicaid populations equal to or greater than that of Louisiana. Additional information may be found in Technical Response Section 2.10.2.1 Proposer Experience.

2.9.1.8 Have its principal place of business be located inside the continental United States.

LHCC's principal place of business is located in Baton Rouge, Louisiana in the continental United States.

****Experience requirements in Sections 2.9.1.6 and 2.9.1.7 may be satisfied if the Proposer is a new MCO or a state-specific entity that takes direction from its parent organization, and the parent organization operates a Medicaid MCO that meets the requirements of those sections.***

SECTION 2.9.2

Conflict of Interests

One of the components that distinguishes Louisiana Healthcare Connections from other insurers is the hands-on approach toward providers and patients in helping to meet and exceed our health goals. I enjoy meeting with Louisiana Healthcare Connections' leadership team throughout the year to discuss our objectives and any issues that could prevent us from achieving mutual goals.

Because Louisiana Healthcare Connections has a reputation for leadership and results, I look forward to continuing to work together as a team. With collective missions focused on meaningful outcomes, our combined efforts represent a powerful resource for our Louisiana patients and communities.

—Donna Saterfiel
President and CEO
All Kids R Us Medical Clinic

2.9.2 CONFLICT OF INTERESTS

Neither the Proposer nor any subcontractor may have any interest that will conflict, as determined by LDH, with the performance of services required under this RFP. To demonstrate freedom from conflicting interests, the Proposer must submit the following:

2.9.2.1 A signed Proposer's certification attesting that no interest will conflict in any manner or degree with the performance required under the Contract;

LHCC attests that no interest will conflict in any manner or degree with the performance required under the Contract.

James E. Schlottman, Plan President and CEO

2.9.2.2 A signed Proposer's certification attesting that the Proposer does not have, nor does any of the Proposer's material subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker Contractor, or in such vendor's subcontractors, if any;

LHCC attests that we do not have, nor do any of our material subcontractors have, any financial, legal, contractual or other business interest in LDH's Enrollment Broker or External Quality Review Organization Contractor, or in such vendors' subcontractors, if any.

James E. Schlottman, Plan President and CEO

2.9.2.3 A statement describing any and all of the financial, legal, contractual, and other business interests of the Proposer and any subcontractor, its affiliates, partners, parent(s), subsidiaries, and related organizations, if any, that may affect or impact its performance under the Contract. In cases where such relationships or interests exist or appear to exist, describe how a potential or actual conflict of interest will be avoided or remedied;

LHCC and our subcontractors, affiliates, partners, parent, subsidiaries, and related organizations do not maintain any financial, legal, contractual, or other business interests that may affect or impact LHCC's performance under the Contract.

2.9.2.4 Any other information that may be relevant to the Proposer's or any material subcontractor's financial, legal, contractual, or other business interests as they relate to the RFP and Contract; and

LHCC does not have any other information to report that may be relevant to our or any material subcontractor's financial, legal, contractual, or other business interests as they relate to the RFP and Contract.

2.9.2.5 A signed Proposer's certification attesting that the Proposer agrees to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to the Proposer's financial, legal, contractual, or other business interests as they relate to the RFP and Contract.

LHCC attests that we agree to submit any additional information requested by LDH that, in LDH's judgment, may be relevant to its financial, legal, contractual, or other business interests as they relate to the RFP and Contract.

James E. Schlottman, Plan President and CEO

SECTION 2.9.3

Moral or Religious Objections

We are writing to express our appreciation to Louisiana Healthcare Connections for its willingness to assist St. Martin Hospital with emergency room utilization for our Medicaid non-emergent patients. We are working diligently to shift our patients to a care management clinic so they care receive follow-up care for chronic disease processes. This effort will promote continuity of care while reducing unnecessary readmissions and high cost emergency room visits.

—Karen O. Wyble
CEO
St. Martin Hospital

2.9.3 MORAL OR RELIGIOUS OBJECTIONS

The Proposer shall provide:
2.9.3.1 A statement of attestation that the Proposer has no moral or religious objections to providing any MCO covered services described in the Model Contract, Part 2, Services; or

LHCC attests that we have no moral or religious objections to providing any MCO covered services described in the Model Contract, Part 2, Services.

2.9.3.2 A statement of any moral and religious objections to providing any MCO covered services. The statement must describe, in as much detail as possible, all direct and related services that are objectionable. It must include a listing of the codes impacted including but not limited to CPT codes, HCPCS codes, diagnosis codes, revenue codes, modifier codes, etc., and if there are none, it must so state.

This statement does not apply as LHCC has no moral or religious objections to providing any MCO covered services described in the Model Contract, Part 2, Services.

SECTION 2.9.4

Material Subcontractors

Since Healthy Louisiana's inception, our practice has enjoyed the dedication, commitment and collegiality Louisiana Healthcare Connections has shown. Louisiana Healthcare Connections works with us to improve the Medicaid delivery system and quality care for our 14,000 Medicaid patients who have signed with this plan. It is a privilege to work collaboratively with a company so dedicated to helping these individuals have access to quality care.

My practice and I look forward to working with Louisiana Healthcare Connections and continuing to build upon the successes we have achieved together.

—Dr. Chris Leumas
North Oaks Pediatrics Clinics

2.9.4 MATERIAL SUBCONTRACTORS

2.9.4.1 The Proposer shall state whether material subcontractors will be used to provide all, or part, of any program area or function that relates to the delivery or payment of MCO covered services under the Contract...

LHCC plans to use the below material subcontractors to provide functions related to the delivery and/or payment of MCO covered services under the contract. In the future, LHCC anticipates contracting with Accountable Care Organizations (ACOs). Per Section 2.17.14.4 of the Model Contract, LDH considers ACOs Material Subcontractors; upon creation of these ACOs, LHCC will submit all required Material Subcontractor information as outlined in the Model Contract.

Material Subcontractor	Principal Address	Telephone
Affiliated		
Centene Management Company, LLC	7700 Forsyth Boulevard St. Louis, MO 63105	(314) 725-4706
Envolve Dental, Inc.	5130 Sunforest Drive Tampa, FL 33634	(888) 234-0810
Envolve PeopleCare, Inc.	20 Batterson Park Road Farmington, CT 06032	(888) 293-0056
Envolve Pharmacy Solutions, Inc.	8427 South Park Circle, Suite 400, Orlando, FL 32819	(855) 422-2742
Envolve Vision, Inc.	112 Zebulon Court, P.O. Box 7548 Rocky Mount, NC 27804	(800) 334-3937
Non-Affiliated		
AdhereHealth	5200 Maryland Way, Suite 200 Brentwood, TN 37027	(615) 346-0880
LogistiCare Solutions, LLC	1275 Peachtree Street NE, 6th Floor Atlanta, GA 30309	(404) 888-5800
National Imaging Associates, Inc.	6950 Columbia Gateway Drive Columbia, MD 21046	(410) 953-1000

2.9.4.2 The Proposer must submit a signed Proposer's Certification attesting that the Proposer:
2.9.4.2.1 Acknowledges it will not be relieved of any legal obligations under any Contract resulting from this RFP as a result of any contracts with subcontractors, that it shall be fully responsible for the subcontractor'....

LHCC acknowledges that we will not be relieved of any legal obligations under any Contract resulting from this RFP as a result of any contracts with subcontractors, that we shall be fully responsible for the subcontractor's performance, and that all partnership agreements, subcontracts, and other agreements or arrangements for reimbursement will be in writing and will contain terms consistent with all terms and conditions of the Contract.

James E. Schlottman, Plan President and CEO

2.9.4.2.2 Acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.

LHCC acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.

James E. Schlottman, Plan President and CEO

SECTION 2.9.5

Financial Condition

Since I'm taking meds for my mental health, my health insurance called me telling me I'm not alone; these meds will help me and to keep with it. Then they said to call anytime if I need help with my mental illnesses. This is the sweetest call ever!

—Elena Scar
Member, via Twitter

2.9.5 FINANCIAL CONDITION [EXEMPT FROM BUSINESS PROPOSAL AND TOTAL PAGE LIMITS]

2.9.5.1 The Proposer shall submit documentation to demonstrate to the satisfaction of LDH that the Proposer's organization (and the Proposer's parent organization and material subcontractors, if any), is in sound financial condition and that any significant financial problems are being addressed with appropriate corrective measures. The documents submitted must include at least the following:
2.9.5.1.1 Copies of audited financial statements for each of the last three (3) years, including at least a balance sheet, profit and loss statement, or other appropriate documentation, and the auditor's report…

LHCC has provided copies of audited financial statements for the last three years for our organization, our parent organization, and Material Subcontractors in ***Attachments 2.9.5.1.1.A-G***. Per the RFP, audited financial statements have been provided as part of the electronic copy submission in lieu of hard copy. This information is exempt from section-specific and total page limits.

Entity	Attachment Title
Proposer	
Louisiana Healthcare Connections	Attachment 2.9.5.1.1.A LHCC 2015 Audited Financial Statements Attachment 2.9.5.1.1.A LHCC 2016 Audited Financial Statements Attachment 2.9.5.1.1.A LHCC 2017 Audited Financial Statements
Parent Organization	
Centene Corporation	Attachment 2.9.5.1.1.B Centene 2016 10K Attachment 2.9.5.1.1.B Centene 2017 10K Attachment 2.9.5.1.1.B Centene 2018 10K
Material Subcontractors	
Centene Management Company, LLC	Attachment 2.9.5.1.1.B Centene 2016 10K Attachment 2.9.5.1.1.B Centene 2017 10K Attachment 2.9.5.1.1.B Centene 2018 10K
Envolve Dental, Inc.	Attachment 2.9.5.1.1.D Envolve Dental 2015-2016 Audited Financial Statements Attachment 2.9.5.1.1.D Envolve Dental 2016-2017 Audited Financial Statements
Envolve PeopleCare, Inc.	Attachment 2.9.5.1.1.B Centene 2016 10K Attachment 2.9.5.1.1.B Centene 2017 10K Attachment 2.9.5.1.1.B Centene 2018 10K
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National Imaging Associates, Inc.	Attachment 2.9.5.1.1.G NIA Magellan 2016 10K Attachment 2.9.5.1.1.G NIA Magellan 2017 10K Attachment 2.9.5.1.1.G NIA Magellan 2018 10K

2.9.5.1.2 A certificate from the taxing authority of the state in which the Proposer has its principal office, attesting that the Proposer is not in default of any obligation under its tax laws.

LHCC is not in default of any obligations under Louisiana tax laws as evidenced by certification from the Louisiana Department of Revenue found in ***Attachment 2.9.5.1.2.A LHCC Tax Clearance***. Additional certifications from our parent organization and material subcontractors may be found in the following attachments:

Entity	Attachment Title
Proposer	
Louisiana Healthcare Connections	Attachment 2.9.5.1.2.A LHCC Tax Clearance
Parent Organization	
Centene Corporation	Attachment 2.9.5.1.2.B Centene Tax Clearance
Material Subcontractors	
Centene Management Company, LLC	Attachment 2.9.5.1.2.B Centene Tax Clearance
Envolve Dental, Inc.	Attachment 2.9.5.1.2.C Envolve Dental Tax Clearance
Envolve PeopleCare, Inc.	Attachment 2.9.5.1.2.D Envolve PeopleCare Tax Clearance
Envolve Pharmacy Solutions, Inc.	Attachment 2.9.5.1.2.E Envolve Pharmacy Tax Clearance
Envolve Vision, Inc.	Attachment 2.9.5.1.2.F Envolve Vision Tax Clearance
AdhereHealth LLC*	Attachment 2.9.5.1.2.G AdhereHealth Tax Clearance
LogistiCare Solutions, LLC	Attachment 2.9.5.1.2.H LogistiCare Tax Clearance
National Imaging Associates, Inc.	Attachment 2.9.5.1.2.I NIA Tax Clearance

*AdhereHealth, LLC does not presently conduct business in the State of Louisiana, therefore the Tax Clearance form provided is from their principal place of business in the State of Tennessee.

2.9.5.2 LDH may determine a Proposer to be non-responsible in accordance with Section 3.5 if the Proposer fails to submit the documents required by this section, or if the documents indicate to LDH, in its reasonable discretion, that the Proposer's, the Proposer's parent organization's, or the Proposer's material subcontractors', if any, financial condition is unsatisfactory.

LHCC acknowledges that LDH may determine us to be non-responsible in accordance with Section 3.5 if we fail to submit the documents required by this section, or if the documents indicate to LDH, in its reasonable discretion, that LHCC's, Centene's, or our material subcontractors' financial condition is unsatisfactory.

SECTION 2.9.6

Required Forms and Certifications

There are significant food deserts within the Lower Ninth Ward, leaving many residents there without immediate access to healthy foods. We want to make a difference there, and this grant from Louisiana Healthcare Connections helps us to plant that seed. Good nutrition equates to better outcomes for people with HIV and chronic conditions.

—Reginald Vicks
Chief Operating Officer
CrescentCare

2.9.6 REQUIRED FORMS AND CERTIFICATIONS [EXEMPT FROM BUSINESS PROPOSAL AND TOTAL PAGE LIMITS]

The Proposer shall complete, sign, and submit the forms detailed below. Electronic versions of the forms are available in the procurement library.

2.9.6.1 The proposal must include a Proposal Compliance Matrix (Appendix C).

Please see ***Attachment 2.9.6.1 Appendix C Proposal Compliance Matrix*** located within the Attachments and Appendices section of the RFP response. This information is exempt from section-specific and total page limits.

2.9.6.2 The Proposer must sign and submit an original Certification Statement (Appendix D). The Proposer must be registered as a vendor with the Louisiana Procurement and Contract Network (LaPAC) prior to submitting their proposal, and must include their vendor number on the Certification Statement. Information on registration may be found at https://wwwcfprd.doa.louisiana.gov/osp/lapac/Vendor/VndPubMain.cfm?tab=2.

Please see ***Attachment 2.9.6.2 Appendix D Original Certification Statement*** located within the Attachments and Appendices section of the RFP response. This information is exempt from section-specific and total page limits.

2.9.6.3 Federal laws require full disclosure of ownership, management, and control of Medicaid MCOs. The Medicaid Ownership and Disclosure Form (Appendix E) must be submitted to LDH with the proposal. The Proposer may submit this information in electronic format in lieu of hard copy.

Please see ***Attachment 2.9.6.3 Appendix E Medicaid Ownership and Disclosure Form*** located within the Attachments and Appendices section of the RFP response. Per the RFP, Appendix E has been provided as part of the electronic copy submission in lieu of hard copy. This information is exempt from section-specific and total page limits.

2.10 TECHNICAL PROPOSAL REQUIREMENTS

The business of pediatrics has been challenging since managed care came to the Louisiana Medicaid program. If it wasn't for the partnership we have developed with Louisiana Healthcare Connections, we at Bayou Pediatrics would have difficulty to both care for our patients with Medicaid and take care of our employees and our families financially. Louisiana Healthcare Connections has provided the guidance we needed to continue to provide the high quality and efficient care that our Bayou Community needs.

—Dr. Rob Clarke
Bayou Pediatrics

SECTION 2.10.1

Executive Summary

Since Healthy Louisiana launched, Louisiana Healthcare Connections has provided resources central to the vitality of our community and we have seen the impact of its commitment to better health.

—Dr. Gary Wiltz
Teche Action Clinic

2.10.1 EXECUTIVE SUMMARY (NOT SCORED) [5 PAGE LIMIT]

The Proposer should provide an executive summary which demonstrates its understanding of LDH's vision for the Contract. The executive summary should describe the Proposer's overall approach to providing access to covered services under the Contract for Louisiana Medicaid enrollees in a manner that will lead to better health, better care, and lower costs.

Louisiana Healthcare Connections (LHCC) was created for the sole purpose of providing high quality, accessible care to Medicaid beneficiaries in Louisiana. As Healthy Louisiana has evolved to add new benefits and populations, we have been proud to be a partner to LDH in improving health outcomes, pursuing health equity and building a better health care delivery system for our state. In alignment with LDH's vision and objectives, Louisiana Healthcare Connections (LHCC) is committed to transforming Louisiana's health, one person at a time. Our goals as an organization align with the Triple Aim and take it one step further through our adoption of the Quadruple Aim: better health, better care, lower costs, and improving provider work life. The programs and initiatives described in this proposal demonstrate the core strategies of our approach to helping LDH achieve its goals: local, Louisiana leadership and investment; unique and innovative provider partnerships; and an unwavering focus on achieving health for our enrollees. This approach imbues LHCC with nimbleness and a sense of urgency to address emerging needs and take advantage of new opportunities to improve health and health care in our state. Select examples of our overall approach to aligning with, supporting and achieving LDH's vision include:

TO ACHIEVE BETTER CARE

Ensuring Enrollee Access to Care ● Decreasing Fragmentation

Ensuring Enrollees Ready Access to Care

LHCC has successfully developed and maintained one of the largest Medicaid provider networks in the State, comprised of more than 20,000 providers, offering comprehensive and timely access to care. In addition to incentivizing after hours and weekend primary care and authorizing psychiatric intensive outpatient services as an in lieu of service for step-down care for enrollees with behavioral health (BH) hospitalizations, we are expanding access through:

Ochsner Health System (OHS) Accountable Care Partnership. Our collaboration brings Louisiana's leading high-

[redacted]

[redacted]

Mobile Solutions. We have contracted with 17 providers offering mobile solutions to expand access to physical, BH, and/or dental services across the state. For example, we are working with Daughters of Charity FQHC to expand their primary care mobile offering in Plaquemines Parish, and with Winn Community FQHC to expand their primary care mobile offering to Grant Parish, increasing access for all Medicaid recipients in these areas.

Decreasing Fragmentation

LHCC understands the importance ***decreasing fragmentation and increasing integration across providers and care settings to provide whole-person care***. We provide education and resources to our network providers and invest in expanding provider capacity to offer evidence-based, integrated approaches to care.

- We will use Quartet to help integrate care and address a statewide shortage of qualified behavioral health (BH) professionals. Quartet will provide enrollees remote behavioral health service access. Quartet also facilitates e-consult services, from BH providers for physical health providers, to bolster the quality of care delivered in the PCP's office for members with mild BH needs.
- To advance BH/PH integration and develop workforce capacity, LHCC offers scholarships in the Post Master's Psychiatric Mental Health Nurse Practitioner (PMHNP) Certification at Southeastern Louisiana and McNeese Universities.

TO ACHIEVE BETTER HEALTH

Incentives to Improve Quality ● Population Health ● Community Care ● Culture of Improvement

With our targeted initiatives to address care gaps through partnerships with FQHCs across the State, more than 90% of our targeted HEDIS measures have shown improvement from 2014-2017.

Financial Incentives to Improve Quality

Value-Based Purchasing. LHCC is a pioneer in transitioning Louisiana Medicaid from pay-for-volume to pay-for-

[redacted]

[redacted]

Population Health

We aim to maximize enrollee health and advance health equity through a data-driven population health approach that integrates across clinical and social care silos, collaborating with communities and LDH to address social determinants of health (SDOH).

Population Health at Our Core. LHCC is in the process of establishing a Population Health Department governed by a Population Health Steering Committee, bringing our range of population health activities under one accountable authority for improved coordination. We are establishing an SDOH Centers of Excellence with specialists in five priority SDOH areas as well as dedicated population health data analysts.

Better Data for Better Outcomes. LHCC collects SDOH data on enrollees today using our 12-question basic needs screening tool, screening more than 11,650 enrollees since 2018. We are implementing an SDOH risk score to identify enrollees at risk for negative outcomes due to unmet SDOH needs and provide opportunities for early intervention. To deepen our population health data, we will use Pennington Biomedical Research Center's LA CaTS program expertise to run supplemental population health assessments.

Community Connections. We will launch Community Connections Platform, a shared electronic SDOH database and referral system for tracking and outcomes reporting statewide. Community Connections offers bi-directional communication among users to ensure effective closed loop service referrals and data feedback, and contains features for both enrollee and provider access to search and refer to community-based resources.

Health and Wellness Platform for All LHCC Enrollees. As part of our Healthy Rewards Program, LHCC will offer enrollees our Health and Wellness Platform, to provide education and activity-based incentives aligning with our Population Health strategy. Based on an assessment completed in the app or portal, enrollees will receive customized health and life management education and opportunities to earn rewards for tracking activities such as activity, diet, and sleep. Enrollees will earn rewards for both clinically-based and activity-based activities.

Community-Based Care

- [redacted]
- ***Community Health Workers.*** LHCC began using CHWs in 2012 to address social needs, and has continually evolved our program since that time, adding more sophisticated analytics to identify and stratify our enrollees, and implementation of SDOH screenings. LHCC is more than doubling our CHW staff to provide in-person assessments, health coaching, care navigation and engagement.

Innovation and a Cultural of Continuous Quality Improvement

LHCC has demonstrated successful outcomes for ***supporting innovation and a cultural of continuous quality improvement in Louisiana***. We develop strategic partnerships with providers serving enrollees with targeted high-risk and complex conditions, in addition to our overall Care Management Program, targeted case management, and disease management programs.

Condition-Specific Innovation. LHCC is partnering with the Diabetes Assessment and Management Center (DiaMC) in Shreveport, through a customized VBP model related to comprehensive diabetes care that has increased HbA1c screening by 12.90%, fundoscopic eye exams by 5.38%, and microalbuminuria screening by 36.39% compared to control group.

Competitive Grant Funding. To foster and facilitate provider innovation, our Transformation Grants make strategic investments in provider initiatives to offer integrated care, move toward PCMH certification, advance cultural competency, offer practice accessibility tools, implement the provider's first Electronic Medical Record, or address social determinants of health.

TO ACHIEVE LOWER COST

Value-Based Purchasing to Increase Efficiency ● Program Integrity

Value-Based Purchasing to Increase Efficiency

LHCC employs a proactive, provider-focused approach to controlling costs by reducing administrative burden, allowing providers to focus their time and money on providing better care to our enrollees. Our providers can point to their evolution under VBP arrangements, demonstrated by comparisons before and after engaging with LHCC in APM models. For example, Bayou Pediatrics experienced a reduction in MLR from 103.2% in 2017 to 84.8% in 2018, with quality scores among the highest levels in the network.

***Tools for Provider Efficiency*.** To support provider efforts to lower costs, our Interpreta real-time analytics tool gives providers a forward-looking view of enrollee needs to close care gaps with retrospective data, enabling them to more efficiently treat patients. Our Centelligence tools allow providers to eliminate or reduce low-value care. Our Provider Portal supports efficient self-service capabilities, including eligibility inquiry, authorization submission and status, claim submission, claim status, and claim payment history.

Program Integrity and Fraud, Waste and Abuse (FWA) Prevention

We prevent, reduce, detect, and report suspected FWA while preventing potential enrollee health risks.

Focused on Prevention. LHCC's FWA practices resulted in approximately $25 million in savings through prepay reviews, cost avoidance, and recovery activities during 2018. LHCC uses several FWA data analytic algorithms to prevent and detect fraud. These tools perform sophisticated statistical analysis, pattern monitoring, and other data mining techniques that enable us to prevent payment on fraudulent, wasteful or abusive claims

Local FWA Team. Our Louisiana-based FWA Team investigates incidents and implements corrective action plans to prevent and detect FWA. The FWA Team cooperates in any investigations, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes. Additionally, we are creating a task force comprised of local providers from multiple disciplines to better identify and address FWA.

Training Programs for Employees, Subcontractors, and Providers. Our comprehensive FWA training program includes local information specific to state laws and contract requirements, and is supplemented by Centene's national compliance training program best practices. Regular, effective education and training of our employees, providers, and subcontractors are ingrained in our culture and a key element to our FWA prevention plans.

TO IMPROVE PROVIDER WORK LIFE

Louisiana Provider Leadership to Reduce Administrative Burden ● High Touch Provider Engagement

Provider Leadership to Reduce Complexity and Administrative Burden

The majority of our board and leadership team are or have been health care providers in Louisiana, bringing real-world experience to guide both strategic and operational decisions. LHCC's strategy for ***reducing complexity and administrative burden for providers*** is informed by Louisiana-based physicians through our provider-led Board of Directors and Physician Advisory Council. We are establishing a physician-led Clinical Policy Committee chaired by Dr. Gary Wiltz (Teche Action Clinic) to reflect local needs and standards of care.

Simplified Authorizations. LHCC makes the authorization process as simple as possible, processes and pay clean claims quickly, and provide a variety of self-service functions via our Provider Portal. For Admission, Discharge, and Transfer data submitted electronically by facilities, our PA automation engine automatically issues an authorization for a stay that meets criteria, eliminating the need for providers to submit a request.

Provider Satisfaction and Retention. Less than one percent of providers have terminated their contracts with LHCC for reasons other than closing their practice or moving out of state. The vast majority of our providers have been in-network without interruption since 2012.

Ranked #1

for all three measures of Provider Relations in the 2018 LDH Provider Satisfaction Survey

High Touch Provider Engagement

Our proactive, high-touch, local team of Provider Engagement Specialists focus on provider support, education, and satisfaction. Through frequent regular and ad hoc meetings, we provide critical support that increases retention and quality of care. Providers consistently rate their satisfaction with LHCC as one of the top two MCOs in the State.

Clinical Nurse Liaisons. To support providers in managing their practice and providing efficient, effective care to enrollees, we will deploy field-based Clinical Nurse Liaisons, strategically throughout the State to support quality improvement and VBP advancement. They will address quality, present evidence-based data, engage on practice transformation, review population health reports, assist with care gap closure, and other clinical initiatives.

For all providers, whether in a VBP arrangement or not, we will also align incentives and build shared capacity to improve quality. Our Experts-on-Call from Medical Management, Quality, Population Health, and Communications provide drop-in support and needed expertise on enrollee engagement, process simplification, population health initiatives, and more. LHCC's Connections Academy curates educational content so every provider has a full roster of educational supports from the technical to the clinical to advance population health. Our four Provider Educators (dedicated to claims, primary care, behavioral health, or VBP) will offer education to facilitate provider success in meeting LDH quality and access goals.

TO TRANSFORM LOUISIANA'S HEALTH

LHCC has been proud to serve LDH, our enrollees and our providers since the inception of Louisiana's Medicaid managed care program in 2012. We are proud of our accomplishments in improving health outcomes, establishing value-based purchasing programs, and investing in community efforts to address social determinants of health.

As an organization whose purpose is to **transform** Louisiana's health – not just improve health and pay claims -- we are enthusiastic and excited by the **transformational vision presented in this RFP**. If selected for this Contract, we look forward to collaborating with LDH, providers, enrollees, and community stakeholders to seize the opportunity this RFP presents to transform Louisiana's health and achieve the Quadruple Aim.

SECTION 2.10.2

Organizational Experience

When the state started talking about going to a managed care model, we were not that thrilled. We were concerned that the insurers wouldn't listen to the provider voice. What we've found since the transition is that we have a partner, especially in Louisiana Healthcare Connections. Louisiana Healthcare Connections works with us and gives us information we didn't have available to us in the pre-managed care days.

Through their portal, we get detailed data about costs, care gaps, health risks and high ED usage that help us focus our efforts on individual patient needs. Louisiana Healthcare Connections works together with us to improve care while saving cost.

We have a direct line to the executives like Dr. Stewart Gordon and Jamie Schlottman, and our Provider Relations Consultant, Cheryl Barrow, does a great job. We really appreciate our partnership with Louisiana Healthcare Connections.

—Greg Ivey
Chief Operating Officer
Pediatric Center of Southwest Louisiana

SECTION 2.10.2.1

Proposer Experience

Together we have proven we can improve health care efficiency as demonstrated in our shared savings program, and put your members, our patients, on the path to better health through beneficial patient-centered initiatives. As an example, over the past two years we have partnered with Louisiana Healthcare Connections to successfully add an LCSW to our practice who provides vital behavioral health services within our clinic on a daily basis. We found this integrated health care delivery model approach to be very efficient and effective as the patients can receive treatment timely due to the involvement and coordination of the PCPs and LCSW. Even more recently, we have partnered with Louisiana Healthcare Connections to enter a childhood/family obesity study in coordination with Pennington Biomedical Research Center.

Considering the partnership we've established with Louisiana Healthcare Connections, we certainly hope they remain as one of the MCOs in the next RFP. Having this continuity for our patients and practice is critical to our ongoing success.

—Dr. Dawn Vick
President
Red Stick Pediatrics

2.10.2 ORGANIZATIONAL EXPERIENCE

2.10.2.1 PROPOSER EXPERIENCE [2 PAGE LIMIT]

2.10.2.1.1 The Proposer should provide a brief summary of the organizational history of the Proposer and its parent organization, organizational goals, the relevance of Medicaid managed care to the mission of the organization, volume of Medicaid managed care business, and in which states the Proposer currently serves the Medicaid population.

Louisiana Healthcare Connections (LHCC) Organizational History

LHCC has partnered with the Louisiana Department of Health (LDH) since Medicaid transitioned from legacy fee-for-service to managed care in 2012, ensuring access to quality care for the Louisianans who need it most. We have consistently demonstrated our ability to expand and refine our capabilities and services to effectively meet the needs of a growing and changing membership. In 2014, LHCC acquired Community Health Solutions of Louisiana, Inc. (CHS) enabling us to expand our network and enhance enrollee access for improved health outcomes; in 2015, we built a behavioral health (BH) network to ensure continuity of care for transitioning enrollees; and in 2016, we ushered the new Medicaid Expansion population into the Medicaid Managed Care program; providing access to a comprehensive network of quality providers and timely access to services including preventive care, and care management. Through each evolution, LHCC has ensured timely access to all covered services, maintained high rates of provider satisfaction, and implemented evidence-based best practices to advance population health in Louisiana. As of Q1 2019, LHCC proudly continues to serve nearly 475,000 enrollees in the Healthy Louisiana program. LHCC has successfully developed and maintained one of the largest Medicaid provider networks in the State, comprised of more than 22,000 providers, offering our enrollees the most comprehensive and timely access to care possible for all provider types. In this new Contract, we look forward to continuing our collaboration with LDH, our providers, and community stakeholders in serving Louisiana's Medicaid enrollees.

Backed by a National Leader in Medicaid Managed Care. LHCC embodies the best practices, financial stability, and long-standing commitment shared by our parent company, Centene Corporation (Centene), and affiliates to deliver high-quality, value-driven care to underserved communities. Founded in 1984 as a single health plan, today Centene is the nation's largest Medicaid managed care organization with 35 years' experience serving more than 14 million enrollees in government sponsored health care programs across 32 states. Through our ability to create innovative solutions and to be flexible to our partners' needs, we are committed to delivering results for our stakeholders: state governments, enrollees, providers, and community organizations. The longevity of our contracts reflects our partners' confidence in us and in the value we provide.

LHCC Organizational Goals

LHCC delivers quality health care through local and community resources that reflect and honor Louisiana's unique and vibrant way of life, while retaining high quality employees. Our organizational goals include creating a culture of continuous improvement, and maintaining the top quartile of employee engagement scores throughout our enterprise. Our complementary goals align with the Triple Aim and take it one step further through our adoption of the Quadruple Aim: ***better health, better care, lower cost,*** and ***reducing provider administrative burden***.

Better Health. We are committed to being number one in external quality review scores statewide and maintaining "Commendable" NCQA accreditation status. With our targeted initiatives to address care gaps through partnerships with FQHCs across the State, more than 90% of our targeted HEDIS measures have shown improvement from 2014-2017.

Better Care. We are committed to being number one in LDH's Quality Performance Measures. For example, LHCC is partnering with the Diabetes Assessment and Management Center (DiaMC) in Shreveport, paying them an enhanced reimbursement for primary care services with additional pay for performance incentives related to comprehensive diabetes care HEDIS measures. LHCC refers eligible diabetic enrollees to this provider in a pilot program to improve outcomes such as controlling HbA1c and blood pressure. DiaMC treats the whole person, focusing on continuous glucose monitoring along with diabetes educators who teach self-care, and a nutritionist who provides face-to-face nutrition and health management services.

Lower Costs. We are committed to maintaining a top medical loss ratio (MLR) of 88% or better to control costs. To lower costs, our Interpreta real-time analytics tool gives providers a forward-looking view of enrollee needs to close care gaps with retrospective data, enabling them to more efficiently treat patients. Our Centelligence Provider and Patient Analytics tools allow providers to eliminate or reduce low-value care.

Reducing provider administrative burden. We are committed to streamlining provider administrative functions as demonstrated by our paperless referral process, multiple entry points for authorizations, and simplified prior authorization (PA) processes. Our authorization automation engine and IQ Connect eliminate the need for providers to submit inpatient admissions paperwork. To reduce burden for providers, facility staff, and enrollees, LHCC requires only the minimum necessary information to process PA requests. Our Provider Engagement Teams offer provider outreach and education, specifically related to value-based purchasing (VBP), primary care practice transformation, assistance with data and report interpretation and other activities related to VBP readiness. Providers consistently rate their satisfaction with LHCC as one of the top two MCOs in the State.

Relevance of Medicaid Managed Care to LHCC's Mission

LHCC was created for the sole purpose of providing high quality, accessible care to Medicaid beneficiaries in Louisiana. Our mission is to provide the best benefits and programs possible to improve the overall health of the families and communities we serve. In alignment with LDH's objectives, LHCC is committed to transforming the health of the community, one person at a time. We are a local, Louisiana-based organization, with local staff and experience, 100% local leadership, and local decision-making.

Volume and Location of Medicaid Managed Care Business

LHCC serves approximately 475,000 Medicaid enrollees. With our 23 affiliate health plans we serve over 8.4 million Medicaid enrollees in Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Michigan, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Mexico, New York, Ohio, Oregon, Pennsylvania, South Carolina, Texas, Washington, and Wisconsin.

2.10.2.1.2 It is preferred, though not mandatory, that Proposers meet the following qualifications prior to the deadline for receipt of proposals:
2.10.2.1.2.1 Have a minimum of seven (7) years of experience in providing health care services for a Medicaid managed care program prior to the deadline for receipt of proposals; and

LHCC began serving enrollees in 2012, meeting LDH's preferred qualification of a minimum of seven years of experience providing health care services for a Medicaid managed care program. Additional affiliate experience is cited above in 2.10.2.1.1.

2.10.2.1.2.2 Have, within the last twelve (12) months, been engaged in a contract or awarded a new contract as a Medicaid MCO in a state with a Medicaid population equal to or greater than that of Louisiana.

Within the last 12 months, our affiliate health plans in Arizona, California, Florida, Illinois, New York, Ohio, Texas, and Washington have been engaged in contracts with statewide Medicaid populations equal to or larger than the Medicaid population in Louisiana.

SECTION 2.10.2.2

Staff Experience and Organizational Structure

To the people at Louisiana Healthcare Connections,
I would like you all to know that the job you do every day
in your life is helping me to be a better mother in my life.

—Sherrika White
Member

2.10.2.2 STAFF EXPERIENCE AND ORGANIZATIONAL STRUCTURE

…should describe its process for identifying its key personnel. . . describe its management structure and organization.

LHCC's organizational philosophy is locally driven accountability and decision making with central support. Our Louisiana-based staff share a passion for providing exceptional service to LDH and the enrollees, providers, and communities we serve. LHCC will comply with all Model Contract requirements related to organization and staffing, including but not limited to Contract Section 2.3 and MCO Manual Sections 2.3.1 and 2.6.

In 2017 alone, LHCC and Centene contributed **$207 million to the local economy** through wages, benefits, taxes, property and state municipal bonds.

Identifying Key Personnel. LHCC has in place the seven Louisiana-based, full-time key personnel who only serve in one key personnel position for this Medicaid product. We comply with all requirements for LDH notification of vacancies and written approval from LDH for all key personnel. If key personnel vacancies occur, we fill the position as quickly as possible, focusing on the skill set and qualifications required for a successful long-term hire. At least bi-annually, LHCC's Executive Team reviews the performance, likelihood of retention, and succession planning for each key personnel position to proactively identify potential vacancies and candidates. Through our active succession planning program, we are often able to identify internal LHCC staff who are qualified and may be ready to move into a key personnel role. Because we are committed to hiring from the Louisiana communities we serve, we have relied heavily on the strong ties we have with our provider and community partners to help us identify local, highly qualified candidates. Through Centene, LHCC has access to an extensive pipeline of experienced and qualified individuals at our affiliates who may be excellent candidates as well. All of the processes described above aid our ability to identify interim key personnel, if needed. For example, HR maintains a contingency list of corporate and affiliate health plan personnel (with the relevant/current certifications/licensures) who can serve in an interim capacity, if needed, while we locate a key personnel replacement. If necessary, a member of our management team will fulfill key personnel requirements on a short term basis until a replacement is hired.

If we are unable to identify candidates through the strategies described above, Centene's Talent Acquisition Specialists and Executive Recruitment Team, in partnership with LHCC, use cutting edge approaches and tools to identify candidates. For example, we access Centene's dedicated recruiter for Veteran, National Guard, and Reserve applicants. Each LHCC position is posted to over one dozen Veteran focused job boards and they partner with RecruitMilitary and HirePurpose (which attract military Veteran talent). We also target job seekers where they search (e.g. LinkedIn, Facebook, Twitter, and MedCareers); purchase resumes of qualified applicants from job sites; use Job Syndication Alliances; sponsor jobs on high visibility sites such as Indeed; and use niche job boards such as the American Psychiatry Association, PracticeLink, and PracticeMatch. LHCC advertises for high profile positions, such as through Google Ads, and works with relevant organizations (e.g. National Association of Addiction Treatment Providers) to create banner ads, social media messaging, and job postings. We also leverage established relationships with local/national staffing and recruitment agencies who specialize in the type of work we perform, as well as local colleges/universities.

Management Structure and Organization. ***Attachment 2.10.2.2.2 Organizational Charts*** (Chart A) shows LHCC's high-level management structure from the Board of Directors (BOD) to the executive (including key personnel) and senior management staff who oversee all health plan functions. The senior management staff and key personnel are full-time, based in Louisiana, and work in LHCC's corporate headquarters in Baton Rouge, Louisiana. LHCC also has offices in Covington, Lafayette, and New Orleans and, in 2020, we will open an office in Shreveport. Chart A depicts our local, physician-led BOD and two key subcommittees, the Regulatory Compliance/Program Integrity Committee and our physician-led Clinical Policy Committee.

Within the gray dashed lines on Chart A, we show the management staff who report to our Chief Medical Director (CMD) and Chief Operating Officer (COO). These staff oversee the functions that support LDH goals and objectives, such as integrated physical health (PH), behavioral health (BH), and Population Health, as well as the entire continuum of services touching our enrollees and providers. Such functions include Medical Affairs (PH

and BH Medical Directors, Psychologists), Network Development and Engagement; Provider Performance; Population Health, which includes integrated Care Management (CM), Utilization Management (UM), SDOH, and Pharmacy; Operations, which includes Claims and Provider (PH/BH) and Enrollee Services; and Quality Improvement. Chart A also shows other key personnel reporting to our Chief Executive Officer (CEO) and the reporting lines between our CEO and VP, Compliance to the BOD. We provide detail below on the key personnel reporting to the CEO and LHCC's key units.

Charts A-H depict our organization/key units. We comply with all Contract staffing requirements, such as but not limited to: background checks; expertise, experience, licensure, and certification requirements; dedicated staff to meet all required timeframes and geographic coverage; and staff trained in the culturally competent provision of services. Centene (see Chart I) provides certain centralized functions such as our Management Information System, including our proprietary suite of integrated decision support and health care informatics solutions, claims and encounter processing, and some finance support.

2.10.2.2.1 For each individual appointed to a key personnel role, the individual's name, résumé, key personnel role filled by the individual, and a brief description of the individual's role in the Proposer's governance and operating structure;

For key personnel names, resumes, role filled, and a brief description of the individual's role in LHCC's governance and operating structure, see ***Attachment 2.10.2.2.1 Key Personnel Resumes***.

2.10.2.2.2 The following information about the Proposer's operating structure: 2.10.2.2.2.1 A description of the operating structure's leadership and how this leadership reports to and otherwise interacts with . . . governance structure;

Governance Structure and Operating Structure Leadership. Our BOD has overall legal and fiduciary responsibility for health plan operations and delegates day-to-day responsibility for the operation of the plan to the CEO. Our CEO, who has led LHCC since 2011 and is the only remaining original Healthy Louisiana MCO CEO, directs and oversees LHCC strategy and operations and is responsible for planning and directing all aspects of operational policies, objectives, and initiatives to ensure optimal plan performance, contractual compliance and financial viability. The CEO reports directly to the BOD and is supported by a Director, Government Relations, Director, HR and the following executives depicted in Chart A:

- **Chief Financial Officer (CFO)** oversees the budget and directs all health plan financial functions; ensures the timeliness and accuracy of all financial reports; oversees all financial analysis, identification of month end financial drivers, and forecasting; identifies medical cost trends and provides leadership on medical cost improvement initiatives and our Value-Based Payment (VBP) Program. The CFO also works closely with Centene's accounting, finance, and actuarial functions.
- **Chief Medical Director (CMD**) is a Louisiana-licensed, board-certified physician who is involved in all major clinical and quality management functions including case, disease and utilization management; pharmacy; and oversees the PH and BH Medical Directors, Psychologist Reviewers and medical reviews. The CMD provides ongoing support to the Senior VP, Population Health (SVP) and his functional areas and to the VP, Quality Improvement (QI). He also directs the Quality Assurance and Performance Improvement (QAPI) Program, chairs the QAPI Committee (QAPIC) and participates in all Quality Committees.
- **Chief Medical Officer (CMO)** is a Louisiana-licensed, board-certified physician who promotes positive relations with the local medical community, including periodic consultation with providers or prescribers; provides oversight/direction for staff and provider training and education; monitors performance indicators to ensure the delivery of cost-effective care within quality standards; and monitors enrollee and provider satisfaction and recommends and implements changes to improve satisfaction levels.
- **Chief Operating Officer (COO)** oversees all other enrollee/provider facing functions, health plan operations and QI to meet Contract performance requirements. The COO is supported by the VP, Marketing; SVP, Population Health; VP, QI; VP, Network Development & Engagement; VP, Provider Performance & Data Analytics; and the VP, Operations.
- **Vice President, Compliance (Contract Compliance and Program Integrity Officer)** oversees the Compliance Program and compliance with Contract, State, federal requirements/laws; identifies and reports compliance risks; and reports directly to the CEO and BOD.

All key teams associated with the above operating structure leadership are further described below.

How Leadership Reports to and Interacts with the Governance Structure. The above leadership reports to and interacts with the BOD through their reporting relationships to the CEO and COO, with the exception of the CFO and VP, Compliance who also attend all BOD meetings. All executives prepare BOD reports that attendees present at meetings for review and/or approval, and they oversee the execution of any BOD directives for their functional areas. In addition, the CMD is actively engaged in the QAPIC which reports to the BOD and is represented to the BOD by the COO. The BOD holds quarterly meetings in the Baton Rouge office with the LHCC attendees listed above and holds ad-hoc meetings as necessary. The agenda includes topics such as QAPI Program reports and updates; operations, financial, compliance, legislative activity reports; and Committee updates. Outside of BOD meetings, the VP, Compliance, CEO and COO also interact with BOD members, as needed, to carry out LHCC functions. They do not interact on actions that require full BOD approval.

2.10.2.2.2.2 An organizational chart of the Proposer's operating structure, depicting the key teams or units involved in performing the Proposer's activities under the Contract, including roles . . . material subcontractors . . . .;

Please see ***Attachment 2.10.2.2.2.2 LHCC Organizational Chart (Charts A-I)*** which depict key teams or units and roles of material subcontractors.

2.10.2.2.2.3 For each such team or unit, a brief description of the role . . . , operating activities . . ., way in which it reports to and informs decisions. . . . 2.10.2.2.2.4 For each such team, number of FTEs, description of major qualifications and competencies, . . . description of . .. lead. Proposer may assume a total enrollment of 375,000 . . . describe its plan to scale staffing levels based on increased or decreased enrollment.

Key Team / Unit(s)	1) Role & Accountable Operating Activities, 2) Ways Reports to/Informs Leadership Decisions, 3) FTEs, 4) Major Qualifications and Competencies, 5) Brief Description of Lead
Note: For ease of review and due to the size of LHCC's organization below we provide a compliant, brief response to the five question elements for each key team/unit with reference to the corresponding organizational chart.	
Population Health (Chart B), FTEs: 10, Lead: SVP Population Health	
1) Ensure integration with all functions required to execute LHCC's plan-wide Population Health (Pop Health) strategy; analyze pop health/SDOH needs for enrollees and the communities we serve; provide SDOH expertise and resources; population analytics. 2) SVP: reports bi-weekly to COO/executive team; participates in Quality Committees (including Pharmacy & Therapeutics – P&T), leads the Pop Health Steering Committee and SDOH Advisory Council; reports functional/Committee activities to the QAPIC; and submits additional reports to the COO for the BOD. 3) 10 FTEs. 4) Range from health informatics (Bachelor's in Mathematics, MIS, or related field, with experience in statistical analysis or data analysis, including measurements); clinical (RN and Advanced Practice Registered Nurses - APRN); SDOH (experience in community and specific areas such as housing). 5) SVP: Current, unrestricted LA licensed RN or PA or Master's degree in Nursing, Therapy, Public Health/Administration, Business Administration, or related field. Management experience and 10+ years health care clinical operations experience.	
Medical Management: Care Management (Chart C), FTEs: 199, Lead: VP Medical Management	
1) Ensure delivery of person-centered CM/care coordination/disease management services; risk stratify enrollees to identify eligibility for CM; conduct HNA, assessment, and care planning processes including monitoring and execution; coordinate all required covered and non-covered services for enrollees in CM; coordinate with providers and external agencies that perform CM, and provide CHW support. 2) VP, Medical Management (VPMM) reports all CM activities and risk to SVP and participates in related decision making; participate in relevant Quality Committees. VP/SVP report CM activities to the COO and executive team bi-weekly; and required CM reports to the QAPIC and BOD. 3) FTEs: 199. 4) Role specific competencies range from LA licensed PH/BH clinicians certified in CM to CHWs with a High School (HS) Diploma or equivalent. Bilingual a plus; experience with/knowledge of local community/agency resources. 5) VPMM: Current, unrestricted LA licensed RN with 10+ years of clinical nursing, QI, and managed care experience; thorough knowledge of NCQA, CM practices, managed care, and Medicaid; minimum of 5 years of management/supervisory experience in the health care field.	

Key Team / Unit(s)	1) Role & Accountable Operating Activities, 2) Ways Reports to/Informs Leadership Decisions, 3) FTEs, 4) Major Qualifications and Competencies, 5) Brief Description of Lead
Medical Management: Utilization Management (Chart D), FTEs: 178, Lead: VP Medical Management	
1) Manage utilization review and authorization of services to ensure consistency, timeliness; ensure transition of care; conduct concurrent review, discharge planning of inpatient stays and retrospective review; monitor, analyze and implement interventions based on UM data, including identifying and correcting over/under-utilization. 2) VPMM reports all UM activities and risk to SVP and participates in related decision making and in relevant Quality Committees. VP/SVP report UM activities to the COO/executive team bi-weekly, and to the QAPIC and BOD. 3) FTEs: 178. 4) Range from LA licensed PH/BH clinicians to HS Diploma or equivalent plus 2+ years of customer service experience & knowledge of medical terminology preferred. Experience with medical decision support tools (i.e. Interqual, NCCN); coding, NCQA and other technical aspects of UM required. For adverse determinations: MDs, RNs and PAs with unrestricted LA licenses required. 5) VPMM: Current, unrestricted LA licensed RN with 10+ years of clinical nursing, QI, and managed care; thorough knowledge of NCQA, UM practices, managed care, and Medicaid.	
Pharmacy (Chart B), FTEs: 18, Lead: Sr. Director, Pharmacy	
1) Oversee LHCC's Pharmacy Benefit Management (PBM) program; implement pharmacy activities; ensure standards are met by vendors; generate, review and analyze drug utilization, UM, financial, and other reports; support pharmacy provider education initiatives. 2) Sr. Director, Pharmacy/SVP report all pharmacy activities to the COO/executive team bi-weekly; escalate risk and potential business decisions to the SVP/COO, and participate in related decision making. Participate in Quality Committees (e.g. P&T) and Vendor Oversight Committee; prepare/submit required pharmacy and P&T reports to the QAPIC and BOD. 3) FTEs: 18. 4) Ranges from LA licensed pharmacists to HS Diploma/equivalent with pharmacy experience, preferably in managed care; Medicaid experience preferred. 5) Sr. Director, Pharmacy: Current, unrestricted LA Pharmacist license; 5+ years' experience as a pharmacist in a retail setting with managerial experience; strong knowledge of pharmaceutical care and PBM practices.	
Quality Improvement (Chart E), FTEs: 59, Lead: VP, QI	
1) Ensure plan-wide integration of quality by assisting clinical/non-clinical management in overseeing quality of health plan activities to improve enrollee health outcomes and service delivery; manage grievances and appeals (G&A), accreditation, and HEDIS performance/reporting functions; analyze clinical, service and utilization data and recommend performance improvement initiatives; oversee delivery of maternal/postpartum care and EPSDT services; and facilitate the Annual QAPI Program Evaluation and develop Annual QAPI Work Plan. 2) VP, QI and staff participate in QAPIC/Quality Committees and prepare/submit related reports; provide monthly HEDIS performance updates to HEDIS Steering Committee; monthly NCQA compliance updates to the Performance Improvement Team (PIT); quarterly G&A updates, including member/provider complaints to G&A Committee; and biweekly updates to the executive team and through the COO to BOD. 3) 59 FTEs. 4) Ranges from LA licensed clinicians with Certified Professional in Health Care Quality (CPHQ), Certified in Health Care Quality and Management (CHCQM), or comparable education/ experience in data & outcomes measurement; experience in G&A, UM, CM, claims, other areas (HEDIS, EPSDT, CQI, Six Sigma, study analysis, NCQA), and medical coding preferably with DHCS/ DMHC. 5) VP, QI: a current, unrestricted licensed RN, physician or physician's assistant (PA), or CPHQ and/or CHCQM, with 10+ years' experience in healthcare operations, QI, NCQA, data analysis, barrier analysis, and integration of external data sources; familiarity with running Risk Adjustment prospective/ retrospective programs, and Six Sigma or other training in QI preferred.	
Medical Affairs (Chart E), FTEs: 9.5, Lead: CMD	
1) Provide PH/BH medical expertise for QI, UM, CM, credentialing, and medical QI activities; collaborate to integrate PH and BH services and evidence-based guidelines; support provider improvement initiatives; oversee Quality Committees and physician advisor activities; assist in development and implementation of physician education on clinical issues/policies, such as targeted training for BH. 2) CMD: Oversee/ participate in all Quality Committees and report results to QAPIC; report biweekly to executive team and through COO to the BOD. 3) 9.5 FTEs. 4) Includes current, unrestricted LA licensed/board-certified MDs or DOs (PH: preferably in a primary care specialty; BH: board	

Key Team / Unit(s)	1) Role & Accountable Operating Activities, 2) Ways Reports to/Informs Leadership Decisions, 3) FTEs, 4) Major Qualifications and Competencies, 5) Brief Description of Lead
certification by the American Board of Psychiatry and Neurology) with 3+ years of training in a medical specialty; Psychologist Reviewers: current, unrestricted LA Psychologist license, BCBA certification required; 5+ years psychiatric or substance abuse experience. Required MCO staff meet MCO Manual 2.3 requirements. 5) CMD: In addition to above, 5+ years post licensure experience as senior clinician responsible for clinical standards, QI, and managed care clinical supervision; experience as a managed care medical director preferred.	
Finance (Chart F), FTEs: 11, Lead: CFO	
1) Manage budget, accounting systems, financial reporting, audit activities; and analysis, budgeting forecasting, and risk arrangement activities; participate in VBP strategy development. 2) CFO: Provide daily, weekly, monthly cross-departmental dashboard metrics; meet monthly with Corporate Controller; report biweekly to executive team; prepare for/participate in BOD meetings. 3) 11 FTEs. 4) Role-based ranges from Bachelor's degree in Accounting, Finance, or equivalent; MBA, CPA, CMA preferred; experience in public accounting, operations, financial analysis, MIS, and health care or insurance desirable; high degree of financial, business and analytical skills required. 5) CFO: CPA and Master's degree preferred; Bachelor's degree in Finance, Accounting, Economics, Business required with 10+ years in a high-level finance role in healthcare or insurance industry.	
Compliance/FWA/Program Integrity (Chart F), FTEs: 19, Lead: VP, Compliance	
1) Execute Compliance Program; ensure compliance with Contract, State, Federal requirements/laws related to Compliance and Fraud, Waste and Abuse (FWA); identify/report compliance risks; oversee FWA investigations, Centene Special Investigative Unit (SIU) and LA-based SIU (FWA) investigators; provide Compliance training support for staff and providers. 2) VP, Compliance (VP): Provide reports to executive team bi-weekly; escalate risk, compliance issues and mitigation status to CEO/executive team; report risks to corporate compliance; report CLAS Task Force reports to the QAPIC; report Compliance PIP status to the PIT & Compliance Committee; prepare and submit Compliance/FWA reports to BOD. 3) FTEs: LHCC Compliance: 9; LA based SIU (FWA) investigators: 10. 4) Role-specific range from LA licensed clinician or coding certification for clinical investigator role, to Bachelor's degree in Business, Criminal Justice, Healthcare, Accounting, Finance, related field or equivalent experience for other roles; experience in health/or managed care compliance/regulatory, medical claim investigation, audit, analysis, or fraud investigations. 5) VP: Bachelor's degree in Public Policy, Government Affairs, Business Administration or related field, Master's or Law degree preferred; 8+ years of compliance program management/contract experience. Extensive knowledge of State administrative code/regulations, insurance laws/regulations, managed care, HIPAA, credentialing, and prompt pay regulations and laws. Experience with State and Federal government agencies and accreditation bodies.	
Network Development & Engagement (Chart G), FTEs: 54, Lead: VP, Network Development & Engagement	
1) Recruit, contract, evaluate, and manage LHCC PH/BH provider networks, and provide overall network management; responsible for provider Contract compliance & provider agreement templates, Network Development/Management, Provider Support and VBP Strategic Plans, and provider setup. Engage with providers to actively improve quality of care & satisfaction through provider engagement model, data sharing and provider education and training. Conduct routine network assessments against Contract requirements. 2) VP, Network Development & Engagement (VP): Provide quarterly reports on network adequacy, provider visits, new provider orientations, and satisfaction survey dashboard to the PIT & QAPIC; biweekly reports to executive team. Support COO with reports for BOD. 3) 54 FTEs. 4) For Claims and other educators: 5 years management experience in area (Claims, BH, PH, VBP) with experience developing/ deploying training; for BH and PH: clinical background preferred. Clinical Nurse Liaison: LA licensed clinician with 4+ years' clinical nursing experience; Medicaid, UM, CM or quality experience preferred. Coding Analyst: CPC or related certifications preferred (e.g. RHIT, CSS) and 3+ years combined managed care, Medicaid or provider experience. Provider Engagement Specialists: Bachelor's degree in Healthcare or Business Administration or related field with experience in negotiations, contract analysis, or provider relations with outstanding customer service skills. 5) VP: Bachelor's degree or equivalent experience in Business /related field; MBA/MHA degree preferred; 10+ years MCO or healthcare network development, contracting, provider relations, management experience required.	

Key Team / Unit(s)	1) Role & Accountable Operating Activities, 2) Ways Reports to/Informs Leadership Decisions, 3) FTEs, 4) Major Qualifications and Competencies, 5) Brief Description of Lead
Provider Performance & Data Analytics (Chart G), FTEs: 27, Lead: VP, Provider Performance & Data Analytics	
1) Develop/deliver analytics required for VBP agreements, provider performance, provider complaints & disputes, and State reports to meet requirements; internal educator on analytic tools across VBP, quality, provider performance, and deliver tailored/ad hoc reporting to support quality/VBP efforts; manage provider complaint/dispute process, including Independent Review; manage audits for data accuracy; monitor secret shopper reports for access/timeliness. 2) VP, Provider Performance & Data Analytics (VP): provide quarterly provider performance/ quality updates to QAPIC; and quarterly reporting for HBR reports for providers on APMs; biweekly reports to executive team; support COO on BOD reporting. 3) 27 FTEs. 4) Role-specific range: experience with provider dispute processes or in analytics, auditing, G&A processes; or project management in healthcare, insurance or related State departments. For analytics: advanced knowledge in relevant technologies and processes, and Bachelor's degree in Mathematics, Health Administration, Marketing or related area or equivalent. Other staff: Experience in health care or insurance customer service, provider/enrollee relations; HS Diploma or equivalent, Associates' degree preferred; 2+ years G&A, claims or related managed care experience. 5) VP: Bachelor's degree in Public Policy, Mathematics, Business Administration, or related field; Master's degree in Biostatistics, Epidemiology, Healthcare Administration or Public Health preferred; knowledge of Medicaid laws/regulations; 10+ years of experience in data analytics, plan operations, provider management or finance.	
Operations (Chart H), FTEs: 196, Lead: VP, Operations	
1) Provide Claims & Contract Support, Enrollee & Provider Services, Business Analytics, and Project Management; claims processing issue resolution; support providers with high claims denial rates, and create improvement plans with Network Team. Update contracts, benefits, system configurations for timely, accurate provider payment. Maintain enrollee PCP assignments; manage telephonic provider & enrollee inquiries, after-hours emergent provider issues; and deliver prompt response, assistance & education. Monitor/maintain required metrics, including for call centers, claims payment, & provider notifications/terminations; and manage/oversee emergency management plan during disasters. 2) VP, Operations (VP): provide biweekly reports to executive team; participate in Network, Vendor Oversight and Joint Operating Committees & report to QAPIC; weekly claims, analytics, other key dashboard measures to leadership; weekly high-level risks to COO; support COO with BOD reports. 3) 196 FTEs. 4) Claims, Business Analytics, Call Center Management: Bachelor's degree in Business, Management, MIS, Computer Science, Healthcare Administration or equivalent experience; function-specific management experience in call center, claims, and business analytics. Call center staff: HS Diploma or equivalent experience, 1-2+ years call center/customer service experience preferred, bilingual/multi-lingual a plus, preference given to candidates who have been or are enrolled in Healthy Louisiana. 5) Bachelor's degree in Business Administration, Finance, Accounting or related field, Master's preferred; 9+ years of healthcare or insurance operations, management; extensive knowledge of state legislative/regulatory processes required.	
Plan to Scale Staffing Levels. We based our staffing model on our March 31, 2019 enrollment of approximately 475,000, which is under the cap of 35% of total Medicaid population. Our staffing ratios include new (e.g. for our SDOH Centers of Excellence) and additional (e.g. field-based CM and Provider Engagement) staff. We have experience, such as during Medicaid Expansion, with increasing staffing levels as necessary. If needed, we will leverage qualified temporary and affiliate staff while permanent staff are recruited. If enrollment drops below that used in our model, we will adjust staffing by not filling approved positions and, if necessary, arrange for employee transfers to other affiliates. Our staffing model includes all required key personnel/staff/liaison roles per the Contract and MCO Manual Sections 2.3.1 and 2.6. We recruit, develop and retain diverse, qualified staff in numbers appropriate for Contract compliance (including all required ratios) and to meet enrollment/provider engagement/support needs. We have leveraged 7 years of local experience to create a staffing model that is not static, includes proactive and proprietary elements and tools, identifies key drivers that require staffing refinements, and includes ongoing monitoring.	

SECTION 2.10.2.3

Material Subcontractors

I've had family members die from cancer simply because it wasn't detected in time. So I love being able to talk to members about their great medical benefits. See a doctor, get treated, stay healthy. It's important.

—Aloysius Hebert
Member Services
Louisiana Healthcare Connections

2.10.2.3 MATERIAL SUBCONTRACTORS [EXEMPT FROM TOTAL PAGE LIMIT]

Where the Proposer utilizes a material subcontractor to provide behavioral health, pharmacy, vision or transportation services, or a value-added benefit such as dental service, the Proposer should provide a completed Material Subcontractor Response Template (Appendix F), including the executed or draft agreement, for each material subcontractor.

Louisiana Healthcare Connections (LHCC) intends to use the below entities as material subcontractors to provide behavioral health, pharmacy, vision, transportation services, or value-added benefits. Please see ***Attachment 2.10.2.3 Appendix F Material Subcontractor Response Template*** located within the Attachments and Appendices section of the RFP response for detailed information, including the executed or draft agreements as applicable.

- AdhereHealth – medication therapy management
- Envolve Dental, Inc. – dental benefit management
- Envolve Pharmacy Solutions, Inc. – pharmacy benefit management
- Envolve Vision, Inc. – vision benefit management
- LogistiCare Solutions, LLC – transportation services

SECTION 2.10.2.4

Proposer Reference Contact Information

Louisiana Healthcare Connections has always been a generous and supportive community partner. Their leadership and staff share our commitment in making our state a healthier place to live and serving our state's most vulnerable citizens.

—Gerrelda Davis
Executive Director
Louisiana Primary Care Association

2.10.2.4 PROPOSER REFERENCE CONTACT INFORMATION

2.10.2.4.1 The Proposer shall provide contact information (name, title, phone number and email) for the lead program manager in each state or municipality, including Louisiana, if applicable, with which its organization has had a Medicaid managed care contract for comparable services within the past three (3) years.

Please see the table below for state contact information for LHCC and each of our affiliate health plans with a Medicaid managed care contract for comparable services within the past three years.

Table 2.10.2.4.1 Reference Contact Information

Health Plan Name	State	Contact Information
Louisiana Healthcare Connections	LA	Jen Steele Medicaid Director LDH/ Bureau of Health Services Financing 225-342-3200 jen.steele@la.gov
Arizona Complete Health Bridgeway Health Solutions	AZ	Meggan LaPorte Chief Procurement Manager Arizona Health Care Cost Containment System 602-417-4538 meggan.laporte@azahcccs.gov
Arkansas Total Care	AR	Cindy Gillespie Director, Department of Human Services 501-682-8648 cindy.gillespie@dhs.arkansas.gov
California Health & Wellness Health Net Community Solutions	CA	Michelle Retke Chief, Managed Care Operations Division Department of Health Care Services - Medi-Cal 916- 449-5083 michelle.retke@dhcs.ca.gov
Sunshine Health	FL	Jessica Lane Medical Healthcare Program Analyst, Plan Management Operations Florida Agency for Health Care Administration 850-412-4051 jessica.lane@ahca.myflorida.com
Sunshine Health (CHIP)		Lindsay Lichti Health, Dental, and EQRO Contract Manager Florida Healthy Kids Corporation 850-701-6105 lichtil@healthykids.org
Sunshine Health (Medicaid D-SNP)		Dan Gabric, FCCM Medicaid TPL Administrator Florida Agency for Health Care Administration 877- 357-3268 dan.gabric@ahca.myflorida.com
Peach State Health Plan	GA	Lynnette Rhodes Acting Executive Director Georgia Department of Community Health 404-656-7513

		lrhodes@dch.ga.gov
IlliniCare Health	IL	William R. McAndrew Account Manager Bureau of Managed Care Department of Healthcare and Family Services (HFS) 217-557-0792 bill.mcandrew@illinois.gov
Managed Health Services	IN	Jeff Neuman Managed Care Compliance Director Indiana Family and Social Services Administration Office of Medicaid Policy & Planning 317-233-2352 jeffrey.neuman@fssa.in.gov
Sunflower Health Plan	KS	Dr. Lee Norman Secretary Kansas Department of Health and Environment (KDHE) 785-296-1500 lee.norman@ks.gov
CeltiCare Health	MA	Aditya Mahalingam-Dhingra Director, MassHealth ACO Program Executive Office of Health and Human Services aditya.mahalingam-dhingra@MassMail.State.MA.US *Please include Karen Powell on any communication:* Karen Powell MCO/CarePlus Contract Manager Executive Office of Health and Human Services 617-847-3432 karen.powell@MassMail.State.MA.US
Michigan Complete Health	MI	Pam Gourwitz Director, Integrated Care Division Michigan Department of Health and Human Services 517-388-4467 gourwitzp@michigan.gov
Magnolia Health	MS	Tara Smith Clark, JD, CHP Executive Administrator, Office of the Governor, Division of Medicaid Mississippi Division of Medicaid 601-359-9276 tara.clark@medicaid.ms.gov
Home State Health	MO	Bobbi Jo Garber Director of Managed Care Missouri Department of Social Services 573-526-4274 bobbi.j.garber@dss.mo.gov
Nebraska Total Care	NE	Kristine Radke DHHS Administrator, Plan Management, Medicaid & Long Term Care

		402-471-4617 kristine.radke@nebraska.gov
SilverSummit Healthplan	NV	Cody Phinney Deputy Administrator, Division of Health Care Financing and Policy 775-684-3735 cphinney@dhcfp.nv.gov
New Hampshire Healthy Families	NH	Henry Lipman Medicaid Director New Hampshire Department of Health and Human Services 603-271-9384 henry.lipman@dhhs.nh.gov *Please include Shirley Iacopino on any communication:* Shirley Iacopino Bureau Chief for Medicaid Managed Care shirley.iacopino@dhhs.nh.gov
Western Sky Community Care	NM	Nicole Comeaux Division Director, Medical Assistance Division 505-827-3100 nicole.comeaux@state.nm.us
New York Quality Health Care Corporation (dba Fidelis Care)	NY	Susan Bentley Director, New York State Department of Health Bureau of Managed Care Certification and Surveillance Division of Health Plan Contracting and Oversight 518-474-5515 susan.bentley@health.ny.gov
Buckeye Health Plan	OH	Amanda Jenkins Contract Manager, Office of Managed Care The Ohio Department of Medicaid 614-752-3622 amanda.jenkins@medicaid.ohio.gov
Trillium Community Health Plan	OR	Nate Cimino Account Representative, Oregon Health Authority Health Systems Division, Delivery Systems Support Unit 503-947-5528 nathan.cimino@dhsoha.state.or.us
Pennsylvania Health & Wellness	PA	Kevin Hancock Deputy Secretary Department of Human Services, Office of Long Term Living (OTOL) 717-525-5320 kehancock@pa.gov
Absolute Total Care	SC	Joshua D. Baker Director South Carolina Department of Health and Human Services 803-898-2504 joshua.baker@scdhhs.gov

Superior HealthPlan Superior HealthPlan Network	TX	Stephanie Muth Associate Commissioner – Medicaid/CHIP Services Health and Human Services Commission of Texas 512-707-6096 stephanie.muth@hhsc.stat.tx.us
Coordinated Care of Washington	WA	MaryAnne Lindeblad, BSN, MPH Medicaid Director Washington State Health Care Authority 360-725-1863 maryanne.lindeblad@hca.wa.gov
MHS Health Wisconsin	WI	Jim Jones Director of Medicaid Wisconsin Department of Health Services jamesd.jones@dhs.wisconsin.gov 608-266-5151

2.10.2.4.2 For each reference, the Proposer should provide a brief description of the types and numbers of individuals served, the Proposer's key responsibilities

[redacted]

KEY – Types of Individuals	
ABD – Aged, Blind, and Disabled **BH** – Behavioral Health **CHIP** – Children's Health Insurance Program **CSHCN**- Children with Special Health Care Needs **D-SNP** – Dual Eligible Special Needs Program **EPO** – Exclusive Provider Organization	**LTC** – Long Term Care **LTSS** – Long Term Services and Supports **RSA** – Rural Service Area **SCHIP** – State Children's Health Insurance Program **SMI** – Serious Mental Illness **SSI** – Supplemental Security Income
KEY – Compliance Actions	
CAP – Corrective Action Plan **CO** – Consent Order	**MP** – Monetary Penalty **NOA** – Notice of Action

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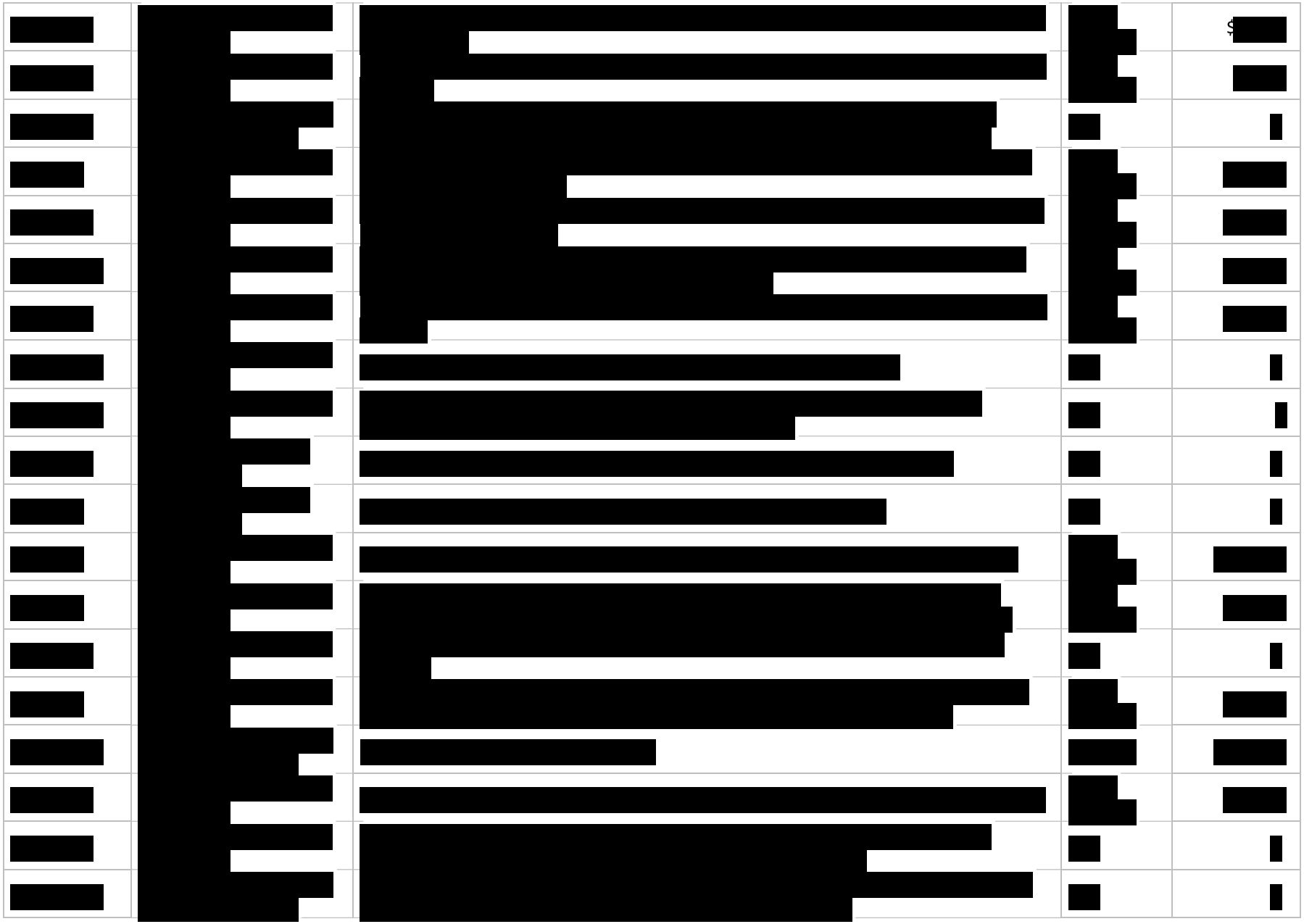

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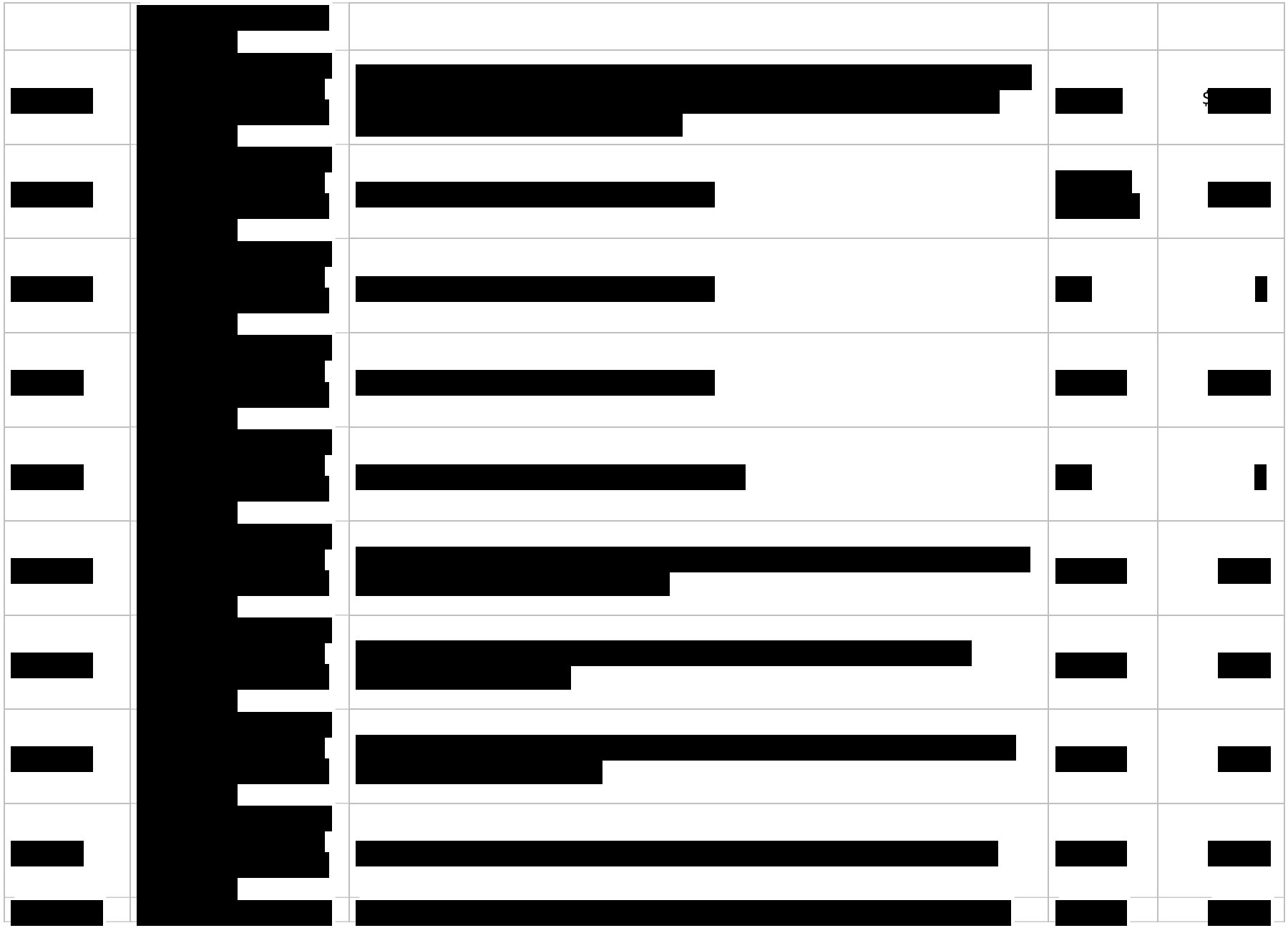
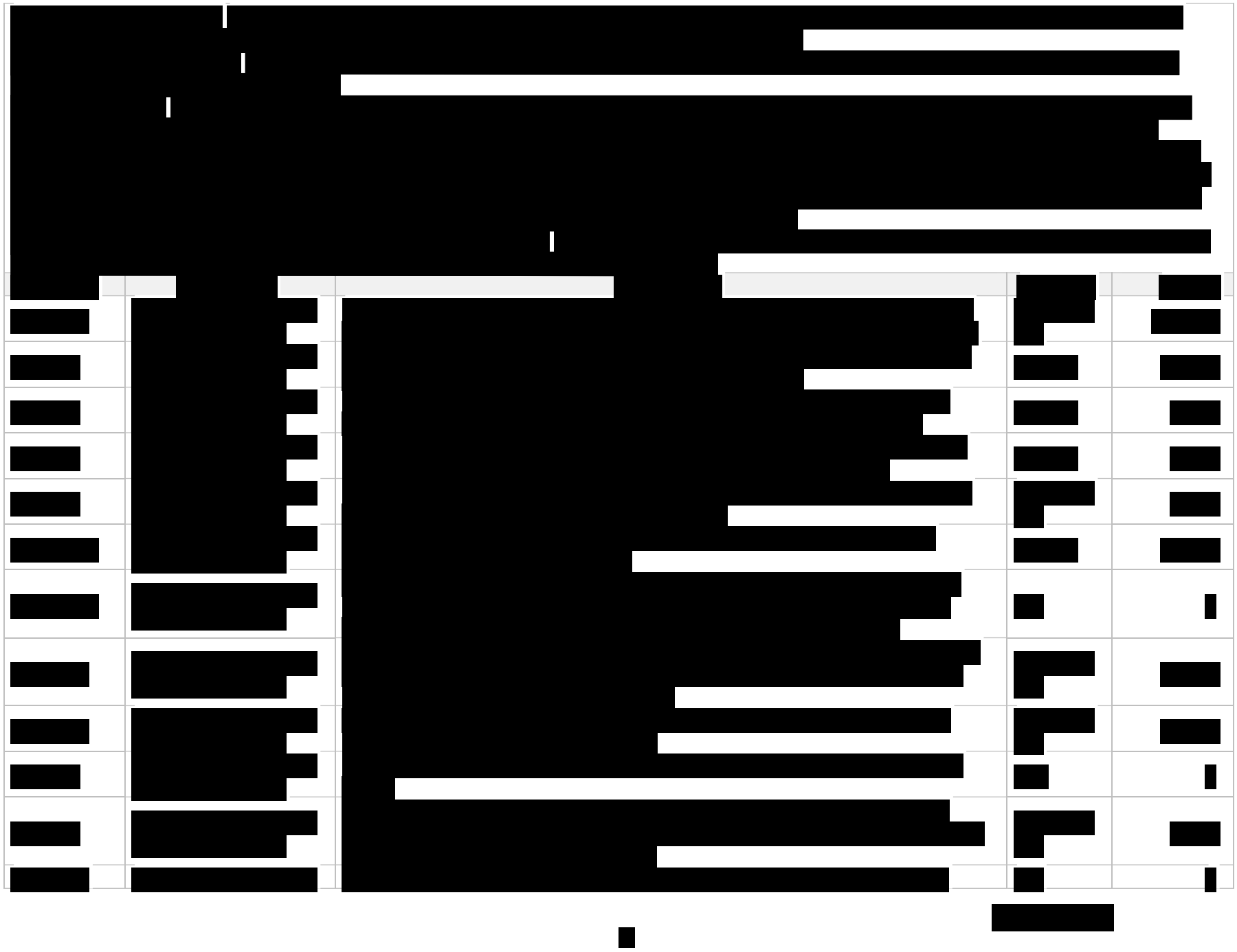



ening.

Number of Individuals Served: Total Medicaid: 91,105



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CONFIDENTIAL

SECTION 2.10.2.5

NCQA Accreditation

I am especially grateful to participate in the community statekholder convenings where we discuss ways to improve services to your consumers. I appreciate having a voice at that table.

—Janet Pace
President and CEO
Volunteers of America – Greater Baton Rouge

2.10.2.5 NCQA ACCREDITATION [2 PAGE LIMIT; ACCREDITATION CERTIFICATES ARE EXEMPT FROM SECTION-SPECIFIC AND TOTAL PAGE LIMITS]

2.10.2.5.1 The Proposer should provide a copy of its certificate of accreditation by the National Committee for Quality Assurance (NCQA) for each of its Medicaid managed care contracts. If the Proposer is not accredited in Louisiana, the Proposer should provide a specific timeline outlining the Proposer's plan to achieve full accreditation in Louisiana as soon as possible after the execution of a contract.
It is preferred, though not mandatory, that Proposers be accredited by NCQA as a Medicaid managed care organization in Louisiana or in another state prior to the deadline for receipt of proposals.

Louisiana Healthcare Connections (LHCC) complies with all health plan accreditation requirements outlined in 2.16.14 of the Model Contract. See ***Attachment 2.10.2.5.1 NCQA Accreditation Certificates*** for NCQA Accreditation Certificates from LHCC and our affiliate Medicaid managed care contracts nationwide.

LHCC'S COMMENDABLE NCQA ACCREDITATION

LHCC has been accredited by NCQA as a Medicaid managed care organization in Louisiana since 2014. NCQA accreditation is not just a process LHCC prepares once every three years, it reflects the rigorous standards of how we conduct daily business and a validation of our commitment to continuous quality improvement (CQI) across the organization. LHCC renewed our NCQA status in June 2017, and by August 2017, improved from Accredited to Commendable, with a significant increase in scoring from 74% in 2016 to 83% in 2017 and again in 2018. In keeping with recent years, LHCC earned a nearly perfect score on the Member Satisfaction (CAHPS) metric with a 12.304/13.0 in 2018. We attribute much of the improvement in our NCQA scoring to our HEDIS quality improvements. LHCC's accreditation is valid through June 1, 2020 and we will update LDH regarding our NCQA status upon request or any changes during the accreditation period.

2.10.2.5.2 Where a Proposer utilizes a material subcontractor to provide behavioral health services, the Proposer should also include NCQA accreditation information for the material subcontractor or describe how it will achieve accreditation.

LHCC does not use a material subcontractor to provide behavioral health (BH) services. LHCC's NCQA health plan accreditation status includes compliance with applicable BH standards.

SECTION 2.10.3

Enrollee Value-Added Benefits

It was like Christmas in November when I got the letter saying I had been accepted for Medicaid and Louisiana Health Connections! I was so happy! I have already been to the dentist and am going to the eye doctor on Wednesday! Thank you for finally getting this expanded program for under-privileged citizens and our loved ones! I applaud you and Governor Edwards!

—Stacey Myer
Member

2.10.3 ENROLLEE VALUE-ADDED BENEFITS [15 PAGE LIMIT]

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2.10.3.2 The Proposer should identify whether it proposes to offer any of the following six (6) optional value-added benefits to its enrollees.

- ***Dental benefits for adults, including exams, preventive services, and restorative services, but excluding extractions;***
- ***Evidence-based non-pharmacologic alternatives to opioids for chronic pain management services for adults;***
- ***Respite care model targeting homeless persons with post-acute medical needs. Model shall address strategies for counseling, nutrition, housing stabilization, transitional care, and other services necessary for successful community reintegration;***
- ***Newborn circumcision benefits;***
- ***Tobacco cessation benefits, not including medications; and/or***
- ***Vision benefits for adults, including annual exam and glasses or contacts.***

OVERVIEW OF LOUISIANA HEALTHCARE CONNECTIONS VALUE-ADDED BENEFITS

Louisiana Healthcare Connections (LHCC) will offer all six optional value-added benefits (VAB) statewide to all enrollees, as applicable. We will offer these VABs as agreed upon with LDH, and may offer additional VABs with LDH approval during the term of the Model Contract and in accordance with the MCO Manual.

These six VABs complement LHCC's core benefits and programs, and maximize the impact of our comprehensive approach to prevention and wellness promotion, chronic disease management, integrated primary care and behavioral health delivery, and crisis response.

All LHCC VABs proposed in this section will be identified as a VAB in encounter data and in accordance with the MCO Manual. In cases where Louisiana Medicaid covers an existing service, LHCC is proposing services beyond those covered by the State as our VAB. In the event that an enrollee is denied a VAB due to ineligibility, LHCC will send the enrollee a notification letter regarding our decision.

We will list our proposed VABs and any amendments annually as part of Attachment C, Value-Added Benefits within the Model Contract.

LDH reserves the right to add additional options during the term of the Contract, and the selected Proposer may provide additional value-added benefits during the term of the Contract at its option.

LHCC understands and acknowledges LDH's right to add additional VAB options during the term of the Contract, and our option to provide additional VABs during the term of the Contract.

2.10.3.3 For each selected value-added benefit, the Proposer should describe:
2.10.3.3.1 The populations who may receive the benefit;

LHCC will offer the six VABs to the following populations:

Value-Added Benefit	Eligible Populations
Adult Dental Benefits	Adults age 21 and older, excluding Specialized Behavioral Health
Adult Chronic Pain Management	Adults age 21 and older, excluding Specialized Behavioral Health
Homeless Medical Respite	Adults age 21 and older, excluding Specialized Behavioral Health
Newborn Circumcision	Newborn male children for the first 30 days of life
Tobacco Cessation	Enrollees age 13 and older; age 13-17 with parental or guardian consent, including Specialized Behavioral Health
Adult Vision Benefits	Adults age 21 and older, excluding Specialized Behavioral health

By offering these benefits, LHCC is enhancing current State-covered services, providing access to services not covered by the State, and supporting improved health outcomes and cost savings.

2.10.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage;

LHCC will offer VABs to all applicable populations statewide. Our VABs are designed to ease day-to-day challenges and pressures faced by our enrollees, enabling them to focus on their health and quality of life. LHCC is committed to improving health outcomes through benefits beyond Louisiana Medicaid coverage that promote overall cost savings and complement existing services as part of a whole-health approach to wellness.

Adult Dental Benefits

LHCC understands that oral health contributes to whole person health, and preventive oral health contributes to improved health outcomes and cost savings by proactively identifying related health concerns. LHCC enrollees ages 21 and older will receive up to $500 per year in benefits, including:

- Dental exams and cleanings (twice a year)
- Preventive x-rays (once a year)
- One whole mouth set of x-rays (every three years)
- Fillings

LHCC will provide this benefit through Envolve Dental, Inc., an affiliate network of dental providers. Enrollees may self-refer to a participating provider or call our Member Services Call Center for assistance. The following table indicates the categories, procedures, and descriptions of services associated with our Adult Dental VAB.

Table 2.10.3.3.2.A Adult Dental Procedure Codes

Benefit Category	Procedure Code	Description
Adult Dental	D0999	Unspecified diagnostic procedure, by report
	D0120	Periodic oral evaluation -- established patient
	D0140	Limited oral evaluation - problem focused
	D0150	Comprehensive oral evaluation – new or established member
	D0210	Intraoral – complete series of radiographic images
	D0220	Intraoral—periapical first radiographic image
	D0230	Intraoral-periapical each additional radiographic image
	D0270	Bitewing – single radiographic image
	D0272	Bitewings - two radiographic images
	D0273	Bitewings - three radiographic images
	D0274	Bitewings - four radiographic images
	D0330	Panoramic radiographic image
	D1110	Prophylaxis – adult
	D2140	Amalgam - one surface, primary or permanent
	D2150	Amalgam - two surfaces, primary or permanent
	D2160	Amalgam - three surfaces, primary or permanent
	D2161	Amalgam - four or more surfaces, primary or permanent
	D2330	Resin-based composite – one surface, anterior
	D2331	Resin-based composite – two surfaces, anterior
	D2332	Resin-based composite – three surfaces, anterior
	D2335	Resin-based composite – four or more surfaces or involving incisal angle (anterior)
	D2391	Resin-based composite – one surface, posterior
	D2392	Resin-based composite – two surfaces, posterior
	D2393	Resin-based composite – three surfaces, posterior
	D2394	Resin-based composite – four or more surfaces, posterior

Existing Louisiana Medicaid Coverage. Louisiana Medicaid coverage includes adult denture services. All existing and proposed LHCC Adult Dental VABs exceed current State coverage.

Adult Chronic Pain Management

We are committed to fighting the opioid epidemic in Louisiana by offering evidence-based alternatives to opiate therapies for chronic pain. By providing alternate services to enrollees, LHCC aims to reduce

pharmacy and medical costs, improve overall health, and reduce chronic pain experienced by our enrollees. LHCC will offer chronic pain management services to adults age 21 and over in evidence-based, non-pharmacologic formats including acupuncture, massage therapy, chiropractic, and physical therapy.

Acupuncture. LHCC proposes to offer alternative pain management via acupuncture in lieu of pharmacological pain management with Schedule II narcotics. In an update of patient data meta-analysis published in the Journal of Pain, researchers with the Acupuncture Trialists' Collaboration concluded that acupuncture is effective for the treatment of chronic pain, that the effects of acupuncture persist over time, and that the benefits of acupuncture cannot be explained away solely by the placebo effect[1]. Acupuncture is considered a generally safe treatment approach with few known complications or side effects. Acupuncturists must be in-network and be licensed by the Louisiana State Board of Medical Examiners for services to qualify. Services require a diagnosis of chronic pain and are limited to up to eight 30-minute sessions over four weeks.

Chiropractic. The American College of Physicians recommends in an evidence-based clinical practice guideline in *Annals of Internal Medicine* that physicians and patients should treat acute or subacute low back pain with non-drug therapies such as superficial heat, massage, acupuncture, or spinal manipulation.[2] Services must be provided by in-network Louisiana State Board of Chiropractic Examiners-licensed providers. Chiropractic services require a diagnosis of chronic pain and are limited to a new patient visit, x-ray, and up to 12 additional visits over a four week period.

Massage Therapy. LHCC proposes alternative pain management via massage therapy provided by a Louisiana Board of Massage Therapy-licensed provider. A study published in Annals of Family Medicine in 2014 found that 60-minute therapeutic massage sessions two or three times a week for four weeks relieved chronic neck pain better than no massage or fewer or shorter massage sessions.[3] Providers must be in-network and licensed by the Louisiana Board of Massage Therapy for services to qualify. Services require a diagnosis of chronic pain and are limited to eight 60-minute sessions over a four-week period.

Physical Therapy. Physical therapy addresses inflammation, stiffness, and soreness associated with pain through services such as exercise, spinal manipulation, and massage. Physical therapists work with enrollees to lessen their pain and restore activity levels. For eligible enrollees, LHCC will offer physical therapy to support decreased pain and increased mobility. Providers must be in-network and licensed by the Louisiana Physical Therapy Board for services to qualify. Services require a diagnosis of chronic pain and are limited to up to eight visits over a four-week period.

Adult Chronic Pain Management services are limited to adult enrollees age 21 and older with documented chronic pain. Services may vary throughout the State and must be rendered by licensed, in-network providers. Adult Chronic Pain Management is limited to one treatment modality at a time. The following table indicates the categories, procedures, and services descriptions associated with our Adult Chronic Pain Management VAB.

Table 2.10.3.3.2.B Adult Chronic Pain Management Procedure Codes

Benefit Category	Procedure Code	Description
Acupuncture	97810	Acupuncture, one or more needles, without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
	97811	Each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles
	97813	Acupuncture, one or more needles, with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
	97814	Each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needles

[1] https://www.jpain.org/article/S1526-5900(17)30780-0/fulltext
[2] https://www.acponline.org/acp-newsroom/american-college-of-physicians-issues-guideline-for-treating-nonradicular-low-back-pain

[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3948757/

Benefit Category	Procedure Code	Description
Chiropractic	98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
	98941	Chiropractic manipulative treatment (CMT); spinal, 3-4 regions
	98942	Chiropractic manipulative treatment (CMT); spinal, 5 regions
	98943	Chiropractic manipulative treatment (CMT); extraspinal, 1 or more regions
Massage Therapy	97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
	97140	Therapeutic Procedure, 15 minutes. Mobilization, manipulation, manual lymphatic drainage, manual traction, one or more regions.
Physical Therapy	97140	Dry-needling
	97161-97163	Physical therapy evaluation: low-complexity (97161), moderate-complexity (97162), and high-complexity (97163)
	97110	Therapeutic exercise

Existing Louisiana Medicaid Coverage. Louisiana Medicaid does not currently cover acupuncture, chiropractic, or massage therapy services for Medicaid beneficiaries, and covers physical therapy services for adults age 21 and older through hospital outpatient or home health services with prior authorization. The LHCC Adult Chronic Pain Management program includes physical therapy services beyond the existing Louisiana Medicaid benefit in freestanding clinics, as well as services not currently covered by Medicaid.

Homeless Medical Respite Model

LHCC understands that enrollees who are discharged with post-acute medical needs and experiencing housing instability are at an increased risk of relapse and hospital readmission. We are aware of the challenges that hospitals face locating a safe place to send an individual who is well enough to be discharged, but is homeless and has no place to complete recovery. According to the United States Interagency on Homelessness, Louisiana's homeless population alone averages over 3,000 individuals on a single day.[4] Of this statewide population, our data estimates approximately 850 LHCC enrollees are homeless, with nearly half concentrated in New Orleans and Baton Rouge. In response to this national and local challenge, we have developed a Homeless Medical Respite Model to support our enrollees.

LHCC will offer temporary respite beds to eligible enrollees who are homeless, being discharged from an acute inpatient stay, and need post-acute medical care, such as home health and nutritional services. Our model is developed to nimbly respond to meet the unique needs of Louisianans and the individual acuity of each enrollee that accesses the benefit. Based on the geographic location, medical necessity, and the level of care needed, LHCC will provide respite in settings such as assisted living facilities and hotels. For example, to ensure beds in Orleans and Jefferson Parishes, where nearly half of LHCC's eligible population is concentrated, we will partner with transitional housing organizations to create respite options and provide wraparound support through both LHCC staff and community-based organizations. In addition, we will leverage our relationships with community-based organizations and post-acute providers, such as additional home health visits through LHC Group and Carpenter Health Network. LHCC has an exclusive arrangement with LHC Group that expands home health coverage to all 64 parishes. Our model will include the following strategies:

- Identify and assess enrollees who are homeless prior to discharge and have post-acute medical needs
- Develop a Transition of Care Plan and provide linkage to respite housing and other needs through a designated Case Manager (CM), if the enrollee is not currently in Case Management, including supports above and beyond Medicaid coverage requirements
- Follow-up and continued evaluation of enrollee needs through their designated CM

All activities will completed by our Transition of Care team who will work in collaboration with discharging facilities and LHCC staff to ensure enrollee needs are met. Below we describe the process for our Homeless Medical Respite Model that will target enrollees who are homeless with post-acute medical needs.

[4] https://www.usich.gov/homelessness-statistics/la/

Identification and Assessment. We will leverage all available resources to identify homeless enrollees in need of medical respite, ensuring a "no wrong door" approach to the benefit access. Methods include, but are not limited to, using a daily census of inpatient enrollees with a filter for enrollees who are homeless, working directly with the discharging facility to identify eligible enrollees, and use of the Homeless Management Information Systems (HMIS). When homeless enrollees are identified as needing post-acute medical care, our Transition of Care Team works closely with the hospital's discharge planning team to identify post-discharge needs including transitional housing. Prior to discharge, our Transition of Care Team will locate a bed for the enrollee and ensure funding for the bed is in place by contracting with an appropriate partner for a bed or securing a hotel room based on the individual's medical acuity. For example, LHCC is able to reimburse shelters at a per diem rate to ensure enrollees are able to stay in the shelter 24/7 while LHCC staff help coordinate stable housing.

Transition of Care Plan. The post-discharge needs inform the Transition of Care Plan, which encompasses the enrollees' health care needs and self-identified goals. We will refer the enrollee into Case Management if not already engaged. LHCC's Transition of Care Team will also link enrollees to the following resources as needed for transitional care needs. This includes:

Housing Stabilization. LHCC has been building a portfolio of quality community-based organizations to serve our enrollees by executing Strategic Alliance contracts since 2012. We currently partner with over 300 community-based organizations, and are continuously developing new partnerships to ensure our enrollees can live stable, successful lives in their communities. Our Transition of Care Team will leverage our relationships with community partners to access resources for continued support and stable housing to help reintegrate homeless enrollees into the community and decrease the likelihood for readmission. For example:

- In Alexandria, LHCC will work with the Central Louisiana Homeless Coalition, one of 10 Regional Continuums of Care throughout Louisiana, to access the HMIS and identify permanent supportive housing options for our enrollees post-respite.
- In Acadiana, LHCC is using a Community Connections Platform to integrate Social Determinants of Health (SDOH) data into our systems, enabling our Case Managers, Housing Specialists, Community Health Workers, and other LHCC staff to identify accessible resources available to help stabilize our enrollees once housing has been secured.
- In Orleans and Jefferson Parishes, LHCC will collaborate with organizations like UNITY of Greater New Orleans, and others to support homeless enrollees, leveraging their agencies providing housing and services.
- Also in Orleans Parish, LHCC has established a Memorandum of Understanding with the Housing Authority of New Orleans to exchange data in order to assist with the identification and prioritization of individuals for stable housing.
- Our Community Health Grants Program financially supports programs that target SDOH, including food, housing, education, employment, and other local population health needs.

Counseling. Our Transition of Care Team will connect enrollees to needed resources such as counseling referrals. Enrollees will also be informed that they may contact Member Services for additional provider referrals if needed. In addition, we talk to enrollees about other options such as access to an LHCC Peer Support Specialist, which allows an enrollee to work with someone with shared experiences. Enrollees generally demonstrate an increased level of trust in individuals who have recovered from a substance use disorder or mental health condition similar to their own, which increases their level of responsiveness and engagement.

Nutrition Services. Our Transition of Care Team will ensure that eligible enrollees are offered three meals a day during post-acute care treatment after being discharged from an inpatient facility. Prior authorization will be required for this service. Enrollees must be discharged from a hospital, skilled nursing facility, or inpatient rehabilitation facility. We will also offer nutritional counseling services to eligible enrollees in medical respite to help them learn about the best foods for their health and conditions, how to shop for healthy foods, and how to prepare nutritious meals. Nutritional counseling is limited to enrollees with complex medical needs and is subject to prior authorization.

Other Necessary Services. Our Transition of Care Team will leverage our SDOH Centers of Excellence to ensure we connect enrollees receiving medical respite to necessary resources to assist them in successfully reintegrating into the community. For instance, we will educate and assist enrollees in applying for a SafeLink phone, which provides up to 1,000 free minutes of service per month and 1 GB of data as well as unlimited texting. Enrollees will be able to have telephone access to their LHCC providers and unlimited calling to LHCC, as well as connect to LHCC peer support services.

Follow-Up. To ensure a holistic approach that captures all enrollee needs, we perform post-discharge outreach within 72 hours of the enrollee's discharge from the in-patient facility to assist in the identification and coordination of services as means of managing readmission risk, medication compliance, and medical equipment needs. This outreach also allows us to capture any care gaps and/or other needs to link enrollees to referrals or resources such as those described above. Once the enrollee is linked to needed resources and has stable housing to recover, our Transition of Care Team will refer the enrollee to a designated CM for ongoing care coordination to increase the likelihood for successful community reintegration.

The following table indicates the categories, procedures, and descriptions of services associated with our Homeless Medical Respite VAB, available to eligible enrollees who are homeless and require post-acute care.

Table 2.10.3.3.2.C Homeless Medical Respite Procedure Codes

Benefit Category	Procedure Code	Description
Home Health Care (non-pregnant adults)	G0154	Direct skilled services of a licensed nurse (LPN or RN)
	G0155	Clinical Social Worker
	G0157	PT assistant
	G0158	OT assistant
	G0159	PT establish or deliver safe and effective PT maintenance program
	G0160	OT establish or deliver safe and effective OT maintenance program
	G0161	SLP establish or deliver safe and effective SLP maintenance program
	G0493	RN for the observation and assessment of the patient's condition
	G0494	LPN for the observation and assessment of the patient's condition
	G0495	RN training and/or education of a patient or family member
	G0496	LPN training and/or education of a patient or family member
Housing Assistance	H0044	Supported Housing, per month
Home Delivered Meals (General)	S9977	Meals per diem; not otherwise specified
Nutritional Counseling	S9452	Nutrition Class
	97802	Medical Nutrition Indiv In
	97803	Med Nutrition Indiv Subseq
	97804	Medical Nutrition Group
	G0270	Mnt Subs Tx For Change Dx
	G0271	Group Mnt 2 Or More 30 Mins

Existing Louisiana Medicaid Coverage. Louisiana Medicaid covers many services included in LHCC's Homeless Medical Respite Model, such as counseling, home health and nutrition services, and Case Management for eligible adults age 21 and older. LHCC intends to provide services above State coverage to ensure this enrollee population has access to additional supports, such as housing assistance, targeted nutrition assistance and education, enhanced behavioral health and counseling coverage, and access to resources necessary to support community reintegration. We understand home health services are currently covered, however we are offering an additional daily visit, if needed.

Newborn Circumcision

LHCC understands the potential medical need and health benefits of circumcision. We will offer optional circumcision for newborn enrollees during initial hospitalization at birth, or in an office setting within the first 28 days of life. The following table indicates the categories, procedures, and descriptions of services associated with our Newborn Circumcision VAB.

Table 2.10.3.3.2.D Newborn Circumcision Procedure Codes

Benefit Category	Procedure Code	Description
Circumcision	54150	Circumcision, using clamp or other device with regional dorsal penile or ring block
	54160	Circumcision, surgical excision other than clamp, device, or dorsal slit

Existing Louisiana Medicaid Coverage. Louisiana Medicaid does not currently cover newborn circumcision. LHCC's VAB is part of our commitment to whole-health for our enrollees.

Tobacco Cessation

Smoking kills more than 6,500 Louisiana residents each year, and increases the risk of stroke, heart disease, cancer, COPD and other chronic diseases for tens of thousands more. Research shows that combination methods of tobacco cessation increase the likelihood of quitting. LHCC will offer training, self-help, and behavioral therapy VAB in combination with covered smoke cessation medications to maximize enrollee success in quitting.[5] LHCC will encourage our enrollees to stop using tobacco through multiple cessation avenues, including in-person education, mailing information, counseling, and formal programs.

Louisiana Tobacco Control Initiative (LTCI). For all adults age 21 and older, LHCC is partnering with the LTCI to support providers in delivering tobacco cessation information and education to our enrollees. The LTCI provides self-help material, behavioral counseling, Quitline assistance, and social support to help tobacco users quit.

Truth Initiative. LHCC has partnered with the Truth Initiative, America's largest non-profit organization dedicated to ending tobacco use, to develop a program for youth who use tobacco products and e-cigarettes. This includes a targeted campaign for adolescents using co-branded materials.

Hypnotherapy. Nicotine and tobacco research shows that hypnotherapy in conjunction with behavioral therapy is more successful than behavioral therapy alone in encouraging tobacco cessation.[6] To support enrollees committed to ceasing their smoking habit, LHCC will offer hypnotherapy in conjunction with psychotherapy sessions. Services are limited to tobacco-using adults and children 13-17 with parental or guardian consent. We will provide up to two behavioral health visits, which include hypnosis with in-network providers and up to three follow-up phone calls within a 6-month period.

Teche Action Clinic. LHCC is working with Teche Action Clinic to promote their comprehensive Smoking Cessation Program for enrollees who qualify for the Louisiana Smoking Cessation Trust. LHCC is partnering with this FQHC and Dr. Gary Wiltz to promote his Smoking Cessation Program, which is a partnership between Teche Action Clinic and the Cardiovascular Institute of the South. The partnership between the two entities is an endeavor including the Louisiana Campaign for Tobacco-Free Living and the Louisiana Smoking Cessation Trust. Through this partnership, Teche Action Clinic will arrange for LHCC enrollees to receive cessation services including intensive cessation counseling, and telephone and web-based support via 1-800-QUIT-NOW or www.quitwithusla.org. This program provides access to cessation tools not covered by Medicaid.

These tobacco cessation programs are designed to prevent the development of chronic disease resulting from tobacco use, complementing the Louisiana Quitline, Louisiana Smoking Cessation Trust, and Tobacco Control Initiative programs by combining online lessons and educational materials to promote positive behaviors and reduce health risks. LHCC will continue to provide a link on our website to Tobacco Cessation Information, including education and prevention program, which we will continue to share through social media, as well. In addition, LHCC is also collaborating with the Centene Center for Healthcare Transformation to support cessation campaigns targeted at adolescents age 13-18 who use e-cigarettes.

The following table indicates the categories, procedures, and descriptions associated with LHCC's Tobacco Cessation VAB.

[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4085918/ Intl. Journal of Preventative Medicine meta-study across 930+ articles on cessation program effectiveness.

[6] https://academic.oup.com/ntr/article-abstract/10/5/811/1074110?redirectedFrom=fulltext

Table 2.10.3.3.2.E Tobacco Cessation Procedure Code

Benefit Category	Procedure Code	Description
Tobacco Cessation	90880	Hypnotherapy for diagnostic/therapeutic purposes; provided in conjunction with psychotherapy

Existing Louisiana Medicaid Coverage. Louisiana Medicaid does not currently cover formal programs for tobacco cessation. LHCC is leveraging existing State programs and providing additional options to support enrollees who want to quit using tobacco in the manner of their choosing.

Adult Vision Benefits

Eye and vision health are an important component of population health strategies and risk factors for social determinants of health. We understand that annual eye exams can detect both vision conditions and other serious health problems, such as diabetes, high blood pressure, high cholesterol, and even cancer. In addition to supporting our enrollees' through corrective vision options, LHCC is committed to overall preventive health through adult vision benefits.

For adult enrollees age 21 and older, LHCC will provide vision services including:

- One annual eye exam and refraction
- Treatment of eye conditions
- One pair of glasses per year
- Medically necessary contacts, bifocal, or trifocal lenses

LHCC will provide vision services to eligible enrollees through our affiliate, Envolve Vision's provider network. Enrollees may self-refer to a participating Envolve Vision provider, or contact LHCC's Customer Service Department for assistance. The following table indicates the categories, procedures, and descriptions associated with LHCC's Adult Vision VAB.

Table 2.10.3.3.2.F Adult Vision Procedure Codes

Benefit Category	Procedure Code	Description
Adult Vision – Routine Exam Codes	92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient
	92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits
	92012	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient
	92014	Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, one or more visits.
	92015	Determination of refractive state
Adult Vision – Routine Eyeglass Codes	V2020	Frames, purchases
	V2100 - V2399	Single vision, bifocal, trifocal, glass or plastic lens; per lens
	99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician or other qualified health care professional.

Existing Louisiana Medicaid Coverage. The current Louisiana Medicaid plan does not cover routine eye exams or eyeglasses for adults age 21 and older. LHCC offers adult vision benefits to our enrollees to encourage ongoing preventive and corrective health.

Enrollee Value-Added Benefits Transportation

LHCC understands the challenges our enrollees face finding transportation to providers and other services, and we are committed to easing that burden with transportation options for the VABs we offer. Enrollees may use non-emergency medical transportation for up to two round trips per month to pre-set locations applicable to VAB services. Prior authorization is required, and transportation services are subject to

availability based upon mode of transportation required, and are limited to a 50-mile radius. All non-emergent transportation services are provided through our material subcontractor, LogistiCare.

Table 2.10.3.3.2.G Transportation Procedure Codes

Benefit Category	Procedure Code	Description
Transportation	A0080	Non-Emergency Transportation- Vehicle Provided by Volunteer, No Vested Interest (Mileage Reimbursement)
	A0090	Non-Emergency Transportation- Vehicle Provided by Volunteer, Vested Interest (Mileage Reimbursement)
	A0100	Non-Emergency Transportation- Taxi
	A0110	Non-Emergency Transportation Bus, Intra- or Interstate Carrier
	A0120	Non-Emergency Transportation Mini-Bus, Mountain Area Transports, or Other Transportation System
	A0130	Non-Emergency Transportation- Wheelchair Van
	A0170	Transportation Ancillary- Parking Fees, Tolls, Other

Existing Louisiana Medicaid Coverage. The current Louisiana Medicaid plan covers non-emergency medical transportation to covered services. LHCC is proposing to offer additional transportation to VABs not currently covered by the State to decrease access barriers for our enrollees.

2.10.3.3.3 Any proposed co-payments;

LHCC is not proposing co-payments for any of the six VABs in this proposal. We understand that to improve outcomes, we must continuously encourage access and utilization. By not imposing co-payments on these impactful benefits, LHCC is supporting enrollees' whole health by providing services and benefits and taking on financial accountability for services not currently covered by the State, working toward improved outcomes with an emphasis on disease prevention, early diagnosis and management of chronic conditions, and improved access to services.

2.10.3.3.4 How the benefit will be provided to enrollees, including, if provided through a subcontractor, either the selected subcontractor or description of how the subcontractor shall be selected; and

Informing Enrollees and Providers about VABs

We include information on all VABs in our enrollee materials and on the provider resources section of the LHCC website to ensure our enrollees and providers are notified of available VAB options. We provide ongoing information in our VAB brochure and periodically in our Member Newsletter, provider trainings, and Provider Newsletter to highlight specific benefits as well as communicate updates to our VABs.

Connecting Enrollees to VABs. LHCC's enrollee-facing staff receive more in-depth VAB training related to their specific roles, whether Customer Service Representatives, Community Health Workers, or Case Management to ensure their understanding of available VABs and refer eligible enrollees to services as necessary. For example, an enrollee in Case Management with a diagnosis of chronic pain and is a high opioid utilizer may be identified through LHCC's pharmacy utilization data. The enrollee's CM may refer them to non-pharmacologic pain management alternatives included in our Adult Chronic Pain Management program to support reduction in opioid use, decreased pain, and an overall improvement in health outcomes. Eligible enrollees seeking access to VABs that do not require prior authorization may select an in-network provider to schedule appointments to receive these services, or contact LHCC's Customer Service Representatives for further assistance.

We will follow this procedure of informing and educating our enrollees, providers, and staff about VABs for all subsequent Contract years to ensure continued access.

Selected Subcontractors and Network Providers

LHCC will provide VABs to enrollees through a combination of selected subcontractors and our provider network, as detailed in the following table:

Table 2.10.3.3.2.H VAB Subcontractors

Value-Added Benefit	Benefit Provision and Description
Adult Dental Benefits	Subcontractor; *Envolve Dental provides the adult dental benefits for our current membership and for consistency and continuity will provide the adult dental benefits for our new Contract with LDH.*
Adult Chronic Pain Management	LHCC Contracted Provider Network
Homeless Medical Respite	LHCC Contracted Provider Network and LHCC Care Management Team
Newborn Circumcision	LHCC Contracted Provider Network
Tobacco Cessation	LHCC Contracted Provider Network and LHCC Care Management Team, and State Partners
Adult Vision Benefits	Subcontractor; *Envolve Vision provides the adult vision benefits for our current membership and for consistency and continuity will provide the adult vision benefits for our new Contract with LDH.*

2.10.3.3.5 How the Proposer will provide oversight of the value-added benefits.

VAB OVERSIGHT

LHCC will monitor our VABs for compliance and effectiveness to ensure oversight of each VAB offered to our enrollees throughout the state. Our VABs are designed to address enrollee needs while supporting improvements in overall health outcomes, enhancing enrollee access to care, promoting healthy lifestyles, and contributing to program cost-effectiveness. LHCC's Senior VP of Population Health will maintain responsibility for the overall deployment and delivery of the value-added benefits, with support from LHCC departments including, but not limited to Vendor Management, Provider Performance, Utilization Management, and Finance.

Oversight to Ensure Compliance

LHCC VABs are offered through material subcontractors, our provider network, and our internal teams. We contractually monitor both our material subcontractors and providers for compliance with State, federal, and Contract requirements related to VABs.

Subcontractor Oversight. To ensure compliance with VABs provided by subcontractors, including Adult Dental and Adult Vision, our Vendor Management Team monitors the day-to-day operations of delegated subcontractors. Depending on the delegated activities, the subcontractor reports and engages in routine conversations with LHCC to ensure our enrollees receive services as outlined in the subcontractor agreement, including both State-covered services and LHCC VABs. We use a Compliance Management System that supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities related to VABs. A cross-functional LHCC team participates in quarterly Joint Operating Committee meetings to ensure ongoing contract compliance and VAB delivery.

Oversight Committees and Operational Meetings. LHCC's Vendor Management Team conducts operational meetings to support subcontractor oversight. These include, at minimum, documented calls as needed, quarterly leadership meetings, and a quarterly Compliance Committee meeting during which internal business leads review subcontractor performance, including VAB metrics. In addition, our Quality Improvement Committee chaired by our Chief Medical Director, reviews subcontractor program documentation and/or any applicable corrective action plans.

Ongoing Review. In addition to formal reviews, LHCC monitors subcontractor performance on an ongoing basis, including an annual audit that uses predetermined tools that consider vendor risks, contractual, NCQA, CMS, and state requirements. We maintain written subcontractor performance monitoring through our Third Party Oversight Program that clearly defines the type and frequency of reporting and monitoring for each subcontractor, establishes specific performance metrics, and evaluates performance against identified metrics.

Provider Oversight. We credential and recredential all providers, as well as follow ongoing monitoring procedures for the Healthy Louisiana program to ensure all LHCC network providers are appropriately qualified

on an ongoing basis. Our provider performance monitoring activities conducted between recredentialing cycles ensure the LHCC provider network consistently delivers high-quality services and care to our enrollees, such as complaints related to the provision of VABs.

Oversight to Ensure VAB Effectiveness

LHCC understands that the goal of a VAB is to offer services beyond-state coverage that to enhance enrollee experience, lead to better health outcomes, and ensure LHCC is maximizing opportunities to improve health. We monitor effectiveness of each VAB through utilization management (UM), VAB outcomes, and encounter and financial reporting to ensure our services are indeed adding value to the Medicaid program.

Utilization Management. LHCC will monitor VAB utilization to ensure our enrollees are aware of the benefits, know how to access them, and are using them appropriately. We will analyze UM data at aggregate and detail levels by enrollee and enrollee demographics, such as age and gender, individual provider or facility, provider specialty, diagnosis, etc. to ensure effective VAB utilization. For example, as part of our Adult Chronic Pain Management VAB, we will analyze claims from enrollees utilizing this VAB to evaluate whether the program is supporting a decrease in opioid usage. We will provide UM analyses to our Quality Improvement Committee to discuss possible adjustments to our VAB offerings and administration to ensure effective utilization.

Outcomes. LHCC will monitor the effectiveness of our VABs through quality and performance measures, such as ED diversion for homeless members. For example, we will track participants in our Tobacco Cessation programs to determine their effectiveness in supporting enrollees in quitting tobacco products. Additionally, we will conduct periodic satisfaction surveys on members engaging in our VABs, to gather data about their experiences with and the effectiveness of LHCC's VAB programming.

VAB Reporting. We are committed to meeting VAB reporting requirements through encounter data and financial reporting as directed by LDH and in accordance with the MCO Manual. For our encounterable VABs, we will submit specific codes, which State actuaries can use to validate the reasonableness of our submissions as part of VAB Utilization Reporting.

2.10.3.4 For each selected value-added benefit, the proposal should indicate the PMPM actuarial value of benefits assuming an enrollment of 375,000 members, accompanied by a statement from the preparing/consulting actuary who is a member of the American Academy of Actuaries certifying the accuracy of the information.

The following table indicates the PMPM actuarial value of benefits based on an enrollment of 375,000 members. Please refer to the end of this section for the Actuarial Certification from our preparing actuary, a member of the American Academy of Actuaries, certifying the accuracy of this information.

Table 2.10.3.4 PMPM Actuarial Value of Benefits

[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]
[redacted]	[redacted]

LHCC will work to adjust the PMPM upon feedback from LDH, should there be any concern during independent review. We understand the proposed monetary benefit of our VAB is considered binding, and that LDH may require an alternate benefit or reconciliation should the aggregated annual PMPM not be expended.

2.10.3.5 The proposal should include a statement of commitment to provide the selected value-added benefits for the entire thirty-six (36) month term of the initial contract and for any extensions, if applicable.

LHCC is committed to providing all of the six selected VABs for the entire 36-month term of the Contract and for any applicable extensions. Should we propose additions, deletions, or modifications to components of our VABs, LHCC will annually seek written pre-approval from LDH at least six months prior to open enrollment, and we will commit to providing all VAB components for at least one year.

CENTENE® Corporation

ACTUARIAL CERTIFICATION

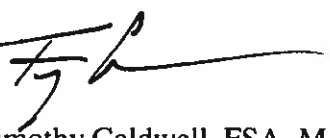
I, Timothy Caldwell, am a Senior Director of Actuarial Services with Centene Corporation. I am a member of the American Academy of Actuaries and meet its Qualification Standards for Statements of Actuarial Opinion. The purpose of this certification is to comply with the requirements of Request for Proposal #3000011953 issued by the Louisiana Department of Health on 2/25/19. I am certifying that the Per-Member Per-Month (PMPM) estimates of the six Value Added Benefits committed to in the Healthy Louisiana RFP were reasonably developed in accordance with generally accepted actuarial standards of practice and are appropriate for the populations to be covered and the services to be furnished under the contract. The PMPM estimates are found in the Appendix on the following page.

In making my opinion for the Adult Vision and Adult Dental benefits, I relied upon data and other information provided by Envolve Vision and Envolve Benefit Options respectively. These two benefits will be covered under capitation arrangements with these two entities, consistent with the current contract. I have reviewed the rating methodology and associated data and pricing assumptions for reasonableness and consistency and am satisfied that the rates are reasonable.

The projections in this certification are estimates only and include assumptions regarding future experience. In my opinion, the assumptions used are appropriate for the purpose of this certification and were reasonably developed. Actual results will differ from the amounts indicated in the cost proposal to the extent that actual experience differs from the assumptions used to develop the amounts.

All actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated by the Actuarial Standards Board, whose standards form the basis of this certification.

This Opinion assumes the reader is familiar with the State of Louisiana Medicaid program, Medicaid eligibility rules, and actuarial rating techniques. The Opinion is intended for LHCC, the State of Louisiana Department of Health, and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.

Signed: 

Name: Timothy Caldwell, FSA, MAAA

Title: Senior Director, Actuarial Services, Centene Corp.

Date: April 29, 2019

Centene Plaza
7700 Forsyth Blvd.
St. Louis, MO 63105
314-725-4477

SECTION 2.10.4

Population Health

There is a tremendous need in our community for healthcare services, and we are grateful for partners like Louisiana Healthcare Connections who share our commitment to helping people get the care they need. By working together as a community, we have the opportunity to truly transform health for local families.

—Donna Collins-Lewis
Baton Rouge Councilwoman, Baton Rouge Free Clinic Director

2.10.4 POPULATION HEALTH [12 PAGE LIMIT]

2.10.4.1 Describe its understanding of, and experience with, improving population health for Medicaid populations including how principles of a population health approach will inform and guide its managed care program in Louisiana. This should include…

Since 2012, Louisiana Healthcare Connections (LHCC) has approached population health management (PHM) with an abiding commitment to fostering both healthy communities and enrollees for generations. We have continually evolved our PHM approaches to incorporate new analytic and data-sharing technologies, emerging evidence-based practices, and our deepening involvement in communities to address social determinants of health (SDOH) and health care access. **LHCC's PHM Program is central to our entire managed care program** and will be further developed and enhanced to fully comply with Section 2.6 of the Model Contract**.** We adopted the Triple Aim successor, the Quadruple Aim, which is our framework to address PHM in terms of **systems, teams, programs and provider engagement**, and provide coordinated, multi-dimensional strategies.

LHCC also incorporates expert PHM analytics, technologies, and approaches from our parent company, Centene Corporation (Centene), which has managed Medicaid populations for 35 years. Centene PHM programs have received multiple industry awards, including from the Institute for Medicaid Innovations for LHCC's fitness program and Centene programs targeting opioid use disorder, Hepatitis C medication use, and perinatal health risks.

Guiding our PHM Program and approach are our **Population Health Principles** which drive and inform our development of initiatives and interventions to achieve the Quadruple Aim across our communities, as illustrated in the examples below.

LHCC'S GUIDING POPULATION HEALTH PRINCIPLES

1. Prevention and Wellness. PHM initiatives are designed to improve the health and wellness of our entire population through prevention and wellness programs and partnerships.

Example: 1. Educational, multi-media promotions such as flu vaccine campaigns, LDH initiatives (i.e. the Active and Healthy Challenge), and partnerships including with LSU AgCenter to develop a series of SNAP/Dollar Store healthy recipe videos to be used in educational social media campaigns by both LSU and LHCC. 2. Prevention programs including partnering with Teche Action Clinic to promote the comprehensive Smoking Cessation Program developed by Dr. Gary Wiltz.

POPULATION HEALTH PRINCIPLES

1. *Prevention and Wellness*
2. *Health Equity*
3. *Continuum of Support*
4. *Enrollee Engagement*
5. *Provider Investments*
6. *Sustainable Community Solutions*
7. *Integrated Multi-Source Data*

2. Health Equity. Our PHM Program will address health disparities among subpopulations through data analytics, targeted and tailored outreach and interventions, and partnering with entities such as LSU Center for Health Equity, the LA Center for Health Quality, and LA Healthy Communities Coalitions to identify SDOH issues and promote solutions.

[redacted]

3. Continuum of Support. Foundational to our PHM approach is addressing barriers and promoting health and wellness along the continuum of care and support for every LHCC enrollee. This includes prevention and wellness through treatment and recovery, integrating and coordinating to provide Whole Person Care across our programs, including health education, care navigation, and Care Management, Transitional Care and Disease Management.

[redacted]

4. Enrollee Engagement. To promote success in our PHM Program we meet enrollees where they are, physically and according to their readiness to engage and change.

LHCC awarded enrollees $2.8 million in rewards through our Healthy Rewards program.

Example: 1. We will offer enrollees a comprehensive Health and Wellness Platform to provide customized prevention and wellness resources based on assessment results, and activity-based and clinically-based incentives as part of our Healthy Rewards program. 2. LHCC has been engaging enrollees in the community since 2012, deploying Community Health Workers (CHW) who share our enrollees' socio-demographic characteristics and help with plan benefits, assessments, and needed services.

5. Invest in Providers. We further support PHM Program success by aligning enrollee and provider strategies and actively engaging provider partners.

Example: 1. Our Value Based Payment arrangements incentivize improved rates for preventive care visits and early identification and treatment of medical conditions to achieve State population health priorities. 2. Toolkits and training for providers on topics such as the importance of evidence-based tools and assessments, SBIRT (substance use) and PRAPARE (SDOH); HEDIS standards and EPSDT periodicity to prevent and detect health conditions; Z code billing to capture SDOH; and Motivational Interviewing and Person-Centered Care Planning to engage enrollees at the point of care.

6. Create Sustainable Community Solutions. One entity alone cannot resolve community or statewide health issues. LHCC seeks relationships with multiple entities to create, implement, and coordinate PHM strategies.

Example: Social Health Bridge Trust™ is Centene's industry-leading company that will provide sustainable funding to community-based organizations (CBO) to address SDOH needs through value-based arrangements with MCOs, providers, and other entities addressing similar issues. Community solutions target the entire spectrum of SDOH, using agreements, joint plans, and contracts to ensure effective coordination.

7. Integrate Multi-Source Data for Data-Driven Strategies. LHCC will continue to use multi-source analytics in an integrative and systematic way to understand and address the social, economic, familial, cultural, and other factors that influence health outcomes. We will also share our data and understandings with LDH, CBOs, our network providers and other aligned organizations to improve health outcomes at every level.

Example: We created an SDOH risk score, made up of a variety of member-level and community-level data, to provide a single metric to help our PHM staff and Case Managers identify and target enrollees and communities at-risk for adverse health outcomes due to the social, economic, and environmental conditions they experience.

2.10.4.1.1 Identifying baseline health outcome measures and targets for health improvement;

MEASUREMENT SELECTION

Improvement Science Approach. LHCC uses an improvement science approach, based on the Institute for Healthcare Improvement's *Model for Improvement*, to identify and select health outcome measures and targets. We also use *Plan, Do, Study, Act* for rapid cycle quality improvement and iterative problem-solving when collecting and analyzing data and testing outcome measure effectiveness. This allows us to systematically identify population disparities, isolate the determinants impacting the measures, complete a root cause analysis of the disparities and determinants, and establish baseline and recurring outcome measures and goals.

Relevant, Trackable, and Evidence-Based. We research cross-sector literature and evidence-based guidelines to identify replicable and valid measures. We use industry-standard outcome measures that are readily used by MCOs and provider systems. Examples of measures include the Model Contract Performance Measures; service utilization metrics such as admissions, morbidity and mortality rates; functional assessment outcomes; enrollee-specific cost of care; and enrollee satisfaction outcomes. We choose measures that enable us to evaluate:

- The acceptance and/or adherence to new or revised practices and processes
- How the new practices are affecting enrollee-centered care and the enrollee's experience of care

Structured Set of Measures. Our approach uses a family of measures to reflect balance among structures, processes, and outcomes. This helps us measure PHM performance over time, identify the impact of interventions and initiatives, and identify improvement opportunities:

- Outcome measures show impacts of programs on enrollee health (e.g., HEDIS Timeliness of Prenatal Care)

- Process measures evaluate the steps within PHM interventions (e.g., the timeliness and accuracy of responding to and resolving enrollee requests for SDOH assistance)
- Balancing measures capture impacts that programs/interventions/processes have on other programs/goals; (e.g., evaluating reduction in lengths of stays against readmission rates).

BASELINE RATES AND TARGETS FOR IMPROVEMENT

Once measures are selected, LHCC compiles performance data to establish baseline rates. For example, we will use the HEDIS Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications and other measures identified in Attachment G to evaluate our success in meeting LDH's Quality Strategy goal to ''Facilitate patient-centered, whole person care." We will use the final, audited LHCC HEDIS rates for measurement year (MY) 2018 as baseline for evaluating MY 2020 performance. If a PHM outcome measure does not have an industry standard performance goal or target, we will collect at least three years' data, as available, and calculate a baseline rate for the MY 2020 based on actual internal performance. To set program improvement targets, LHCC establishes *SMART* (Specific, Measurable, Achievable, Relevant, and Time-bound) goals. We compare the baseline rates to either: (a) establish performance goals, such as those included in the Model Contract; or (b) we identify a reasonable and statistically significant performance target by calculating the standard deviation on our available baseline data. This method enables our determination of the average performance on the measure over time and statistical significance, to ensure that performance targets are achievable and will demonstrate meaningful improvements.

2.10.4.1.2 Measuring population health status and identification of sub-populations within the population;

MEASURING HEALTH STATUS WITH MULTI-DIMENSIONAL, MULTI-SOURCE DATA

At least annually, LHCC will conduct a comprehensive Population Assessment. On a continuous basis, LHCC's Population Health staff will assess population and subpopulation health status, disparities and driving determinants. Our comprehensive analyses aggregate a wide variety of data gained from 834 files; LHCC claims, encounter and authorization data; ADT data; enrollee self-reported SDOH and clinical assessment data; HEDIS and non-HEDIS outcome measures; CAHPS survey results; and Louisiana Community Health Needs Assessments data. We also draw from national sources. For example, our SDOH Risk Score (see Section 2.10.4.3) draws from the CDC's Social Vulnerability Index (among other sources), and our hot-spotting from U.S. Census tract data. We will also draw from the Louisiana Health Information Network Encounter Notification Service® (LHIN-ENS). To further deepen our data review, we will use Pennington Biomedical Research Center's LA CaTS program expertise to run a supplemental population health assessment, using LHCC and LA CaTS data. Our PHM Program metrics will be a primary data source for our Quality Assurance and Performance Improvement (QAPI) Program to identify LHCC's overall quality performance and areas for improvements.

IDENTIFYING SUBPOPULATIONS THROUGH SYSTEMATIC ANALYSES PLUS REFERRALS

LHCC continuously identifies targeted populations for interventions in a systematic series of analytical drill-downs subsequent to an analysis of overall population health and performance. For example, we will embed the LDH-defined and other identified subpopulations in our PHM Program and model. Through ongoing surveillance and analysis, we will isolate and continue to identify additional subpopulations.

We assess our performance on key access and health outcome measures broken out by subpopulation. As feasible, these assessments include stratified analyses of performance by each of the demographic factors specified in the Model Contract. For select HEDIS or other measures with sufficient data, we will do second-order analysis, for example analyzing first by disability status, then by gender within each disability status category. Using the results of this assessment process, we identify subpopulations that demonstrate disparate outcomes and needs for which we develop targeted interventions. We also identify subpopulations for targeted intervention through enrollee self-referrals and provider referrals.

Tools That Support This Extensive Set of Analyses

Population Health Assessments. These assessments report clinical, SDOH, administrative, and population health data displaying trends in health outcomes and disparities by subpopulations. They also report cost and enrollee distribution along the health continuum, recommending interventions likely to have the largest impact on health outcomes. These assessments also include the following components:

- ***Clinical Vignettes***. Vignettes illuminate high-prevalence, high-spend, or other priority clinical conditions by describing the epidemiology, demography, and burden of disease across our membership. Vignettes also provide a fuller understanding of the factors driving major health trends.
- ***Hot-Spotting***. We will use hot-spotting to identify high-risk areas and cost drivers in our populations and subpopulations. Using internal and external clinical, geographic, and social data, hot-spotting visually depicts the geographic dispersion of conditions, such as disease clusters and SDOH patterns.

Predictive Modeling. Our diverse suite of predictive models supports the development and prioritization of targeted interventions by identifying risks in subpopulations related to health and/or SDOH. Our specialized predictive models include, but are not limited to, the following: [redacted]

Community Assessments. To strengthen our data resources, in 2020 our CHWs will also begin conducting Community Assessments to detect the lack of or change in options such as fresh produce/food; community play areas/parks; primary, urgent/emergent, or pharmacy care; and laundry, library, and other community facilities.

2.10.4.1.3 Identifying key determinants of health outcomes and strategies for targeted interventions to reduce disparities;

IDENTIFYING KEY DETERMINANTS

Our Population Health Nurse Informatics Team – assisted by our SDOH Business Analyst and Centene analytics staff – will use a variety of methods such as key driver diagrams, root cause analyses, and statistical analysis to identify determinants most important to a given subpopulation in order to reduce disparities and improve outcomes. Based on LHCC experience and state priorities, our key determinants will include health access, cost, quantity, and quality; enrollee substance abuse, diet, exercise, and motivation to engage in disease or care management; and the SDOH factors of housing, food security, transportation, safety, and employment. We also will address other significant determinants as they arise in our analyses.

IDENTIFYING STRATEGIES FOR TARGETED EVIDENCE-BASED INTERVENTIONS

Population Health Steering Committee for Comprehensive Strategies. After the analyses cited in Section 2.10.4.1.2 are complete and we've identified key determinants driving the outcomes and disparities, LHCC's Population Health Steering Committee will identify evidence-based interventions to address each key determinant and will monitor intervention effectiveness. The Steering Committee will be comprised of directors of LHCC's functional departments plus representatives from our SDOH Advisory Council and our Culturally and Linguistically Appropriate Services (CLAS) Task Force. This structure ensures inclusive staff decision-making, with expertise in enrollee experience; provider experience; population health programs, barriers, and disparities; community relations; finance; and quality improvement. The structure also supports intervention integration across the care continuum, offering multiple approaches.

Use of Centene Expertise and Innovations. LHCC leverages and contributes to Centene's national evidence-based repository, Outcomes Improvement Central (OIC), which catalogs over 700 population health programs deployed by our affiliate health plans. LHCC uses OIC to learn about program design and outcomes to determine best practices and innovative interventions applicable to Louisiana. LHCC also enlists Centene's Health Economics, Research, and Outcomes (HERO) Team for assistance with tailoring OIC projects.

LHCC Support of Best Practice Research. LHCC participates in several studies to identify evidence-based strategies. We are helping fund two initiatives with the Pennington Biomedical Research Center (PBRC):

- TEAM UP, a study of two family-centered obesity treatment programs
- Its "Bench to Patient" role as a Medicaid provider for treating type 2 diabetes

The Centene Center for Health Transformation ™ is a community-industry-academic partnership of Centene, Washington University in St. Louis, MO and Duke University in Durham, NC that is researching innovative, evidence-based interventions to enhance care. LHCC has participated in more than 12 studies, including:

- Defining profiles/predictors of success for attaining recovery from substance abuse
- Four studies on diabetes care best practices – including a study also funded by the National Institute of Diabetes and Digestive and Kidney Diseases on the impact of basic needs navigation interventions

- Two studies on pediatric obesity – studying the impact of peer coaching and family engagement methods
- Two studies on flu campaigns – studying various flu campaign concepts and messaging

The Center is also researching prevention and treatment strategies for Alzheimer's disease, breast cancer, diabetes, obesity, and other conditions. Centene has committed $100 million over 10 years for this effort.

Structured Process. After identifying interventions, our development process includes:

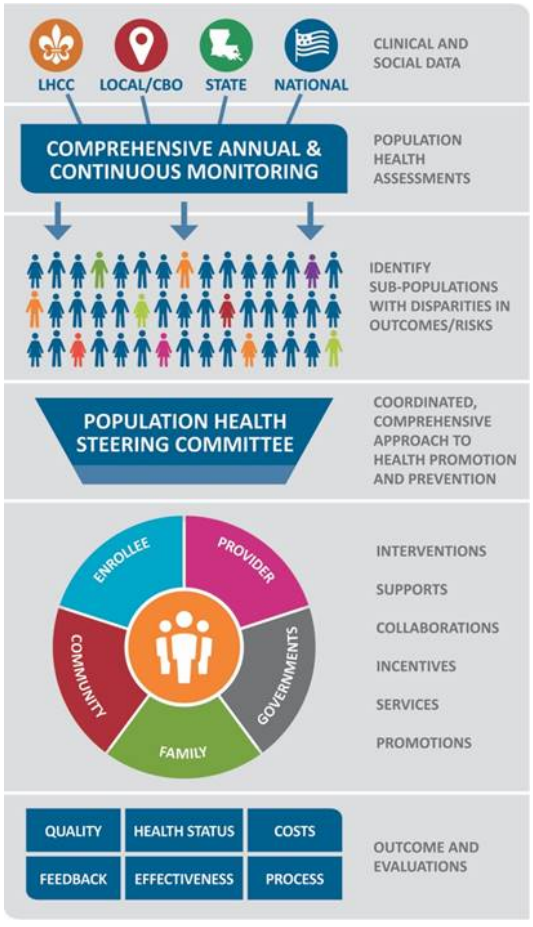
1. Obtaining enrollee and stakeholder input on the planned intervention *prior to* implementation, such as input from our Member, Provider and Community Advisory Committees
2. Setting goals for intervention success, such as process measures to establish milestones and timelines
3. Identifying and assessing relevant cross-sector evidence-based interventions and best practices using sources from recognized professional entities (e.g. CDC, American Academy of Pediatrics, AHRQ, USDA, HUD) as well as proven Centene affiliate interventions and results from research organizations (cited above).
4. Defining an intervention and data collection plan
5. Developing action plan that include goals and measures; responsible parties; timelines; and feedback loops
6. Implementing the intervention and measuring the results against objectives and goals
7. Adopting the change, abandoning it, or iterating and modifying the intervention and repeating the cycle

2.10.4.1.4 How required components of this procurement and other Proposer developed initiatives are integrated, representing a comprehensive approach to population health; and

INTEGRATED ORGANIZATIONAL STRUCTURE

LHCC is in the process of establishing a Population Health Department governed by a Population Health Steering Committee. This will bring our multidimensional range of PHM activities under one roof for a comprehensive, coordinated set of approaches and enable stakeholder feedback to be directed to an accountable authority.

Our ***Senior VP of Population Health*** oversees the departments of Population Health, Education and Training, Medical Management, and Pharmacy, and chair Steering Committee meetings. This position will coordinate all enrollee clinical care with health promotion/disease prevention activities and related trainings. It will further foster a culture of population health improvement across the enterprise and ensure population health concepts are embedded within each department's policies, practices, and trainings.



Population Health Steering Committee

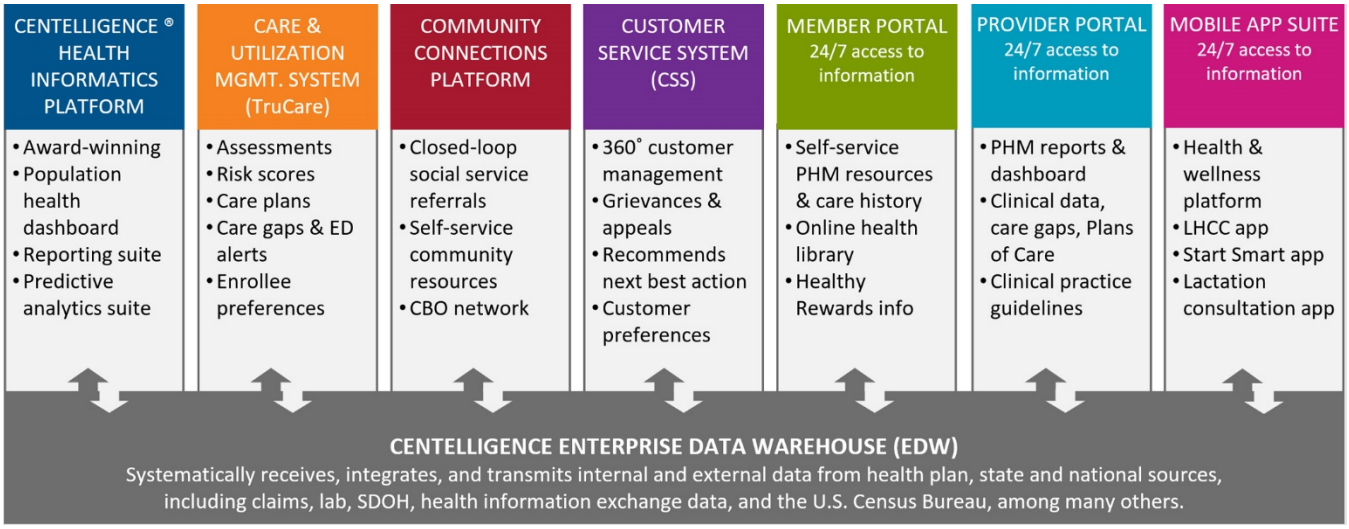
This Committee will be comprised of LHCC department directors, and members of our SDOH Advisory Council and CLAS Task Force. The Steering Committee will meet quarterly to review reports such as population assessments, disparities, and risk stratifications; and program and training effectiveness. It will direct the development and implementation of our Population Health Strategic Plan and all PHM activities. It will consider recommendations from staff, enrollees, providers, and other stakeholders, such as CBOs and LDH, to improve our PHM program. We will ensure this input through such vehicles as our SDOH Advisory Council; the VP of Population Health's participation in advisory committees; staff involvement on local, State, and national organizations; and the research sources cited in Section 2.10.4.1.3. This Steering Committee will be a subcommittee of our QAPI Committee, thereby coordinating population health with overall health plan quality. Committee members will also be on our HEDIS subcommittee to ensure PHM initiatives support improved HEDIS outcomes.

Population Health Department

This department will guide, support, and assess the effectiveness of health promotion/disease prevention activities that span LHCC functional areas. It will be headed by a Vice President and consist of a Nurse Informatics Team and an SDOH Centers of Excellence Team. The Nurse Informatics Team will systematically review enrollee and other recognized data to identify trends in health outcomes, including disparities by subpopulations. Our SDOH Centers of Excellence Program Managers will respond to staff, provider, and enrollee requests for assistance in addressing issues of housing, food insecurity, physical safety, transportation, employment, and education. They will also collect relevant SDOH data from our enrollees and providers and transmit that data into TruCare so that it can be used in our PHM analyses. Our SDOH Business Analyst will analyze SDOH program effectiveness, including our referral program data to determine whether enrollees obtained services. LHCC's Quality Improvement staff will help ensure appropriate and effective analyses.

INTEGRATED INFORMATION TECHNOLOGIES

Our information technology systems and platforms integrate and coordinate data and services among staff, providers, CBOs, and enrollees, as shown below.



Through EDW, LHCC staff (such as Case Managers, CHWs, Member Services), enrollees, providers, and CBOs can support population health with the most current information available and with Centelligence analytics. The Member Portal and mobile app suite also enable enrollees (or their authorized guardians/parents) to complete an HNA and a Notification of Pregnancy (NOP); receive calendar alerts to help manage medication adherence; view a health alert, gap-in-care, or their care plan; and communicate with our nurse advice line or LHCC staff.

2.10.4.1.5 Other considerations the Proposer may seek to present.

ROBUST COMMUNITY FIELD WORK TO CREATE HEALTHY COMMUNITIES

LHCC's augmentation of field-based staff and new initiatives in 2019-2020 will substantially improve our population health surveillance and response. Our high-touch, on-the-ground linkage with neighborhoods and enrollees will create healthy communities and add valuable, often real-time data for timely responsiveness.

Examples of our in-the-field work include:

- [redacted]

- Our **Provider Engagement Teams** and **Clinical Registered Nurse Liaisons** will provide in-person help to providers on use of the data, population health reports, and analytics tools we give them to better manage their enrollees' health, address SDOH barriers, and meet performance goals.
- [redacted]

Our deepening integration into Louisiana communities will enable enhanced data collection and sharing. Our CHWs will conduct community assessments, with the resulting data used in our PHM assessments, intervention development, and care planning. We can also share timely data with CBOs and OPH on emerging issues and more quickly mobilize responses, partnerships, and interventions.

2.10.4.2 Describe what the Proposer will do to address population health in the first year of the Contract, including milestones and timeframes.

Our PHM Program infrastructure will be fully established by January 1, 2020. We are building upon and scaling our current activities to apply new Contract requirements ahead of time. In December, we will conduct a full population health assessment to identify baseline outcomes and to prepare for the possible impact of new enrollees.

FIRST YEAR IMPLEMENTATION (JANUARY 1 – DECEMBER 31, 2020)

Year 1 activities will consist of operationalizing our PHM programs, conducting continuous assessments to gauge population SDOH disparities and health outcomes, and modifying or implementing new interventions as needed.

Operationalizing our PHM Program

We will be expanding or phasing-in initiatives based on successful initial results or – as in the case of our Earned Income Tax Credit (EITC) program, community initiatives, and LDH program promotions – to meet the circumstances and needs of external entities and events. For example:

- In Q1 2020**,** we will finalize and submit our Population Health Strategic Plan (by March 1) and begin implementation upon LDH approval; [redacted] We will begin implementing Feeding Louisiana and FQHC partnerships to set up FQHC food pantries to provide food insecure patients a food package and links to resources for further assistance (at least one FQHC pantry by Q2). We will further define data-sharing and assessment requirements with PBRC/LA CaTS, with the goal of running test assessments by Q2 and a full supplemental assessment by Q4. We will implement our EITC toolkit and continue our educational EITC campaign until mid-April.
- In subsequent quarters, we will expand local or pilot initiatives into other areas of the state, such as our Community Connections enhancement (*see* Section 2.10.4.4) and our FQHC food pantry initiative.

Scheduled PHM Assessments, Promotions, Improvements, and Reporting Throughout the First Year

Assessments. LHCC will run full population and subpopulation health assessments at least annually; re-stratify the entire population and stratify new enrollees to identify subpopulation health issues and risks at least monthly; and conduct ongoing community assessments through our CHWs. We assess health outcomes and PHM program effectiveness, including Healthy Rewards Incentives, VBP, staff training and compliance with policies and procedures (including use of SDOH data and referrals to appropriate care) and measure effectiveness of provider supports, screenings and referrals to PHM programs at least quarterly. The Population Health Steering Committee will meet quarterly to review assessment results and possible PHM modifications.

Health Promotion. We will follow our multi-dimensional communications plan for promoting LDH and LHCC programs and services to enrollees, providers, and community stakeholders. We will enhance current or execute new promotions as needed and implement or enhance *at least one* collaboration with OPH and/or a CBO in compliance with Model Contract Section 2.6.1.2.7.

Program and Performance Improvements. We will share results of population health analyses with collaborating VBP and other provider partners at least quarterly. At least annually, LHCC will update CM/DM and CHW program descriptions and identify new or modify current provider trainings, collaborations or

incentives to improve PHM engagement. Quarterly reports to LHCC Committees include: population assessments to the Population Health Steering Committee; PHM reports for Provider, Enrollee and Community Advisory committees to obtain input on PHM programs and SDOH issues; and reports from the Population Health Steering Committee to the QAPI Committee.

LDH Reporting. Keeping all stakeholders apprised of PHM performance is key to ensuring we are meeting population needs and resolving disparities. Annual and semi-annual reports to LDH include: our Health Promotion and Disease Prevention Report; PHM Evaluation Plan; Intervention Effectiveness Report; PHM performance updates (also to network providers); and Strategic Plan Implementation Reports annually and during LDH contractor performance reviews.

Timely, Ongoing or As-Needed PHM Activities to Meet Emerging Needs, Resources and LDH Requirements

LHCC's PHM organization and IT technologies enable us to quickly meet changes in population/subpopulation needs, and we will do so as needed based on our assessments and input from stakeholders. Other first year activities include: evaluating the results and applicability of evidence-based programs as they arise from partnering institutions, such as PBRC and the Centene Center for Health Transformation; modifying or enhancing staffing, technology, collateral educational materials, and resources to implement new or modified PHM activities; and identifying new or modifying current communication strategies as needed. Model Contract-specified activities include creating joint plans with LDH programs; and reports to LDH on assessment/ stratification changes and CHW activities.

2.10.4.3 Describe the Proposer's recent experience with utilizing data regarding social determinants of health (SDOH) to improve the health status of targeted populations, including the Proposer's approach to collecting SDOH data. Include at least one example ….

EXPERIENCE USING SDOH DATA TO IMPROVE THE HEALTH OF LOUISIANANS

Using Data to Connect Enrollees to Resources

LHCC uses SDOH data in a comprehensive, coordinated fashion to develop and provide sustainable solutions at the enrollee, provider, community, and statewide levels.

Full-Service Staff Assistance. Member Services staff use enrollee-reported SDOH issues or concerns to respond to SDOH needs during incoming calls, connecting to community services using our Community Connections Platform and referring to CM for additional outreach as indicated. CM/DM staff and CHWs assess enrollees for SDOH issues as part of health needs and comprehensive assessments, care and discharge planning, condition-specific coaching, and regular enrollee contact. Upon identification of issues, staff connect enrollees to SDOH supports and monitor impact through the Plan of Care (POC). Case Managers also will use the Centene-developed SDOH Risk Score (see below) to identify enrollees at risk of having SDOH barriers and determine appropriate level of care, outreach, and POC development.

Supporting Providers. Our Provider Engagement Team (PET) uses SDOH data to help providers identify relevant causes of poor health outcomes in their patient roster. The PET also helps providers identify LHCC, community and/or LDH resources to help their patients. For example, our LHCC Hunger for Health Toolkit educates providers about how to address food insecurity using a three-step process: identifying a need through the Hunger Vital Sign screening tool, addressing food insecurity with food assistance flyers, and documenting with the appropriate ICD-10 Z codes. We also give providers access to our community referral tools, including our Community Connections Platform.

Quality Initiatives. Quality staff use SDOH data collected through assessments to help identify quality initiatives and address potential barriers to success under clinical initiatives. For example, with have collaborated with faith-based and community based organizations (CBO) across the State to improve population health. Recognizing transportation and access barriers, particularly in rural areas, as a driver of participation in preventive care services, we have brought services to the community by participating in health fairs and other events for outreach and education, providing free health, dental, and vision care to more than 2,000 uninsured and under-insured Louisiana residents at several free clinics in 2018 and 2019. We use data from our basic needs screening in our population assessments and to monitor our performance in assisting enrollees.

SDOH Centers of Excellence. Our use of enrollee-reported SDOH data will be enhanced by our establishment in 2019 of an SDOH Centers of Excellence, a centralized resource to help enrollees, staff and providers. It will

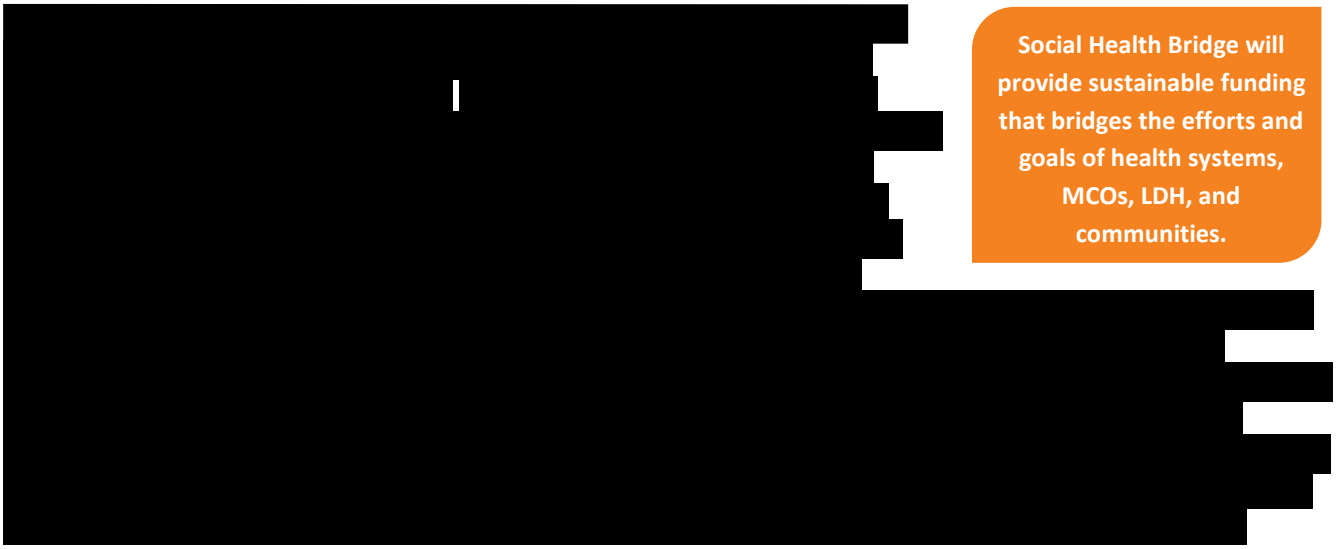
consist of staff specialists in the areas of housing, food insecurity, transportation, safety, employment, and education. SDOH data derived from interactions will be used in population assessments and risk stratification.

Building Sustainable Community Capacity and Empowerment

LHCC uses SDOH data to identify, seek and build relationships with community and support organizations to address local and State needs, and to provide education and capacity-building on SDOH issues. We do this by direct service and financial and in-kind donations, such as with the Louisiana Healthy Communities Coalitions, local parish summits, MetroMorphosis, and youth organizations. Through our Community Health Grants Program, we have funded programs targeting food insecurity with Abraham's Tent Association of Lake Charles, the Food Bank of Central Louisiana, and the New Orleans Aids Task Force/Crescent Care of New Orleans.

In 2020, LHCC will provide Transformation Grants to our provider and CBO partners based on identified SDOH needs. The provider grants will be strategic investments to support areas such as cultural competency and SDOH integration. The CBO grants will expand upon our current grant program to focus on investments that build capacity to serve individuals with SDOH disparities and to address SDOH root causes. Other efforts include:

- Conducting direct outreach campaigns. In 2018 we partnered with Feeding Louisiana to educate enrollees and their families about local food resources, including food banks and SNAP applications.
- Partnerships with youth organizations. For example, we are working with the YWCA to develop, pilot, and evaluate a program specifically designed to address unique challenges faced by low-income teenaged girls of color that impact their long-term health/wellness.
- Funded creation of community gardens across the State to help create a permanent, nutritious source of food for communities (and an evidence-based practice to increase vegetable consumption for children).
- The provider and field-staff initiatives described in Section 2.10.4.1.5 that provide sustainable, whole-person care, and from which we can build upon to meet Population Health Strategic Plan requirements (MC 2.6.4.3.2).



Social Health Bridge will provide sustainable funding that bridges the efforts and goals of health systems, MCOs, LDH, and communities.

Continuous Improvement

We continually enhance our collection and use of SDOH data to improve population assessments and risk stratifications, and to identify enrollee and community needs. We are engaged in national efforts, such as the National Quality Forum Action Team on integrating clinical and SDOH data, and Aligning for Health, a coalition promoting SDOH programs. Because efforts to expand ICD-10 coding could take years to incorporate more SDOH information, Centene's HERO Team will help LHCC develop SDOH metrics that include clinical, quality, social, and satisfaction measures. We will link screening data, Z codes and other SDOH data sources to evaluate our improvement of enrollee and population health by meeting SDOH needs.

EXPERIENCED AND COMPREHENSIVE SDOH DATA COLLECTION

Basic Needs and Comprehensive Screenings. LHCC collects SDOH data on enrollees today using our 12-question basic needs screening tool. Since 2018, we have screened and assisted more than 11,650 enrollees with SDOH issues. We also capture and document enrollee-reported data through HNAs and UM authorizations, and during LHCC staff interactions and events such as health fairs. We may conduct a supplemental follow-up assessment to provide meaningful assistance. Our affiliate, CMG, and other provider partners will also conduct HNA and SDOH assessments which we will capture in our Centelligence Platform to support PHM.

***Targeted Online SDOH Needs Surveys*.** Periodically, LHCC conducts provider and enrollee SDOH Needs Surveys. Our 2017 enrollee survey identified the most common unmet need was lack of food, which initiated our development of multiple food-related interventions (as described below and in Section 2.10.4.4).

***Provider, Local, and National Data*.** Aligned with SDOH data best practices, we integrate a variety of SDOH data sources into our clinical and administrative workflows. For example, we have been collecting and using Z code data since 2018, and we are continually encouraging providers' use of Z codes via training, in-person and telephonic support, and toolkits. We will incentivize Z code use with value-based purchasing models that reward providers who use specified Z codes, and when their Z code billings match with targeted outcomes. Our EDW also aggregates SDOH data from community assessments, the LA State Health Assessment, and national sources such as CDC's Social Vulnerability Index (socioeconomic status, household composition and disability, minority status and language, housing and transportation); USDA's Food Access Research Atlas (proximity to healthful food and transportation), and the NYU City Health Database (health behaviors and outcomes, and care access).

Community Connections Platform. This platform enables all stakeholders – LHCC staff, enrollees, CBOs, and providers – to identify SDOH resources in real-time. It includes direct access to LA Association of United Ways' 2-1-1 community resource tool by LHCC staff (precluding the need to use the 2-1-1 operator), and an online Community Services Directory, which we created in 2015 and promote on social media and our website. To access our platform, LHCC Case Managers use TruCare, and enrollees and providers use their secure portals. LHCC enhanced this platform in Q1 2019 in Lafayette, where the 2-1-1 community resource database was limited. This enhancement will offer closed-loop information and SDOH data collection and reporting in areas such as service delivery history and metrics to gauge health outcomes and SDOH gaps. CBOs use a secure online platform for this enhancement, creating bi-directional communication capabilities among users to ensure coordinated, appropriate service access and use and reliable documentation.

EXAMPLE OF IDENTIFYING AND ADDRESSING HEALTH OUTCOMES IMPACTED BY SDOH

Identification. LHCC's 2017 SDOH needs assessment identified food insecurity as the greatest SDOH need among enrollees (22%). In addition, the State Health Assessment and Improvement Plan (LASHIP) 2016-2020 identified food and nutrition issues as key factors in obesity and unhealthy eating. It also stated that "public understanding of nutrition and the importance of healthy eating remains poor ..." Researchers at the USDA documented the strong correlation between food insecurity and chronic health conditions among low-income working-age adults. Our goals included a long-term decrease in diabetic crises, malnutrition, and obesity.

***Interventions*.** Based on these findings, LHCC built new partnerships, education programs, and community investments to address food insecurity and increase nutritional literacy, such as:

- Increasing access to nutritious foods by funding community gardens in Jeanerette, Baton Rouge, Opelousas and Bastrop; also to community-based food sources through education and targeted social media outreach
- Implementing SNAP match programs at farmers markets in food deserts (as recommended in LASHIP)
- Training providers with nationally established screening tools referring enrollees to local resources
- Expanding the scale and scope of CBO programs with community grants in Alexandria and Lake Charles
- Collaborating with regional Louisiana food banks to create food pantries integrated in primary care settings to increase access to nutritious and emergency foods

***Assessment*.** We conducted pre- and post-surveys of SDOH needs among our membership, analyzed trends in self-reported food insecurity in our case management basic needs screening, and monitored CBOs' reports of program participation and resource utilization. Ongoing monitoring and analysis will assess long-term impact of addressing food insecurity on our enrollee's Body Mass Index, diabetes control and cost of care.

***Outcomes*.** Short-term results are promising, and we are still assessing health outcomes. In Jeanerette, LHCC made the foundational investment in a community garden for a locally directed student-focused program to improve healthy eating that included more than 1500 residents. By 2018, students reported eating 13% more fruits, 6% more vegetables, and 4% more leafy greens. Families reported a decrease in fast food meals by 32%. The school board has since assumed sustaining the project. The SNAP Match program and awareness campaign increased SNAP matching use by 33% at farmers markets in north Baton Rouge. The month following our campaign saw self-reported food insecurity drop from 5.1% to 4.07% of enrollees assessed for case management.

EXAMPLE OF USING HEALTH AND SDOH DATA TO ADDRESS LDH POPULATION HEALTH PRIORITIES

Reduction of key communicable diseases: HIV, HCV, and syphilis. The spread of these diseases is well-documented, for example, Baton Rouge and New Orleans have two of the top three highest rates of HIV diagnosis in the United States. Through our population assessments, we already know that approximately 1.3% of our enrollees have been diagnosed with HIV/AIDS, HCV, or syphilis. SDOH affecting the spread of these diseases tend to include homelessness, low education, low health literacy, cultural norms, poverty, and lack of access to care.

We have already developed multi-dimensional strategies to address this priority and will modify our interventions as necessary based on our new assessments. The following interventions are intended to address the SDOH that might be impacting the spread of these communicable diseases in identified target communities.

- [redacted]
- Our Successful Transitions to Employment (STEP) workforce development and employment support resource program was developed to address employment and education barriers. Through STEP, we will partner with community organizations across the state, including New Orleans and Baton Rouge, to provide opportunities for our enrollees to further their education and pursue meaningful employment. The STEP program will include community job fairs, HiSET vouchers, referrals, and assistance with career counseling services. For enrollees who are interested in pursuing their HiSET, LHCC will provide vouchers to purchase the HiSET prep test for each testing section (4 sections). Enrollees wanting to pursue a college degree would complete a STEP scholarship application.
- [redacted]
- Improving access to and health information on HIV/AIDS and testing, we partnered with CrescentCare (formerly New Orleans AIDS Task Force) to host a mobile testing event in New Orleans that had more than 100 participants, and will partner with the New Orleans Regional AIDS Planning Council to help expand prevention programs in New Orleans.
- Our provider trainings (e.g., on how to care for enrollees with HIV/AIDS, on using SDOH assessments, including PRAPARE, and on Z code billing) will also help address both the health and SDOH needs of our enrollees with these conditions.

2.10.4.4 Describe the Proposer's approach to contracting with community-based organizations and OPH to coordinate population health improvement strategies

LHCC has been contracting since 2012 with CBOs and OPH for PHM initiatives and we have since partnered with more than 300 CBOs and 10 OPH programs. Our Population Health Steering Committee will use population

assessment findings and stakeholder input to recommend evidence-based interventions, including contracting with external partners. It will direct staff to engage identified potential partners, and will oversee the process.

TAILORED AND COMPLIANT CONTRACTING PROCESSES

LHCC uses a three-pronged approach to tailor the right type of agreement for the partnership: Care Provider contracting, Strategic Alliance contracting, and Community Partner contracting.

Care Provider Contracts

Our Network Development and Contracting department manages all contracts with providers that file claims, including certain CBOs and OPH programs. Since LHCC contracts with over 22,000 providers, this department has well-established processes. Provider contracts currently address the six topics required in the Contract. They comply with State and federal requirements on prohibited entities and on credentialing, using thorough initial vetting and ongoing verifications to make sure providers remain in good standing. Our contracting staff negotiate the language and payment rates. Our finance, contract standards, and configuration departments then review and approve the contracts.

Example: We have a contract with LDH that covers OPH providers in programs including family planning, STD control, maternal-child health, immunizations, genetics, children's health, and pharmacy, among others.

Strategic Alliance Contracts

For programs requiring partners that are compensated for services, Vendor Management develops a contract following a rigorous procurement checklist that includes security audits and, as applicable, a Business Associate Agreement (BAA) covering HIPAA compliance. These contracts contain the six topics in the Contract as well as meet State and federal requirements. For programs requiring no compensation or a one-time investment, our Community Relations team engages the partner and develops the program, coordinating with other plan staff as necessary, such as Care Management. Vendor Management helps develop a Memorandum of Understanding (MOU) for these partnerships as needed, and adds a BAA as applicable.

Examples: Since sickle cell disease disproportionately effects African Americans (who are about 47% of our enrollees), we have provided operating funds to the Sickle Cell Association of South Louisiana since 2016, and have a new MOU to establish coordination between our Case Managers and their CHWs (we are the only MCO to do so). We were the first MCO to contract with the Louisiana Association of United Ways to enable our Case Managers direct access to the regional United Ways' 2-1-1 database.

Community Partner Contracts

We partner with and support CBOs, OPH, and others on events or projects to address population health needs in which there are no ongoing financial transactions or exchanges of enrollee data. These are handled by our Community Relations team. In the past, these agreements took various forms. In the future, agreements will either be a Memorandum of Understanding (MOU) that meets all applicable requirements or a type of value-based contract to solidify our growing network of partnering CBOs.

Examples: Since 2017, our multi-pronged hunger initiative (described above) used these contracts, such as for a SNAP benefits matching program with Sankofa markets in New Orleans and BREADA in Baton Rouge; a provider toolkit and targeted outreach with Feeding Louisiana; and gardens and education at the LSU AgCenter in Morehouse Parish, one of the most food insecure parishes in the State.

2.10.4.5 [OPTIONAL] Community Health Worker (CHW) demonstration project
Respond to the following questions to be considered for piloting a Community Health Worker (CHW) demonstration project as described in the Louisiana Demonstration Community Health Worker Program Overview and the Blueprint for a Louisiana Demonstration Community Health Worker Program documents in the procurement library.
Note: This is an optional question. Responses will not be evaluated by the evaluation team nor counted toward the proposal score. If the Proposer chooses to respond, it should limit responses to five (5) pages, though responses to this question will not be counted against the Population Health response page limit or total proposal page limit. The Proposer may submit this information in electronic format in lieu of hard copy.
2.10.4.5.1 Why is the Proposer interested in this opportunity?
2.10.4.5.2 How many CHWs does the Proposer currently employ? In what parts of the state?
2.10.4.5.3 What is the Proposer's CHW/member ratio?
2.10.4.5.4 What are the main activities in which the Proposer's CHWs are currently engaged?
2.10.4.5.5 How are the Proposer's CHWs currently trained? What are the minimum training requirements?
2.10.4.5.6 Does the Proposer have a process to ensure that its CHWs are trusted by the communities they serve? If so, please describe.
2.10.4.5.7 What data does the Proposer collect to know if its CHW program(s) is (are) working?
2.10.4.5.8 How are the Proposer's CHWs or other care management staff integrated with providers?
2.10.4.5.9 Who is the contact person for this application?
2.10.4.5.10 Who is the lead team member who will oversee implementation?

Per Addendum 2, 2.10.4.5 has been provided as part of the electronic copy submission in lieu of hard copy. This information is exempt from section-specific and total page limits.

SECTION 2.10.5

Care Management

We appreciate the passionate spirit of your team, particularly when we are working together to facilitate the coordination and care for our shared patients. With collective missions focused on meaningful outcomes, our combined efforts represent a powerful resource for women in our community.

—Kim Sangari
CEO
Louisiana Women's Healthcare

2.10.5 CARE MANAGEMENT [15 PAGE LIMIT]

2.10.5.1 The Proposer should describe its anticipated approach to meeting the care management requirements of this procurement. Specifically, the proposal should include:

OUR ANTICIPATED APPROACH TO MEETING CARE MANAGEMENT REQUIREMENTS

LHCC will comply with all Care Management requirements of this procurement including, but not limited to Model Contract Sections 2.7 Care Management and 2.8 Continuity of Care and the corresponding sections in the MCO Manual, as well as all other state and federal requirements. Our Care Management Program is built on the Case Management Society of America's evidence-based, integrated program. It is designed to achieve the Quadruple Aim and help enrollees achieve the highest possible levels of wellness, functioning, and quality of life. Our Senior VP Population Health, a doctorate-prepared Advanced Practice Registered Nurse (APRN), oversees our Program, bringing a strong clinical foundation, extensive experience providing care to the Medicaid population and an enrollee-centric, in-the-field perspective to our approach.

Our Successful Care Management Approach

Care Management satisfaction scores consistently over 90%

Over 90% of targeted HEDIS measures improved from 2014-2017

5% reduction in preventable ED utilization

Our overall approach to meeting the care management requirements are depicted in the graphic below.

IDENTIFICATION	STRATIFICATION	ASSESSMENT	CARE PLANNING	MONITORING
•Use of enrollment information, state data and Welcome Call •Health Needs Assessment (HNA) completed within 30 days •Use of historical claims and utilization data •Ongoing identification through predictive modeling or referrals	•Predictive modeling tools to stratify enrollees for CM intervention •Stratified into three levels that drive frequency and intensity of CM •All enrollees with SHCN offered CM •Transitional CM available for enrollees moving between settings	•Comprehensive assessment to assess PH, BH, functional and SDOH, as indicated by HNA, referral or change in enrollee status or setting •Motivational interviewing to identify enrollee goals and barriers	•Person-centered, whole person including PH, BH, and SDOH •Engage enrollee, PCP and desired supports •Team-based using lead Case Manager and a multidisciplinary team •Includes action steps, timeframes, and support programs	•Care plan reviewed and updated at every interaction •Meeting frequency driven by enrollee need, no less than monthly for Tier 3 and quarterly for Tier 2 •Formal reassessment completed at least annually or upon change

Reinforcing our model are the following key components:

- A cutting edge community-based Care Management Model that meets enrollees face-to-face and actively engages providers in providing care coordination and management at the point of care.
- A data-driven process supported by industry-leading technology solutions that pinpoint the need for intervention and provide real-time, actionable information to staff and providers.
- A commitment to collaborating with providers in the joint endeavor of improving enrollee and community health. For example, we are establishing a physician-led Clinical Policy Committee, chaired by Dr. Gary Wiltz (Teche Action Clinic) that will report to our Board of Directors. The Committee will develop clinical policy that reflects local needs and standards of care and ensure LHCC and our network are working hand in hand to manage enrollee care.

- A population health foundation to ensure our programs and interventions are relevant to the changing needs of our enrollee populations.
- Person-centered planning to promote active enrollee engagement in the care management process.
- Integration across the continuum of behavioral health (BH), physical health (PH), and social needs to provide whole person care.
- Comprehensive, innovative strategies to identify and risk-stratify enrollees who would most benefit from case management interventions.
- A pioneering solution to addressing Social Determinants of Health (SDOH) that leverages LHCC resources, bridging the gap between community based organizations and payers to improve the overall health of the community.

Community-Based Care Management Model

A key element of LHCC's Care Management approach will be the emphasis on our community-based Care Management Model. This Model will *meet enrollees where they are* through in-person case management provided in the enrollee's home or community, as well as at the point of care. We will leverage and reinforce the enrollee-provider relationship to improve engagement and outcomes. We also will deploy evidence-based practices for collaborative care, tools and specialized expertise to further promote enrollee engagement and support providers. LHCC has already implemented the first phase of transition to Community-based Care Management. This includes in-person engagement while enrollees are inpatient, in-person follow up after discharge to support appropriate follow-up and linkage to resources, and onsite concurrent review in some network hospitals. We will expand our community-based activities as we move into the next phase of our Model, comprised of two elements:

- ***Expansion of Face-to-Face Care Management*** provided by PH and BH Case Managers, Community Health Workers (CHWs), and onsite concurrent review (CCR) nurses. This includes locating Care Management Teams (CM Teams) in various regions, including embedding staff in provider locations, and increasing use of CHWs. See 2.10.5.1.3 below for detail.
- ***Provider-led Care Management*** that reinforces enrollee relationships with the medical home as the optimal mechanism for engaging them in care. This complements our Value-Based Purchasing (VBP) Program by giving providers the tools and support needed to drive improvements in care and outcomes. See Section 2.10.5.5 below for detail.

Technology Solutions Supporting Coordination of Care

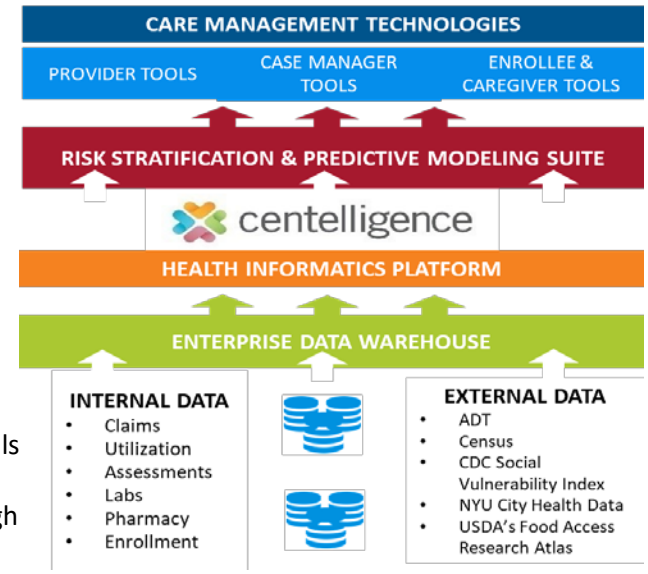
Another foundational component of our Model is LHCC's Management Information System (MIS), which combines comprehensive internal and external data sources and a powerful suite of best-in-class analytics tools and innovative technology solutions to support effective care management. Our Centelligence® health informatics platform provides a data-driven foundation for timely identification of needs, predictive analytics, and stratification to determine the types and level of support needed integrating across the continuum of health and social needs. Centelligence powers our tools for care management, offering a variety of analytics and actionable data for providers and CMs, as well as enrollee and caregiver education, support, and self service functions.

Care Management Tools. In addition our full suite of predictive modeling tools (described in Section 2.10.5.1.2 below), care management tools include:

- TruCare, Utilization and Care Management System: Enables collaborative, enrollee-centric care coordination and utilization management. TruCare houses the plan of care and a unique profile for each enrollee, including demographics, referrals, authorizations, case notes, and enrollee preferences such as language preference.

- Interpreta: Identifies emerging enrollee health issues at the earliest, clinically appropriate time before they become significant health conditions (care gaps).
- Appointment Wizard: Assists in managing appointments by allowing LHCC staff to schedule appointments, issue text or email reminders for enrollees, and attach documentation to the appointment for care gaps to ensure a thorough enrollee office visit.
- Community Connections Platform: Enables LHCC staff to search and electronically refer enrollees to multiple community-based organizations (CBO) to address SDOH. Once an enrollee consents and referrals are made, one of the CBOs will accept the referral, ensuring accountability for seeing that referral through and closing the loop for the enrollee. Through the activity feed, LHCC will have insight into actions taken by the CBO for their enrollees, and CBOs can log detailed notes for Case Managers to view. CBOs can also refer our enrollees to other CBOs, if additional social needs are discovered.

Figure 2.10.5.1 Technology Support for Care Management



Provider Tools. LHCC provides a range of tools to engage and support providers in Care Management such as:

- Provider Portal: Supports self-service capabilities on a web-based platform, including administrative functions and clinical information such as assessment results, the Plan of Care, online care gap notifications, Emergency Department (ED) high utilizer flags, provider and patient analytics, and clinical practice guidelines.
- Provider Performance Management Dashboards: Enables providers to identify and prioritize enrollees based on clinical needs and opportunities by bringing together actionable and timely clinical and administrative data. Providers can use this information to understand the next best action to improve patient outcomes.
- Quartet: Improves PH/BH integration by enabling PCPs to identify enrollees who need BH referrals, find a BH provider who fits their needs, refer the enrollee to that provider and track the status of the enrollee after referral. We are currently piloting use of Quartet in Region 1.

Enrollee/Caregiver Tools. To promote enrollee engagement and support them and their families and caregivers with education and resources, we provide the following tools:

- Member Portal and Mobile App: Offers enrollees and their caregivers online and mobile access to their LHCC information and several self-service functions such as care gaps, viewing their clinical services and medication history, printing a temporary ID card, changing PCPs, updating their contact information or taking an online health needs assessment.
- Health and Wellness Platform: This mobile solution provides targeted prevention and wellness resources. Based on their HNA and the platform's proprietary "Real Age Screening", enrollees will receive customized content on health and life skills and education and opportunities to earn rewards through our Healthy Rewards Program, including rewards for tracking activities such as diet, sleep, and exercise.
- Virtual Assistant: Providing enrollees with the next generation of consumer experience, Virtual assistant is an innovative artificial intelligence (AI) enabled personal assistant, designed to help streamline enrollee onboarding, and enable them to get the most out of their coverage. Able to speak Spanish and English, the virtual assistant can help enrollees complete tasks such as understanding their benefits, getting provider recommendations, and learning how to earn and redeem rewards. In other markets, AI has had strong adoption and usage with powerful outcomes in key areas: increasing engagement, activating enrollees to complete important tasks, establishing a trusted relationship, and boosting enrollee satisfaction.

2.10.5.1.1 The Proposer's process for ensuring that there is success in completing enrollee health needs assessment (HNA) within the required time periods;

TIMELY COMPLETION OF HEALTH NEEDS ASSESSMENTS

LHCC staff will attempt to complete the LDH health needs assessment (HNA) ***within 30 days of enrollment for all enrollees*** including but not limited to those with special health care needs (SHCN), to identify those with conditions or unmet needs who may need case management. We will work with OB providers to complete the standardized risk-screening tool at each initial visit for all pregnant enrollees.

Initial Attempt

We use multiple methods to complete the initial HNA including Welcome Calls (phone), Welcome Packets (mail), and web-based submission (Member Portal). If an enrollee calls our Member Services call center and has not yet completed the HNA, our customer service representative completes the HNA at that time. We also screen for SDOH needs at every enrollee contact and educate enrollees through the Member Handbook, Member Portal, Member Newsletter, and during enrollee contacts to complete a new screening when their needs change. As necessary, we deploy one of our CHWs to an enrollee's home to encourage completion of and assist with the HNA.

Innovations to Support HNA Completion

We have developed solutions to support HNA completion that facilitate enrollee ease and access, such as asking enrollees to complete an HNA during new enrollee orientation sessions we hold in high volume areas. Other solutions we have developed include:

- Our ***Healthy Rewards Program,*** which offers incentives for HNA completion.
- LHCC is partnering with a vendor to include our HNA, notification of pregnancy (NOP) and other assessments on ***health kiosks*** in every Walmart store in Louisiana. Enrollees who complete the HNA will receive a financial incentive through our Healthy Rewards Program which can automatically be used to purchase items from Walmart (excluding tobacco products, alcohol or firearms). The health kiosks will also allow enrollees to complete certain biometric screenings such as blood pressure and BMI. All of this information will be integrated within our care management platform, TruCare, to ensure that relevant health information is available to LHCC staff to facilitate timely enrollee outreach as needed.
- [redacted]
- ***Partnering with providers*** by identifying hard to reach enrollees and requesting assistance in completion of the HNA. For example, we may ask the provider to contact us when the enrollee is in their clinic or ask the home care provider to help us get the enrollee on the phone. We will also outreach to complete the HNA through our staff embedded at provider locations (*see* Section 2.10.5.1.5).
- ***Partnering with community organizations*** such as when our CHWs work with homeless shelters and community organizations to outreach to and screen enrollees**.**

If Initial Attempts are Unsuccessful

If initial attempts are unsuccessful, we attempt to contact enrollees by phone within 90 days (30 days for enrollees with special health care needs) of enrollment, making at least three calls at different times of the day on different days of the week. During the call, we verify receipt of the Welcome Packet and ID Card, provide benefit education, and attempt to complete the HNA. We may send our CHW to the last known address or a community location known to be frequented by enrollees. Our CHWs attempt contact with enrollees in homeless shelters and through PCPs and pharmacies, and they make best efforts to partner with local hospitals/facilities to connect with enrollees prior to discharge from the ED or inpatient admission.

2.10.5.1.2 How the Proposer will utilize predictive modeling, referrals and the HNA process to identify individuals who can potentially benefit from case management;

USING PREDICTIVE MODELING, REFERRALS, HNA TO IDENTIFY ENROLLEES FOR CASE MANAGEMENT

LHCC uses a comprehensive 'no wrong door' approach, multiple methods, and innovative strategies to identify and risk-stratify enrollees who would most benefit from case management interventions. We identify enrollees through predictive modeling; referrals from a provider, enrollee, family, or other person or entity including community based organizations; and the HNA process.

Predictive Modeling

Our suite of best-in-class analytic tools allows us to pinpoint enrollee risks and needs across the continuum of care including SDOH. LHCC's Centelligence predictive analytics engine examines large data sets daily using clinical predictive modeling rules to identify risk level and need for CM. We identify PH, BH, and SDOH needs through claims, pharmacy, utilization management (UM), and other data (including lab results) supplemented by referrals and HNA results. We also incorporate ADT data to ensure the most current view of enrollee risk. In Q3 2019, our predictive modeling tool will have the capability to identify/stratify enrollees based on an SDOH Risk Score. Using the predictive analytics engine, we stratify our entire population to identify and prioritize enrollees for case management outreach and engagement. We continuously update our algorithms to improve the predictive value of risk scores. LHCC uses additional targeted predictive models (described below) to further stratify using algorithms customized to conditions that are top utilization/cost drivers.

Table 2.10.5.1.2 Specialized Predictive Models and Tools

SUD Segmentation Model	ED Super-Utilizer Predictive Model	Uncontrolled Diabetes
Stratifies individuals into one of six SUD risk segments based on utilization, clinical severity, and cost to guide appropriate and timely follow up and care management interventions.	Identifies enrollees at risk of having four or more ED visits within 12 months. The algorithm analyzes enrollee demographics, medical history, area ED statistics, and SDOH data.	Identifies uncontrolled diabetes status for enrollees without a hemoglobin lab test, enabling outreach to those at risk of poor control.

Readmission Prevention Model	Opioid Risk Tool
Assigns a probability of readmission at the time of admission. This allows us to prioritize post-discharge outreach and direct resources to enrollees who need the most support.	Assesses self-reported risk for opioid abuse of adults prescribed opioids for treatment of chronic pain. This validated tool can be administered and scored in less than one minute.
SDOH Risk Score	**Care Management Engagement Score (CMES)**
Generates a score to identify enrollees at-risk for adverse health outcomes due to SDOH needs. In conjunction with other predictive modeling tools, the SDOH score is a significant cost predictor.	Generates a score indicating enrollee likelihood to engage with a CM. Allows us to determine the intensity of outreach that may be required.

Referrals

LHCC's Care Management Program accepts enrollee referrals from our staff (including care, utilization, and disease management; quality improvement; Member Services; and nurse advice line staff); enrollees; families/caregivers; guardians; medical consenters; delegated entities (e.g. vision, dental, etc.); providers and facility staff; community/social service agencies; State agencies such as OBH, OAAS, OCDD, OPH and DCFS; State enrollment center; and the judicial system. We outreach to and assess any enrollee referred to us for Care Management, enrolling in the appropriate level based on need. At least annually, we analyze aggregated summary results of the number of enrollees referred by each source to ensure referrals are being received from a variety of sources. We incorporate referral data into the predictive modeling tools described above.

HNA Process

LHCC staff completing the HNA by phone or in the field will immediately escalate enrollees identified with a potential care management need to a Case Manager to complete a comprehensive assessment. For those HNAs that do not indicate immediate need, Care Management staff will review HNA results within 14 business days of completion to identify enrollees with care management needs. We review for SHCN, unmet health or SDOH needs, lack of adherence, need for education on self-management or appropriate utilization, ongoing services, previously-scheduled procedures or admissions, and care coordination needs.

3x increase

in CM engagement resulted from our in-home and in-hospital BH CM outreach. We have conducted 836 visits to date, engaging high-risk enrollees with mental illness and high ED visits.

2.10.5.1.3 How the Proposer will engage enrollees who may potentially benefit from case management in the program;

STRATEGIES TO ENGAGE ENROLLEES WHO MAY BENEFIT FROM CASE MANAGEMENT

Care Management staff outreach to identified enrollees and complete a comprehensive assessment as soon as possible, but no later than 30 days of identification. LHCC averages 12 days from initial outreach to comprehensive assessment and Plan of Care creation. During the initial outreach, we introduce the Case Manager, explain the Care Management Program and respective roles and responsibilities, and obtain enrollee consent to participate. Care Management staff schedule the assessment at a time/place convenient to the enrollee and invite the enrollee's chosen circle of support to participate in the assessment and care planning process as described in 2.10.5.1.4.

12 Days

LHCC averages 12 days from initial outreach to comprehensive assessment and Plan of Care creation.

Evidence-Based Engagement Approaches

Our Care Management staff use evidence-based approaches that improve enrollee engagement and adherence, such as Motivational Interviewing, Active Listening, the Teach-Back Method, the Strengths-Based Approach, the Recovery Model, and Trauma-informed Care. Another important approach we use is *Person-Centered* Planning, which supports active engagement and builds the Plan of Care around enrollee goals. We focus on enrollee strengths, promoting small milestone successes. During multidisciplinary team (MDT) meetings and during all aspects of care planning and revision, the CM keeps the enrollee at the center by providing education, encouraging input on progress, obtaining consent, and ensuring enrollee understanding (such as through the Teach Back method). LHCC will leverage Centene Corporation's (Centene) Person-Centered Planning Trainer, who is certified by The Learning Community for Person-Centered Practices, to train our Care Management staff on Person-Centered Planning.

In-Person Engagement through our Expanded Community-Based Model

[redacted]

Embedded Staff. [redacted] This point-of-care integrated model will allow us to share CM resources and evidence-based practices in population health to better address SDOH and advance health equity.

[redacted]

Expanding Community Health Worker Presence. LHCC is increasing the number of CHW staff to support in-person engagement and our CHWs will be Centene-certified in community health coaching. Currently, CHWs visit high-risk inpatient enrollees to engage them in Care Management and provide post-discharge follow up. This includes post-discharge assessment of the reason for the hospitalization, discussing medication changes that occurred during the inpatient stay, verifying that a follow-up appointment is scheduled, and any assistance needed to access it, and helping the enrollee access services to address SDOH needs. CHWs will assist with activities such as completing the HNA in the community, provide health coaching and navigation support, and attend appointments at enrollee request to facilitate communication.

67%

Through a collaborative partnership with Our Lady of the Lakes, 67% of enrollees with sickle cell engaged in CM during in-person visits with LHCC staff at their medical appointments.

Promoting Care Management at the Point of Care. LHCC is working with key network providers to support enrollee engagement and convenience and build on established provider-enrollee relationships. This includes:

- [redacted]

Matching Enrollees with the Right Case Manager and CM Team

LHCC engages and supports enrollees across the continuum of care using multidisciplinary integrated CM Teams, recognizing that our membership includes individuals with multiple chronic conditions, BH, pharmacy, SDOH, long term care, and other needs. Enrollees are assigned a CM (a licensed RN, LCSW, or LMHP) who leads the CM Team for that enrollee and serves as the enrollee's primary LHCC contact. We match enrollees with a CM based on geography as well as enrollee preferences such as gender, race, language and primary need. BH Case Managers shall be the lead when there is an enrollee with primary BH needs. The Chief Medical Director, PH/BH medical directors, Medical Management Coordinator, PH/BH Case Management Directors and Supervisors, pharmacy staff, health coaches, UM staff, and non-clinical staff support each CM Team. CM Teams also receive support from our Maternal Child Health EPSDT coordinator, Peer Support Specialists, Addictionologist, and liaisons dedicated to specific state agencies. Our specialized CM Teams are described below.

Table 2.10.5.1.3 LHCC Care Management Teams

Adult Team	Pediatric Team	OB/NICU Team
Focus: Adults who do not meet criteria for other teams ***Staff specializations***: Department of Corrections, ED diversion, high inpatient utilizers, hemophilia, Hepatitis C, HIV, physical health, sickle cell, SMI/co-morbid SUD	***Focus***: Children who do not meet criteria for other teams ***Staff specializations***: BH, ED diversion, foster care PH, hemophilia, Hepatitis C, HIV, high inpatient utilizers, NICU, physical health, sickle cell	***Focus***: Pregnant/postpartum enrollees and NICU infants ***Staff specializations***: BH, ED diversion, high inpatient utilizers, hemophilia, Hepatitis C, HIV, physical health, perinatal SUD, sickle cell

Transition of Care Team	Disease Management
Focus: Enrollees transitioning between levels of care • *Transition Team*. Clinical and non-clinical coordination and support for discharge planning • *PH Outreach Team*. In-person outreach during and after hospitalization • *BH Outreach Team*. In-person outreach to Region 2 high utilizers/ frequently readmitted (pilot) ***Staff***: RNs, BH clinicians, Care Coordinators, CHWs	***Focus***: Enrollees with chronic conditions • *BH Team*. ADHD, anxiety, depression, perinatal depression • *PH Team*. Asthma, CHF, chronic low back pain, COPD, diabetes, heart disease (CAD), hypertension, weight management ***Staff:*** Health coaches/clinicians with condition-specific expertise

PASRR/DOJ Team	DCFS/OJJ/OBH/OCDD Team
Focus: PASRR assessments and transitions for DOJ Agreement Target Population. ***Staff***: LOCUS and PASRR-trained CMs	***Focus***: Coordination with DCFS, OJJ, OBH, OCDD for enrollees involved with those agencies ***Staff***: Dedicated liaison for each agency; CMs trained on special requirements for each population/agency.

Through the Connections Academy learning environment, we provide Care Management training on topics such as integration, clinical practice guidelines, BH crisis, cultural competency, evidence-based engagement, and SDOH. We provide training on special populations (such as Chisolm, DOJ Agreement Target Population, HCBS Opt-In, foster care, state custody) and coordinating with state agencies and other entities to integrate across the system of care. We provide web-based trainings targeted to specific staff roles and higher levels of certification, such as LHCC-developed American Nurses Credentialing Center accredited CEUs for our nursing staff on issues important to the health and welfare of our enrollees.

2.10.5.1.4 How the Proposer will identify the appropriate tier of case management for an enrollee using objective measures and criteria, which types of support are provided in each tier, and the process for developing an individual plan of care; and

IDENTIFYING APPROPRIATE TIER, TYPES OF SUPPORT, DEVELOPING PLAN OF CARE

LHCC's data-driven process allows us to pinpoint enrollee risk and needs and identify the appropriate level of support needed, balancing objective criteria with individual needs and goals. We use predictive modeling and other information to identify the most appropriate tier, then confirm and modify as needed using results of the comprehensive assessment, clinical judgment, and enrollee preference for level of support.

Identifying Appropriate Tier

The first step in identifying the appropriate tier is using Centelligence predictive analytics described above to evaluate overall enrollee health burden and risk based on demographic, utilization, readmissions, diagnoses, cost and other data. Our targeted predictive models provide another layer of data mining to provide a comprehensive picture of risk and impactability. We stratify our enrollees needing Case Management into one of three risk levels based on our predictive modeling and risk stratification processes and use this information to identify preliminary tier assignment. We then combine this with comprehensive assessment results, clinical judgment of our Case Managers, and enrollee preferences, strengths, and goals to verify, or if needed, modify enrollee assignment into one of three case management intervention tiers. In addition to support specific to their assigned tier, enrollees receive all support described in lower tiers. Regardless of tier, we integrate across the continuum of care and address SDOH. We also offer a range of targeted case and disease management programs to enrollees in any tier who meet program criteria. Enrollees move to higher or lower tiers as their needs change and goals are met.

Table 2.10.5.1.4.A Case Management Tiers, Criteria, and Support Provided

TIER 3 **Intensive Case Management** **CRITERIA:** High risk. Require intensive support for clinical care needs and to address SDOH. Complex needs e.g.,special health care needs; catastrophic, high-cost, high-risk, or co-morbid conditions; intensive service needs; history of non-adherence; experienced a critical event; consistent high utilization of high levels of care; and frail, elderly, disabled, or at end of life. **PLAN OF CARE:** Completed within 30 calendar days of assessment, updated at least monthly.	**ASSESSMENTS:** Comprehensive in-person assessment including home environment/priority SDOH; formal in-person re-assessment quarterly. **CASE MANAGER MEETINGS:** In-person, at least monthly • Complex case management: high-intensity support/monitoring • Attestations of monthly plan of care updates and communication to enrollee and PCP • Telemonitoring as applicable **MULTI-DISCIPLINARY TEAM MEETINGS:** At least monthly
TIER 2 **Case Management** **CRITERIA:** Rising risk, such as change in utilization that suggests instability and risk for high use of acute PH/BH services (e.g. new diagnoses, more medications, rising cost trend) and decreased service use (not filling prescriptions, care gaps). Require focused attention to support clinical care needs and address SDOH. **PLAN OF CARE:** Completed within 30 calendar days of assessment, updated at least quarterly.	**ASSESSMENTS:** Comprehensive in-person assessment including home environment/priority SDOH; formal in-person re-assessment quarterly. **CASE MANAGER MEETINGS:** At least monthly • Implement plan of care, prevent institutionalization and adverse outcomes, support enrollee to achieve their goals including self-management • Attestations of quarterly plan of care updates and communication to enrollee and PCP **MULTI-DISCIPLINARY TEAM MEETINGS:** At least quarterly
TIER 1 **Case Management** **CRITERIA:** Low risk. Require care coordination and support in addressing SDOH. **PLAN OF CARE:** Completed within 90 calendar days of assessment, updated at least annually **ASSESSMENTS:** Comprehensive in-person assessment including home environment, priority SDOH; formal in-person re-assessment annually or with a change in condition.	**CASE MANAGER MEETINGS:** At least quarterly • Outreach, education, support services to facilitate access, prevent and close care gaps, promote self-management/adherence, integrate care. • Case and disease management programs based on individual needs • Attestations of annual plan of care updates and communication to enrollee and PCP
ALL **Supports for All Enrollees** • Connect to medical home • Appointment scheduling assistance • Disease management and health education	• Nurse Advice Line • Local BH Crisis Line • Member Portal/mobile apps • SDOH Centers of Excellence/SDOH support • Transition of care

Case Management Programs Available to Enrollees at any Tier

***Transition of Care Program*.** LHCC addresses transitions of care between clinical settings through our evidence-based Transition of Care (TOC) Program. Our team-based TOC Program emphasizes prevention, continuity of care, coordination, and integration of PH and BH, incorporating the Coleman principles that have been shown to reduce avoidable readmissions. Our robust data infrastructure and integrated, interdisciplinary processes provide the framework for us to identify enrollees with high readmission risk and deploy the right resources to avoid potentially preventable events (PPE), including ED visits, admissions, and readmissions. A key LHCC differentiator is our holistic approach to each individual's unique combination of clinical and non-clinical needs, including SDOH, and proactively advocating for each enrollee. The Transition of Care Team (TOC Team), in collaboration with the enrollee's Case Manager, if one is already assigned, begins to plan for discharge in collaboration with the MDT upon admission (or upon enrollment for enrollees already in an institution), adhering to policies and procedures which address all transition of care requirements across all settings and levels of care. We follow up with enrollees within 72 hours following discharge/transition to ensure that services are being provided as detailed in the transition plan of care. The plan of care identifies circumstances in which the follow-up includes a face-to-face visit. Through our program, we will provide and ensure:

- Assessment of the barriers which led to the enrollee's admission or readmission
- Collaboration with enrollee and facility discharge staff for transition planning; timely implementation of effective discharge plans that consider PH, BH and SHCN needs; and coordination of appropriate care from one level of care to another. For enrollees transitioning from Psychiatric Rehabilitation Treatment Facilities or therapeutic group homes, for example, our team reviews the discharge timeline, plan, and barriers with the provider. Ninety days prior to discharge, we request referrals, including Coordinated System of Care (CSoC), by the provider as appropriate, and work with the CM Team to assure transition supports are in place 30 days prior to discharge.
- In person support during or after transition by concurrent review nurses, CHWs, and Case Managers.
- Appropriate support to enrollees and caregivers as needed in obtaining referrals, locating providers, scheduling follow up appointments and arranging transportation, DME, supplies, and medications; and accessing non-covered services and community services to keep them safe in the community.

Table 2.10.5.1.4.B below lists our targeted case and disease management programs. Following the table, we highlight some of these programs in greater detail.

Table 2.10.5.1.4.B LHCC Case and Disease Management Programs

Condition-Based Case Management Programs				Utilization-Based Case Management Programs	
ADHD Chronic Pain Depression	Hemophilia Hepatitis C HIV/AIDS	Palliative Care Perinatal/NICU Perinatal SUD	Sickle Cell SUD Transplant	ED Diversion Medication Therapy Management (MTM)	Pharmacy Lock-In Transition of Care
Disease Management and Health Coaching Programs					
ADHD Asthma Anxiety	CHF Chronic Pain Depression	Diabetes HIV/AIDS Hypertension	Obesity Pain Management (low back) Perinatal Depression		

Start Smart for Your Baby® (Start Smart) Program. LHCC uses Centene's award-winning Start Smart perinatal management program to improve birth outcomes. Start Smart staff assist enrollees to gain access to prenatal care, provide education on health care needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and other services, such as specialty BH services and value-added dental services, and community resources. The program extends through the postpartum period to improve

Compared to matched controls, Start Smart participants have:

- **31%** fewer low birth weight deliveries
- **35%** lower NICU admission rates
- **23%** fewer births with gestational age <37 weeks for those taking 17P

maternal outcomes and prevent risk in subsequent pregnancies and extends through the first year of life for LHCC-enrolled babies. To supplement one-on-one and online education, we offer a *Start Smart mobile application* that provides on-demand information and support. We refer eligible enrollees to the Nurse Family Partnership to provide additional face-to face support and education to first-time moms on parenting and recommended infant care, and to close care gaps. To reduce infant mortality, we are partnering with Cribs for Kids to offer cribs, a baby sleep sack, and safe sleeping education for enrollees in the Shreveport and Monroe regions. We are developing a *Pregnancy Medical Home* with Associates in Woman's Health (AWH) as part of our value-based purchasing strategy. AWH will provide enhanced pregnancy management, integrating BH care through their on-staff LCSW. AWH also will use the SBIRT (Screening, Brief Intervention, Referral & Treatment) instrument to assess for BH and SDOH needs (including alcohol, tobacco, and other drug use, domestic violence, and housing, utilities, and child care needs) and use Z codes to help us track SDOH issues.

Start Smart for Your Baby® Program Components

- Early identification of pregnancy
- Risk screening and stratification
- Outreach and education
- Incentives for prenatal and postpartum care access
- A progesterone (17P) injection program
- Specialized management of depression/SUD
- NICU management and follow up
- High risk OB management
- Provider education and incentives

Perinatal Substance Use Disorder (SUD). Our Perinatal SUD program provides education and connects pregnant enrollees with SUD to appropriate providers and community resources. The program engages the enrollee to improve birth outcomes and help her achieve and maintain the best possible quality of life. Our Perinatal SUD RN and BH Case Managers and other staff receive specialized training in addiction and evidence-based techniques to engage the enrollee in treatment and facilitate change. We ensure person-centered care and connects the enrollee to and integrated treatment team. We also connect the enrollee to StrongWell, a peer support care community that helps expectant mothers with SUD, without fear of stigma. StrongWell also educates about Hepatitis C screening, use of 17P, and long-acting reversible contraception.

OpiEnd Program. LHCC will be offering OpiEnd, a multi-disciplinary, evidence-based approach to putting an end to opioid misuse. OpiEnd leverages machine learning to identify and intervene for enrollees at risk of opioid use disorder with a goal to effectively manage pain and prevent opioid misuse. The Program focuses on four strategic pillars: Pharmacy, Provider, Enrollee, and Community. Collectively, these efforts will provide clinical best practices to proactively prevent opioid misuse.

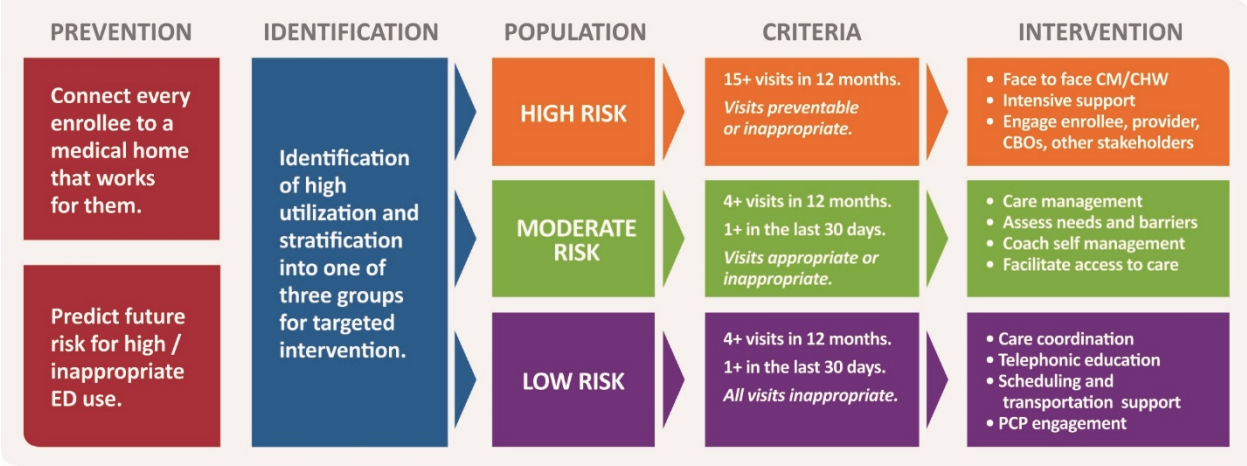
Hepatitis C Program. Key components of this program include outreach, engagement, education, assessment, support, and referrals to help increase the enrollee's understanding of risk factors. We assist with and promote medication compliance and supportive nutrition, managing fatigue and nausea, avoiding infection risks and provide education for preventing spread of the disease.

HIV Program. We collaborate with enrollees, providers, caregivers/family, and community services to provide specialized medication therapy monitoring, assist with co-morbid conditions, and promote appropriate access. We also educate enrollees on pre-exposure prophylaxis (PrEP), an antiretroviral drug that can be taken by an HIV negative person to reduce risk of HIV infection.

ED Diversion. Our ED Diversion Program deploys a two-part strategy aimed at *preventing* high and inappropriate utilization before it occurs, and *identification and mitigation* of high utilization. The first part of our strategy is prevention, which includes connecting every enrollee to a medical home that works for them. This starts upon enrollment with education and support to select an appropriate PCP and includes our incentives and value-based purchasing arrangements that promote after-hours access. Prevention also includes identifying enrollees on a path to high utilization. Our ED Super-utilizer predictive model, described previously, helps us identify enrollees who may become a high utilizer and allows us to determine whether the enrollee is on a path to inappropriate ED use, or to appropriate but preventable high ED use, so we can intervene effectively. Interventions may include care coordination, assessment for case management, linkage to SDOH resources, and other assistance. The second strategy is identifying and stratifying high utilizers into three groups, with different

interventions for each based on the amount and type of ED utilization identified. We will build on the interventions described for the potential high utilizers and focus in on the specific utilization drivers for each group, with in-person care management and CHW support offered as needed. The graphic below depicts our ED Diversion Program.

Figure 2.10.5.1.4 ED Diversion Program



Disease Management Programs

LHCC offers evidence-based coaching and support for prevalent conditions within our population such as asthma, diabetes, and hypertension. We train Care Management staff on the pathology and evidence-based treatment of these conditions along with self-management skills to enable them to provide effective interventions and enrollee education. For low-risk enrollees, Health Coaches (licensed clinical staff such as a respiratory therapist, certified diabetes educator, registered dietician) take the lead. For high and moderate risk enrollees, the assigned Case Manager takes the lead in working with the enrollee/family to promote a coordinated, proactive, person-centered approach to improving self-management and clinical outcomes and appropriate use of services. For higher risk enrollees, we also will offer telemonitoring. For example, enrollees in the Shreveport and Monroe areas with uncontrolled high blood pressure will receive a digital blood pressure cuff that connects to a smart phone that sends home blood pressure readings to our contracted Hypertension Digital Medicine team of pharmacists who will evaluate readings against other enrollee data and evidence-based guidelines to recommend treatment or medication changes.

LHCC's pilot with Diabetes Assessment and Management Center (DiaMC) in Shreveport to provide enhanced point-of-care condition management increased HbA1c screening by 12.90%, fundoscopic eye exams by 5.38%, and microalbuminuria screening by 36.39% compared to control group. We are continuing and expanding this effort.

Process for Developing an Individualized Plan of Care

Comprehensive Assessment. The Case Manager invites the enrollee, or legally authorized representative or guardian, family members, circle of support (as authorized by the enrollee), PCP, and other members of the multi-disciplinary team (MDT) to identify enrollee needs, preferences, supports and services, and goals. We accomplish this through a comprehensive assessment process conducted in a location of the enrollee's choice, soliciting additional input from the MDT. Our assessment tool incorporates the Substance Abuse and Mental Health Services Administration's (SAMHSA) eight domains of wellness which impact physical and mental well-being. Our Case Managers use this tool and other condition- and population-specific assessment tools (see ***Table 2.10.5.1.4.C***) to identify and evaluate PH and BH needs, ongoing special conditions that require a course of treatment or regular care monitoring, conditions that require a course of treatment or regular care monitoring, functional needs, accessibility needs, strengths and supports, goals and other factors that inform the need for case management and services. We will assess for mental health rehabilitation services

and ensure that BH providers conduct an assessment within 12 calendar days of referral based on potential need for community psychiatric support and treatment and psychosocial rehabilitation. Other areas we assess include, but are not limited to SDOH, domestic violence, problem gaming, and tobacco use.

Our Case Managers use age-appropriate, open-ended questions, a person-centered approach, and evidence-based engagement techniques to foster an understanding of overall health and needs, and to identify goals and barriers. Goals are enrollee-driven, short- and long-term, specific, realistic, and measurable. LHCC does not withhold necessary services while awaiting completion of the comprehensive assessment and immediately authorizes and arranges services to meet enrollee needs and prevent avoidable admissions and poor outcomes.

Condition/Population-Specific Assessments

- High Risk Obstetric Comprehensive Assessment for high and moderate risk pregnant enrollees
- Edinburgh Depression Screening for all identified pregnant enrollees
- Condition-Specific Assessments such as PHQ-9 for depression, CAGE-AID for co-occurring alcohol and drug problems, Vanderbilt Scale tool for ADHD, GAD 7 for generalized anxiety disorder, Adverse Childhood Experiences (ACE) Questionnaire.
- Emergency Diversion Assessment to identify barriers, other factors causing preventable visits
- Transition of Care Assessment factors which contributed to the inpatient admission

Plan of Care Development and Implementation. Once the enrollee's needs, preferences, supports and services, and goals are identified, they are incorporated into the plan of care. Areas addressed in the plan of care include all covered and non-covered services and all elements described in section 2.7.10.5 of the Model Contract. The Case Manager reviews and confirms enrollee understanding of their role and responsibility, and willingness and ability to participate. Each plan of care documents the timeline and schedule for evaluation and monitoring.

The Case Manager and CM Team coordinate appropriate referrals and assist with scheduling and transportation as needed. This includes referrals to covered services providers as well as community resources (discussed in more detail below). With enrollee consent, we also connect enrollees to providers for gaming support and tobacco cessation, including the Louisiana Tobacco Quitline and the Louisiana Smoking Cessation Trust, as appropriate. We also coordinate referrals for potentially eligible women to the local WIC program.

The Case Manager monitors and updates the plan of care as needed and follows up regularly with enrollees and the MDT to evaluate progress, continually assessing any need for revision. Factors that trigger a revision include, but are not limited to a change in medical or BH status, social stability, functional capacity, progress made in reaching goals, adherence or changes in enrollee or family satisfaction with the Care Management Program or other services addressed in the plan of care.

Multidisciplinary Team (MDT). The Case Manager is responsible for coordinating the MDT, which includes the enrollee, their chosen circle of support, providers and other stakeholders involved in the enrollee's care as desired by the enrollee. The Case Manager obtains required authorizations for information release to coordinate with all providers and identified supports as appropriate. LHCC digitally shares information and recommendations with the entire MDT to integrate across the continuum of care. Care Management staff communicate with the CM Team in person and via phone to discuss enrollee goals, assessment results, provider recommendations, and other information to facilitate development and implementation of person-centered plan of care. Where the enrollee's PCP or BH provider offers case management, we will support the provider as the lead case manager on the MDT.

Integration of Behavioral Health. LHCC uses the Substance Abuse and Mental Health Services Administration's (SAMHSA) nationally-recognized definition of whole-person health care as a systematic and bi-directional integration that includes the continuous communication and coordination of PH, BH, and/or substance use disorder (SUD) treatment. In addition to providing integrated CM Teams, we encourage enrollees with BH needs to choose providers that offer co-location as well as those that use the Collaborative Care Model (CCM), the gold standard of integration treatment approaches. Aligning with this, we are working with our affiliate, Community Medical Group (CMG), a provider of integrated primary care clinics, to support opening two new clinics that will provide a "one stop shop" for PH/BH and SDOH needs, with same-day and after-hours appointments to accommodate working enrollees.

Integration of Social Determinants of Health. LHCC is implementing a comprehensive strategy to address unmet health related needs (such as food insecurity; housing instability; transportation; personal safety, and employment/education) that builds on the latest research and innovations implemented nationally by our Centene affiliate health plans and others.

The foundation of our strategy is our new SDOH Centers of Excellence (SDOH Centers), through which we will support all LHCC efforts to meet enrollee SDOH needs, integrate SDOH into our population health and quality infrastructure, and work with local stakeholders to address community SDOH needs. Dedicated SDOH Program Managers will provide information, in-person assistance (e.g., filling out applications), and linkages to local community resources and social services for unmet needs. For example, our Housing Specialist will help identify appropriate, affordable housing for homeless enrollees. In addition, while we will continue to provide a Community Services Directory of available community SDOH and other resources, we are going far beyond this basic tool. We will be using an enhanced software platform for referring enrollees to community resources, and to close the loop through data and tracking.

Our strategy builds on this foundation to address SDOH for the entire community. LHCC will be the first Centene health plan to offer services through the Social Health Bridge™ Trust, Centene's groundbreaking new SDOH solution that integrates across the silos of health and social care. Our initial project will be a housing pilot in New Orleans where a number of our enrollees now reside in the same building. We will work through the SDOH Engagement Specialist to provide services that benefit the entire building community such as health fairs, nutritional demonstrations, and bringing in financial professionals for tax preparation. We also will provide additional services targeted to our enrollees (such as post-discharge check-ins).

2.10.5.1.5 How the Proposer will coordinate with providers and state staff that may provide case management support to enrollees so as to not duplicate services.

COORDINATION WITH PROVIDERS AND STATE STAFF TO PREVENT DUPLICATION OF SERVICES

Coordination with Providers That Provide Case Management

LHCC will establish formalized agreements with providers that provide case management that outline standardized work and data sharing processes and each party's roles and responsibilities to ensure coordination and prevent duplication of services. Agreements will be customized to each provider and incorporate a mutually agreed upon division of responsibility that matches the provider's capabilities, capacities, preferences, and Model Contract requirements. Where the enrollee's PCP or BH provider offers case management, we will support the provider as the lead case manager on the MDT. We will further prevent duplication through our integrated technology solutions and joint case rounds. We will support providers with a robust set of tools, resources, and solutions that include technical assistance and deployment of Clinical Registered Nurse Liaisons to supplement versus duplicate provider-based case management. As providers desire to take on more case management responsibility, LHCC will meet them where there are, wrapping around

appropriate supports to promote success and moving them along the continuum of providing case management; sharing of evidence-based PH/BH integration models, training, tools and best practices; practice transformation resources; and technical assistance and data analytics. LHCC always retains ultimate accountability and oversight of care management to ensure contract compliance, positive enrollee health outcomes and a seamless experience for enrollees and providers.

Coordinating with State Staff Providing Case Management

We provide agency-specific dedicated CM Teams and a liaison as a single point of contact between LHCC and agency case managers to support coordination and prevent duplication.

Dedicated CM Teams
Enrollees in Foster Care
Enrollees in OBH, OJJ, DCFS Custody
HCBS Waiver Opt-In Enrollees

Dedicated CM Teams (shown in the table) regularly communicate with state case managers, involving them in the assessment and care planning process with enrollee consent. CM Teams also participate as requested in state agency assessment and care planning activities. They share monitoring information as applicable and participate in rounds with state case managers including during transitions of care. CM Team coordination with state agencies that provide case management also includes coordination with Magellan for enrollees receiving services through the Coordinated System of Care.

Our dedicated liaisons support coordination and communication between the CM Team and state case managers to prevent duplication of services such as through participation in meetings between LHCC and agency staff. Our dedicated liaisons support the following populations: LDOE, DCFS and OJJ, LGEs, Tribal enrollees, Behavioral health consumer and family organizations, Permanent Supportive Housing (PSH) programs, Intellectual/Developmental Disability (I/DD), MCO compliance with both the provision of supports and services for individuals referred to and residing in Nursing Facilities (NF), as well as all activities related to the DOJ Agreement and the My Choice Louisiana program.

SECTION 2.10.6

Case Scenarios

When hard-to-reach member, Bill, said he was heading to Walmart, Care Manager Mel Lavigne knew this was her chance. She found Bill in the produce section and helped him shop as they developed dialogue about Bill's health and ED utilization. At the end of the trip Bill said, "I didn't think you were going to come, but I'm sure glad you did."

2.10.6 CASE SCENARIOS [5 PAGE LIMIT PER SCENARIO]

The Proposer should provide its approach to serving Louisiana's Medicaid managed care enrollees through its response to three case scenarios. As part of its response to each case scenario, the Proposer should describe how it will ensure access to appropriate MCO covered services and provide support to enrollees through case management or other tools. In addition, the Proposer should provide details on the resources and infrastructure that it will bring to serve these individuals in Louisiana.

2.10.6.1 Case 1: A 38 year old enrollee resides in St. Helena Parish and has multiple health issues including, Hepatitis C, diabetes, hypertension, multiple emergency room (ER) visits for pain, and back problems. She had three recent pregnancies complicated by hypertensive disease of pregnancy. Her doctor suggested surgery for her back but the Proposer is requiring she first attempt a trial of pain management and physical therapy (PT) prior to surgery. There are no PT services available in the enrollee's area. The enrollee has been receiving pain management through her primary care physician for several years, but the Proposer did not realize that until recently. Describe how the Proposer will manage care to achieve the best outcome for the enrollee.

APPROACH TO SERVING THIS ENROLLEE

People who live in St. Helena Parish face a disparate level of barriers to good health compared to most Louisiana residents, such as access to specialty and ancillary services. The parish ranks in the lowest quartile on factors such as high school graduation rates and percentage of children living in poverty. To achieve the best outcome for Mary and her family, Louisiana Healthcare Connections (LHCC) will work with her to identify her goals, strengths, and supports and develop a person-centered Plan of Care (POC) that addresses her whole-person needs, such as her comorbid conditions, risks associated with chronic pain, and any Social Determinants of Health (SDOH).

Stratification and Assessment

We identified Mary on our Case Management Prioritization Report as a result of her comorbid diagnoses of hypertension, diabetes, and Hepatitis C (HCV), and a recent fourth visit to the emergency department (ED). As an element of the Prioritization Report, Mary's Case Management Engagement Score (CMES), generated by our Centelligence predictive analytics platform, shows she is likely to engage with a Case Manager (CM). Because of her multiple comorbid conditions, multiple ED visits, and referral from her doctor for back surgery, Mary qualifies for Tier 3 Intensive Case Management. LHCC assigns a registered nurse (RN) as her CM and primary point of contact, supported by a CM Team that includes a Licensed Mental Health Professional (LMHP) and Community Health Worker (CHW) to address behavioral health (BH) and SDOH. The CM Team provides integrated case management, collaboratively coordinating their outreach, face-to-face assessment, and collaboration with providers.

Review of Health History. In preparation for the Comprehensive Assessment, Mary's CM reviews all records available within our system, including her previously completed Health Needs Assessment which contains a screening for social determinants of health (SDOH), any electronic medical records available from her PCP at Southeast Community Health System (SCHS), and other providers and facilities where Mary has been treated. The CM reviews all previous treatment interventions for HCV, including medication management, treating providers, and blood work to determine the prescribed medications' efficacy. They also verify through pharmacy claims data whether Mary has been refilling her prescriptions on a regular basis. [redacted]

Comprehensive Assessment. The CM begins the person-centered care planning process by meeting with Mary face-to-face and asking her to tell the CM about herself. As the CM listens to Mary's story, she focuses on Mary's strengths. Mary is a committed mother to her children and invested in living a healthy, drug-free life. Mary's mother and brother live nearby, but her mother is in poor health and her brother works full-time. Mary expresses that she feels that she has her diabetes and hypertension under control. Mary tells the CM that her HCV was diagnosed prior to her pregnancies and probably resulted from IV drug use (heroin). She identifies as a person in recovery from substance use disorder (SUD). The CM has been trained in recovery principles and looks for opportunities to help Mary be hopeful about the future for herself and her children. During this discussion, Mary identifies relieving her back pain as her primary goal since it affects her ability to care for her children and to work. Her secondary goals are to get a job and improve the family's food security, since she often struggles

toward the end of the month to buy enough fresh food. Mary thinks she could get a better job if she completed her high school equivalency test (HiSET).

Physical health. As part of the Comprehensive Assessment, the CM performs an environmental assessment of the general safety of the home environment. This enables the CM to determine if there are appropriate diabetes supplies, healthy food choices, a blood pressure cuff, and a supportive mattress to help prevent back pain. If possible, the CM observes Mary checking her blood glucose. During the home visit, the CM confirms that Mary's children are receiving EPSDT services and all appropriate follow-up care at the SCHS clinic in Greensburg.

The CM completes a Pain Assessment and evaluates the interventions Mary and her providers have used to address her pain. The CM will perform a thorough medication reconciliation with Mary and identify any barriers that may have resulted in medication noncompliance. If pain medication is being used, the CM reviews the extent, frequency, history of use, who is prescribing the medication and whether Mary has safe storage for the medications at home. The CM identifies if an MRI or neurological exam has been completed and if so, requests the results.

If Mary's pain is contributing to frequent ED visits, the CM will coordinate follow up with her PCP and other providers to identify interventions to support her pain management. Mary shares that her doctor recommended back surgery, but she was told she first needed to complete a trial of pain management and physical therapy. She expresses concerns that she has been receiving non-opioid pain medication through her PCP for several years, but she is still in pain. Mary is also concerned that there are no physical therapists in her parish.

The CM and Mary discuss her family planning goals, complications from hypertension during her three recent pregnancies, and interventions to reduce complications in the future. The CM also provides education on alternative contraceptive options, and the risk of HCV transmission to future children. After this discussion, Mary states she doesn't want to have another child.

Behavioral health. The CM helps Mary identify how her chronic conditions may be impacting her quality of life and mood. With Mary's consent, the CM assesses for depression using the Patient Health Questionnaire (PHQ-9), for SUD using the CAGE Substance Abuse Screening tool, and for Adverse Childhood Experiences (ACEs). Mary reports that she previously completed a SUD program to stop using IV drugs, participated appropriately in aftercare follow-up appointments, and is active in a recovery support group. Based on Mary's ORCA score and reported abstinence, Medication Assisted Therapy (MAT) is not needed.

Social determinants of health. Our priority SDOH assessment reveals that Mary and her family have stable housing and physical safety, but have some concerns about food insecurity and an unreliable vehicle that makes trips of any great distance unsafe.

SUPPORTING MARY THROUGH CASE MANAGEMENT AND OTHER TOOLS

Person-Centered Plan of Care

Once the assessments are completed and within 30 days of when she was identified for case management, the CM works with Mary in a face-to-face meeting to develop a comprehensive POC, ***based on her stated goals***. To develop Mary's POC, the CM works with Mary's identified MDT, which includes Mary, her mother and her brother as part of her circle of support, her PCP, the doctor who recommended back surgery, the CHW, and her recovery sponsor. The POC incorporates her physical health, behavioral health, and SDOH needs. Once the POC is completed and Mary signs it, the CM gives Mary a copy, makes it available on both the member and provider portal, and forwards a copy to Mary's PCP. Subsequently, the CM holds face-to-face meetings at least monthly at Mary's preferred location, and her POC is updated at least monthly and formally re-assessed in person at least quarterly.

Mary's Goals	Person-Centered Plan of Care
I want to have less back pain so I can work and take care of my children.	• Ensure access to care by arranging for Mary to receive in-home PT through LHCC's [redacted] • Based on lack of relief from current pain management modalities, coordinate referrals and authorization for alternative pain management, such as acupuncture and/or therapeutic massage services, as needed. • After a recommended trial of PT and alternative pain management, re-evaluate and coordinate appropriate referrals for further treatment, such as to a neurosurgeon or orthopedist for a surgical evaluation if needed.
I want to get a job and I want to be able to afford fresh foods, even at the end of the month.	• Refer Mary to the WIC program at SCHS to augment her SNAP benefits. • Provide Mary pamphlets for the Greensburg Farmers Market, open on the last Saturday of the month, and the St. Helena Farmer's Market, sponsored by the LSU AgCenter on Wednesday mornings at Turner Chapel A.M.E. church in Greensburg. Both accept SNAP benefits so she can stretch her benefits further and buy fresh foods. • Enroll Mary in the Successful Transitions to Employment (STEP) program (see Innovative Programming section below) and refer her to the WorkReadyU Program at Northshore Technical Community College in Greensburg for HiSET prep classes, career assessment, and guidance. • Work with Mary to get her children enrolled in age-appropriate childcare offered by the St. Helena Parish School District Head Start and Early Head Start programs. Provide assistance assembling the immunization records and other paperwork necessary to enroll her children. • Ensure that Mary is aware of transportation provided by SCHS to appointments at the clinic. Connect Mary with LHCC's transportation vendor for other non-emergency medical transportation to medical appointments outside of Greensburg, so she doesn't have to use her unreliable vehicle for longer trips. • Arrange for Mary to receive a SafeLink Wireless phone, preprogrammed with phone numbers for her to contact any member of her MDT, the Nurse Advice Line, the BH Crisis Line, and 911.
I want to continue my recovery from SUD.	• Confirm Mary's pain management regimen and treatment plan with her PCP and collaborate with the PCP to provide services that help maintain recovery. • Connect Mary with peer support on LHCC's Health and Wellness platform, which provides 24/7 access to certified peer support specialists via her phone/mobile device.

Assessment and Reassessment

The CM works with the MDT to assess and reassess any barriers to services and interventions at regular intervals during monthly in-person visits with a goal to stabilize conditions and support transition to Tier 1 (low risk) case management and self-management. Mary will be re-assessed at least quarterly or upon any change in condition.

Other Care Coordination

The CM collaborates with Mary's PCP to:

- Coordinate the treatment services Mary has been receiving for diabetes and HCV, including curative medication therapy, and ensure the PCP has provided education about avoiding the use of acetaminophen-containing products.
- Provide a long-acting reversible contraceptive (LARC) based on Mary's decision that she doesn't want another child.
- Ensure Mary receives screening for STDs, including HIV, and counseling regarding pre-exposure prophylaxis for HIV if she resumes use of IV drugs.

The CM enrolls Mary in Medication Therapy Management (MTM) with a comprehensive medication review (CMR) and recommends a local pharmacy close to Mary. The pharmacist will initiate the CMR face-to-face or over the telephone if Mary prefers and contribute to Mary's POC. They also will facilitate consultation with Mary's PCP and/or specialist for interventions, if needed, and keep them informed of the POC. If areas of concern are noted during the CMR, the pharmacist will initiate a targeted medication review (TMR) and continue as needed to help Mary optimize her therapeutic outcomes.

Other Enrollee Support Tools

Enrollee Education. Mary's CM will refer Mary to the Louisiana Maternal, Infant and Early Childhood Home Visiting program to determine if she is eligible for family coaching and support services under the Parents as Teachers (PAT) programs, depending on the ages of her children. The CM will also work with Mary's PCP to provide education about:

- Options other than the ED, such as extended Thursday hours offered by her clinic, Urgent Care Clinics in her area and LHCC's Nurse Advice Line and Behavioral Health Crisis line, available 24 hours a day, 7 days a week
- Managing her multiple prescriptions, including drug interactions or adverse reactions to watch for and the importance of keeping them out of reach of her children. LHCC will provide her with a pill box to help manage the pills.

The CM suggests to Mary that she participate in SCHS' Healthy Eating and Food Resources group for nutrition education/counseling services that will help her implement and maintain healthy eating practices.

Crisis Planning

With Mary and the MDT, the CM coordinates a Crisis Prevention Plan that addresses symptoms to identify when Mary may be in a crisis situation and potential triggers, frequency of interventions (outpatient appointments, etc.), an action plan to address potential decompensation (e.g. Mary's pain management), resources to contact in the event of a crisis (i.e. BH providers, community crisis resources, 24-hour Nurse Advice Line and Behavioral Health Crisis Line numbers, etc.), and contact information for the MDT. Once completed, the CM will share the Crisis Plan with Mary's PCP and other providers. If needed, the CM will present Mary's case in Internal Integrated Care Rounds to consult with LHCC's PH and BH Medical Directors.

RESOURCES

Provider Partnerships

- LHCC is dedicated to ensuring access to appropriate home health care in every parish, for every enrollee. [redacted]
- Mary is already a patient at the SCHS clinic in Greensburg which has services and supports in place to serve Mary's comprehensive whole-person needs. The clinic also provides transportation to the clinic for services.

Innovative Programming

- Mary can earn rewards through LHCC's Healthy Rewards Program for getting preventive care for herself and her children, and she can use those rewards to pay bills, pay rent or purchase select items at Walmart.
- Through our Successful Transitions to Employment (STEP) program, Mary can receive vouchers to purchase the HiSET prep test and attend Job Fairs sponsored with Walmart and her FQHC. She also can get transportation to her HiSET preparation classes, as well as to job interviews and job fairs.

INFRASTRUCTURE

Provider Support

Incentives for Weekend Hours. The CM contacts Mary's PCP about Mary's continued use of the ED and any contributing factors identified in the in-person assessment. Recognizing that the SCHS clinics do not have weekend hours available for enrollees, the CM reached out to our Provider Development and Contracting Team. The Contracting Team schedules an in-person meeting with SCHS to remind them that as a participating provider of the statewide integrated FQHC network, the LPCA ACO, they are offered support to expand after-hours and weekend clinic availability.

Education on SUD Screening and Intervention. The CM provides Mary's PCP with a tool kit based on the evidence-based, integrated, public health approach of Screening, Brief Intervention and Referral to Treatment (SBIRT) and any other SUD education the PCP requests. He ensures the PCP is aware of the requirement to report prescriptions of eligible controlled substances to Louisiana's Prescription Monitoring Program.

IT Systems

Below are examples of LHCC's technology tools for Case Management:

Identification / Stratification / Monitoring	Other Tools for Care Management Staff	Support for Provider	Support for Enrollee/Caregiver
• **Predictive Models** support identification and risk stratification for enrollees who may need case management • **Interpreta** identifies emerging enrollee health issues before they become significant health conditions (care gaps)	• **TruCare** health management platform for collaborative case management and utilization management; TruCare also houses the POC • **Unite Us** software platform for referring enrollees to community partners that address SDoH needs • **Appointment Wizard** offers enrollees real-time appointment scheduling	• **Provider Portal** supports "self-service" capabilities, including eligibility inquiry, authorization submission / status, claim submission / status, clinical applications • **Patient Analytics** dashboard allows access to patient disease registries to view critical information including care gaps	• **Mobile apps** provide an integrated mobile "one stop shop" for enrollees, free of charge • **Member Portal** offers online access to their LHCC information and several "self-service" functions

2.10.6 CASE SCENARIOS [5 PAGE LIMIT PER SCENARIO]

2.10.6.2 Case 2: The Proposer has an enrollee who is 11 years old and presents at the ER. He has post-traumatic stress disorder (PTSD) stemming from early childhood sexual and physical abuse that persisted over several years of his life. He resides with his father and stepmother and has ongoing involvement with OCDD. The youth experiences high rates of anxiety daily. He has nightmares and is reliving events with dissociation. He also has mild features of an Autism Spectrum Disorder but low to normal IQ and good language skills. The youth presents at the ER secondary to symptom escalation, including unrelenting distressing memories, almost continuous attempts to injure himself, which his parents cannot safely manage, and attempts to self-induce vomiting. This is the third presentation to the ER in recent weeks. During a previous ER visit secondary to increased self-injury, evaluators determined a need for psychiatric inpatient hospitalization, but after several days in the ER without the ability to secure an inpatient bed, he was released to home. Approximately forty-eight hours prior to the current ER visit, he was taken to the ER and discharged home. In the context of the escalating crisis for the youth, both parents, who have psychiatric disorders in remission for some years, are showing worsening of their own mental health conditions. Describe how the Proposer will manage care to achieve the best outcome for the youth.

APPROACH TO SERVING THIS ENROLLEE

With post-traumatic stress disorder (PTSD) stemming from early childhood sexual and physical abuse, mild features of Autism Spectrum Disorder (ASD), anxiety, and increasing self-harming behaviors, Jacob will require specialized behavioral health (BH) services that address his whole health needs in a setting experienced serving children with these challenges. Recognizing Jacob's ongoing involvement with OCDD, we will collaborate with OCDD to identify the appropriate level of care or appropriate placement and our CM will facilitate regular communications to prevent duplication of services. We will use person and family-centered case management, utilization management (UM), key partnerships with provider and community organizations, and innovative programs to ensure Jacob and his parents have access to appropriate Medicaid covered services and the supports needed to best care for Jacob in the least restrictive environment. Based on Jacob's health history, he is in Tier 3 Intensive Case Management with a Licensed Mental Health Professional (LMHP) assigned as his primary Case Manager (CM), with support from a registered nurse on the CM Team to address physical health needs. We are notified of Jacob's current presentation in the ED through our real-time ADT feed from the Louisiana Health Information Network-Encounter Notification Service (LHIN-ENS), and we deploy our Transition of Care Team (TOC Team) to the ED in Jacob's home town of Lafayette.

Ensuring Access to Covered Services

LHCC's TOC Team collaborates with Jacob's CM, father and stepmother, and current BH providers. For Jacob, the role of the TOC Team is to facilitate placement to the most appropriate and least restrictive setting, move him out of the ED as quickly as possible, and address any barriers to care that may contribute to future ED visits and possible admissions. Jacob's provider considers several immediate treatment options including:

- Acute inpatient psychiatric placement with specialized support to meet Jacob's needs
- Psychiatric Residential Treatment Facility (PRTF) designed to treat children with ASD, PTSD, and BH problems, sexual abuse trauma and cognitive/developmental challenges.

Based on his level of need, Jacob's BH providers determine that a PRTF is the appropriate level of care. The TOC Team then works with UM staff and the BH Medical Director to identify an available bed and validate medical necessity according to InterQual criteria and facilitate a pre-screen for PRTF in accordance with the Model Contract Section 2.12.7. A bed is available at the newly opened Acadiana Treatment Center PRTF in Sunset, near Lafayette. Upon approval, the CM explains to Jacob's parents that successful treatment will likely require their son to move through a continuum of care, from residential treatment to home with wraparound services varying in intensity to meet his needs. We will continue to collaborate with OCDD for Jacob's continued needs.

Reassessment Post Change in Condition

Review of Health History. Prior to working with Jacob and his parents to re-assess and update his person-centered Plan of Care, the CM reviews all records available within our systems, including his previously completed Health Needs Assessment which contains a screening for social determinants of health (SDOH), and any electronic medical records (EMR) available from previous providers. The CM verifies through pharmacy claims whether Jacob's parents have been refilling his prescriptions on a regular basis. If not, upon discharge

from the PRTF, the CM will complete a medication reconciliation and provide education on the importance of helping Jacob adhere to the medication regimen. With the parents' permission, the CM contacts current PCP, BH and OCDD providers for information about any previous or current treatment services provided.

Comprehensive Reassessment. Jacob's CM begins the re-assessment process by meeting with Jacob and his family face-to-face and asking him to tell the CM about himself. As the CM listens to Jacob's story, with Jacob's father filling in some details, the CM looks for opportunities to help Jacob and his family be hopeful about his future. Jacob doesn't respond when asked about his goals for treatment, except to say that he wants the nightmares and bad memories to end. His father and stepmother echo him in that goal and also hope that he stops attempting to self-harm or self-induce vomiting. They are worried about him going into inpatient treatment but also are worried about managing his care at home. During the visit, the CM determines that Jacob still does not feel safe from the person who previously sexually abused him. The father and stepmother maintain that their son is safe from his previous abuser, who lives elsewhere and has no contact with the enrollee. Jacob's parents report that they have stable housing, food security and transportation, but their worsening mental health conditions are making it more difficult for them to maintain full-time hours in their jobs.

Behavioral health. The CM assesses Jacob's history of Adverse Childhood Experiences (ACEs) to rule out continuing or ongoing trauma and identify triggers that induce his nightmares, dissociation, self-harming behaviors and strategies that address these triggers. With permission from his parents, the CM contacts Jacob's school in the Lafayette Parish School System (LPSS) to see if they are aware of events that may be triggering the escalation in his symptoms.

While assessing Jacob's needs, the CM identified that his father and stepmother also have BH diagnoses. With their consent, if they are LHCC enrollees, the CM will assess the BH risks and administer an ACES screening to assess for cross-generational negative experiences that may be impacting Jacob's current condition. If appropriate, the CM will recommend treatment options that treat the family as a holistic unit, offer case management services, and coordinate implementation of the POCs. If they are not LHCC members, the CM will provide contact information for local mental health resources, and/or assist the parents with making an appointment with their BH provider(s) if possible, as well as provided education and training on how to best support Jacob.

The CM determines Jacob was appropriately screened by his pediatrician for ASD when he was 24 months old, using the Modified Checklist for Autism in Toddlers (M-CHAT). His pediatrician referred him for further assessment, which determined he has mild features of ASD, but low to normal IQ and good language skills. He has not been receiving ABA therapy but has had an Individualized Education Program (IEP) in place with LPSS since he began attending school. He also learned that Jacob has had significant absenteeism due to BH issues.

Physical health. The CM assesses Jacob's self-induced vomiting, which may lead to nutritional issues, malabsorption of medication, electrolyte imbalance, and dental concerns, including enamel erosion and cavities. The CM also assesses for comorbid conditions such as gastroesophageal reflux disease (GERD), rules out the presence of an eating disorder, conducts a lead toxicity screening, and obtains his height, weight and body mass index. If necessary, the CM Team will coordinate with the PCP to screen Jacob for sexually transmitted diseases to which he may have been exposed.

Social determinants of health. During an environmental and priority SDOH assessment, the CM further assesses the family's SDOH needs, including the family dynamics, stability of the home environment and personal safety of Jacob and his family. If there are indicators that Jacob's safety may be compromised, the CM will consult with the LHCC Medical Director and other leadership and complete a Department of Children & Family Services (DCFS) report if indicated.

Coordinated System of Care (CSoC) Screening. After Jacob is placed in the appropriate out-of-home level of care, and at least 30 days prior to the anticipated discharge date, the CM conducts a risk screen for CSoC eligibility. If he appears eligible based on that screen, the CM will make a warm transfer to Magellan, where a brief Child and Adolescent Needs and Strengths assessment will determine if he's eligible for CSoC. The CM will document in his record whether he met criteria for CSoC presumed eligibility and the date he was referred.

ENROLLEE SUPPORT THROUGH CASE MANAGEMENT AND OTHER TOOLS

Person-Centered Care Planning

After the assessments are complete, a Multi-Disciplinary Team (MDT) comprised of Jacob's parents, the CM Team, OCDD, Jacob's PCP and any BH providers, will meet and update Jacob's person-centered Plan of Care. The comprehensive Plan of Care is based on Jacob's stated goals. Ongoing face-to-face case management meetings will continue at least monthly at the location the family prefers, and his Plan of Care updated at least monthly and formally re-assessed in person at least quarterly or upon any change in condition. After the Plan of Care is updated and reviewed with Jacob and his parents and his parents sign it, the CM gives them a copy, makes it available on both the Member and Provider Portal, and forwards a copy to Jacob's PCP.

Jacob's Goals	Person-Centered Plan of Care
I don't want to have bad dreams or bad memories. **I don't want to feel like I have to hurt myself or make myself vomit.**	• Arrange for Jacob's placement in the newly opened Acadiana Treatment Center PRTF in Sunset, near Lafayette as ordered by his provider, and collaborate with the PRTF to ensure Jacob receives services appropriate for all of his diagnoses, including ASD. (see provider partnerships below). • Once Jacob is admitted, work with OCDD and his parents to support improved management of his symptoms and allow him to transition from the PRTF to an outpatient setting. Coordinate all outpatient services: o HOMEBUILDERS® Intensive Family Preservation Services will provide intensive, in-home crisis intervention, counseling, and life-skills education to Jacob and his family. We estimate that Jacob will receive these services for approximately one month. o When indicated by medical necessity criteria, Jacob will step down to the wraparound set of services provided under CSoC for Parent Support and Training, Youth Support and Training, skills building and short-term respite. o Once Jacob is discharged from CSoC services, the CM will coordinate continuing family therapy services for him and his parents. o Applied Behavior Analysis (ABA) Therapy. During and after receiving services under CSoC, LHCC will provide ABA therapy services as ordered by his Provider to address Jacob's ASD. • Offer Peer Support Services to the family, including visits to provide recovery support and improve Jacob's social functioning and self-esteem. To further improve coping skills and reduce hospitalizations, the Peer Support Liaison will identify community resources such as support groups (see Enrollee Support below).
I want to live at home with my parents and I want to feel safe.	• The Safety Program Manager in the LHCC SDOH Centers of Excellence will work with Jacob and his family to increase his feelings of security, including exploring the possibility of working with a non-profit community organization to obtain a PTSD-trained service dog. • Ensure that, as part of services provided at the PRTF and continuing at home, Jacob and his parents receive family therapy services. • Assist Jacob's parents to apply for a monthly stipend from the Flexible Family Fund to help offset costs, such as missed work hours, associated with Jacob's care. Help them determine whether they are eligible for Family and Medical Leave.

Ongoing Assessment and Reassessment

Throughout the integrated and collaborative CM processes, the CM will continue to work with the MDT to assess and reassess any barriers to services and interventions, with a goal to stabilize Jacob's condition and transition to a lower level of case management. In the meantime, Jacob will be re-assessed at least quarterly or upon any change in condition. In preparation for discharge from the PRTF, the LHCC TOC team will be re-engaged to help arrange for aftercare services to be in place thirty (30) calendar days prior to discharge.

Other Care Coordination

Physical Health. Due to Jacob's history of induced vomiting, he is at increased risk for dental complications. The CM will coordinate with Jacob's parents to make a dental appointment and, if possible, will locate a dentist who

is trained in Trauma Informed Care (TIC). With permission from Jacob's parents, the CM Team will inform the provider of Jacob's PTSD diagnosis. With Jacob's diagnosis of ASD, a Community Health Worker will be available to accompany Jacobs and his parents to a practice dental visit prior to his scheduled appointment.

Coordination with School. With permission from his parents, the CM will contact Jacob's school to inform them of his treatment out of the community, and to see if his IEP needs to be updated. If his teachers have not received training in trauma-informed pedagogy, the CM will inform them of the micro-credential available through the Louisiana Association of Educators.

Other Enrollee Support Tools

Enrollee and Parent Education and Support. The CM will connect Jacob's family with supports and services offered by the Acadiana chapter of the National Alliance on Mental Illness (NAMI), including the Family Support Group and the Family to Family class, and any support groups specific to the parents' BH diagnoses. When appropriate, the CM will connect Jacob with Acadiana NAMI's PTSD support group. The CM will connect Jacob's father and stepmother with Hearts of Hope, which offers a Non-Offending Caregiver Group to build knowledge and skills parents need to help children deal with long-term trauma effects throughout their development. The CM will note in Jacob's Plan of Care that when he turns 14, he may enroll in Heart of Hope's Weekly Teen Support Group.

Crisis Planning

To prevent future unnecessary hospitalizations or institutional placements, our CM also will work with the MDT to coordinate a Crisis Prevention Plan. The Plan will include:

- A crisis assessment, including identifying past triggers of symptom escalation, evaluating whether they are still present and planning to address them
- Resources and contact information for each MDT member
- Frequency of interventions (CM, outpatient appointments, etc.) and action plan to address potential behavioral and/or physical decompensation
- Review of symptoms to identify when Jacob may be in crisis and potential triggers to a crisis situation.
- Resources to contact in the event of a crisis (i.e. BH providers, crisis line, community crisis resources, 24-hour nurse line and BH crisis line numbers, etc.).

Once completed, the Crisis Prevention Plan will be shared with Jacob's providers. If needed, the CM Team will present Jacob's case in Internal Integrated Care Rounds to consult with PH and BH medical directors.

RESOURCES

Provider Partnerships

[redacted]

Primary Care. To establish a health home for Jacob, his CM will suggest he see a PCP at Southwest Louisiana Primary Health Care Center's location in Lafayette.

Innovative Programming

Jacob's CM will connect his family with LHCC's Health and Wellness platform, which provides 24/7 access to an LHCC Peer Support Specialist via telephone or mobile device.

INFRASTRUCTURE

Support for Enrollee

Jacob's parents will have access to the secure Member Portal, enabling them to view Jacob's health information and POC, and communicate with his CM and other staff as needed at LHCC.

Support for Providers

Jacob's CM assists his family in identifying providers, including a dentist, who have received training in trauma-informed care (TIC). If necessary, the CM will connect Jacob's providers with LHCC's nationally recognized TIC training to help them understand the effects of trauma on development and particularly on behavior in both children and adults. The training aligns with ACES and focuses on recovery and resiliency.

IT Systems

Below is a sample of LHCC's technology tools for case management:

Identification / Stratification / Monitoring	Other Tools for Care Management Staff	Support for Provider	Support for Enrollee/Caregiver
•**Predictive Models** supports identification and risk stratification for enrollees who may need case management •**Interpreta** identifies emerging health issues before they become significant health conditions (care gaps) •**ADT** data near real-time from the Louisiana Health Information Network-Encounter Notification Service (LHIN-ENS)	•**TruCare** for collaborative case management and UM. Houses the POC. •**Unite Us** for referring enrollees to community partners to address SDOH needs	•**Provider Portal** supports "self-service" capabilities, including eligibility inquiry, authorization submission / status, claim submission / status, clinical applications	•**Mobile apps** integrated mobile "one stop shop" for enrollees, free of charge

2.10.6 CASE SCENARIOS [5 PAGE LIMIT PER SCENARIO]

2.10.6.3 Case 3: The Proposer has an enrollee who is a 65 year old Medicare-eligible male with a history of schizoaffective disorder, bi-polar sub-type. He has a history of medication non-compliance, suicide attempts, and multiple psychiatric hospitalizations with the last occurring several months ago. The enrollee has high blood pressure and suffers from chronic pain and weakness due to unspecified neuropathy. Though his chronic pain and subsequent weakness is limiting his ability to ambulate independently, the majority of his functional deficits are due to anxiety in performing tasks and/or not having proficiency in completing tasks independently. The enrollee is currently residing in a nursing home, though a recent evaluation of functioning by the state authority indicates he no longer meets eligibility for this level of care. Additionally, assessments by clinicians affiliated with the Pre-Admission Screening and Resident Review (PASRR) Level II office indicate the nursing home is not the least restrictive setting. He is estranged from his family and was evicted from his apartment during his nursing facility stay but expressed his preference to return to his previous apartment or another apartment. He has a history of frequent emergency department visits prior to his nursing facility stay for both physical health and behavioral health causes. Describe how the Proposer will manage care to transition him into the community and achieve the best health and behavioral health outcomes for the enrollee.

APPROACH TO SERVING THIS ENROLLEE

John is automatically identified for intensive case management when clinicians performing his PASRR Level II evaluation find that the nursing home in which he resides is not the least restrictive setting so he falls into the target population covered by Department of Justice (DOJ) Settlement Agreement on Case 3:18-cv-00608. John is in the process of transitioning from a nursing home (NH). As required, John will begin to receive case management prior to leaving the NH and will continue to receive it for at least 12 months after his transition.

Stratification and Assessment

Our specialized DOJ Transition Team (DOJ Team) brings together behavioral health (BH) and physical health (PH) care management expertise and our Housing Specialist to meet John where he is based on the information discovered during the PASRR evaluation, work with him to identify his goals, remove any barriers that might prevent him from returning to live in the community and help him achieve the best health outcomes. Because of his involvement in the DOJ Settlement Agreement population, multiple comorbidities, and frequent psychiatric hospitalizations, John qualifies for Tier 3 Intensive Case Management. A Licensed Mental Health Professional will serve as his lead CM, communicating with John and his circle of support to develop his person-centered Plan of Care.

Medicare Eligibility. Our DOJ Team assesses John to determine all available benefits and resources that may be available to him as a senior. When they learn that John is Medicare-eligible, the DOJ Team assists him in applying for Medicare coverage and utilizing the Eldercare Locator Tool offered by the U.S. Administration on Aging to connect him with additional supports. Depending on the type of Medicare eligibility, the enrollment process could take as little as 1 – 2 months or as many as 24 months.

Review of Health History. Prior to working with John to develop his person-centered Plan of Care, the CM reviews all records available within our systems, including his previously completed Health Needs Assessment which contains a screening for social determinants of health (SDOH), and any electronic medical records (EMRs) available from previous providers. The CM also reviews prior PASRR documentation and outreaches to the NH social worker to obtain medical records of the physical health care he received in the NH, schedule an in-person comprehensive assessment with John, and collaborate on his transition.

Comprehensive Assessment. The CM meets John at the NH to conduct a comprehensive assessment, including a full medication review, to help him determine what he needs for a successful and sustainable transition back into the community. The CM closely collaborates with the Office of Behavioral Health (OBH) Transition Coordinator. She asks about the results of his assessment of John; reviews John's needs with him; informs him that LHCC's comprehensive assessment has been scheduled and invites him to attend; provides updates about housing opportunities; and discusses the anticipated transition date.

The CM begins the person-centered process by meeting with John face-to-face to complete the Comprehensive Assessment. The CM asks him to tell the CM about himself. John describes that he wants his own apartment, not only to sleep, but to paint, and shows the CM one of his paintings. As the CM admires John's painting, John describes his love for painting. The CM has been trained in a strengths-based approach and takes the time to

discuss what is important to John, learning both his assets (e.g. painting) and needs (his own space). John says that his primary goal is to return to living in an apartment of his own, preferably in the New Orleans area where he was raised. He says he's also tired of being in pain, sometimes barely able to get out of bed in the morning, and wishes he were stronger and better able to take care of himself. The CM asks him about the report that he is anxious about performing tasks and John says the "anxiety" is because he has gotten out of the habit of doing things for himself and is worried that he is too weak, due to the neuropathy, to do them "right". The CM also asks him why he sometimes does not take his medications as prescribed and John reports that he had trouble with that when he was living alone before because "there are too many and it's too confusing." During this face-to-face meeting, John tells the CM that he has not seen his family for a long time, but he would like to see his sister and would like to have some "social life".

Behavioral health. As part of the Comprehensive Assessment, our CM works with John to identify how his chronic conditions may be impacting his quality of life and mood, and how LHCC can assist with improving his overall well-being. They discuss and assess John's prior history of schizoaffective disorder, bipolar subtype; as well as his previous suicide attempts, including known triggers, the nature of the attempts, and previous and current interventions. The CM administers a Columbia-Suicide Risk Severity Rating Scale and develops a suicide prevention plan with John. In addition to addressing John's known BH conditions, the CM assesses for additional BH symptoms, using the Patient Health Questionnaire (PHQ-9) to screen for depression and the CAGE Substance Abuse Screening tool for substance use disorders (SUD). The CM asks John about his reported anxiety in performing tasks independently and assesses the need for ongoing mental health and psychiatric services post-discharge from the NF.

Physical health. The CM collaborates with John's primary care provider (PCP) to determine whether John has been monitored for diabetes as his medications for schizoaffective disorder may increase his risk of developing diabetes. In addition and with John's consent, the CM discusses with the PCP John's pain and neuropathy diagnoses, confirming when they were diagnosed and what interventions he or his providers have used to address them. If a diagnostic evaluation of his pain and neuropathy have been completed, the CM requests the results. The CM will coordinate an evaluation for Physical and Occupational Therapy services with the PCP. If John is using pain medication, the CM will review the extent, frequency, history of the use, and identify the prescriber. The CM will assess John's risk for opioid misuse using his medication records and documented history in the NH.

Social determinants of health. Our priority SDOH assessment documents John's need for housing and related supports, as well as a need for social connectedness. Although John will be placed at the top of the Permanent Supportive Housing (PSH) waitlist due to his priority as part of the DOJ Settlement Agreement population, our Housing Specialist will continually assess John's progress toward PSH and will prepare a menu of transitional housing options for John to choose from until he is awarded PSH. John will be connected to LHCC's SDOH Centers of Excellence to continually assess and address additional needs that must be met to be able to live in the community independently.

ENROLLEE SUPPORT THROUGH CASE MANAGEMENT AND OTHER TOOLS

Person-Centered Care Planning

After the assessments are complete, the CM meets with John face-to-face again to develop a person-centered Plan of Care based on John's stated goals. The CM assures John that LHCC can put supports and services in place so he can live independently in his own apartment. In developing the Plan of Care, the CM works with a Multi-Disciplinary Team (MDT), which includes John, his sister who has agreed to participate, his PCP and other outpatient providers, the NH, the CM and the OBH Transition Coordinator. The Plan of Care addresses John's PH, BH and SDOH needs; particularly housing, safety, food security, and social connectedness. After the Plan of Care is developed and reviewed with John and he signs it, the CM gives John a copy, makes it available on both the Member and Provider Portal, and forwards a copy to John's PCP. Subsequently, the CM will meet face-to-face with John at least monthly at the location John prefers, update his Plan of Care at least monthly, and formally re-assess John, in person, at least quarterly or upon any change in condition.

Transition Into the Community

Our DOJ Team helps John develop his Transition Plan to successfully transition back to living in the community. The Transition Plan includes securing appropriate housing, ensuring that John feels prepared to perform daily functions, putting the outpatient services he needs in place, and confirming that additional SDOH needs are addressed. After John transitions back into the community, the DOJ Team will help John coordinate appointments with his providers, schedule appointments as needed with specialists, and continuously reassess his needs in his new setting.

Written Transition Plan. When John is ready to discharge from the NH, the CM will provide him with a written Transition Plan, which will include post-discharge appointments, list of medications, patient education and self-management strategies, and the CM's contact information.

John's Goals	Person-Centered Plan of Care
I want to live in my own apartment.	• Work with LHCC's Housing Specialist, Permanent Supportive Housing (PSH) Liaison and the OBH Transition Coordinator to help John complete the application for the PSH Program, including John's preference for living in the New Orleans area. Maintain timely communication with LDH PSH staff. • Connect John with pre-tenancy and tenancy support services. He's lived alone before but wants a refresher on paying bills including rent. • With John, complete the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPAT) and help him enroll in the HUD Homeless Management Information System to access HUD housing opportunities. • Develop plan for transitional housing and supports through an organization like Unity of Greater New Orleans while John is awaiting PSH. • Arrange Assertive Community Treatment (ACT) to begin after his transition to the community and coordinate a referral from the ACT provider to a psychiatrist. • Connect John with LHCC's transportation vendor for non-emergency medical transportation to his medical appointments. • Arrange for John to receive a SafeLink Wireless phone, preprogrammed with phone numbers for him to contact any member of his MDT, the Nurse Advice Line, the BH Crisis Line and 911. • Once permanent housing has been secured, continue to coordinate SDOH needs through our SDOH Centers of Excellence.
I want to have less pain and feel stronger so I can take care of myself.	• Based on the findings of the PT/OT assessment, [redacted]. Continuously assess the efficacy with John. • Refer John to New Orleans Resources for Independent Living (NORIL) for additional life skills training. • Connect John with exercise programs at senior centers run by the New Orleans Council on Aging to address balance, endurance, and strength. • Assess whether John requires equipment to improve his mobility and stability while performing functions, such as an elevated toilet seat and shower grab bars in the bathroom. Ensure there are no tripping hazards such as throw rugs in his apartment. • Work with John's PCP to address the complications and possible causes of unspecified neuropathy and to try alternative pain management such as chiropractic, acupuncture, and/or therapeutic massage.
I want to reconcile with my sister and make new friends	• To address potential social isolation and loneliness (which contribute to high blood pressure and a recurrence of suicidal ideation), help John access Connect2Affect, an AARP program that provides a social isolation risk self-assessment and related resources. • Connect John to peer support at NORIL and programs at his local senior center. • With John's consent, contact his estranged sister to inform her that John is transitioning out of the NH and secure her agreement to be part of his circle of support.

Coordination with Medicare

Upon John's enrollment in Medicare confirmed through MARx, the Medicare enrollment and payment system, the DOJ Team will adjust John's Plan of Care to recognize that services including primary care and PT/OT are now covered by Medicare. The Medicare care manager will be added to John's MDT and the DOJ Team will collaborate with the Medicare care manager to coordinate services and supports for John, prevent duplication, and ensure that no gaps arise.

Assessment and Reassessment

LHCC's experience shows that post-transition monitoring will be a key element of John's successful transition to home. For example, once John is successfully transitioned into the community, the CM will conduct a face-to-face follow up visit with John within 72 hours following his discharge to ensure services are being provided according to the Transition Plan. The CM coordinates this face-to-face visit with a home evaluation by John's PT/OT providers to ensure that his new apartment provides a safe environment, is free of tripping hazards and is equipped with appropriate features like grab bars that empower John to continue living independently. If a PT/OT assessment after John is living independently determines that he requires Personal Care Services (PCS) through Fee-For-Service Medicaid, the CM will assist him in contacting the Long-Term Care Access Services Office for an evaluation of his need for PCS.

With John's MDT, the CM continues to manage John's care for at least one year after his transition out of the NH and into the community. The CM assesses and reassesses at regular intervals any barriers to services and interventions, monitors continuation of services and coordinates care as needed. If the CM observes consistent signs of stability, John's case status may be transitioned to medium acuity and face-to-face visits (including updates and reassessments) will be completed no less than quarterly. The CM will offer John referrals and will remain available, as needed, if he chooses to opt out of case management services at any time.

Other Care Coordination

The CM enrolls John in LHCC's Medication Therapy Management Program in which a pharmacist will assist John and his providers in optimizing his therapeutic outcomes and avoiding adverse events. It will begin with a comprehensive, interactive medication review, including identifying drugs that are high risk in older adults, and continue with frequent monitoring and interventions as needed.

With John and his MDT, the CM also explores the use of a Long Acting Injectable Medication to support stability of John's BH symptoms.

Housing. Our Housing Specialist will conduct ongoing coordination with the PSH Program and any additional providers of housing and housing support services that John needs in order to be successfully independent in the community. This might include, but is not limited to, collaboration with LDH, the Louisiana Housing Corporation, Unity of Greater New Orleans, NORIL, and other community based organizations identified in John's Plan of Care.

Coordination of Physical Therapy and Occupational Therapy. The CM collaborates with John's PCP to coordinate a Physical Therapy (PT)/Occupational Therapy (OT) evaluation to identify therapy services that will help John overcome both the neuropathy that is limiting his ability to ambulate independently, and the anxiety over performing tasks independently that is limiting his ability to perform other Activities of Daily Living (ADLs).

Other Enrollee Support Tools

Enrollee Education and Support. The CM works with John's PCP to provide education about:

- Hypertension and the importance of medication adherence
- Options other than the ED such as the Urgent Care Clinics in his area and LHCC's Nurse Advice Line and BH Crisis line, which are available 24 hours a day, 7 days a week
- Preparing nutritious meals, emphasizing the importance of good nutrition to ensure that the medications he takes for his BH disorder do not cause him to develop diabetes.

Crisis Planning

With John and the MDT, the CM coordinates a Crisis Prevention Plan that addresses: symptoms to identify when John may be in a crisis situation and potential triggers; frequency of interventions (outpatient appointments, etc.); an action plan to address potential behavioral or physical decompensation (e.g. John's pain management); resources to contact in the event of a crisis (i.e. BH providers, community crisis resources, 24-hour Nurse Line and BH Crisis Line numbers, etc.); and contact information for the MDT. Once completed, the CM will share the Crisis Prevention Plan with John's providers. If needed, the CM will present John's case in LHCC's Internal Integrated Care Rounds during which she can consult with LHCC's PH and BH Medical Directors.

RESOURCES

Provider Partnerships

[redacted]

INFRASTRUCTURE

IT Systems

Below is a sample of LHCC's technology tools for case management:

Identification / Stratification / Monitoring	Other Tools for Care Management Staff	Support for Provider	Support for Enrollee/Caregiver
•**Predictive Models** supports identification and risk stratification for enrollees who may need case management •**Interpreta** identifies emerging health issues before they become significant health conditions (care gaps) •**ADT** data near real-time from the Louisiana Health Information Network-Encounter Notification Service (LHIN-ENS)	•**TruCare** for collaborative case management and UM. Houses the POC. •**Unite Us** for referring enrollees to community partners to address SDOH needs •**Appointment Wizard** allows LHCC Customer Service to offers members real-time appointment scheduling	•**Provider Portal** supports "self-service" capabilities, including eligibility inquiry, authorization submission / status, claim submission / status, clinical applications •**Patient Analytics** dashboard allows access to patient disease registries to view critical information including care gaps	•**Member portal** offers enrollees online access to their LHCC information and several "self-service" functions such as viewing their clinical services and medication history, changing PCPs, updating contact information or taking an online health needs assessment. •**Mobile apps** integrated mobile "one stop shop" for enrollees, free of charge

SECTION 2.10.7

Provider Network

I work with Special Programs as the Liaison for Pediatric Day Health Centers (PDHC). A PDHC is a special type of day care for the medically fragile child. I assist the providers and visit the sites to observe our medically fragile members. Meeting the providers face-to-face has enhanced their relationship with our health plan. And it allows me to assist them with any questions they may have and to help to streamline their authorization process.

—Ginger W. Lynch
Medical Management
Louisiana Healthcare Connections

2.10.7 PROVIDER NETWORK [ATTACHMENTS ONLY, NO NARRATIVE; EXEMPT FROM TOTAL PAGE LIMIT]

2.10.7.1 The Proposer shall provide an electronic list of all providers within its network, by provider type pursuant to the Provider Network Listing Response Template located in the procurement library. Where indicated, the list should include information on the provider's name, location, specialties, languages spoken, whether the provider is accepting new patients and their accessibility for persons with mobility disabilities. Where the Proposer is not currently participating in the Louisiana Medicaid managed care program, the Proposer should also submit the template for its letters of agreement to participate in the Proposer's network under the resultant Contract. The Proposer should include a summary table of its provider network listing with total provider counts by provider type and by parish. The response should be in Excel format.

2.10.7.2 The Proposer should submit documentation that its provider network meets or exceeds the time, distance and ratio requirements as detailed in Attachment D to the Model Contract using the Provider Network Capacity Response Template located in the procurement library. The response should be in Excel format.

Per the RFP, 2.10.7.1 Provider Network Listing Response and 2.10.7.2 Provider Network Capacity Response have been provided as part of the electronic copy submission in lieu of hard copy. This information is exempt from section-specific and total page limits.

SECTION 2.10.8

Network Management

I am writing to express my appreciation to Louisiana Healthcare Connections as we have enjoyed an excellent relationship in serving their patients. They continue to be open to identifying new ways we can work together to keep patients healthier while reducing the overall cost of care and improving outcomes, leading to a more productive community.

—Paul Molbert
Lafayette General Health

2.10.8 NETWORK MANAGEMENT [15 PAGE LIMIT]

The Proposer should demonstrate how it will ensure timely access to culturally competent primary and specialty care services, necessary to promote LDH's goals. Specifically, the proposal should include:

Louisiana Healthcare Connections (LHCC) successfully developed and maintains a comprehensive Medicaid provider network, offering enrollees timely access to culturally competent primary, behavioral health (BH), and specialty services by:

LHCC ENROLLEES REPORT TIMELY ACCESS TO CARE

In our 2018 CAHPS survey, 95% of pediatric and 82% of adult enrollees reported a positive response when asked if they were able to get care quickly

- ***Continuously analyzing and refining our network to meet evolving enrollee needs***. Our Network Development and Contracting Team (Contracting Team) conducts continuous network monitoring, formal recurring cross-departmental assessments, and solicits external input to ensure timely access to all covered services (see RFP 2.10.8.1). LHCC complies, and will continue to comply, with all applicable requirements in 42CFR §438.12, §438.14, §438.207 (c), § 438.214; State requirements; the RFP, Model Contract including Section 2.9, and Attachment D.
- ***Creating a high-value network***. Our network of more than 22,000 contracted providers ensures enrollee access in every parish in the State. As an incumbent with seven years of experience in Louisiana, we continually refine our contracting approach to focus on recruiting and retaining providers that provide the most efficient, culturally competent, and highest quality care. This aligns with LDH's goals to advance evidence-based practices, high-value care, and service excellence. [redacted]
- ***Prioritizing Provider Satisfaction and Retention***. *Less than one percent of network providers have terminated their contracts with LHCC* for reasons other than closing their practice or moving out of state. The vast majority of our provider contracts have been in place, without interruption, since 2012. We have accomplished this, and consistently maintained high rates of provider satisfaction, in two major ways:
  - Adoption of the Quadruple Aim. We take the Triple Aim one step further through our adoption of the fourth leg of the Quadruple Aim: improving provider satisfaction and experience. For example, in 2014, Community Health Solutions of America, Inc. (CHS) assigned its shared savings contract under the Bayou Health to LHCC. Through this agreement, we honored CHS's current payment structure – despite not having implemented similar arrangements at that time – to ease their transition to managed care and demonstrate our commitment to keeping providers whole.
  - Empowering Physicians to Lead. Providers are the backbone of Louisiana's Medicaid Program and, over the last seven years, LHCC has established physicians in leadership positions (such as with our majority physician-led Board of Directors) that inform our strategic direction and day-to-day operations, including related to culturally competent network design and provider satisfaction efforts.
- ***Focusing on Health Equity.*** We are committed to meeting the primary, BH and specialty needs of all enrollees, including those detailed in Model Contract 2.9.9.2 and with Limited English Proficiency (LEP), disabilities regardless of race, religion, sexual preference, or national origin ancestry. Through initiatives and strategic contracting activities that are based on data driven population assessments, we reduce disparities related to health and social determinants of health (SDOH) and increase access to care. These efforts are guided by our Cultural Competency Plan and supported by our CLAS Task Force (*see* 2.10.8.5 for details).

2.10.8.1 Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);

LHCC has established our comprehensive network on the following premise: network adequacy is more than having the right number of providers; it is having those providers that are best able to meet the complete needs of enrollees and eliminate barriers to access. Our approach to identifying network gaps and access issues goes beyond geomapping analysis and incorporates a local understanding of Louisiana, the Medicaid program, and the provider landscape in each region. We also consider numerous additional factors (detailed below) such as population characteristics and demographics, patterns of care, SDOH needs/barriers, and provider capacity - including ratios, appointment availability, panel status, willingness to accept Medicaid enrollees, and urgency of

the need for services. For example, LHCC understands that many enrollees, specifically Medicaid Expansion adults, often require access to after-hours and weekend primary care and clinic availability to accommodate their work schedules. To ensure timely access to these services, we offer enrollees access to after-hours clinics in each parish, nearly 100 locations statewide. We complement this access through 37 (of over 220 contracted) FQHCs that offer after-hours clinic availability in 24 parishes, and by supplementing the Medicaid fee schedule for any provider offering care after normal business hours.

Following implementation of after-hours incentives in November 2015, ***providers offering after-hours services increased*** *from 19.2% in 2014 to 26.8% in 2018*

Cross Functional Accountability for Assessing our Network

LHCC's annual assessment and resulting Network Development and Management Plan ("Network Plan") guides our contracting efforts, and our formal quarterly assessments ensure we stay on track with the Network Plan. We conduct daily, weekly, and monthly monitoring to identify opportunities prior to the next quarterly assessment, and to confirm we are meeting LDH adequacy standards and quality objectives. We will continue to comply with all reporting requirements to demonstrate accessibility and availability of covered services. LHCC holds our entire staff responsible, and implements a "no wrong door" approach to ensuring enrollees have timely access to services. Regardless of how staff identify an access issue, they notify our Contracting Team directly or through our Provider Lifecycle Management System, which allows automatic, electronic communication of network needs.

Our Contracting Team participates in recurring meetings with staff to discuss access, such as:

- Medical Management, to conduct a monthly regionally-focused, data-driven network analyses, including review of single case agreements (SCAs) and enrollee utilization metrics that may impact adequacy.
- Quality Assessment and Performance Improvement Committee (QAPIC), quarterly, to review the previous quarter's network adequacy data to determine what refinements, if any, are needed to our network design. Participating staff in QAPIC meetings include: Executive Leadership and UM, Medical Management, Care Management, Provider Engagement and Provider Performance Management.

Incorporating Stakeholder Feedback into Network Design

LHCC staff regularly solicit and receive network adequacy input from local stakeholders such as Member, Physician, and Community Advisory Committee members; State and local medical and provider associations; network primary care, BH, and specialty providers; and community organization partners. Quarterly, our staff also facilitate Joint Operating Committee meetings with vendors, hospital systems and other large provider groups to discuss potential adequacy and access issues as a routine part of the agenda. These stakeholders are critical to helping us understand local communities, enrollee characteristics and patterns of care, and barriers to access (such as transportation or SDOH issues). They provide key input into relevant solutions for these issues.

Metrics, Data, and Information Analyzed to Identify Gaps and Access Issues

Using the above methods and frequency, our Contracting Team and cross-functional staff compile and analyze numerous data and information as further detailed in the table below to proactively identify network gaps and ensure timely access to culturally competent and disability accessible primary, BH and specialty services:

Data Source/Information	How Data Helps LHCC Identify Gaps/Access Issues
Parish-level geoaccess mapping; provider-to-member ratios; and panel status reports	Confirms the availability of providers considering distance/travel time from enrollees' residences and identifies potential capacity issues.
Appointment Availability Audits	Proactively identifies potential capacity and access issues as well as provider compliance with network standards. Also confirms adequate access to after-hours and weekend care for enrollees.
Population Health, SDOH, and Cultural Competency Needs Assessments	Overlays network with enrollee characteristics/needs and potential enrollees to identify network gaps/access issues based on disease prevalence, SDOH barriers, and geographic, racial, ethnic, linguistic, or other disparities. Identifies providers with capacity to appropriately address enrollee needs.
Current and Anticipated Enrollment and Utilization by Zip Code	Considers enrollee demographics and health care needs, as well as network capacity or gaps based on these needs.

Data Source/Information	How Data Helps LHCC Identify Gaps/Access Issues
SCAs, Out-Of-Network (OON) Utilization Reports, and Authorized Transportation Reports (for enrollees who travel more than 50 miles to a provider)	Identifies potential provider availability issues by region/provider type (categorized by type for population served, services authorized) and enrollee patterns of care trends. Also identifies potential contracting and/or workforce development opportunities.
CAHPS; Provider Satisfaction, other Survey Results; Complaints, Grievances/ Appeals	Identifies enrollee and provider satisfaction issues and complaint trends related to access, accessibility, and appointment availability.

NETWORK GAPS/ACCESS CHALLENGES IDENTIFIED BASED ON CONTINOUS MONITORING/LOCAL KNOWLEDGE

LHCC has continuously demonstrated our ability to ensure consistent, timely access to *all* covered services for *all* enrollees. Through the efforts detailed above, supplemented by our local expertise and experience, we know how to resolve network deficiencies or access issues should they occur. We have executed contracts with more than: 2,400 PCPs, 2,000 BH providers, 1,700 ancillary providers, 165 hospitals, 220 FQHCs, and 19,000 specialists. We embrace LDH's efforts to continuously enhance adequacy standards to ensure that 100% of all Medicaid recipients have access to all provider types. However, with the more rigorous standards detailed in Attachment D, LHCC has identified some areas of non-compliance with time/distance standards that did not previously exist. LHCC will always ensure that our enrollees receive the covered services they need, from the most highly qualified providers, regardless of any challenges we may encounter. LHCC understands and will comply with Model Contract Section 2.9.6, should requests for exceptions to access requirements be necessary.

Compliance with Ratio and Time and Distance Standards

In all nine regions, LHCC exceeds LDH's Provider Ratio Standards. Our most recent geoaccess analyses indicate that the majority of LHCC's statewide network meets or exceeds LDH's *new* time and distance standards at the parish, regional, and statewide levels. For the provider types listed in the Provider Network Capacity Response Template and RFP Section 2.10.8.3, geomapping analyses identified network gaps (per standards detailed in Attachment D) that are detailed below. For this analysis, we consider LHCC to have met requirements if 99.5% (or above) of all potential enrollees (more than 1.5 million) have access under these standards. Of the network gaps identified, numerous are in LDH-designated urban parishes that have rural characteristics, for example, Cameron, Plaquemines, and Grant parishes.

Primary Care, Pediatric, and OB/GYN Access. LHCC's network meets LDH access standards for both adults and children in rural parishes for access to two PCPs. Our network also meets adult PCP time/distance standards for access to 1 PCP within 10 miles for 97.5% of adult enrollees and 97.2% of pediatric enrollees in urban-designated parishes. Further, although 94% of all potential enrollees have OB/GYN access in urban parishes and 96.2% in rural parishes, we identified gaps in certain parishes in every region.

Specialty Access. LHCC's latest geomapping analyses indicates that we meet time and distance standards for numerous specialties statewide, including cardiology (pediatric and adult), gastroenterology, neurology, ophthalmology, hematology/oncology, orthopedics (pediatric and adult), otorhinolaryngology/otolaryngology, nephrology, and urology. We have identified gaps for dermatology (for parishes in Regions 1, 5-8), endocrinology/metabolism (for parishes in Regions 1, 5-8), and pulmonology (for parishes in Regions 1, 6-8).

Behavioral Health. Louisiana faces a statewide shortage of licensed and qualified BH providers, and we identified gaps for psychiatrists in urban parishes statewide and in rural parishes in Regions 4-8; and Licensed Mental Health Specialists in Regions 1-3 and 5-9. Although LHCC meets time and distance standards, statewide, for American Society of Addiction Medicine (ASAM)-Certified Providers for pediatrics; Louisiana has shortages of ASAM-certified providers for adults:

• ASAM 3.3/3.5, urban shortages in Regions 1-3 and 5-9	• ASAM 3.7, urban shortages in Regions 1 and 7
• ASAM 3.3/3.5, rural shortages in Regions 3-9	• ASAM 3.7, rural shortages in Regions 6-9

Other Identified Network Access Challenges. Through our established provider relationships and a deep understanding of the Louisiana landscape, we have identified access challenges that go beyond basic geomapping and address the multi-layered needs of enrollees:

Psychiatric Residential Treatment Facilities (PRTFs). LHCC meets statewide time and distance standards for PRTFs; however, these facilities are over-burdened because criminal youth are often directed there by DCFS and Family Court Judges. This and the lack of secure units has forced enrollees to go out of state for PRTF services.

Access to Post-Acute Care, Long Term Acute Care, and Home Health Services. Although LHCC contracts with and meets standards for adult and pediatric home health and Long Term Acute Care (LTAC) providers statewide, many of these providers do not readily accept Medicaid enrollees. As a result, hospitals have difficulty securing appropriate post-acute services (such as home health) to facilitate timely discharge, increasing the average hospital length of stay. This specifically effects adult Medicaid expansion enrollees who tend to have a higher need for wound care and IV antibiotics to limit infections.

Intermediate Care for Behavioral Health. Psychiatric Intensive Outpatient (IOP) Services is not a Medicaid covered service in Louisiana, which leaves few options available to support more intense outpatient BH treatment to avoid inpatient hospitalization, and for enrollees to step down from an inpatient psychiatric stay to a less intensive and restrictive treatment setting. This can result in higher psychiatric inpatient admissions, readmissions, and ED utilization, and longer lengths of inpatient stay.

2.10.8.2 Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;

When LHCC identifies a network gap, or enrollee access issue, we deploy the following overarching strategies:

- ***Short term solutions*** that provide all medically necessary services required to meet immediate enrollee needs, even if those services are not available from a contracted provider. Solutions may include requesting PCPs open panels, expand their scope of services, or serve more enrollees; asking providers contracted in other LHCC programs to expand participation to Medicaid; providing transportation to the closest network providers available; facilitating OON service authorizations or SCAs with an OON provider pursuant to the Model Contract, including Sections 2.9.2 and 2.9.5; and through comprehensive telemedicine services.
- ***Longer term strategies*** that often improve access for all Medicaid enrollees through innovative provider partnerships and capacity expansion initiatives that increase or create access where none previously existed. These strategies are deployed via multiple methods: helping to finance additional brick and mortar provider sites; supporting providers and/or community partners to increase access points; innovative value-based arrangements that incentivize expanding capacity (i.e. after-hours clinic availability); and creating or providing funding for new telemedicine, telehealth, or technology solutions that increase access anywhere.

Below we detail innovative provider partnerships, investments, and capacity expansion initiatives that LHCC is developing (or has implemented) to address the network gaps and access/capacity issues identified in 2.10.8.1. Through these partnerships and investments – LHCC is creating Medicaid-tailored access where there was none before – benefiting all Louisianans, not solely our enrollees.

Targeted Strategies to Expand Primary Care, Pediatric, and OB/GYN Capacity

[redacted]

[redacted]

Targeted Strategies that Expand Specialty Care Capacity

The strategic partnerships below, and our comprehensive telemedicine and telehealth solutions (described below), will *expand specialty capacity* to address gaps identified in 2.10.8.1:

[redacted]

Targeted Strategies that Expand Behavioral Health Access

Innovative strategies described below will expand existing capacity to address BH network gaps or access issues:

[redacted]

Targeted Strategies that Address Other Identified Access Challenges

LHCC is implementing the innovative solutions below to address other identified access challenges:

[redacted]

[redacted]

Mobile Solutions. LHCC has contracted with 17 providers that offer mobile solutions to expand access to physical, BH, and/or dental services in six regions. Through these provider-partnerships, we will continue to expand access in areas that have network gaps. [redacted].

Telemedicine and Telehealth. Our comprehensive telemedicine and telehealth strategy will provide additional access to primary care and specialty services throughout the state, as detailed below:

Solution/ Partner	Telemedicine, Telehealth, and Telemonitoring Services Provided
Physical Health	
[redacted]	[redacted]
Lafayette General Medical Center (LGMC)	Telehealth Virtual Visits: LGMC will provide LHCC enrollees in Acadiana video access to a nurse practitioner 24/7 through the LGMC mobile app. If the enrollee is not paneled with LGMC, LGMC will secure message the PCP of record to inform them of the visit.
Behavioral Health	
[redacted]	[redacted]
South Central Louisiana Human Service Authority (SCLHSA)	SCLHSA will offer LHCC enrollees BH telehealth services from all BH centers using their own licensed BH staff. LHCC will pay the origination fee to encourage adoption of BH telehealth services if access to an appropriate BH provider is not available in person. SCLHSA has four BH centers: Lafourche, River Parishes, St. Mary and Terrebonne.
[redacted]	[redacted]
Quartet	Quartet will provide enrollees remote BH services access, such as online therapy and virtual BH. Quartet also facilitates e-consult services, from BH providers for physical health providers, to bolster the quality of care delivered in the PCP's office for members with mild BH needs.
On Demand Health	
Teladoc	Offers access to primary care and BH providers through the enrollee's phone or laptop computer.

Border Providers. If needed to address a gap in border regions of the State, and when doing so would support existing patterns of care, we offer enrollees access to providers contracted with our affiliates in the bordering states and counties in Arkansas, Mississippi, and Texas. For example, our network analysis revealed that the pattern of care for enrollees residing in Vidalia, on the eastern border of Concordia Parish was to obtain OB/GYN, Orthopedic, and Nephrology services in Natchez, MS due to lack of these providers within proximity to Vidalia.

LHCC honors this pattern of care through contracts with these specialists in Natchez.

2.10.8.3 Strategies (including a description of data sources utilized) for monitoring compliance with the provider network standards in Attachment D to the Model Contract for the following provider types and supporting enrollees and…

Continuous, locally-informed data analysis and transparent collaboration with LDH and provider partners, as described above (see 2.10.8.1), is key to our strategy for monitoring compliance with provider network standards in Attachment D to the Model Contract for all providers, including those listed in Section 2.10.8.3.

98%
of LHCC enrollees reported they can get specialist care for their children as soon as they need it. (2018 CAHPS)

Monitoring Compliance with Time/Distance and Ratio Standards

We conduct continuous/daily monitoring, supplemented by quarterly geoaccess mapping, monthly ratio analyses, and ongoing analyses of multiple data points, such as claims and utilization, patterns of care, and SCAs. On a quarterly basis, we report compliance with time/distance standards and provider-to-enrollee ratios for each provider type identified in this section to LDH. We are enhancing our approach for the listed providers by conducting monthly geoaccess mapping (vs. quarterly) and provider-to-enrollee ratios weekly (vs. monthly).

Monitoring Compliance with Appointment Availability and After Hours Access Standards

For each of the provider types listed, LHCC uses a statistically valid sampling methodology to conduct appointment availability and after-hours access audits quarterly, auditing the entire network over the course of one year. Our third party vendor conducts appointment availability audits via "secret shopper" calls to providers to confirm compliance with Attachment D. The auditor asks the provider for the next three available appointment times for the appointment category being audited, depending on the provider type. For example:

- ***PCPs*** (pediatric and adult): We audit emergency care, sick, and routine appointments
- ***OB/GYNs***: We audit appointments by trimester, for family planning, and for high-risk pregnancies
- ***Licensed Mental Health Specialists and Psychiatrists (pediatric and adults)***: We audit non-urgent, urgent, inpatient (emergency, voluntary, and involuntary) as well as withdrawal management, and PRTF availability
- ***Specialist***: We confirm that all specialist appointments are available in less than 30 days
- ***After-hours***: A provider must answer or a designated practitioner must return the call within 30 minutes.

Providers that do not meet LDH standards fail the study. LHCC PE Specialists reach out to these providers to re-educate them on their contractual obligations related to availability. We require all non-compliant providers to confirm availability that meets standards within 90 days, and we re-audit the office within 90-180 days to validate that the issue has been corrected.

LHCC also analyzes enrollee complaint and grievance data related to appointment access quarterly; PCP complaints related to specialty access monthly; and appointment access related CAHPS survey results annually. We analyze data and trends to identify and proactively resolve appointment access issues.

Provider-Specific Capacity Monitoring

Additional monitoring efforts, for the specific provider types listed include:

- ***Licensed Mental Health Specialists and Psychiatrists (pediatric and adults)***. Our monitoring efforts will incorporate onsite reviews and enrollee interviews for specialized BH providers.
- ***Specialists.*** Our Contracting and Provider Engagement Teams collaborate to confirm that PCPs are able to obtain specialist appointments, and identify where capacity issues may exist. In assessing network adequacy and compliance, we identify, and separately report on specialists with limited provider agreements (i.e. SCAs) and those that preclude access to appointments outside of the hospital.
- ***OB/GYN and PCPs***. We closely monitor OB/GYN and PCP (pediatric and adult) panels and encourage providers to maintain an open panel and accept new enrollees through outreach, education, and VBP arrangements. Quarterly, we assess panel status during site visits by PE Specialists and through telephonic secret shopper audits, during which we inquire whether the provider is accepting new Medicaid patients. Our full-time Provider Directory Specialists also will validate provider panels during recurring outreach

efforts via email, fax, and telephone. If a provider advises LHCC they are treating only existing patients, we track this response in our Provider Lifecycle Management System, and re-audit the provider next quarter.

Supporting Enrollees and Providers with the Scheduling of Appointments

LHCC supports the scheduling of appointments through a proactive, locally-based-and-proven strategy that incorporates staff support, technology, tools, and leverages innovative provider partnerships.

Staff Support. We provide focused appointment scheduling support based on an enrollee's condition or needs:

- CHWs address barriers to completing appointments (i.e. transportation, child care), schedule and offer appointment reminders, and advocate in-person during the visit, as needed. Where CHWs are embedded at a provider location, they offer enrollees real-time scheduling support. For enrollees in our BH Readmission Prevention Program, CHWs connect with enrollees prior to discharge to assist with scheduling post-discharge appointments.
- Call Center staff and Member Advocates support enrollees and providers by scheduling family-level appointments that allow the entire family to visit their PCP in one block of time. This reduces burden for enrollees and providers, and reduces the likelihood of no-shows.
- Member Advocates assist enrollees if they are perceiving difficulty scheduling an appointment, arranging transportation, and finding appropriate specialty or BH care.
- Care Management Teams assist enrollees in LHCC's Care Management Program in scheduling appointments for all types of services, provide reminders, arrange transportation as needed, and conduct follow-up.
- Our affiliate Envolve contacts enrollees to schedule diabetic eye exams and address associated care gaps.

Technology and Tools that Support Providers and Enrollees to Schedule Appointments. LHCC's technology solutions support appointment scheduling for all providers and enrollees. For example:

- **Specialist Referral Locator** addresses issues PCPs had with scheduling specialty appointments for enrollees and refers to our dedicated channel through which providers can obtain assistance securing appropriate referrals and appointments – within one business day. Member Advocates outreach to the requesting PCP and targeted specialists, then offer PCPs their choice of specialists with confirmed availability, enabling the PCP and enrollee to select the best-suited specialist for the enrollee's care.
- [redacted]
- **Appointment Wizard** supports real-time appointment scheduling via a secure, cloud-based portal. Call Center staff make outbound calls to enrollees with care gaps and with enrollee consent and direction, they schedule an appointment directly in the participating providers' system, without the need for multiple calls to and from provider offices. In 2018, we expanded outbound calls until 7:00 pm to improve outreach efforts to enrollees after working hours.

Innovative Provider Partnerships that Support Appointment Scheduling. [redacted]

2.10.8.4 Strategies for recruitment and retention efforts planned for each provider type, including quality and/or performance metrics that will be used to determine provider's success in making progress towards LDH goals for access…

Based on the results of the continuous network assessments described above (see 2.10.8.1), we implement short-term targeted recruitment strategies and long-term network building and retention activities, supported by high-touch, local, provider engagement staff. The cornerstone of these efforts are innovative infrastructure

development initiatives that both facilitate recruitment and enhance retention while also improving access and strengthening the quality of our network to meet or exceed LDH's goals. Below, we describe an example of one of these innovative initiatives.

Infrastructure Investments that Enhance Recruitment and Retention Efforts

Introduced above (*see* 2.10.8.2), three statewide integrated networks will enable us to recruit and retain the highest quality BH, primary and specialty care providers. These IPAs/ACOs provide infrastructure support, reduce administrative burden, empower individual providers, and encourage providers to open panels to LHCC and other Medicaid enrollees. Further, they allow providers who have not historically participated in VBP, or could not participate due to small membership volumes, a vehicle through which to participate.

- [redacted]

Additional Recruitment Strategies for all Provider Types

In addition to leveraging our statewide clinically integrated networks, for the primary, BH, and specialty care providers in RFP 2.10.8.3, and for all provider types listed in the RFP and Model Contract, we implement the following immediate actions to address network access or capacity issues:

- ***Encourage Out of Network Providers under SCAs to join LHCC's network***. Our Provider Engagement Teams work closely with providers under an SCA agreement, providing support and demonstrating our strengths as a partner, as a successful experience is critical to an out of network provider's decision to join our network.
- ***Deploy targeted, strategies for specific provider types***:
  - PCPs (pediatric and adult) – We initiate contracting efforts with PCPs who submit claims with a non-par status; engage non-par providers who appear on LDH's website; and collaborate with associations including the American Academy of Pediatrics for referrals.
  - Specialists – We review other Louisiana MCO network lists and SCA reports to identify non-par providers with which to initiate contracting efforts, and obtain agreements through hospital systems that incorporate contracts with their extensive specialist networks.
  - BH Providers – Through collaboration with LGEs, wraparound agencies, PRTFs, psychiatric facilities, and substance providers, we successfully identify, recruit and retain BH specialists.

Providers ranked overall satisfaction with LHCC at 76%: 11% above the benchmark rate of 68.1%. (2018 Provider survey)

- ***Use comprehensive third party data sources*** to help inform our targeted provider recruitment, such as review of CMS data, and use of competitive analysis tools like Zelis Network 360.®
- ***Collaborate with our statewide and national partners*** to identify high performing PCPs, specialists, and BH providers. In addition, network prospecting includes referrals from provider partners such as Ochsner, LCMC, Verity, Local Governing Entities (LGEs), PRTFs, and Centene national provider contracts.
- ***Analyze Potentially Preventable Event (PPE) Trends to Identify Potential Specialty Access Issues.*** Every six months, LHCC analyzes PPE trends to identify those regions with the highest rates, considers the major diagnostic categories driving those rates, and determines whether the root cause for each trend relates to an access issue for a specific specialty. We use this data to target certain specialties for recruitment.

Additional Retention Efforts for All Provider Types

High Touch Provider Engagement. The fourth leg of the Quadruple Aim (improving our providers' work life and experience with LHCC) guides our retention strategy and provider partnership approach. Our proactive, high-touch, local, provider-facing team of PE Specialists all live in the parishes in which they work, and focus on provider support, education, and satisfaction. Through monthly, bi-monthly, and quarterly meetings with providers, our PE Specialists provide critical support that increases retention and quality of care.

To support providers in managing their practice and providing efficient, effective care to enrollees, we will deploy field-based Clinical Nurse Liaisons (CNLs), strategically located throughout the State to support provider quality improvement and VBP advancement. In addition, our four Provider Educators (dedicated to claims, primary care, BH, or VBP) will offer in-person, and focused education to facilitate provider success in meeting LDH quality and access goals.

Payment Reform Strategies. Through the clinically-integrated high-value networks described above, we enable participating providers to engage in more advanced VBPs, which enhances provider satisfaction and retention. In addition, we increase provider satisfaction and retention through:

- **Innovative VBP arrangements** that meet providers where they are on readiness and engage them to move along the HCP-LAN continuum towards accepting greater risk.
- **Enhanced Reimbursement** to providers in certain markets where their specialty is needed to close an access or adequacy need. For example, we offered – and continue to offer – enhanced rates to providers to conduct PASRR screenings, and thereby increased access to this service and expanded the network.
- **Grant Funding and Incentives** to providers that offer integrated care, for example: to clinics to employ BH providers in primary care settings and to BH clinics to employ a PCP in a psychiatric specialty setting.

***Supporting the Basics*.** LHCC knows that paying a provider on time and correctly is fundamental to retaining satisfied providers, and we pay 99.5% of clean claims within 30 days. We also monitor timely and accurate claims payment and offer providers access to our highly trained Provider Claims Educator and Coding Analysts to improve claims submission and payment. These staff are supported by our dedicated Claims and Contract Support Team that research claim issues and facilitate appropriate resolution, such as provider configuration corrections. To further reduce administrative burden and support retention, we offer:

- **Accurate, timely, and simplified payment processes** centering on use of national EDI clearinghouses for claim submission, online claim submission and claim status inquiry tools, electronic funds transfer, and expedited claims processing for network providers
- **Streamlined administrative functions** as demonstrated by our paperless referral process, multiple entry points for authorizations, and a simplified prior authorization process
- **Physician practice management tools**: provider-tested and driven medical home strategies and integrated delivery system tools augmented by Centene resources to assist providers in accomplishing their objectives.

PERFORMANCE AND QUALITY METRICS USED TO FACILITATE PROVIDER PROGRESS TOWARD LDH GOALS

LHCC measures and supports provider progress towards LDH goals stated in the RFP, Model Contract, and other communications including to advance progress toward quality measures in Attachment G and meet access measures in Attachment D. PE Specialists and CNLs share relevant, actionable data and performance metrics with providers in a consistent and transparent manner. These data enable providers to identify, establish, and

track their own quality and efficiency performance on a frequent basis, course correct in a timely manner, and improve their patients' outcomes. Through this process, we also encourage, support, and promote PCP attainment of PCMH Recognition or Accreditation status, aligning with the Quadruple Aim and LDH goals.

Metrics Used to Determine Provider's Success in Making Progress Toward LDH Access and Quality Goals. LHCC considers numerous metrics to determine whether providers are meeting LDH and LHCC access and quality goals. We also understand that a provider's ability and capacity to appropriately deliver care, close care gaps, and prevent unnecessary utilization demonstrate whether enrollees have adequate access to quality care. As such, we consider metrics that include, but are not limited to the following:

Provider	Access and Quality Metrics Used to Determine Provider Success
All Providers Types	• Care gaps and care gap closure rates, high utilizers, and MLR • ED inpatient, primary care, pharmacy, and laboratory costs in comparison with peers • Claims data, including ED admissions and inpatient utilization, to identify PPE trends • Progress by quality indices and performance metrics based on HEDIS measures in Att. G • ADA accessibility, cultural competency, and linguistic capabilities • Accessibility based on enrollee and provider location • Appointment availability, including after-hours • CAHPS results related to access to care
PCP (adult and pediatric)	• Panel size and availability • Progress for top five quality measures based on highest number of non-compliant enrollees • Summary of progress by quarter compared to the progress of the practice TIN • Pharmacy Reports, including alternative drug reports
OB/GYN	• Rate of postpartum visit • Rate of women with previous pre-term deliveries that had Makena in prenatal period • Rate of C-Section deliveries • Rate of risk-adjusted preterm births • Long acting reversible contraceptives (LARC) administered 56-day post-partum
Behavioral Health	• Adherence to antipsychotic medications for enrollees with schizophrenia • Diabetes monitoring for people with diabetes and schizophrenia • Cholesterol and blood sugar testing for youth on antipsychotic medications • Follow-up post mental health admissions within seven days of discharge date • Initiation and Engagement of Alcohol and Substance Use Treatment
Specialists	• Follow Up After Inpatient Stays (both 7 & 30 days) • Controlling Blood Pressure • Comprehensive Diabetes Care: Controlling Disease Management sub-measures • Asthma Medication Ratio • Statin Therapy for Patients with Cardiovascular Disease

Through outreach, meetings, education, and provider scorecards, CNLs and executive or medical leadership help providers meet or exceed performance, quality, and access benchmarks using the metrics detailed above, delivered through frequently updated and actionable reports. We provide technical assistance and customized training for quality management and quality improvement purposes. For example, CNLs provide progress report cards and side-by-side comparisons during onsite provider visits to demonstrate performance. Our network management approach complies with Model Contract Section 2.9.7, to include the use of provider profiling and benchmarking data to identify and manage outliers. We incorporate enrollee and provider feedback, utilization and claims data, credentialing, and data analytics to continually improve the quality of our network.

2.10.8.5 Strategies to ensure that its provider network is able to meet the multi-lingual, multi-cultural and disability needs of its enrollees; and

The cornerstone of our strategy to ensure that our provider network meets the needs of its enrollees is our commitment to contracting the right providers. LHCC prioritizes recruiting providers who have traditionally served the State's Medicaid populations as they are familiar with the unique characteristics, disability needs,

and cultural considerations of the population. Our network includes a broad representation of providers, including safety net providers, which have historically served Medicaid enrollees and are familiar with the diverse cultures and needs of our State. For example, we contract and partner with community-based, locally staffed organizations (such as FQHCs) that employ providers experienced in addressing each communities' cultural and health care needs. Through provider-partnerships, such as CMG, we offer access to multi-lingual staff (English, Spanish, and Creole). In addition, LHCC's multi-faceted strategies to ensure our provider network fully meets the multi-lingual, multi-cultural, and disability needs of our enrollees incorporate:

In interactions with our team, enrollees overwhelmingly report that LHCC recognizes and addresses their cultural and language needs. *(2018 CAHPS)*

- Comprehensive network analysis and continuous monitoring efforts
- Offering providers continuing support via financial investments, education, tools, and technology
- Cross-departmental systemic focus on cultural and disability accessibility.

Network Analysis and Monitoring Ensure Multi-lingual, Multi-cultural, and Disability Needs are Met

LHCC's annual assessments analyze our enrollee population in each region to identify pockets of cultural groups and enrollees with limited English proficiency. We then overlay and compare this with network provider data to identify network gaps. This process enables us to pinpoint the linguistic and cultural expertise required to meet enrollee needs, identify the best providers to meet those needs, and develop targeted recruitment strategies. Further, we seek feedback from providers and enrollees, for example through CAHPS and provider-survey questions designed to identify potential disparities. Based on this collective data, we develop interventions to improve our network's cultural competency.

We regularly solicit feedback from staff who interface with providers, enrollees, and their communities to help identify barriers to care, including those that are disability-related; for example:

- Member, Provider and Practice Management Advisory Committees help us better understand the communities we serve, and obtain suggestions to improve cultural and ADA access in these areas.
- Population Health Steering Committee help us identify multi-lingual, multi-cultural, and disability needs of enrollees at a population level.
- SDOH Council provides valuable input about community level health equity issues that need to be addressed to facilitate better access.

Additional monitoring efforts that ensure providers are meeting enrollee needs include:

- Requiring providers to attest to having ADA compliant offices, conducting provider site visits to assess ADA accessibility, and tracking accessible facilities
- Tracking and trending enrollee and provider complaints related to culturally competent care, services available to enrollees with LEP, and ADA accessibility
- Verifying reasonable accommodations for enrollees with behavioral health conditions such as: delivery of materials in easily understood formats; accommodating service animals; allowing enrollees who are anxious around others to wait in a less populated area; scheduling appointments later in the afternoon for someone who takes medication at night for sleep; permitting caregivers to accompany enrollees to appointments.

If we identify a deficiency, our Provider Engagement Specialists educate and support the provider, develop a CAP if needed, and follow up within 90 days to confirm compliance.

Supporting Providers Efforts to Meet Cultural, Linguistic and Disability Needs

LHCC supports and educates providers to promote culturally competent services to all enrollees, including for those with disabilities. Key causes of provider inaccessibility include lack of awareness of disability access requirements, financial support, and lack of enforcement. We are committed to providing equal access to quality health care and services that are physically and programmatically accessible for enrollees with physical and mental disabilities. All network providers are contractually required to provide physical access, reasonable accommodations, and accessible equipment for enrollees with physical and mental disabilities. We will offer

providers financial support, in the form of one-time grants to help providers increase physical access and offer accessible equipment to enrollees.

Similarly, providers need focused support and education to meet the multi-lingual and multi-cultural needs of enrollees. To support provider efforts to increase accessibility and culturally competent services, we:

- Provide and track free Cultural and Disability Competency trainings to providers, including focused sessions about cultural humility and considerations when caring for patients with disabilities, and training related to American Indians. We offer Continuing Education Units (CEUs) for social workers, counselors, and nurses for completion of these trainings.
- Educate and train providers about the culture of poverty, including through a partnership with LPCA at which we will offer access to poverty simulation training at their annual summit.
- Offer our Developmental Disabilities Health Care E-Toolkit and Cultural and Disability Competency Provider Toolkit online or in hard copy. These Toolkits include best practice communications and links to resources.
- Offer language resources/tools to our providers, such as our *How to Speak Cajun* cheat-sheet detailing the proper pronunciation of common last names and Louisiana parishes; and our *Language Identification Tool*, which includes the top 19 non-English languages spoken in Louisiana to help providers identify the language the enrollee is speaking and link the provider to appropriate interpretation and translation services.
- Are improving our Provider Directory by enhancing filters related to disability access, allowing enrollees the ability to filter attributes such as parking, external and internal building features, and programmatic access.

Meeting Members Multi-Lingual Needs. Providers can view enrollees' language preferences through the Provider Portal and, when needed, we can provide in-person, real-time telephonic, and video remote access to individuals who are professional interpreters for Spanish, Vietnamese, French Creole, and American Sign Language. Interpreters assist providers, onsite or by phone, to discuss technical, medical, or treatment information at no cost to the enrollee, and meet HIPAA, CMS, and ACA requirements. In addition, we offer:

- On demand supports for 220 languages/dialects to assist provider communication with enrollees; honoring the value of non-verbal communication through provision of iPads and video interpretation services
- Written material translated into any language upon request, including large print and braille
- TDD/TTY access for enrollees who are hearing impaired through 711

Organization-wide Focus on Culturally and Disability Competent Care

Through our Cultural and Linguistic Appropriate Services (CLAS) Program, we continuously assess interventions to confirm we adequately address/reduce disparities. Our Cultural Competency Plan guides our commitment, and tracks and informs interventions to ensure our provider network meets the multi-lingual and multi-cultural needs of enrollees. Our CLAS Task Force oversees and maintains LHCC's Cultural Competency Plan, meets on a quarterly basis, and is a key component to ensuring our provider network meets enrollees' multi-lingual, multi-cultural, and disability needs. The Task Force reviews data including language services utilization reports (interpretation/ translation services requested), the BH provider cultural competency training report, CLAS related grievances, and any gaps in culturally competent services identified by recurring assessments and monitoring. Using this information, the Task Force develops and implements targeted interventions, ultimately reporting to QAPIC.

2.10.8.6 Details regarding planned protocol for terminating network providers for no cause, including how to minimize negative impact on enrollees.

Since our inception as a Medicaid MCO in LA in 2012, we have terminated less than .01% of our network. LHCC's provider termination process follows our written Policies and Procedures, which adhere to all federal and State requirements, including those noted in the RFP, Model Contract, and Provider Manual. We will limit the termination of provider agreements without cause to coincide with the annual open enrollment period and will provide LDH 90 days' notice prior to a contract termination. For material changes related to BH providers, LHCC will provide written notice to LDH, no later than seven business days of contract termination. We will submit required information in accordance with the Provider Manual, the MCO Contract, and as specified by LDH and will request LDH approval prior to terminating agreements with providers listed in Section 2.9.8.1.6.

In the rare situation in which we term a provider without cause, our Network Development Team sends a letter to the provider, 180 days in advance, notifying them of their upcoming termination date. PE Specialists and Provider Services Call Center staff are provided a copy of the letter and educated about the termination and how to respond to provider inquiries.

Minimizing Negative Impact on Enrollees

Within 15 days of provider termination, Member Services provides written notice of termination to all enrollees who have received services from the provider within the past 12 months. If the provider termination results in a material change to our network, we will provide 30 days advance written notice to affected enrollees , which will explain how to select an alternative PCP and remind enrollees that failing to do so will result in auto-assignment. We also will assist with choosing a new provider to ensure a seamless transition with no disruption in care. LHCC tracks all enrollees impacted by a provider or material subcontractor's suspension, limitation, termination to ensure covered service continuity. We will provide this information, as requested, by LDH.

If we terminate a provider due to nonrenewal or expiring contracts, we allow the provider to continue treating an enrollee who is in an ongoing course of treatment or has an ongoing special condition. LHCC Case Managers, CHWs, and Call Center staff will assist impacted enrollees currently receiving services from a terminated provider by transitioning them and helping them select a new network provider. For enrollees with special health care needs, LHCC will implement Care Management Team meetings with the enrollee, their family/caregiver or legal guardian, and the enrollee's circle of support or requested by the enrollee to discuss and revise the Plan of Care, addressing any changes in services or providers. Our Case Managers will work with the Office for Citizens with Developmental Disabilities for the BH needs of the intellectual/developmental disability co-occurring population.

For enrollees receiving services from a terminating specialist, we will attempt to contact them through phone and mail explaining their options for selecting a new provider. To ensure continuity of care and prompt service delivery, we assist with scheduling an appointment (or setting up regular appointments) and our Transition of Care Team will coordinate care for enrollees in active care with open authorizations. Upon provider termination, LHCC will maintain effective continuity of care and care transition activities that include care for pregnant women and enrollees with special health care needs; pharmacy services; BH care; and DME, prosthetics, orthotics, and certain supplies.

SECTION 2.10.9

Provider Support

Since the initial launch of Healthy Louisiana, my practice has enjoyed a genuine partnership in working together to make a difference in our community. I have been very pleased with how responsive Louisiana Healthcare Connections is to issues I bring to their attention. Having valued their presence here since the adoption of Medicaid managed care, it would provide great continuity for my practice and patients to have them remain as one of the MCOs for the next RFP reward.

—Dr. Bryan G. Sibley, FAAP

2.10.9 PROVIDER SUPPORT [14 PAGE LIMIT]

2.10.9.1 The Proposer should offer support to providers in a number of ways under the Contract to ensure that providers receive timely payment and appropriate support over the course of the Contract. In its response, the Proposer should…

Louisiana Healthcare Connections (LHCC) maintains a formal provider relations function compliant with Section 2.10 of this Model Contract, along with an expansive provider engagement strategy. We develop and deploy provider supports as a component of our provider engagement strategy, which is aligned with our annual QAPI Plan and tailored to advance State priorities and assist providers in clinical transformation and care improvement efforts at a regional and practice level. Our highly-trained, field-based staff throughout Louisiana meet providers where they are in their communities. We consistently deliver supports that minimize and remediate provider issues. As examples, this year we will implement:

- Increased staffing for our provider engagement model (*see* Section 2.10.9.3 below)
- Technology solutions that increase administrative simplification and quality, such as Quartet (see below)
- Expanded provider educational offerings via LHCC's Connections Academy and three new dedicated provider Educators for physical health (PH), behavioral health (BH), and Value-Based Purchasing (VBP) to develop and deliver transformative content
- Developed a Strategic Claims Education Plan to support providers with high claims denial rates
- Continued robust provider communications linked to delivery preference and message urgency

2.10.9.1.1 Its process to determine adequate provider relations staffing coverage for the provider network;

Provider relations staff are recruited and hired locally. We leverage a suite of proprietary Staff Modeling Tools to determine the appropriate staffing number and type needed to cover our network responsibilities and engagement model. The tools consider the Contract's complexity, network size, experience, and needs, projected enrollment levels, and enrollee stratification; and required functions such as staff documentation, ongoing staff training, reporting, auditing, and contractual performance standards. Centene Corporation (Centene) provides, as guardrails, traditional staffing ratios based on national standards to ensure that LHCC does not artificially minimize staffing. Our core philosophy is that we staff to network need and locally-informed experience, not to ratios. Where staffing need can fluctuate rapidly, such as in the Provider Call Center, we use sophisticated workforce management tools to predict/maintain adequate staffing in real-time.

Our Staff Modeling Tools evaluate staff skill sets against our network's needs so that we consistently recruit optimal, appropriate talent. Using our Provider Readiness Assessment, we evaluate the network's core competencies across 160 value and quality dimensions to ensure we have adequate staff with the right skills. For instance, we are adding two additional Clinical Nurse Liaisons (CNL) to our local Provider Engagement Teams (PE Teams) to work directly with providers on interpreting performance analytics (ED visits, high cost/low value prevalence, adverse practice patterns, population risk trends, etc.) and to collaboratively develop action plans.

2.10.9.1.2 Strategies to provide effective and timely communications with providers, including the development of a provider education program;

Our communications strategy is part of LHCC's provider engagement model and also supports QualityPATH, our comprehensive program to move providers along the continuum of VBP arrangements. We deliver messaging consistently, and often repeatedly, across multiple channels to maximize effectiveness, maintain transparency, and encourage dialogue. We also maintain messaging for Contract compliance and internal policies and procedures.

Strategies for Effective Communications. To be effective, we deliver relevant communications to our providers via their preferred methods. We monitor effectiveness of emailed provider notices, tracking open and unsubscribe responses and have achieved an open rate that is double the industry norm. Through Twitter and LinkedIn, we send messaging related to Social Determinants of Health (SDOH) and Quality initiatives to our more than 6,000 followers. For convenience, we host on-demand provider orientation webinars on our website. PCPs have praised the launch of our Specialist Referral Locator, a user-friendly process through which PCPs obtain assistance in securing appropriate specialist referrals and enrollee appointments in one business day. To enhance provider simplification, we will integrate Click-to-Chat in our Provider Portal, giving providers instant access to a Provider Call Center Representative. Combined with our Support-a-User feature, we offer assistance

with portal navigation without the disruption of screen sharing**.**

Our communications deliver actionable details for maximum effectiveness such as around best practice tools and evidence-based supports. This year we are introducing Quartet, a unified technology communications solution that enables PCPs to connect enrollees to BH providers, ensure appointments are scheduled, and assemble virtual care teams to collaborate on treatment plans. Our launch messaging includes email, web pop-ups, webinar, and in-field and regional training.

We leverage physician champions in communications for effectiveness. For example, our Chief Medical Officer Stewart T. Gordon pens both our *Quality In Practice* blogs and a column in the *Healthcare Journal of Baton Rouge,* offering evidence-based provider resources to improve health outcomes, streamline administration, and increase patient satisfaction and value.

Strategies for Timely and Responsive Communications. We deliver communications based on the importance and urgency of the information. For the most important communiques such as Medicaid program changes, we employ "pop-ups" on our website which link to the notice details, and magnify the delivery via all other channels (email, blast fax, web bulletins, etc.). All Medicaid Announcements are logged on one provider landing page with an easy search function. We target email and fax messages by provider type, region, claims history, and other relevant attributes. We train all member-facing staff (Call Center, Claims Support, etc.) to deliver accurate information via our *Connections Academy* desk trainings and an interactive desktop tool delivering urgent quick-action training, ticker-tape bulletins, and comprehension testing.

Honoring Provider Communication Preference. We will use our newly enhanced Provider Lifecycle Management System (PLMS) to systematically outreach to our providers in a targeted fashion, orchestrating their communications across every touch point. Our Provider Manual, hard copy Provider Directory delivered quarterly, newsletter, and detailed website with a searchable, machine-readable Provider Directory serve as references. Our toll-free LHCC Provider Call Center offers backbone support for many provider inquiries, including non-routine prior authorization (PA) requests 24/7 and provider access to interpreter services. We deliver communications compliant with Federal, State, and Contractual requirements, including related to settlements, court orders, and consent decrees.

LHCC incorporates feedback on provider communications needs, such as from our Provider Advisory Council, Practice Management Advisory Committee, Joint Operating Committees, and regional forums**,** to improve messaging and materials. For instance, provider feedback was critical in the development of our Provider Toolkit on Social Determinants of Health (SDOH), launched last year and available on the provider website.

Our Provider Education Program: Customized for Transformation

Our provider education strategy recognizes that not all providers currently have the training required to fully engage in LDH's vision of care driven by quality and value. It is our role to bridge that gap with effective, timely, and accessible educational supports. *Connections Academy* curates educational content so *every* provider has a full roster of educational courses, from the technical to the clinical, and that support administrative simplification. Our strategies are designed to:

- ***Expand our clinical coursework continuously to enhance transformation.*** Our new dedicated PH, BH, and VBP Educators will collaborate with Centene's national best practice training experts and Louisiana's professional community to bring expanded, evidence-based, clinically-rich coursework directly to our providers, such as on Adverse Childhood Experiences and Adverse Incident Reporting. We provide content for ease-of-use, including CEU delivery, resource material, practice guides, playbooks, and toolkits. New features this year include attendance monitoring and storage.
- ***Meet Louisiana provider needs****,* such as for CANS and CALOCUS training, prescriber education, technical assistance (e.g. billing, BH and PH authorizations, cultural competency, etc.) and by working with LDH on provider education programs around population health issues.
- ***Increase provider competency***. In 2018, we provided more than 800 hours of free training to more than 5,600 providers across the State. For example, our Trauma-Focused Cognitive Behavioral Training (TF-CBT) course, offered free-of-charge last fall, provided 14.5 clinical contact hours of and assistance in obtaining TF-

CBT certification to 42 Louisiana Licensed Mental Health Professionals. The program was so well received we are repeating it in April. In addition, almost 100 providers attended Recognizing the Signs and Symptoms of Teen Violence, and more than 500 completed coursework in Treatment and Service Planning. Our Child-Parent Psychotherapy Training, an 18 month program, is training 35 providers free-of-charge to treat trauma-exposed children. Our first class will graduate in January.

- ***Deploy modalities that encourage participation***, including webinars (stored and live), "push training" to specific providers such as primers on VBP arrangements, and pop-up ads on our public provider pages to drive interest. Our PCPs also appreciate our in-person, quarterly regional forums designed for "pick-and-choose" flexibility with concentrated modules and LHCC staff on site to provide individual assistance.
- ***Promote transformation coursework.*** Connections Academy's dedicated VBP Educator will curate and deliver Triple Aim, VBP, and other transformation coursework designed specifically for LHCC and from among courses offered by successful developers of targeted provider education. Coursework also will be informed by our local partners such as the Louisiana Center for Health Equity.

We comply with Model Contact Section 2.10.7 requirements for LDH training approvals, monitoring, and reporting.

2.10.9.1.3 The processes that the Proposer will put in place to support providers with high claims denial rates; and

Dynamic Wraparound Service to Reduce High Claims Denial Rates

LHCC delivers high-touch service to providers around claims inquiry to prevent issues from becoming denials. Our Claims Research (CR) Specialists work personally and in real-time with providers to resolve small batch and low dollar threshold claims. For complex claims, CR Specialists research and report back to the provider. Providers know their CR Specialist's name and phone number. This aggressive approach with providers has had a significant impact: LHCC reduced total provider complaints regarding claims by 64% from Q1 2018 to Q1 2019.

64% ↓

reduction in total provider claims complaints Q1 2018 to Q1 2019

To build on that success and reduce high claims denial rates across the network, this year, LHCC is expanding upon our comprehensive approach, launching full wraparound support to providers with high claims denial rates. Using Centelligence, our integrated health informatics platform with business support tools, Claims and Contract Support staff have identified the five provider types with the highest claims denial rates and the major drivers for these denials. We are developing a Strategic Claims Education Plan with integrated supports tailored to each provider type, targeting interventions for the prioritized reasons for denial. We will electronically "push" the trainings to the identified provider types. We also will post Connections Academy's Claims Training Catalogue to our website to support the entire network.

In addition, we will identify at least five individual providers with the highest denial rates within each provider type quarterly and develop and deliver (via in-person, webinar, live video conference) trainings tailored to their specific issues. Support will include post-training follow-up, provider survey for efficacy and satisfaction of training, and monitoring of each provider's claims denials and complaints to ensure improvement. For large provider groups and facilities, our Joint Operating Committees (JOC) will review claims denial rates as part of each meeting and deliver any needed training or supports.

Proactive Solutions to Minimize Denials. Ongoing, Claims and Contract Support staff serve as an early warning system to minimize provider denials and complaints. Staff conduct root cause analyses using the Plan-Do-Study-Act (PDSA) model for rapid-cycle quality improvement and develop actions to remediate issues. We also implement proactive guardrails against high claim denials. In 2018, we recognized that Applied Behavioral Analysis (ABA) providers would need significant claims support during their transition to managed care. Among many actions, we provided tailored training to all ABA providers, contacted ABA providers telephonically daily to review and resolve claims issues, and overrode all PA requirements for ABA services for the first 30 days. During the first 90 days, we outreached to 43 ABA provider groups and resolved 646 claim denials.

In 2019, we will deploy these additional Provider Portal technologies to avoid high claim denial rates:

- Claim Status Tracker, a user-friendly graphical depiction of claims status. The tracker will include the ability to submit, view, and receive email notifications for Reconsiderations.

- Provider Claims Scorecard, with actionable claim information for providers to improve timeliness and accuracy of their claim and encounter submissions, reducing the need for revisions.

2.10.9.1.4 The processes that the Proposer will put in place for evaluating and resolving provider disputes in a timely manner, including disputes specific to the automatic assignment policy and the assignment of an individual enrollee.

LHCC recognizes our obligation to proactively identify and remediate provider issues *before they rise to the level of dispute*. For those issues we cannot remediate, our Provider Solutions staff manage the research, resolution, and reporting processes for provider disputes, including those specific to the automatic assignment policy and assignment of an individual enrollee, and those specific to pharmacy management. These processes are compliant with this Model Contract, including Sections 2.10.9 and 2.17.11, and with the MCO Manual.

Process for Evaluating and Resolving Disputes. Our Provider Solutions Department receives provider disputes from all sources, assigns the case and tracks cases for compliance against standards. Staff personally outreach to the affected provider, collect information, and assemble resources, including the Medical Director as necessary, to review and reach resolution/decision. We inform the provider of the results and next-step options.

Disputes Specific to Enrollee Assignment. Our dispute process does not exceed 10 business days and we will submit this process to LDH for approval. LHCC, with LDH guidance, conducts quarterly claim/encounter-based analysis using available historical information about the enrollee's use of health care services during a 12-month look-back. To preserve the enrollee-provider relationship, we offer misaligned enrollees reassignment either to their most-visited PCP or the most recently seen PCP, and we notify both impacted providers of the reassignment with a copy of the analysis. We also will flag the enrollee and date of reassignment on the provider's panel in our Provider Portal. We update provider panels electronically in near real-time so the provider always has an accurate panel view and a provider may dispute the results within 15 business days. We will continually monitor to determine if changes to our assignment methodology are required to improve care and Care Management and will submit all required reports on PCP assignment and disputes as specified by LDH.

Independent Review (IR) Request. Provider Solutions also includes staff, policies, procedures, and technology to support providers who request claim reconsideration, appeal, arbitration and/or IR Request in compliance with House Bill No. 492 Act No. 349. For provider simplification, we assign a key staff member to assist the provider who elects to use multiple processes. If the provider remains dissatisfied with the outcome of the first level IR Request, the provider may submit the IR to LDH.

2.10.9.2 The Proposer should describe how it will support the provider to improve quality and reduce costs through delivery system and payment reform strategies. Specifically, the Proposer should describe:

LHCC knows that early provider success in delivery system and payment reform implementation is critical for sustainable, long-term transformation to improve quality and reduce costs. To deliver that early success, we have designed and implemented provider supports to:

53%

We have increased VBP payments by 53% since 2015 to $12.5 million in 2018

- Foster innovation and the culture of quality that already exists in our network
- Decrease fragmentation and increase integration across care settings including for specialists
- Leverage our existing relationships to develop delivery system innovations
- Link independent providers and BH providers to practice coaching and direct infrastructure supports.

LHCC is continuously moving our providers toward meaningful participation in delivery system and payment reform. More than 168,000 LHCC enrollees, or 37% of all LHCC enrollees, are served by providers participating in our VBP arrangements. We have offered providers enhanced rates to promote HEDIS quality measures and management of condition specific measures, such as DiamC in Shreveport, with good results. We also have partnered to improve quality and reduce costs by funding Nurse Practitioners (NP) at St. Martin Hospital in Breaux Bridge and we have offered enhanced rates for home visits to connect enrollees with their PCPs. We have developed telehealth solutions to reduce unnecessary enrollee Emergency Department use, such as with Verity Health and Teche Action Clinic in Region 3. For more details on our VBP strategies and solutions, please see our response to Section 2.10.12.

Below we detail our support strategies with examples of our concrete, locally-driven solutions built on discussions and partnerships with our providers to improve quality and reduce costs.

2.10.9.2.1 Strategies to support primary care providers, including but not limited to investments in primary care infrastructure and practice coaching to support delivery system reform;

[redacted]

[redacted]

We also are collaborating with AbsoluteCARE, an NCQA certified Level III PCMH and NCQA Case Management

[redacted]

[redacted]

- ***Supporting Integration Through Technology.*** LHCC will launch Quartet, a technology platform that enables PCPs to identify members with BH conditions, connect them to personalized BH care, and collaborate with their BH providers on treatment plans. Quartet offers enrollees online therapy, eliminating distance as a barrier for service. It also facilitates e-consults from BH providers to PCPs to increase integration and quality of care for enrollees with mild BH needs.

Invest in Population Health at the Provider Level. Last year, we successfully launched our SDOH Provider Toolkit, *Hunger for Health*, which helps PCPs identify and document food insecurity and provide patients with local resources. Based on that success, we are launching Community Connections Platform, a shared electronic SDOH database and referral system for tracking and outcomes reporting of SDOH needs statewide.

LHCC will also offer provider Transformation Grants to individual providers as strategic investments that support efforts to move toward PCMH certification and advance cultural competency. Grants will fund practice accessibility tools, such as specialty exam tables for patients with disabilities, implementation of the provider's first Electronic Medical Record, or SDOH initiatives.

Practice Coaching to Advance PCP Transformation. Our provider engagement model (explained below) includes practice coaching through our local CNLs. Centene's Provider Engagement Playbook has a proven step-by-step guide for CNLs to engage providers with coaching tools. Our CNLs will assist more experienced providers to help them interpret their performance and share best practices to improve quality. They will work with independent practices and those with pay-for-performance arrangements on developing achievable quality goals with actionable tactics and monitor results. Our new VBP, BH, and PH Educators will develop coursework specific to a PCP's need for maximum effectiveness. To amplify their field efforts where specific competencies are needed, CNLs and our Educators can access our Experts on Call from LHCC's Utilization, Medical, Quality, and Care Management Departments to deliver customized supports. We will continue to engage providers regarding use of the integrated provider assessment tool (IPAT), per State guidance.

2.10.9.2.2 Strategies to support behavioral health and other specialty providers to participate in delivery system reform activities; and

LHCC's goal is to ensure that all network providers have the access, opportunity, and knowledge to participate in delivery system reform activities. Some examples of LHCC's strategies to support BH and other specialty providers' participation, and increase the quality and value of our network, are below.

[redacted]

[redacted]

2.10.9.2.3 Strategies to share provider performance data with providers in a timely, actionable manner.

LHCC's strategy for sharing data with providers focuses on recurring delivery of reports, supported by in-person and technological supports and education that empower providers to course correct in a timely manner. We share performance data with providers via Patient and Provider Analytic Dashboards on the Provider Portal, supported by our Centelligence health informatics platform. We also offer reports tailored to the provider's QualityPATH APM participation. We support providers on the use and interpretation of the dashboards, reports, and data to ensure they fully understand their practice, patient, financial, and population health analytics, which drive improved quality outcomes and reduce overall cost.

Frequent System-Wide Updates Support Timely Data Sharing. To facilitate timely sharing of provider data, we conduct frequent system-wide updates that exceed industry standards and contract requirements. We update utilization and cost measures monthly, quality and risk scoring algorithms weekly, and enrollee panels in near real time, far exceeding the Model Contract's requirement of monthly delivery of updated panel information to VBP providers. We share performance and claims data for attributed enrollees with VBP providers at least quarterly. Through our alliance and equity stake in Interpreta, Inc., we improved our ability to deliver prospective care gap analytics capabilities to providers. Interpreta's care gap information is re-computed and updated in near real-time, compared to the traditional weekly or monthly cycles, significantly improving our staff and providers' ability to more timely address enrollee care gaps. (see Section 2.10.12.4)

Actionable Data that Support Quality and Value. LHCC's Analytics Suite offers providers comprehensive access to actionable clinical, cost, and utilization data, illustrated by graphics that highlight relevant and important facts, and make the information easy to understand. Included within are both Patient and Provider Analytics:

- Patient Analytics Dashboard is a population health analytics platform enabling providers to access their patient disease registries (at the PCP or practice level) to view critical information including evidence-based care gaps and quality improvement opportunities. This dashboard offers an integrated view of physical and behavioral health diagnoses, and medication, lab, and Care Team data, on an enrollee level.
- Provider Analytics Dashboard is a provider performance management platform, offering providers the ability to assess cost and utilization trending, quality measure performance, active and non-active enrollee pattern analysis, disease-state prevalence, readmissions, and population health trends. Authorized users can interact with the dashboards through extensive custom selection, drill-down, and export capabilities, helping providers identify potential casual factors behind clinical and cost performance. Through the provider analytics dashboard, providers can monitor their performance toward contractual, VBP, or bonus goals.

17.8% ↓

Percentage drop in MLR for Bayou Pediatrics from 2017-2018, with assists from LHCC Analytics tools and training. The group's quality scores remain among the highest in our network.

To complement Provider Analytics, we will also offer providers access to 3M's Provider Performance Dashboards through Centelligence via our Provider Portal. The 3M Dashboard delivers 12 months of rolling data and calendar year-to-date information at both the aggregate and enrollee-level, on preventable readmission, utilization and cost data, and data on high-needs individuals. 3M's Dashboards include a Value Index Score (VIS), a calculation based on a provider's ability to deliver high quality, efficient, and cost-effective care.

High Touch Data Delivery and Provider Support. Using the Healthcare Analytic Adoption Model from HealthCatalyst, our field staff analyze, interpret and prioritize performance insights for the provider. They discuss performance opportunities both for value and quality and focus on provider-level solutions for meaningful change. As one example, we have found that our "shadow" reports, identifying how a provider would have performed against a future risk arrangement, are excellent learning tools.

2.10.9.3 The Proposer should describe in detail its provider engagement model. Specifically, the Proposer should include the following elements in its description:

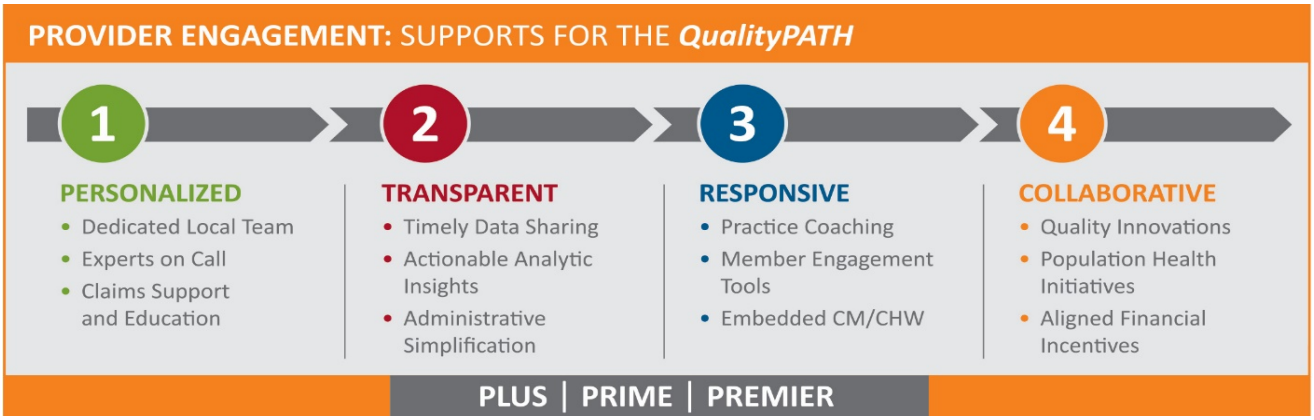
Engaging Every Provider to Improve Quality and Reduce Cost

LHCC's locally-based provider engagement model is organization-wide, high-touch and physician-informed, and is designed to support the Quadruple Aim (improving enrollee care, advancing population health, increasing value, and enhancing provider experience and satisfaction). Through this model, we engage all network providers, regardless of size of practice, technical sophistication, or types of services offered.

- ***Organization-wide***. Every LHCC staff member plays a role in provider engagement. All LHCC staff are trained in our provider engagement model, are fully read into quality improvement and population health initiatives and access a suite of desktop tools through our Provider Lifecycle Management System (PLMS) to answer provider inquiries and direct the right expert to the provider task at hand.
- ***Physician-informed***. We worked hard over the last seven years to establish physicians in leadership positions that inform LHCC's strategic direction and day-to-day operations. Our Board of Directors is provider-led, and our newly informed Clinical Policy Committee (CPC), chaired by Dr. Gary Wiltz, Teche Action Clinic, will empower local physicians to ensure clinical policy reflects local practice patterns and standards of care, and addresses provider concerns.
- ***High-touch and locally-based***. Since our first Louisiana Medicaid managed care contract in 2012, LHCC has hired, trained, and located provider field representatives in the regions and parishes they support. Our wraparound model starts with Medical and Executive Leadership involvement and support; includes delivery of robust, user-friendly analytics with actionable insights and hands-on interpretation assistance; and provides a high-touch, field-based team of experts across clinical, financial, and operational areas.

Further, our engagement model supports providers on the LHCC QualityPATH suite of Alternative Payment Models at three tiers (**QualityPATH Prime, QualityPATH Plus, and QualityPATH Premier**). We tailor the assistance and data based on what is most relevant and applicable to providers participating in each model, helping focus providers on what matters most to their success. Below is a depiction of our engagement model with a summary of supports, all detailed in this response.

Figure 2.10.9.3: Provider Engagement Supports for QualityPATH Participants



2.10.9.3.1 The Proposer's staff that play a role in provider engagement;

Working cross-departmentally, LHCC staff directly engage and support providers, as follows:

Medical and Executive Leadership meet with providers regularly and large providers at least quarterly. As Clinical Champions, our Medical Directors ensure an innovation-values fit between providers and our quality programs. Through these recurring meetings, and informed by our provider-led Board of Directors and Physician Advisory Council, our Clinical Champions ensure that our providers guide LHCC process and policy. They obtain provider feedback on enrollee needs, quality and population health initiatives, cultural competency, and macro and micro strategies designed to improve provider engagement and satisfaction. Our Executive Leadership directly engage providers on value initiatives and innovations such as those described above (see Section 2.10.9.3) and drive organizational supports on an enterprise-wide level.

Provider Engagement Teams (PE Teams) collaborate with, and support providers to actively improve care delivered to enrollees through outreach and education that includes face-to-face visits during which they focus on quality management and improvement activities and strategies. We staff to ensure capacity to conduct both ad hoc and regularly scheduled and recurring visits to provider sites, and provide technical assistance (e.g., LHCC systems, billing, authorizations, linguistic/cultural competency, etc.) for PH and BH providers. The PE Team also supports providers in understanding, managing, and monitoring their quality performance and VBP progress. PE Team staff (including our PH, BH, and VBP educators and our CNLs) and roles are detailed below.

Our PE Team closely collaborates with our Network Development and Contracting Team, which focuses on ensuring and that the network provides adequate access points to the full spectrum of covered services across all enrollees and that providers have panel capacity to deliver consistent, timely, and culturally competent care to assigned enrollees.

Provider Services manages our Provider Call Center, which assists with general and claims-related inquiries, program operations and requirements, and provider access to interpreter services Monday through Friday 7 a.m. to 7 p.m. Central Time. The Provider Call Center also provides coverage for emergent provider issues, enrollment verification, and non-routine PA requests 24/7 per Sections 2.10.3 and 2.10.4 of the Model Contract.

Claims and Contract Support Team manages and resolves provider issues related to complex claims and provides wraparound support to providers with high claims denial rates. Through continuous analysis of provider call trends and inquiries related to claims, these dedicated staff conduct root cause analyses using evidence-based tools and develop interventions to remediate claim issues before they become complaints.

Provider Performance and Data Analytics Department organizes and aggregates utilization and quality data, consolidates information and reporting from Operations and Finance, and develops analyses and reports to support provider quality and value goals. Staffed by Data and Business Analysts, this department provides the analytics required by the PE Team to identify, discuss, and establish improvement goals with providers and to track providers' progress toward those goals. Within this Department is our team of eight full time Provider Directory Specialists who perform daily telephonic and system audits to maintain provider demographic and directory accuracy. [redacted]

2.10.9.3.2 The presence of local provider field representatives and their role;

Face-to-face interaction with our providers is the cornerstone of our provider engagement strategy. Through this outreach, deployed by our local PE Team described below, we collaborate with providers to improve the quality of enrollee care consistent with LDH quality goals and measures.

Provider Engagement Teams for Total Field Support. Regionally-based PE Teams bring clinical and administrative expertise, tools, education, and back-room operational supports directly to our providers. Supports are based on our comprehensive evaluation of provider need and extensive and continuous dialogue with each provider. We also tailor our supports to the specific QualityPATH model in which a provider participates. PE Teams are dedicated to assigned regions and work with all providers in their region, deploying an approach that respects the provider's unique support needs related to capacity, accessibility, quality, efficiency, and value-based transformation.

LHCC IS LOCAL

In our 2018 Provider Satisfaction Survey, 77% of our providers reported knowing their assigned Provider Engagement Specialist

We tailor the frequency of in-person meetings to provider need and desired engagement. For example, PE Teams meet at least quarterly with PCPs, OB/GYNs, hospital systems, and large provider groups. These providers may also participate in quarterly Joint Operating Committee (JOC) meetings. If a provider requests an in-person visit, or if data or feedback indicates a need for additional support, our PE Teams respond and schedule ad hoc meetings as needed. In addition, depending on a particular provider's QualityPATH status, PE Teams will meet at least quarterly with participating providers to review their progress toward their VBP incentive payment arrangement with a deep-dive into specific care gap, HEDIS, and financial benchmarks. They offer to meet monthly with QualityPATH Plus providers to review their quality metrics, care coordination activities, and

performance against key metrics in their shared savings arrangement. Supports become more sophisticated as the provider advances; for example a QualityPATH Premier provider may require weekly telephonic touch points.

PE Team members include:

- Provider Engagement Specialists (PE Specialists) provide education and support to providers to operate in compliance with the State Contract and LHCC policies and procedures. They are a consistent presence in the region, developing relationships and serving as a direct connection to LHCC. They respond quickly with assistance so the provider can focus on quality of care and their assigned enrollees' needs.
- Clinical Nurse Liaisons (CNLs) address quality goals, present evidence-based data, support practice transformation efforts, VBP provider performance, review population health reports, and develop and support practice-level initiatives in case management, disease management, care gap closure, and other clinical initiatives.
- Coding Analysts educate provider billing staff on proper capture of codes to remove barriers to prompt, accurate payment for services.
- Experts on Call from Medical Management, Care Management, Quality, Utilization Review, Population Health, and Communications provide drop-in support as needed on issues related to enrollee engagement, process simplification, population health initiatives, and more.
- Provider Educators (dedicated to claims, primary care, BH, or VBP) offer in-person and focused education to facilitate provider success in meeting LDH quality, access, and performance goals.

As LHCC's vehicle for local provider support across all provider types, PE Teams:

- Provide orientation, train providers to all policies and procedures, and engage providers in quality initiatives, such as our *HEDIS in a Box* program to close care gaps
- Analyze and interpret quality, risk, and utilization data and synthesize performance results
- Strategize member outreach and assist providers to address cultural competency and SDOH barriers for our enrollees using such supports as LHCC's SDOH Centers of Excellence and Community Connections Platform, a database and referral system to track enrollee SDOH resource use
- Monitor provider transformation education needs, including for practice coaching, and deliver the appropriate supports and staff from LHCC's Connections Academy
- Assist in identifying providers who may be partners for more advanced APMs based on their success in value and quality initiatives
- Support provider progress along QualityPATH goals, including direct assistance with identification and mitigation of barriers to progress and effective use of actionable data and quality improvement techniques.

To ensure our staff adapt to the quickly evolving delivery system and payment reform landscape, and are well-equipped to advance excellence in our provider engagement model, LHCC will support select PE Team staff to complete appropriate certification programs from nationally recognized sources (e.g., AHIMA Certified Health Data Analyst®, NCQA PCMH Certified Content Expert, or HealthCare Information and Management Systems (HIMSS) Advanced Certifications).

2.10.9.3.3 The mechanism to track interactions with providers (electronic, physical and telephonic);

LHCC tracks every interaction (electronic, physical, and telephonic) with providers to resolution, to ensure effective and efficient use of provider time and facilitate increased provider satisfaction. Our Provider Lifecycle Management System (PLMS) offers a single relational repository for all LHCC's core provider functions including provider recruiting, credentialing and qualifications, training, data management, claims, workflow, and provider engagement. Staff enter and update provider data in our PLMS, ensuring that all provider data comes from one governing source for complete data integrity. It allows all operational and clinical departments, as well as the provider call center, to track and manage interactions efficiently and accurately. Key components of the PLMS include our:

- ***Provider Engagement Management System (PEMS)***: a new workforce tool which track visits with providers and assists staff in preparing for provider visits, simplifies scheduling, identifies necessary provider supports

and monitors open follow-up items. PEMS allows for capture of sign-in sheets, agendas, action items, and materials used. Visit documentation shall be provided to LDH upon request.

- ***Customer Service System (CSS)*** tracks and maintains each provider's entire interaction history, by accessing the most up-to-date information on providers through near time integration with our Enrollment System and timely exchange with our PLMS. CSS allows us to track frequency and timeliness of engagement and issues addressed, and to promptly queue actionable items to correct personnel for resolution. CSS features task lists and work queues that rapidly communicate prioritization and urgency of provider follow-up actions to supporting staff.
- ***Quarterly Provider Engagement Planner (QPEP***) tracks individual provider engagement priorities through resolution, including a timeline of deliverables to support and guide PE Team activities and in-person visits.
- ***Visit Routing Optimization Tools*** helps confirm our field staff visits with providers are efficient and effective.

Aggregated data from these tools provides scorecard analysis of provider support staff effectiveness and, combined with Centelligence Provider Analytics, enables efficient development and tracking of provider quality and value goals.

2.10.9.3.4 How the Proposer collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;

Robust Data Collection to Identify Relevant Training Needs. LHCC collects utilization, provider practice, clinical quality, and cost reporting data across platforms via Centelligence, which reports on all datasets in our platform, including those for HEDIS, EPSDT services, claims, complaints and disputes, Potentially Preventable Events (PPEs), payments, risk stratifications, Performance Improvement Project informatics, and other critical aspects of our operations. We pay special attention to claims, complaints, and call center category trending data as leading indicators of both provider satisfaction and training needs. Using Centellligence, we have the capability to create reports that identify provider training opportunities.

In addition to quantitative data, we collect qualitative provider feedback from our Provider Advisory Council, onsite PE Team meetings and ongoing outreach to providers, post-training evaluations and comments in the Provider Performance Education Satisfaction Survey, executive and medical leadership discussions with network providers, juvenile justice and child welfare advocates and experts, and stakeholders. We also obtain provider and stakeholder feedback through our active involvement in community and State professional groups, such as the Louisiana Association of Healthcare Quality where our Vice President, Network Development and Engagement is actively involved as a board member. LHCC also tracks other information related to the quality of our network to proactively identify training needs. For example, we track provider certification, training, and licensure to confirm providers are appropriately qualified to deliver high quality care to enrollees. This information enables LHCC to identify priority training needs that inform training program design or delivery.

Identifying Specific Training Needs is an LHCC Key Strength. Our Provider Performance and Data Analytics Department analyzes and reviews Centelligence reports to identify training opportunities at a large-scale (regional or provider type) level. Then, using the analysis, our Claims, PH, BH, and VBP Educators curate the best trainings for our providers, including offering clinical coursework aligned with the LDH's key population health priorities, such as improving PCP visits, breast and colon cancer screening, and newly diagnosed diabetes.

Additionally, each PE Team determines where education or other supports are needed at the regional and provider level. The PE Teams review key drivers in PEMS and QPEP, such as individual provider complaints and reasons for claim denial, to determine specific practice training needs. When a need is indicated, or upon request, PE Teams retrain providers in specific processes or direct them to appropriate coursework from Connections Academy's extensive on-line course catalogue. They also work directly with our Claims, BH, PH, and VBP Educators if a more tailored or personal approach is needed and can engage our Experts on Call to align identified need with training opportunity. We have learned that conferencing with the appropriate LHCC Expert on Call can be an effective proxy for formal coursework. For example, when we identified a rise in complaints about the PA process, Utilization Management created a new provider training program and PE Teams personally trained select providers with supplied playbooks and decks.

2.10.9.3.5 The metrics used to measure the overall satisfaction of network providers;

As described above, LHCC uses multiple touch points to measure the overall satisfaction of our network providers. Metrics used include overall satisfaction, provider loyalty, access to linguistic assistance, provider enrollment, provider education communications and trainings, including cultural competency trainings, finance issues, including claims processing and reimbursement, resolution to provider complaints, network/coordination of care, and utilization and quality management processes. We also monitor and track claims and complaint data, call center after-call surveys, call category data, post-interaction surveys, ad hoc surveys such as our provider and member survey on SDOH and our *Provider Performance Education Satisfaction Survey*, a survey of PE Team training delivery and the results of any statewide survey as directed by LDH. The Quality Assessment and Performance Improvement Committee (QAPIC) monitors all satisfaction metrics and findings to identify areas for continuous improvement.

"Our practice has enjoyed the dedication, commitment, and collegiality LHCC has shown us to improve the Medicaid delivery system and quality care for our 14,000 LHCC patients."
- Chris Leumas, MD
North Oaks Pediatrics Clinics

2.10.9.3.6 The approach/frequency of provider training on MCO and Louisiana Medicaid managed care program . . . . .

LHCC's approach to provider training on Managed Care and LHCC requirements is to begin training early in the contracting process and then offer it frequently throughout the life of the provider contract. This ensures that all providers and their staff understand the requirements of the Contract, including limitations on marketing and identification of special needs enrollees. LHCC's Connections Academy staff develop training specific to our policies and processes and LDH requirements and regulations, and our Vice President, Compliance reviews the content and validates it for accuracy. LHCC uses multiple outlets and modalities, including individual and group training through our regional PE Teams, professional trainers for in-person clinical course delivery, lunch and learns, forums and webinars. LHCC also provides an extensive catalogue of web-based, on-demand coursework which providers can complete any time. Connections Academy offers a consolidated page on our website so providers can review the entire course catalogue, allowing them to select their own staff refreshers and deploy focused trainings on-demand.

Provider Orientation. LHCC provides orientation within 30 days calendar days of placing a newly contracted provider on active status. We furnish orientation in an all-inclusive manner, stressing all Contract requirements, and those related to quality and provider incentive agreements. We layer in information on LHCC support and best practice initiatives for claim submissions and tips to avoid rejections, and tools and resources to streamline office administrative workflows. We provide technical assistance (on billing, linguistic/cultural competency, etc.) for all providers, including BH providers, and prescriber education, training and outreach to support BH pharmacy management activities. We survey providers post-training to determine the efficacy of training, any potential improvements, and applicability of the training delivered. To deliver the most effective training, most providers receive a complete orientation from their assigned PE Specialist. Our PE Specialists conduct hands on demonstrations of web and portal tools, forms, claims submissions, etc. We also offer orientation training on-demand in a webinar prominent on our website. Our monthly regional orientations, provided during times of network expansion, have proven to be both successful and popular with our providers.

Frequency of Ongoing Training for Program Requirements. In addition to our provider communications on new or updated program requirements as noted in Section 2.9.10.2, we also keep providers current via:

- Immediate delivery via multiple modalities, including website pop-ups, for urgent State, contract, or policy information, as described above.
- Quarterly in-person updates on administrative and Contractual changes in our regional forums
- Ongoing delivery of LDH required coursework for non-licensed BH providers available 24/7 directly from our website, with monitoring for successful completion. For example, 132 providers participated in our Level of Care Utilization System (LOCUS) trainings in 2018.
- On-demand personalized technical assistance and policy and Contract updates; also offered during regularly scheduled PE Team meetings with all network PCPs

- Specialized, evidence-based Connections Academy physical and BH coursework, many offering CEUs, to all PCPs and BH specialists directly from our website.

2.10.9.4 The Proposer should provide the results of any provider satisfaction survey reflecting its performance in Louisiana or any other state Medicaid program over the last three (3) years. Where results identified provider…

As described throughout this response, LHCC assesses provider satisfaction and dissatisfaction, through a number of surveys and feedback loops. For the purposes of this response, we chose the results of our annual provider satisfaction survey (PSS) conducted by SPH™ Analytics, a National Committee for Quality Assurance (NCQA) Certified Survey Vendor. SPH used a valid survey methodology and a standardized tool that provided year over year results. SPH tracked and trended metrics such as those listed in Q2.10.9.3.5, above, to identify leading indicators for provider satisfaction. Table 1 below shows our survey results as composite scores from 2016-2018. We submitted the full PSS Reports, including key findings and opportunities, to LDH 120 days after the end of the plan year. In the 2018 PSS, overall satisfaction with LHCC was 76.3%, a rate 11% above the SPH Medicaid Book of Business (BoB) benchmark rate of 68.1%. The Provider Relations Composite yielded the highest rate of satisfaction as compared to the other survey categories. Notably, our provider's awareness of our engagement activity is evident in the survey's results: 77.7% of providers know their provider representative compared to the BoB rate of 49.1%.

When calculating satisfaction rates**,** LHCC only considers "well above average" and "somewhat above average" to determine satisfaction; we do not include "average." For areas of dissatisfaction, our cross-functional Provider Satisfaction Task Force (Task Force) collaborates to conduct root cause analyses and implement solutions. While the Task Force addressed all areas of dissatisfaction identified in each of the three annual surveys, we focus below on dissatisfaction with Health Plan Call Center staff which SPH highlighted as demonstrating a statistically significant decline in satisfaction year over year.

Table 2.10.9.4. LHCC 2018-2016 Provider Satisfaction Survey Composite Results

Composites/Attributes	2018 Summary Rates	2017 Summary Rates	2016 Summary Rates	2017 SPH™ Medicaid BoB
Overall Satisfaction with LHCC	**76.3%**	**76.3%**	**77.5%**	**68.1%**
All Other Plans (Comparative Rating)	39.0%	39.1%	44.3%	36.0%
Finance Issues	34.7%	37.8%	37.5%	31.5%
Utilization and Quality Management	31.6%	33.9%	33.0%	33.2%
Network/Coordination of Care	23.8%	24.4%	33.3%	29.0%
Pharmacy	21.2%	20.3%	21.4%	23.0%
Health Plan Call Center Staff	32.1%*	36.3%	45.9%	38.0%
Provider Relations	37.6%	NA	NA	NA
Recommend to Other Physicians' Practices	53.2%	NA	NA	NA
***Scores statistically significantly lower than for 2016.**				

Analysis of Identified Dissatisfaction. A correlation analysis indicated that the strongest potential impact on call center satisfaction was perception of the call center's ability to answer questions and resolve problems in areas such as PAs, availability of specialists, and enrollee eligibility. Call center data also showed that the 4th largest volume of provider calls was related to accessing specialists and PA status inquiries. Additionally, we reviewed provider complaints and identified that the 2nd highest complaint category for Q1 2017-Q1 2018 was Other Questions and Concerns. Complaints in this category center on customer service and managed care business processes, including PAs. The 3rd highest provider complaint category for the same period was related to PAs. Further analysis identified the general area of "call center" as an area for improvement, including the provider's ability to access accurate information across business processes. Below, we present key elements of our Call Center Satisfaction Improvement Plan. We will continue to submit all issues identified in the annual PSS, all improvement activities, and how we track and resolve issues over time, in our annual QAPIC Work Plan.

Call Center Satisfaction Improvement Plan. Our cross-functional Task Force, led by a dedicated quality improvement professional and using the scientifically sound PDSA model, developed and executed focused interventions such as:

- Retooling our call center staff onboarding, increasing intensity of call quality audits and near real-time retraining when needed, and instituting an after-call satisfaction survey
- Redesigning Interactive Voice Response hierarchy to prompt providers directly to the appropriate expert (UM, Case Management, PE Specialists)
- Developing with UM process flows, scripts, and Q&As for PAs; auditing provider call center and UM staff for resulting knowledge transfer; and improving call center visibility into general PA status requests
- Targeting specific providers based on complaint data and providing training on PA procedures, documentation, and submission using UM-supplied tools and decks. After training was provided, UM monitored for results.

Improvements. Our interventions to improve call center processes and services continues to yield positive results. Using complaints as a proxy measure, PA complaints as a percentage of all complaints dropped from 14.6% in Q1 to 10.8% in Q4 2018, with a steady downward trend all year. Early analysis of Q1 2019 shows PA complaints have declined to 6.5% of all complaints. The category of Other Questions and Concerns showed a yearlong downward trend in 2018, with a 36% drop from Q1 2018 to Q4 2018. LHCC will continue these interventions and we anticipate improvement in both call center scores in the 2019 PSS survey, as well as continued declines in complaints.

SECTION 2.10.10

Utilization Management

Louisiana Healthcare Connections doesn't just deny services. We help find alternate ways to help the member get the exact services they need. We notify the member and provider and let them know exactly why the services were denied, what they need to do or how to transition our member to services that better suit their needs.

At the end of the day, we aren't denying our services; we are collaborating with providers to ensure our members get exactly the care that suits their needs.

—Kacie Drake
Concurrent Review Nurse
Louisiana Healthcare Connections

2.10.10 UTILIZATION MANAGEMENT [15 PAGE LIMIT]

2.10.10.1 The Proposer should describe how it will satisfy the requirements for authorization of services set forth in the Contract. The Proposer should submit a flow chart depicting the proposed workflow from initial request to final disposition, including the proposed workflow for expedited authorizations.

Louisiana Healthcare Connections (LHCC) operates our Utilization Management (UM) Program to ensure timely access and authorization for the provision of medically necessary covered services. LHCC will comply with all Model Contract requirements including those in 2.12 Utilization Management; the MCO Manual; state and federal requirements including 42 C.F.R. §438.210; and any court-ordered requirements such as Chisholm v. Gee, the Wells Settlement, and U.S. v. Louisiana Department of Health. We provide details of our UM Program in 2.10.10.2 and our experience with UM in 2.10.10.3 below.

AUTHORIZING SERVICES

Our strategies to satisfy contract requirements and ensure timely, efficient authorizations that meet local standards of care for enrollees to receive the right care, at the right time, and in the right setting include:

- Minimal prior authorization (PA) requirements to simplify the process for timely access to care and reduce the administrative burden on providers.
- Industry leading technology solutions that integrate data and provide UM and other staff with a near-real time, whole-person context for any single episode of care and track operational performance and timeliness.
- Nationally-recognized, commonly-used criteria and Louisiana-specific policies to reduce the amount of variation across MCOs and Inter-rater Reliability (IRR) testing to monitor consistency of criteria applications.
- On-the-ground, locally-based staff who understand the individual needs of enrollees and providers including factors influencing health and service requirements which include subpopulations such as Chisholm, Wells, and the Department of Justice (DOJ) target population and dedicated teams for specific service types.

Minimizing Authorization Requirements

LHCC requires PAs for a limited number of services. We continually review and revise our PA list to include only those services for which the PA process can favorably influence quality of care and appropriate utilization. We remove the PA on services that we consistently approve, and our UM staff submit any services that meet these criteria to our UM Committee to recommend removal from the PA list. In addition to all required exceptions for PA as outlined in Contract 2.12.10 Exceptions to Requirements and in the MCO Manual, we do not require a PA for selected outpatient surgeries performed in a participating ambulatory surgical center; multi-systemic family therapy; crisis related services, intervention, and stabilization; ASAM Level 1 services; and portable oxygen for pediatric enrollees. LHCC contractually requires providers to submit PAs for inpatient physical health (PH) and behavioral health (BH) non-emergency admissions. We do not deny payment for emergency services and LHCC covers services needed to diagnose, stabilize, and treat enrollees with emergency medical conditions. LHCC partners with our providers to ensure timely notification of admission so Transitional Care and Care Management (when needed) staff can begin coordinating a comprehensive discharge plan upon notification, including for high-risk enrollees with typically short inpatient stays. Pursuant to EPSDT requirements, we do not apply benefit limits for enrollees up to 21 years of age. We do not deny the continuation of higher-level services for failure to meet medical necessity unless LHCC can provide the service through an in-network or out-of-network provider at a lower level of care.

LHCC worked with LHC Group to develop a collaborative home health authorization process that allows clinicians to focus on providing care rather than waiting for authorizations.

Streamlining Pharmacy Authorizations. LHCC follows the LDH Preferred Drug List (PDL) and pharmacy PA requirements, and we expanded our PDL to be less restrictive than LDH's PDL. For example, we added three vaccines (meningitis, shingles, and pneumonia) that the LDH PDL does not cover. Our pharmacists and Medical Director review pharmacy exception requests for enrollees to receive condition-appropriate medications regardless of whether the medication is on the PDL. For all enrollees under the age of 21, we consider individualized needs including any benefit limits. We do not require a PA for a drug exempted from federal law and State requirements and make all non-preferred drugs available through our PA process. We consider

recommendations from providers and enrollees and use our State Drug Utilization Review (DUR) activities to improve pharmacy PA processes and requirements. LHCC maintains a DUR program in accordance with LDH DUR initiatives, to ensure that outpatient drugs are appropriate, medically necessary, and are not likely to result in adverse medical results in accordance with Section 1927(g) of SSA. Our DUR standards (prospective, retrospective, and educational) are consistent with the standards established by LDH and the DUR Board, on which our Pharmacy Director and Chief Medical Director participate. Participating on the Board allows them to provide input in reviewing all state DUR Board initiatives and meetings.

Simplifying the Authorization Process

LHCC understands the demands on providers and offers a simplified, timely PA process. Providers may call to request an authorization, submit requests by fax, or through our secure web-based Provider Portal. Our PA Request Tool, available to all providers regardless of network status, allows the provider to verify whether a service requires an authorization. Using this tool, providers can submit requests through a HIPAA 278 transaction and view the status of their requests.

To provide rapid approvals, we offer IQ Connect through our Portal. This point-of-care solution incorporates Interqual® criteria in a fully automated, interactive workflow that supports real-time medical appropriateness review and determination for select services. In addition, we encourage hospitals to participate in near real-time Admission, Discharge, and Transfer (ADT) data exchange. In return, our authorization automation engine and IQ Connect eliminate the need for providers to submit inpatient admissions paperwork. To reduce burden for providers, facility staff, and enrollees, LHCC requires only the minimum necessary information to process PA requests.

***Table 2.10.1.A* Streamlining Processes to Ensure Timely Access**

Referrals	We do not require PCPs to issue paper referrals. We only require a PA for referral to certain specialty physicians and non-emergent out-of-network providers.
Second Opinions	LHCC authorizes requests for a second opinion, at no cost to the enrollee, when there is a question concerning diagnosis, options for surgery, other treatment of a health condition, or when requested by any member of the enrollee's health care team, including the enrollee, parent, guardian, or social worker exercising a custodial responsibility. We authorize second opinions from out-of-network providers if there is no in-network provider available.
Extended Specialist Services	LHCC provides extended authorizations for enrollees who require ongoing care from a specialist. We authorize access to specialty care centers for enrollees with life-threatening conditions or diseases that require specialized medical care over a prolonged period of time.
Out-of-Network Services	LHCC authorizes out-of-network services when services are not available from a qualified network provider or when necessary to ensure continuity of care in complex cases.

Responding to our Providers
BH providers asked for alternatives to our telephonic request submission process. As a result, LHCC implemented fax and web-based submission of requests.

LHCC is proactive in seeking pertinent medical information from the treating provider to make a determination. If the provider does not provide the information needed, our staff or Medical Directors outreach to providers to elicit needed information. LHCC provides a mechanism for enrollees or their authorized representative to submit authorization requests orally or in writing. They can make a verbal request or complete a treatment request form, and we educate enrollees about the availability of this process in our Member Handbook or during the grievance process. Once we approve an authorization, our system provides the authorization number to the provider along with effective dates. Our system electronically stores time and date requests, LHCC's decision, the clinical data used to support the decision, and notification timeframes for providers and enrollees. Our dedicated Chisholm Review Team approves ongoing authorizations if no changes occur with the enrollee's condition. If we do not receive necessary information, our dedicated Prior Authorization Nurse (PA Nurse – UM Liaison) outreaches to the provider, or other involved party such as the LDH EPSDT case manager, to obtain additional information to approve the request. Enrollees can make a prior authorization request if the provider refuses to submit one and the PA Nurse outreaches to the provider for any needed information to make a determination.

Technology Solutions for a Near Real-Time, Whole Person Context

LHCC offers interoperable systems that seamlessly integrate information to support holistic decision-making and facilitate PA requests or other UM activities. We use Centelligence, Centene's proprietary family of integrated decision support and health care informatics solutions, to facilitate comprehensive data collection, indicator measurement, analysis, and improvement activities. Centelligence uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows the collection, integration, and reporting of internal and external data including PH, BH, and pharmacy claim or encounter data, and external data such as state immunization registry and clinical laboratory results. Claim and encounter transaction data is loaded into Centelligence nightly. We will integrate data from external sources, such as the Louisiana Health Information Network Encounter Notification Service (LHIN-ENS) near real-time data from hospital EMRs across the State, and the Louisiana Immunization Network for Kids. This provides context for UM staff and medical directors considering PA requests and requires minimally necessary supporting information from the provider. Receiving ADT also allows our PA automation engine to automatically issue an authorization for a stay that meets criteria, eliminating the need for providers to submit a request.

Enabling Holistic Context for Single Episodes of Care. TruCare, our integrated health management platform, leverages the comprehensive, integrated information in Centelligence to provide UM and Care Management staff and Medical Directors a whole health context to fully understand the single episode of care. LHCC uses all available information to understand the enrollee's care needs and any barriers including the information submitted by providers during the UM review, discharge planning, and care coordination processes.

Use of Nationally-Recognized, Commonly-Used Criteria

As described in more detail in 2.10.10.2.1 below, we use Interqual and other nationally recognized criteria commonly used by health plans in addition to IRR to test consistency. Because these criteria are so common, most providers are familiar with the type and scope of documentation and processes required for medical necessity reviews, resulting in minimal impact on their practice and enrollees. Providers indicate that other Medicaid MCOs use Interqual, which helps to simplify the administrative impact for providers contracted with multiple MCOs.

On the Ground, Local Staff

[redacted]

Our Senior VP of Medical Affairs, has been a hospitalist for St Tammany Hospital for 3 years. In this role, he sees firsthand how MCO policies and processes impact providers and enrollees. He leverages this experience to improve LHCC as well as other MCO UM processes.

Our Medical Directors, Network Management, and Care Management staff provide in-person assistance to providers and enrollees on UM processes. Through these interactions, we stay current on local patterns of care (which we reflect in our application of criteria) and we are alerted to issues with our requirements or processes.

Dedicated Staff and Teams

LHCC has dedicated staff and teams who manage authorizations for specific services and populations.

Table 2.10.10.1.B Dedicated UM Staff and Teams

Staff/Team	Description
Special Services Team	This team focuses on appropriate utilization of skilled services such as extended home health, pediatric day healthcare centers (PDHC), personal care services (PCS), custom DME (via Physical Therapist review), hospice, nursing facility, and BH services such as for ABA, SUD, and PRTF.
Chisholm	Our integrated Chisholm Review Team includes RN Case Managers, RN PA Liaison, and Medical Directors. Our dedicated PA Nurse (UM Liaison) works with EPSDT case managers, Support Coordinators, providers, and enrollees to eliminate unnecessary bureaucratic barriers to obtaining PA for all prior authorized

	services. Our Chisholm Review Team works closely with LDH and participates in meetings to discuss Chisholm population trends and recommendations for UM processes for this membership.
DOJ Target Population	LHCC provides in-person PASRR Level II screenings via our dedicated PASRR Team and we contract with 31 LMHP providers to conduct these screenings in communities throughout the State.
Wells	Our dedicated Pharmacy Coordinators and RNs on our Correspondence Team review and provide a secondary proofing process prior to submission of these notifications in Wells-compliant templates.

Meeting Timeliness Standards for Authorization Requests

LHCC has service authorization policies and procedures for prior, concurrent, and post authorization that comply with 42 C.F.R. §438.210, Model Contract Section 2.12.9, and court-ordered requirements. We conduct reviews in a timely manner, in compliance with State and federal laws, Contract requirements, and as appropriate, based on the severity of the enrollee's condition and the urgency of the need for treatment as documented in the request including timing of authorizations and any exceptions listed in the Contract.

Table 2.10.10.1.C Completing Timely Authorizations

Type of Review	Timeframes
Standard Service Authorization	We make 80% of determinations within 2 business days of obtaining appropriate medical information, and 100% within 14 days following receipt of request. In 2018, we completed 93.62% of BH and 99.7% of PH requests within the required timeframe.
Expedited Service Authorization	If decisions could seriously jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function, we make a decision as soon as possible within 72 hours of request. In 2018, we completed 99.4% of BH and 100% of PH expedited requests within 72 hours.
Extensions	We extend the timeframe for standard requests up to a total of 14 calendar days and expedited requests by two business days if requested by the provider or enrollee, or we determine and justify the need for more information and how the extension is in the enrollee's interest.
Concurrent Review	For inpatient reviews, we review 95% of determinations within 1 business day and 99.5% within 2 business days of obtaining appropriate medical information. For ongoing services already approved, we obtain additional clinical information prior to the end of the authorization period. All concurrent determinations are completed within both the Contract and current NCQA guidelines. In 2018, we completed 97.95% of BH and 97.7% of PH inpatient concurrent reviews within 1 business day.
Adverse Action	For any adverse decisions related to a termination, suspension, reduction, or previous authorization of a Medicaid covered services, we send notification to the provider within two business days of making the determination, not exceeding NCQA current guidelines.
Pharmacy	We complete review of a retail drug requiring PA within 24 hours of request. For retail requests, we permit and reimburse pharmacists to provide a 72-hour emergency supply to ensure continuity.
Informal Reconsideration	We allow the enrollee (or provider/agent on behalf of an enrollee) a reasonable opportunity to present evidence and allegations of fact or law, in person and in writing within one business day of receiving the request for the informal reconsideration.
Post Authorization	We make retrospective review determinations within 30 calendar days of obtaining the results of any appropriate required information. In 2018, we completed 99.43% of BH and 99.9% of PH reviews within the required timeframe.

FLOWCHARTS

Attachment 2.10.10.1.A Authorization and Informal Reconsideration Workflows depicts our PA process from initial response to final disposition, including for expedited authorizations and informal reconsiderations; and ***Attachment 2.10.10.1.B Chisholm Workflow*** depicts our process for Chisholm authorizations.

2.10.10.2 The Proposer should describe how it will satisfy the requirements for utilization management set forth in the Contract. Such description should include:

LHCC meets and exceeds UM requirements through our UM Program, designed to achieve the Quadruple Aim, which includes improving the work life and satisfaction of providers. We ensure enrollees receive the right care, at the right time, in the right setting, in alignment with LDH requirements and nationally recognized, evidence-based criteria, and our UM and Care Management programs fully integrate PH and BH to promote timely, appropriate care. Our program monitoring and processes comply with Model Contract section 2.12 and MCO Manual section 2.12; regulatory requirements and accreditation standards, including NCQA Health Plan Accreditation requirements for UM; federal regulations including 42 CFR 422, 431, 438, 455, and 456; relevant State requirements, such as LAC 50:I.1101 for medical necessity determinations; and all other related RFP, Model Contract, and MCO Manual requirements.

Key Strategies for Meeting UM Requirements. Our collaborative UM approach uses a person-centered focus and a fully integrated PH/BH UM Team. Examples of our strategies to satisfy UM requirements and improve enrollee care include:

- **Serving as the enrollee's advocate to obtain timely, needed services.** Our UM clinicians, which include RNs, Licensed Mental Health Professionals (LMHP), Physical Therapists, Pharmacists, and LPNs obtain information needed to approve requests for enrollees to receive what they need, when they need it.
- **Using the UM function to promote whole-person care.** We consider the enrollee's entire range of needs including social determinants of health (SDOH) and collaborate with other LHCC staff (such as CMs, CHWs, pharmacy staff) and providers to promote whole-person care.
- **Ensuring local provider leadership on clinical policy**. LHCC's physician-led Clinical Policy Committee (CPC) will empower local physicians to ensure clinical policy reflects local practice patterns and standards of care, and addresses provider concerns. Dr. Gary Wiltz, from Teche Action Clinic will chair the CPC.
- **Supporting providers.** Collaboratively, our UM and Provider Engagement Team offer training and support to providers to simplify our UM processes. We also offer our comprehensive clinical trainings and easy-to-use web-based resources to determine services requiring authorization and to submit and track requests.
- **Supporting continuous improvement through industry-leading technology capabilities.** We use our Centelligence platform and data analytics tools to track and trend data, inform UM activities and to support planning and evaluating improvement activities.

UM Program Scope. Our comprehensive UM Program applies to all eligible enrollees across all product types, age categories, and range of diagnoses. Our program incorporates all care settings including preventive, emergency, primary, specialty, acute, short-term, long term, and ancillary care services. Our UM process uses the following program components: authorization and pre-certification, concurrent review, ambulatory review, retrospective review, retroactive eligibility review, 24-hour nurse triage, referrals, second opinions, discharge planning, and transition of care activities. LHCC's UM Program also complies with UM requirements for subpopulations and court orders, which includes:

- Ensuring Chisholm class enrollees receive all medically necessary EPSDT services in a timely manner, following the stipulations and judgments of Chisholm v Gee and the guidance in the Chisholm Compliance Guide. This includes the required liaisons, authorization and notice requirements, and an outreach and referral system that connects class enrollees with an Autism Spectrum Disorder to qualified professionals for Comprehensive Diagnostic Evaluations required to establish medical necessity for ABA services.
- Conducting UM and review functions for the Coordinated System of Care (CSoC) population and applying an initial risk screen for CSoC eligibility. We warm transfer enrollees to the contracted administrator of the CSoC program to assess for CSoC presumptive eligibility and use the LDH 313 report to monitor utilization of these services. UM staff, CMs, and our CSoC Liaison coordinate with Magellan and CSoC providers.
- Completing PASRR reviews using our dedicated staff and contracted vendors (*see* Section 2.10.10.2.3) to ensure enrollees in the DOJ target population receive services in the appropriate setting.
- Providing denial notices in compliance with the Wells Settlement and guidance in the Companion Guide.

- Performing pre-screening and timely notices of determination for, and authorization of, PRTF services in compliance with the Model Contract Requirements in 2.12.7. We complete pre-screening for youth pending release from a secure setting if it is anticipated the youth will be re-enrolled with LHCC following release.

LHCC maintains, or requires providers and contractors to maintain, an individual medical record for each enrollee, in accordance with the MCO Manual and in compliance with Model Contract requirement 2.12.1.27, 2.12.2, and 2.12.4. Our UM Program includes monitoring and addressing trends in service requests, approvals, denials, terminations, reductions, and suspensions. Examples of our improvement efforts include removing PA requirements as noted above and the initiatives we describe below in 2.10.10.3.

UM Program Oversight. Our Board of Directors has ultimate authority for our UM Program and delegates oversight of the UM Program to the Medical Management Committee (MMC), which includes network providers. The MMC reviews and approves all UM policies, procedures, and performance and makes improvement recommendations to our Quality Assessment and Performance Improvement Committee (QAPIC). Our MMC also monitors the UM activities of both LHCC UM staff and our providers under the direction of our Chief Medical Director. Our CPC will make decisions directly affecting medical coverage issues and impacting patient care and overall medical management such as medical policy. Our Senior Leadership Team monitors day-to-day UM Program activities, and Louisiana-licensed professionals with deep roots in this State provide clinical oversight of our UM Program. These professionals have long-standing relationships with Louisiana providers and many years of experience providing direct care to the Medicaid population.

2.10.10.2.1 The proposed criteria to use in its utilization management process and how such criteria will be applied, including both determination of appropriateness of treatment and site of treatment;

LHCC uses nationally recognized, evidence-based criteria relevant to our population to ensure effective care in the most appropriate setting. We use Interqual for PH and BH inpatient, outpatient, and residential services; American Society of Addiction Medicine (ASAM) for inpatient and outpatient substance use disorder (SUD) services; and LOCUS/CALOCUS for BH inpatient and outpatient services. LHCC adopts criteria from nationally recognized, reputable organizations that establish standards for clinical decision management; LDH's definition of medical necessity; and internally developed clinical policies and guidelines in the absence of nationally recognized review criteria or where local practice patterns do not align with Interqual. Our internally developed clinical policies are consistent with and no more restrictive than FFS requirements and our local provider-led Clinical Policy Committee (CPC) will ensure these policies are consistent with local practice patterns and standards of care. We review and update our UM criteria/guidelines at least annually and as needed, and prior to adopting these criteria/guidelines, we ensure relevance to the specific characteristics of our enrolled populations through review and approval by our CPC, UM Committee and QAPIC. This process includes input from local practicing providers experienced who serve these populations. For adverse determinations, we distribute specific underlying criteria to the provider, enrollee, or enrollee's authorized representative upon request.

LHCC has adopted PH and BH clinical practice guidelines (CPG) from national medical specialty or government organizations and as required in Model Contract section 2.12.1.4 and MCO Manual 2.12.3. LHCC also has adopted and measures compliance with CPGs for specialized BH services. We have adopted the following CPGs from LDH's reporting tool #358 Provider Quality Monitoring: ADHD, Depression, Schizophrenia, SUD, and Suicide Risk. Our Quality Department reviews all BH providers for CPG compliance at least once every two years. We require corrective action for any scores <80%, and work with the provider to improve documentation and educate as needed on the CPG. Re-audit occurs after 180 days and until the score increases to at least 80%.

Providers and enrollees can access our comprehensive list of adopted CPGs on our LHCC website. If we develop CPGs internally, we review and approve them through the CPC, which includes representation from appropriate board-certified specialists. We review and update all CPGs at least every two years or more frequently as new technology and research dictates. While LHCC does not use CPGs as criteria for medical necessity decisions, our Medical Director(s) and UM staff make medical necessity decisions that are consistent with CPGs distributed to network providers.

LHCC works with LDH and other MCOs to develop and coordinate common UM policies and CPGs to minimize provider burden as described below. For example, LHCC worked with LDH and incumbent MCOs to develop a common hospital observation policy, which we implemented July 2018. We also coordinated development of specialized BH CPGs with other MCOs to avoid providers receiving conflicting CPGs from different MCOs.

Applying Criteria Including Determining Appropriateness of Treatment and Site of Treatment

Our UM staff and Medical Directors use review criteria as evidence of generally accepted medical practices that support the basis of a medical necessity determination and not solely as a basis to deny, reduce, suspend, or terminate a good or service. Applying criteria to determine appropriate treatment and site of treatment involves ensuring there is no other effective and more conservative or substantially less costly treatment, service, or setting available. LHCC ***looks beyond clinical factors*** to assess social and other non-clinical factors to adequately determine appropriateness and necessity. For example, Medicaid enrollees on a ventilator who no longer meet criteria for inpatient care may not have an appropriate alternative setting for a safe discharge. We also authorize less restrictive services as a substitution, when appropriate, such as a nursing facility as a substitute for inpatient, when the enrollee does not meet inpatient level of care but is not ready for discharge to home. Below we describe what LHCC considers when determining appropriate treatment and site.

Table 2.10.10.2.1 Applying Criteria

Considerations in Applying Criteria to Determine Appropriate Treatment and Site of Treatment	
For All Enrollees	**Enrollee-Specific Considerations**
Characteristics of the local delivery system: • Clinically trained staff in locations affected • Specialty providers in specified regions • Availability of requested services • Location of enrollee's place of primary residence • Family or caregiver Support • Community Resources including for SDOH	• Age, co-morbidities, complications, progress in treatment, psychosocial situation, and home environment • Special circumstances that may require deviation from criteria such as disability, acute condition, co-morbidities, life-threatening illness, or risk of institutionalization
Additional Considerations for All Enrollees	
Determining Appropriate Treatment	**Determining Appropriate Site of Treatment**
Is the treatment: • Appropriate and consistent with the treating provider's diagnosis and omission could adversely impact the enrollee's medical condition • Compatible with community standards of acceptable medical practice • Not provided solely for convenience of the enrollee, provider, or facility providing the care • Most conservative, equally effective and least costly available	**Is the treatment:** • Provided in a safe, appropriate, and cost-effective setting given the diagnosis and severity of the symptoms • Not primarily custodial care unless custodial care is a covered service or benefit for the enrollee • In the least restrictive setting

Ensuring Consistent Application of Criteria

Inter-rater Reliability Testing. Annually, we perform Inter-rater Reliability (IRR) testing to monitor the consistency of criteria application for all LHCC staff who participate in the medical necessity review of services. All staff must obtain a score of 90% in each tested subset or complete additional training and retesting to ensure comprehension. We use McKesson's IRR test for Interqual criteria, which evaluates the consistent application of criteria by comparing decision-making among clinical reviewers against the standards provided by Interqual.

96%

Average IRR score of our clinical review staff in 2018 (includes BH criteria)

Physician Reviews. Annually and as needed, Centene's Medical Management Audit (MMA) Department reviews decisions by our PH and BH Medical Directors to determine accuracy and consistency. Medical Directors from Centene plans across the country review decisions made by their peers and provide a rationale for their

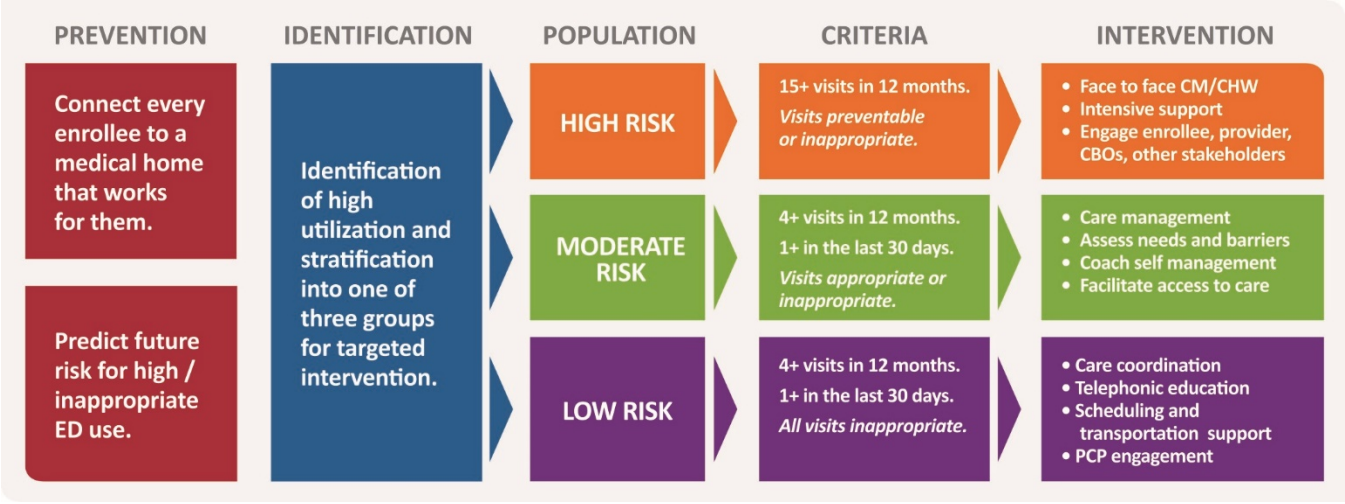
evaluation. If needed, our audit staff develop a corrective action plan, which may require additional training. LHCC further ensures physician consistency through quarterly IRR reviews by Centene's MMA Department of medical directors across affiliate plans in specific regions. LHCC Medical Directors also discuss cases (including denials) in twice monthly and ad hoc medical staff meetings to improve consistency.

2.10.10.2.2 The Proposer's process for monitoring and addressing high emergency room utilization;

LHCC monitors a wide range of data to identify high ED utilization, analyzing factors such as specific diagnoses, providers, times of year, or geographic areas. We use our ED Dashboard, which allows filtering such as on specific regions or providers, to track and trend ED claims and utilization data. We also will track statewide ADT data through the Louisiana Health Information Network Encounter Notification Service (LHIN-ENS) to identify enrollees with an ED visit in the previous 24 hours. We drill down on root causes and develop initiatives to address them.

Enrollees with High Utilization. Our ED Diversion Program, as depicted in the graphic below, deploys a two-part strategy: 1) preventing high utilization before it occurs; and 2) stratifying high utilizers and developing targeted mitigation strategies. ***Prevention.*** Upon enrollment, LHCC connects enrollees to a medical home that works for them by educating them and supporting the selection of an appropriate PCP. We offer provider incentives and VBP arrangements to promote after-hours and weekend access. Prevention also includes identifying enrollees on a path to high utilization. Our ED Super-utilizer predictive model helps us identify enrollees who may become high utilizers and determine whether they are on a path to inappropriate ED use, or to appropriate but preventable high ED use, so we can intervene effectively. ***Stratification/Intervention.*** LHCC identifies and stratifies high utilizers into three groups, with interventions for each based on the amount and type of ED utilization. We build on the interventions for the potential high utilizers and focus in on the specific utilization drivers for each group, including face-to-face Care Management and CHW support as needed.

Figure 2.10.10.2.2 ED Diversion Program



Engaging Providers

LHCC alerts providers of ED use via the ED Flag on the enrollee Member Health Record on our Provider Portal. For providers with multiple linked enrollees with high ED use, we offer technical assistance and training through our Clinical Registered Nurse Liaisons and our Provider Engagement Team. These staff address provider performance such as care gaps, ED use, and primary care utilization in comparison with peers; appointment availability; ADA or cultural competency issues; and follow-up after discharge. We provide multiple tools and reports to help providers analyze and address performance to reduce avoidable ED utilization.

Provider Analytics. Centelligence Provider Analytics, available through our secure Provider Portal, bring together actionable and timely clinical and administrative data. Using these data, LHCC staff and providers can identify and prioritize enrollees for outreach based on clinical needs. Providers can access custom selection, drill-down, and access data exporting and reporting capabilities to identify factors behind clinical and cost performance, and strategically develop clinical actions. Providers can see, at a high-level,

the number of admissions/readmissions and the overall admission/readmission rates. We will also offer providers access to 3M's Provider Performance Dashboards, which will deliver 12 months of rolling data on preventable readmission and ED utilization, and calendar year-to-date information at both the aggregate and enrollee-level.

2.10.10.2.3 The Proposer's process for pre-admission screening and concurrent reviews;

COMPLETING PASRR LEVEL II SCREENINGS

LHCC maintained 98 to 100% compliance for the past two years, with an average compliance rate of 99.25% for 2018, despite a 54% increase from 2017 to 2018 in number of PASRR requests received from OBH due to implementation of My Choice Louisiana.

LHCC has a dedicated PASRR team of Care Coordinators and CMs and we contract with 31 LMHP providers to ensure our ability to perform timely in-person assessments for enrollees in any part of the State. When LHCC receives PASRR documentation from the Office of Behavioral Health, we confirm eligibility and a PASRR Coordinator ensures completion of the PASRR II assessment. LHCC PASRR staff or an independent assessor reviews all relevant enrollee information in TruCare; completes the PASRR assessment, LOCUS, and supplemental documentation; and returns all documentation and a recommendation on appropriate placement to our PASRR Coordinator within three days of receiving documents from OBH. UM staff review all documentation and the recommendations and either agree, disagree, or request corrections or clarification from the assessor before making a determination. Once a determination is made, the PASRR Coordinator uploads documents to OBH's PASRR site, and sends an email stating that documents were uploaded along with the recommendation statement. Our Transitional Care Team follows up with the enrollee for PASRR-recommended services or to offer Care Management and assistance accessing alternative BH services, as applicable. LHCC tracks enrollees in nursing facilities who have completed the PASRR process, those identified with SMI, and those receiving specialized services per 42 C.F.R. §483.130. LHCC trains assessors on PASRR and LOCUS, including the process for completing the evaluation and LOCUS forms. With the implementation of My Choice Louisiana, OBH enrolled their transition coordinators in LHCC's PASRR trainings.

COMPLETING CONCURRENT REVIEWS

LHCC's Concurrent Review (CCR) staff determine appropriateness of treatment rendered and level of care and monitor to verify professional standards of care for services already approved or initiated. Information assessed includes clinical information on the enrollee's status to support the appropriateness and level of service proposed; whether the diagnosis has changed; additional days, services, procedures proposed; and reasons for extension of treatment or service. We conduct concurrent review for hospitalizations throughout the inpatient stay, with each day approved based on the enrollee's current condition and evaluation of medical necessity. Concurrent review can occur onsite, through documentation exchange (hard copy or remote electronic access), or telephonically. Review frequency is based on severity or complexity of the enrollee's condition or necessary treatment and discharge planning activity. If, at any time, services do not meet inpatient criteria, discharge criteria are met, or alternative care options exist, the CCR nurse contacts the requesting provider to justify continuation of services. When we cannot determine medical necessity, the Medical Director reviews the case. Our Transition of Care Team participates in the CCR process to anticipate needs for a safe transition to the next level of care.

2.10.10.2.4 How the Proposer complies with mental health parity requirements; and

LHCC has an LDH-approved plan to ensure compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and applicable federal and State requirements. We ensure that medical necessity determinations for mental health (MH) and SUD benefits are available to all enrollees in the same manner as for medical or surgical benefits. Quantitative treatment limitations are no more restrictive than predominant limits applied to substantially all medical or surgical benefits in each classification. We make available in hard copy (upon request at no cost to the requestor) and on our website the criteria for medical necessity determinations for MH/SUD benefits to any enrollee, potential enrollee or provider per 42 C.F.R. §438.236(c) and 438.915(a) and in compliance with Model Contract Sections 2.3.11.2.3 and 2.3.11.3. We also ensure parity for application of non-quantitative treatment limitations (NQTL) with that of medical/surgical benefits. We do not apply NQTL for MH/SUD benefits in any classification unless factors used in applying the NQTL are comparable to, and applied no more stringently than,

the processes, strategies, evidentiary standards, or other factors used in applying the NQTL for medical or surgical benefits in the classification. LHCC applies comparable processes, standards, and criteria to both MH/SUD services and medical or surgical services. We further comply with the NQTL review of process, strategies, evidentiary standards, or other factors used in applying the NQTL including all 13 LDH-selected NQTL areas for analysis including:

- ***Utilization Review***, 4 NQTLs: PA, concurrent review, retrospective review, and outlier review
- ***Clinical Review***, 3 NQTLs: Documentation requirements (treatment plans), application of medical necessity criteria/LOC determinations, and step therapy
- ***Network Review***, 4 NQTLs: Requirements in addition to licensure or state required certification, for unlicensed/uncertified practitioners and staff, standards for out-of-network coverage, and provider reimbursement
- ***Pharmacy Review***, 2 NQTLs: Formulary development and lock in programs.

LHCC provides MH benefits in compliance with MHPAEA for the benefit classifications, which include the use of inpatient services, outpatient services, emergency care, and prescription drugs when applying mental health parity. We structure our benefit delivery system for enrollees to receive MH services in a manner that is comparable to medical and surgical services to ensure access to care.

2.10.10.2.5 How the Proposer identifies and mitigates over-utilization, including any targeted categories.

Identifying Over-Utilization. LHCC identifies over-utilization using claim and encounter data; information from prospective, concurrent, and retrospective reviews and DUR; analysis of adverse determinations; and Care Management information. We monitor and analyze data at aggregate and detail levels by enrollee, individual provider or facility, provider specialty, type of service, diagnosis, place of service, region, and comparing services authorized to services received, including SDOH information. We also identify over-utilization through staff contact with enrollees and providers. For example, UM and Care Management staff may identify potential utilization issues during transitional care planning, monitoring, or other face-to-face or telephonic interactions. In each case, we compare performance to average network performance or national benchmarks to identify issues. Our Provider Performance Unit staff may identify trends as part of ongoing review of network performance and drill down reports that may reflect potential under-, over-, and inappropriate utilization of services; or potential fraud, waste, and abuse.

Mitigating Over-Utilization/Targeted Categories. Below, we summarize mitigation strategies followed by targeted categories.

Table 2.10.10.2.5 Strategies for Mitigating Over-Utilization

Programs	Clinical Policy	Provider Education	Provider Incentives	Enrollee Education
Developing or modifying CM programs that target high utilization such as ED Diversion or Pharmacy Lock In	Adopting or revising clinical policy to reflect local characteristics and incorporate provider input on effective practices	Developing or updating provider training on evidence-based treatment of diagnoses driving high utilization	Incentivizing PCPs to expand after hours and weekend availability and incentivizing development of new urgent care capacity and telehealth	Implementing outreach campaigns and developing or revising education materials

Mental Health Rehabilitation (MHR) Services. LHCC created our MHR Dashboard to monitor overutilization of MHR services and track our compliance with submission of the attending provider's NPI. LHCC collaborated with LDH to provide input on development of this rule. Once we identify trends, potential overutilization, or evaluate if a lower level of care is appropriate, we collaborate with the provider, our Provider Engagement Team, Care Management staff, and our Medical Director to develop mitigation strategies. [redacted]

Long-Term Lengths of Stay in ED/Inpatient Facility Due to Lack of BH Services. Our UM and Care Management staff use near real-time ADT data to identify individuals and trends related to long-term lengths of stay in the ED or BH inpatient facilities due to limited availability of necessary BH services. When we identify enrollees experiencing this situation, our Medical Director, Care Management staff, and our Transition of Care Team (TOC Team) collaborate with the facility to develop a comprehensive and appropriate discharge plan and setting. We increased access and coordinated crisis services to reduce long-term lengths of stay, such as additional crisis stabilization beds for children, and developed provider partnerships to expand availability of PRTF beds and IOP services. In accordance with 2.12.1.20, we will develop and submit a plan to reduce lengths of stay in the ED based on lack of BH services.

High ED and Readmissions. LHCC uses a multi-tiered approach to monitoring and addressing high ED utilization and readmissions. Our strategies and approach for monitoring high ED overutilization, described in response to Section 2.10.10.2.2, are similar to those we use for monitoring readmissions and readmission risk**.** To address readmissions, we implemented a Readmission Prevention Program (see box). This program targets enrollees with a score of 50 or above (out of 100) on our ***Readmission Risk Score (RRS)***. We generate the RRS upon admission and include it in our Daily Inpatient Census Report, which identifies risk of readmission and poor outcomes. The next phase of RRS development will incorporate ADT and provider EMR data. We evaluate RRS and input from facility staff, attending physicians, other providers, and our CHWs to identify type and duration of post-discharge supports. [redacted]

Readmission Prevention Program

In-Hospital Engagement. CHWs connect with these high-risk enrollees to engage them in Care Management.

Medication Reconciliation. If enrollees need home health or IOP, we will complete pre-discharge medication reconciliation. LHCC completes fill-the-gap and post-discharge reconciliation via our TOC Team or Care Management staff.

Transition of Care Team. Our dedicated Transitional Care staff and CMs collaborate with our UM staff on discharge planning and seamless transitions.

Onsite Concurrent Review. [redacted]

Face-to-Face Coaching/Support. CHWs or Care Management staff conduct in-person coaching on 'red flags' and readmission risks and provide coordination assistance.

Link to SDOH Resources. CHWs, Transition staff, CCR nurses, and CMs identify needed SDOH resources and ensure enrollee access.

Another example of how we are addressing high ED utilization and readmissions is through our partnership with Children's Hospital Ventilator Assisted Care Program. Eligible enrollees will have access to this Program which provides a team of nurses, social workers and community support services to provide 24/7 on call services to children and their families upon discharge from the hospital including care coordination, caregiver training and education, as well as in-home RN visits if needed.

Custom Durable Medical Equipment (DME). We identify areas of inappropriate or high Custom DME utilization through our authorization process and data review. In July 2018, we hired a Physical Therapist as a part of our UM Team to assess and provide educational support to therapists or other providers ordering Custom DME for enrollees. This added competency has resulted in more than a 50% decrease in the overall Overturned Denial Rate for these inappropriate DME. When we identify trends or potentially inappropriate requests, our Physical Therapist works with providers to ensure enrollees receive DME that meets their clinical needs/requirements.

Prescription Drugs. This is a key area we target for identification of overutilization and mitigation. For example, we use Centene's nationally recognized Psychotropic Medication Utilization Review (PMUR) Program, originally designed for children in foster care, to identify psychotropic medication prescribing practices that fall outside of the recommended standard of care. In 2018, PMUR prescriber interventions reduced the number of inappropriate prescriptions by 11%, number of quantity dispensed per claim by 12%, cost per claim by 19%, and cost per enrollee by 16%. Our ADHD Medication Monitoring Program, a PMUR and Disease Management Collaboration, expands beyond the typical PMUR peer review processes to perform an intensive review of enrollees under age six prescribed one or more stimulants with no other BH interventions. Our Pharmacy Lock-In Program detects and prevents prescription abuse by restricting enrollees to one pharmacy and controlled substance provider for a defined period of time. To identify and mitigate opioid overutilization, our OpiEnd Program provides enrollee interventions (Care Management, education, pre- and postnatal support to address neonatal abstinence syndrome); provider interventions (buprenorphine waiver training with targeted education and mentoring for prescribing; pain management education for physicians, nurses, and pharmacists; quality/cost analyses; personalized treatment plan options); pharmacy utilization tracking using CDC guideline measurements and Prescription Drug Monitoring Program reporting; and community education.

Our Chief Medical Director visited our highest volume OBGYNs in 2017 to review their utilization compared to LHCC peers. He reviewed prenatal and post-partum care, notification of pregnancy, use of 17P, plus 3 birth outcomes (C-sections, pre-term births, low birth weight deliveries). In 2018, 13 of 17 providers showed improvements in all 3 birth outcomes compared to 2016.

2.10.10.3 The Proposer should describe its historical experience with utilization management of comparable populations. Such description should include:

LHCC has managed utilization for Louisiana Medicaid enrollees since 2012. Our experience encompasses all eligible populations, including those in state custody through OBH, OJJ, and DCFS; Chisholm class enrollees; DOJ target population; and the Medicaid expansion population. LHCC also leverages Centene's 35 years of experience, currently managing utilization for over 8 million enrollees in 27 states in populations comparable to all Louisiana Medicaid-eligible populations. We use a fully integrated, collaborative approach to work cross-departmentally to address all elements of the Quadruple Aim and consider the continuum of PH, BH, and SDOH needs. LHCC uses a *listen first* approach to understanding provider needs and challenges. For example, after BH providers indicated that our telephonic authorization process was burdensome and time-consuming, we implemented fax and web-based reviews.

2.10.10.3.1 Challenges identified with high utilization and increasing medical trends;

LHCC continually monitors for challenges to address high utilization and increasing medical trends. Below we describe examples of challenges identified during the current contract period.

Table 2.10.10.3.1. Challenges Identified with High Utilization and Increasing Medical Trends

Challenge	When and How Identified
High ED utilization in Regions 4,5, and 6	In Q4 2017, we analyzed an overall increase of high ED utilization in Regions 4, 5, and 6, and identified low availability of outpatient and after-hours alternatives as drivers.
Increased NICU utilization by drug-exposed infants	In Q2 2017, we identified an increase in number of NICU admissions due to neonatal abstinence syndrome (NAS). We determined that a key factor was increased stigma related to SUD use which prevented enrollees from seeking prenatal treatment.
Medicaid expansion enrollees with no previous source of care	In 2017, we analyzed high utilization of services for the expansion population when first enrolled, and determined the increased utilization was due to gaining coverage.
Increase in ED and inpatient use for BH diagnoses	After BH was carved in in 2015, we identified an increase in ED and inpatient use for BH diagnoses due to lack of BH step-down options and community-based treatment.
Increased use of pediatric day health care (PDHC)	When analyzing utilization for enrollees with special health care needs (SHCN) in Q4 2016, we identified the high use of PDHC, a 10% increase in PDHC requests, and concurrent use of overlapping services

Long inpatient lengths of stay (LOS)	In 2018, we identified hospitals in each region with longer than average LOS. Our Medical Director met with hospital medical directors and UM staff to identify barriers to discharge.
Increase in PRTF use by enrollees in DFCS custody	Based on 2017 utilization review indicating high PRTF use by enrollees in DCFS custody, we identified the need for DCFS staff education on appropriate levels of care and increased availability of outpatient services.
High number of requests for unnecessary DME	In October 2017, we identified a 47% overturned denial rate on custom DME reviews and an increase in secondary reviews sent to consultants.
High prescribing rates of ADHD medication for children under seven	In 2017, through our ADHD medication monitoring initiative, we identified enrollees prescribed at least one ADHD stimulant. We outreached to identified enrollees and their providers to determine whether non-medication treatment options were offered.
High rates of ED use for dental pain	In Q3 2016, we identified an increasing trend in ED use for dental pain. Drill down identified that the Medicaid expansion population was driving this trend.
Increase in HIV and Hepatitis C diagnoses	Since 2016, utilization data has shown an increasing annual trend in monthly average number of enrollees with HIV and Hepatitis C.

2.10.10.3.2 Initiatives undertaken to manage high utilization;

In addition to using our care and disease management programs, transitional care strategies, and ongoing enrollee education/support for accessing needed care appropriately, we have implemented initiatives to manage high utilization. Below, we summarize initiatives to manage challenges described in 2.10.10.3.1.

Table 2.10.10.3.2 Initiatives to Manage High Utilization

Challenge	Initiative Description and Components
High ED utilization in Regions 4,5, and 6	LHCC implemented provider incentives for after-hours availability. We also are adding more CHW support to address access and SDOH issues through our community-based care management model.
Increased NICU utilization by drug-exposed infants	We implemented our Perinatal SUD Program in 2017 to provide care, counseling, and support during and after pregnancy. This helped us decrease average LOS for NICU NAS admissions by 29% from 2017-2018. In 2019, we will partner with StrongWell to implement a peer support program to assist pregnant moms with SUD.
Medicaid expansion enrollees with no previous source of care	We worked with FQHCs and PCPs to schedule preventive and primary care appointments and implemented a basic needs assessment to improve early identification of needs
[redacted]	[redacted]
Increased use of PDHC	We implemented multidisciplinary CCR to determine appropriateness of ongoing authorizations; added onsite CCR staff; and completed rounds with PDHC staff. As a result, we transitioned 10% of enrollees from PDHC to a less intensive environment in 2017.
[redacted]	[redacted]
[redacted]	[redacted]
High number of authorization requests for unnecessary DME	In July 2018, LHCC hired a Physical Therapist to review DME requests and offer education and support to providers on appropriate DME. During the subsequent 9 months, we decreased our overturned denial rate by 20%.

High prescribing rates of ADHD medication for children under six	We implemented our ADHD Medication Monitoring Initiative, which expands beyond the typical PMUR peer review processes. We perform an intensive review of enrollees under age 7 prescribed 1 or more stimulants with no other BH interventions. We explored clinically supported best practices for young enrollees with BH disorders such as behavioral therapy, behavioral analyst, and non-medication related treatment alternatives.
High rates of ED use for dental pain	We enhanced our adult dental value add (implemented in 2015), resulting in a downward monthly trend in ED use for dental pain in 2018. In February 2019, we further enhanced our adult dental value add, including dental exams and cleanings, preventive x-rays, and fillings.
Increase in HIV and Hepatitis C diagnoses	We educated 39 RNs on HIV treatment and protocols and 37 RNs on Hepatitis C treatment and protocols. We implemented primary, secondary, and tertiary measures for population health to address increased HIV and Hepatitis C diagnoses. For example, we educate providers and at-risk enrollees of the availability of pre-exposure prophylaxis (PrEP) to prevent HIV infection. [redacted]

2.10.10.3.3 Initiatives to address use of low value care;

LHCC identifies and addresses underutilization of high value services and overutilization of low value services, as guided by LDH's Quality Strategy. We work collaboratively with LDH to prioritize specific efforts anticipated to improve high quality, cost-effective care for enrollees. In addition to connecting every enrollee to a medical home, our initiatives not previously described include the following:

Addressing Low-Value Care Through Value Based Purchasing (VBP). Our VBP strategy is our overarching initiative to prevent and address low value care. Our alternative payment models incorporate metrics and benchmarks that address LDH's key population health priorities and that signify meaningful improvement in delivering evidence-based care when achieved. We have also enhanced our provider profiling program to support improving quality of care and reducing low-value care. Profiles include measures that identify low-value care, including those in Attachment G.

Improving BH Outpatient Care Quality. [redacted]

*LHCC will leverage the **Choosing Wisely** campaign to encourage providers and enrollees to reduce use of low value care. While our UM policies will not be more restrictive than FFS, we will provide education on evidence-based care for areas of Choosing Wisely focus, such as imaging for non-specific low back pain. We also will provide information on practice variation and costs to providers.*

Addressing Inappropriate Antibiotic Use. In Q1 2019, we identified low value antibiotic use, and associated preventable ED use, for child upper respiratory infections and adult bronchitis. We developed a cross-departmental initiative that includes enrollee education through our UM, Care Management, pharmacy, and population health outreach teams via our enrollee portal, social media posts, emails, and community events. Our Clinical Nurse Liaisons (CNL) educate providers on evidence-based antibiotic use and antibiotic drug resistance, and our Medical Director offers peer education to providers inappropriately prescribing antibiotics for these conditions. We also offer pharmacy team consultations for appropriate prescribing.

Improving Mental Health Rehabilitation (MHR) Utilization. In February 2018, LHCC initiated our MHR Reduction project upon LDH direction to ensure appropriate utilization of Community Psychiatric Support Treatment and Psychosocial Rehabilitation services. In June 2018, we received LDH approval to modify re-authorization request frequency from 6 months to 60 days to improve provider communication of enrollee status and progress. The rates ED use and inpatient admissions for these enrollees fell, both overall and after normalizing for population count change. **This initiative saved more than $25 million, exceeding LDH's $17 million target.**

2.10.10.3.4 Initiatives to address long term stays of enrollees in the ER based on limited availability of mental health and/or substance use services; and

[redacted]

Promotion of Assertive Community Treatment (ACT). When an enrollee receiving ACT services enters the ED with a mental health need, we promote the use of the ACT team to meet the enrollee at the ED to prevent a prolonged stay or inpatient admission. From January 2016-December 2018, ED visits for enrollees receiving ACT decreased by 56%.

2.10.10.3.5 Initiatives undertaken to support providers with high prior authorization denial rates.

Clinical Nurse Liaison (CNL) Education. In 2018, we identified over 100 providers with high rates of inpatient psychiatric PA denials. We identified the root cause as the lack of supporting documentation to justify the requested level of care, and our CNLs provided in-person education on necessary documentation. We also added two clinical psychologists and our UM BH Medical Director, improving our peer-to-peer review capability. Provider feedback indicates that they better understand the authorization process, medical necessity criteria, and the appeals process, and between 2017 and 2019 provider complaints decreased by 57%.

Extended Authorization for NAS Monitoring of Asymptomatic Neonates. In August 2017, we identified a hospital that was receiving a high number of denials for a third inpatient day to monitor asymptomatic newborns with in utero drug exposure. LHCC authorizes two days for vaginal delivery with an extension for neonatal abstinence syndrome monitoring based on supporting clinical documentation, including a recent positive maternal drug screen. The denials were due to the hospital not completing the screens. In working directly with the provider to review data supporting their process, our Medical Director made the decision to authorize the third day without requiring a recent maternal drug screen.

SECTION 2.10.11

Quality

The Partnership is a long-time supporter of Louisiana Healthcare Connections, and we have consistently been impressed by the comprehensive and essential health and care management programs you provide. We are most impressed by your level of community engagement that puts healthcare within reach for so many Louisiana families.

On behalf of our board of directors, I am happy to endorse the efforts of Louisiana Healthcare Connections enthusiastically and without reservation. We believe the work you are doing is critical to helping Louisiana's children have the brightest possible futures.

—Susan East Nelson
Executive Director
Louisiana Partnership for Children and Families

2.10.11 QUALITY [20 PAGE LIMIT; CLINICAL PRACTICE GUIDELINES AND NCQA RATING ATTACHMENT ARE EXEMPT FROM SECTION-SPECIFIC AND TOTAL PAGE LIMITS]

2.10.11.1 The Proposer should describe its organizational commitment to quality improvement and its overall approach and specific strategies that will be used to advance Louisiana Medicaid's Quality Strategy and quality measures #27, 35, 37, and 50 from Attachment G to the Model Contract.

ORGANIZATIONAL COMMITMENT TO QUALITY

Louisiana Healthcare Connections (LHCC) is committed to the provision of a well-designed and well implemented Quality Assessment and Performance Improvement (QAPI) Program that meets all state, federal, NCQA, Model Contract and MCO Manual requirements. Since our inception, LHCC's culture, systems and processes have been structured around its mission to improve the health of all enrollees and achieve the Triple Aim, which directly aligns with LDH quality goals. Accountability for the QAPI program begins with our Board of Directors who delegates operational authority to our QAPI Committee, which includes network provider representation. Based on the principles of Continuous Quality Improvement (CQI), our QAPI Program articulates priority areas; establishes clear aims, goals and objectives; and utilizes reliable and valid methods of ongoing monitoring, analysis, evaluation and improvement. This systematic approach provides a continuous cycle for assessing and improving the quality of care and services through such areas as preventive health, population health, acute and chronic care, behavioral health (BH), access and availability of care, over- and under-utilization, continuity and coordination of care, transitions of care, patient safety, enrollee and provider satisfaction, social supports affecting health, and administrative and network services.

Since 2015, LHCC has achieved the top score among MCOs on its External Quality Review audits.

Accountability Across the Organization. As a quality-driven organization, LHCC has adopted CQI as a core business strategy for the entire health plan, encouraging all health plan staff to continuously ask, "How are we doing?" and "Can we do it better?" Our executive and management teams apply data-driven decision-making in strategic planning and daily operations. Each functional area has defined service metrics with accountability to the Senior Leadership team and reported up through the QAPI Committee. Key leaders are trained on QAPI methodologies. For example, LHCC's Senior Leadership team completed a Quality Boot Camp in February 2019, which included a refresher on topics such as NCQA, HEDIS measurement, CQI and Lean Six Sigma. Forty-three LHCC staff have previously or are currently in Lean Six Sigma training/projects, 18 staff hold Six Sigma certification, and three staff have CPHQ certification. Supported by a designated Quality Improvement (QI) Coordinator, functional area leads and cross-departmental staff engage in monthly meetings to review utilization and other quality data (e.g. appeals, grievances, quality of care, HEDIS, CAHPS, and provider satisfaction survey results) for trends or variances. This allows LHCC to determine root causes and develop, implement and evaluate improvement strategies. Each department is also responsible for ongoing monitoring, analyzing and recommending interventions to improve the quality of care and service to enrollees.

Culture of Excellence:

LHCC's senior leadership includes 3 staff credentialed as Certified Professionals in Healthcare Quality (CPHQ). The CPHQ credential distinguishes quality leaders dedicated to excellence.

OVERALL APPROACH TO QUALITY

LHCC complies with and supports the Louisiana Medicaid Managed Care Quality Strategy and aligns with LDH's priorities, goals, and objectives, which are fully integrated into our QAPI Program and infused throughout LHCC daily operations. Our QAPI program strives to deliver quality care that enables enrollees to stay healthy, prevent poor outcomes, and prevent and manage a chronic illness or disability. Supporting CQI and our ongoing analysis, evaluation and systematic enhancements is our commitment to:

- Quantitative and qualitative data collection with data driven decision making using our Centelligence integrated decision support and health care informatics solutions. Centelligence facilitates our use of data by collecting, integrating, storing, analyzing, and reporting data from all sources.
- Up-to-date evidence based practices guidelines including those developed by professional societies such as

the American Academy of Pediatrics, American College of OB/GYN, American Diabetes Association and the American Psychiatric Association

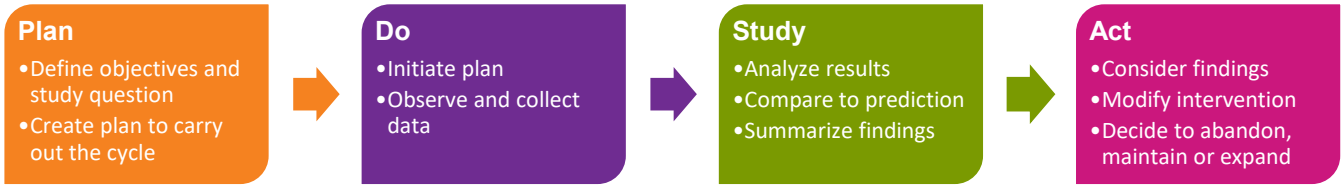
- Feedback provided by enrollees and providers in the design, planning and implementation of CQI activities through our Member Advisory Committee, Community Advisory Committee and Provider Advisory Committee as well as evaluation of enrollee and provider satisfaction and grievance and appeals data
- A focus on issues identified by LHCC or LDH including but not limited to: cancer, prematurity, ADHD, IET, dental care, opioids, diabetes, asthma and Hepatitis C.
- QI/QM requirements of the Contract applied to both PH and BH services

Commitment to the Triple Aim and Beyond. Our entire LHCC staff, starting with our Chief Executive Officer, are committed to focusing our clinical, network and operational processes towards achieving the Triple Aim: improving outcomes and experience while lowering costs. We are also committed to the fourth leg of a ***Quadruple Aim***: improving the provider experience. This commitment is evidenced by our performance and sustained improvements on HEDIS measures, population health, provider satisfaction, and cost savings as described throughout this response.

Figure 2.10.11.1.A Quadruple Aim

Model for Improvement. The purpose of CQI programs is to improve health care by identifying problems, implementing and monitoring corrective action and studying its effectiveness. To do this, LHCC employs the evidence-based Institute for Healthcare Improvement (IHI) Model for Improvement. The IHI Model starts with three questions: • What are we trying to accomplish? • How will we know that a change is an improvement? • What changes can we make that will result in improvement? In the second phase of the Model, staff use rapid cycle process improvement and the Plan-Do-Study-Act cycle to test selected high priority interventions on a small scale and to modify them as needed prior to full implementation. We use data, including structure, process, and outcome measures, to monitor success of interventions and appropriately modify, refine, or replace as indicated.

Figure 2.10.11.1.B Plan-Do-Study-Act (PDSA)



LHCC also incorporates Six Sigma into its quality improvement activities because of the defined sequence of steps and supportive tools and techniques. LHCC staff use Six Sigma DMAIC (Define-Measure-Analyze-Improve-Control) methodology selectively for improving health plan work processes, while the PDSA model is used more generally for improving outcomes. Use of these QI models and tools has produced sustained improvements over time. A sampling of these measures are shown below.

Using Data to Drive Improvement. Centelligence health informatics platform is LHCC's proprietary, comprehensive family of integrated decision support and health care informatics solutions that facilitates objective and systematic monitoring of data by collecting, integrating, storing, analyzing, and reporting data from all sources. Centelligence provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator Dashboards with "drill down" capability, allowing users to focus on a specific piece of content in an interactive manner. Through Centelligence, we have been able to report on all datasets in our platform, including those for HEDIS, EPSDT services, claims timeliness, and other critical

Figure 2.10.11.1.C Sample HEDIS Measures

Sample of HEDIS Measures with Sustained Improvement from HEDIS 2015 to 2018

HEDIS Measure	2015	2018
Well-Child 15 Months	52.64	58.54
Well Child 3-6 Yrs	60.82	67.92
F/U Hospital for Mental Health	28.22	38.65
Timeliness of Postpartum Care	50.23	63.42
Child Imms Combo 2	60.00	73.24
CDC – HbA1c Screening	81.86	84.43

aspects of our operations for all provider types, including physical health (PH), BH, pharmacy, and vision. We use Centelligence to detect and address underutilization of high value services and overutilization of low value services. Centelligence also supports our population health strategy through a suite of best-of-breed predictive modeling solutions that incorporates hot-spotting technology to identify and report significant health risks and health care disparities at population, enrollee, and provider levels. Centelligence also powers our provider practice patterns and provider clinical quality and cost reporting information products.

SPECIFIC STRATEGIES TO ADVANCE LOUISIANA MEDICAID'S QUALITY STRATEGY

LHCC has found that aligning our messaging and interventions across key stakeholders achieves higher results that are sustained over time, leading to a multi-faceted approach to quality, targeting enrollees, providers, and community partners to improve outcomes. This includes system-wide education and training, technology solutions, outreach campaigns, incentives, and community events.

Enrollee Strategies. LHCC's enrollee strategies include a multi-faceted array of general and targeted education materials including Member Handbook, Member Newsletter, and our Member Portal. We support enrollees to take an active role in their health care through our Health and Wellness Platform and our Healthy Rewards program described in our response to Section 2.10.11.2.2 below.

Provider Strategies. LHCC engages providers in quality by including providers on Quality committees; obtaining input and incorporating feedback; sharing data such as care gaps; providing technical assistance; and offering a variety of value based payment models (see response to Section 2.10.11.2.2). LHCC collaborates with local FQHCs to implement HEDIS Health Fairs to close care gaps including wellness visits, cancer screenings, and flu shots, as well as to reconnect diabetic enrollees who were not receiving care to their primary care providers (PCPs) for screenings and treatment. In 2018, we hosted six HEDIS Health Fairs, at which enrollees received both an immediate $25 gift card for closing care gaps in addition to claims-based incentives they were eligible for through our Healthy Rewards Program.

Community Strategies. LHCC has collaborated with more than 300 community-based organizations to improve population health including but not limited to developing educational materials and coordinating with partners to participate in health fairs and other events for outreach and education. LHCC along with our community partners provided free health, dental, and vision care to more than 2,000 uninsured and under-insured Louisiana residents at several free clinics in 2018, and heath information and screenings to over 800 residents at the Community Health and Wellness Festival in New Orleans in July 2018.

In addition to the activities noted above, below we describe strategies to address specific quality measures.

Table 2.10.11.1 Sample of Specific Strategies

Specific Strategies to Improve Childhood Immunizations (#27)	
Enrollee Strategies	• Targeted automated messaging campaigns through Eliza • Targeted outreach by EPSDT/Health Check to educate about importance of immunizations and to identify and address barriers to access (appointment scheduling, transportation, etc.) • Use of Appointment Wizard to make appointments real-time • Free Clinics and HEDIS Health Fairs at select provider offices
Provider Strategies	• Vaccine Adherence for Kids (VAKS) reminder recall program through automated messaging • Partnerships with FQHC mobile units and school based clinics • HEDIS Quick Reference guides pertaining to appropriate billing for HEDIS measures • VBP Arrangements tied to compliance with Childhood Immunization Measure
Community Strategies	• Work with Shots for Tots Coalition and State Chapter of American Academy of Pediatrics (AAP)
Outcomes	• LHCC's Childhood Immunization Status, Combo 2 rate has shown sustained improvement over time increasing from 60.00% in 2015 to 73.24% in 2018.
Specific Strategies to Improve Cervical Cancer Screenings (#35)	
Enrollee Strategies	• Targeted automated messaging campaigns through Eliza and social media campaigns • Conduct health disparities analysis to identify targeted intervention • Start Smart perinatal education campaign

Provider Strategies	• HEDIS Quick Reference guides pertaining to appropriate billing for HEDIS measures • P4P Incentive for OB/GYN providers and VBP arrangements for PCPs • CMD peer to peer outreach to lowest performing providers based on academic profiling
Community Strategies	• Participated in and sponsored women's health events engaging over 1,700 attendees and Women's Healthy Day Retreat by the Louisiana Center for Health Equity since 2016 • Sponsor of the American Cancer Society of Baton Rouge (ACSBR) • Executive participation on ACSBR Volunteer Leadership Council and Taking Aim at Cancer
Outcomes	• LHCC's Cervical Cancer Screening rate for 2018 was 49.14%
Specific Strategies to Improve Colorectal Cancer Screenings (#37)	
Enrollee Strategies	• Targeted automated messaging campaigns through Eliza and social media campaigns • Home testing kits mailed to enrollees who have not completed a screening
Provider Strategies	• General Education (Provider Manual, Website, Newsletters) and Care Gap Alerts on Provider Portal • VBP arrangements for PCPs • HEDIS Quick Reference guides pertaining to appropriate billing for HEDIS measures
Community Strategies	• Participated in and sponsored five cancer-specific health fairs/events reaching over 650 individuals; including a Colon Cancer Awareness and Screening event attended by more than 200 people • Sponsor of the American Cancer Society of Baton Rouge (ACSBR) • Executive participation on ACSBR Volunteer Leadership Council and Taking Aim at Cancer
Outcomes	• LHCC's Colorectal Cancer Screening rate for 2018 was 34.08%
Strategies to Improve Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (#50)	
Enrollee Strategies	• Life Coach pilot provides face to face discharge planning after initiation of treatment • Screening for SUD during initial Health Needs Assessment and Comprehensive Assessment • SUD Predictive Algorithm to identify enrollees who may benefit from Care Management • Perinatal Substance Use Program to participate in CM • Perinatal SUD education developed with National Organization on Fetal Alcohol Syndrome • Encourage enrollee participation in NAMI St. Tammany peer support program
Provider Strategies	• SUD Screening Tool Kit and assistance with referrals • Sponsor of the Louisiana Association of Substance Abuse Counselors and Trainers 4 day conference that provided continuing education to over 550 providers (2017 and 2018) • Mental Health Association of Greater Baton Rouge – partner on provider CEU conference, including education on treatment of anxiety and addiction • Encourage OB/GYN providers to screen for alcohol, tobacco and substance use during pregnancy
Community Strategies	• Annual sponsor of NAMI Louisiana state annual provider and peer education conference since 2014 • Substance use treatment education at community events including NAMI Walks
Outcomes	• LHCC's 2018 rate for IET Initiation (46.03%) and Engagement (14.09%) both exceed the HEDIS 2018 NCQA Medicaid 50th percentile.

2.10.11.2 The Proposer's approach should also include: 2.10.11.2.1 A description of the Proposer's assessment (using available data sources) of utilization rates and the potential for improvement;

ASSESSMENT OF UTILIZATION AND OPPORTUNITIES FOR IMPROVEMENT

LHCC monitors the over- and under-utilization of services of its enrollees via trend analysis reports; predictive modeling tools; inpatient, outpatient, and emergency department (ED) claims data; quality performance measures; grievances and appeals; enrollee and provider feedback; and medication utilization data. LHCC also incorporates population demographics such as age and gender, disease prevalence and health disparities.

Data Sources. LHCC combines data from multiple sources including medical, behavioral and pharmacy claims/encounters; electronic health records; UM and CM activities (e.g. assessments, SDOH); and advanced sources such as Homeless Management Information System, ADT feeds, all-payer claims databases or health information exchanges (e.g. Louisiana Health Information Network – Encounter Notification System - LHIN-ENS) and census data. Provided below is a sample of utilization measures used by our staff daily, weekly, monthly and annually to monitor utilization rates and identify areas of opportunity.

Table 2.10.11.2 Sample Utilization Measures

Category	Utilization Measure Examples
Prevention	Well child and adolescent visits; immunizations; breast cancer, cervical cancer and other screening rates; prenatal and postpartum care; high blood pressure control rates; flu vaccines
Over- and Under-Utilization	ED visits/1,000; admits/1,000; average length of stay; NICU days/1,000 and NICU average length of stay; narcotic prescriptions, prescribers and pharmacies; chronic condition medication fill data; child and adult preventive health screenings; immunizations; prenatal and postpartum care; and appropriate treatment of pharyngitis; upper respiratory infection and acute bronchitis
Management of Chronic Conditions	ED visits/1,000; admits/1,000; Prescriptions for and compliance with recommended medications for chronic conditions (e.g., asthma, heart disease, sickle cell disease, ADHD and diabetes); screening tests; and ongoing monitoring such as diabetes screenings
Reductions in Health Disparities	Utilization of services by race/ethnicity/language and geographic location; access to care including primary care and specialty providers; use of interpretive and transportation services

Benchmarks. We have established thresholds for all utilization measures, and monitor and trend achievement on a routine basis. Targets are based on historical trends across our affiliate health plans, local experience in Louisiana and national industry trends or benchmarks. For example, we target at least the NCQA 50th Percentile (or 2% improvement year over year) for targeted HEDIS measures in alignment with Attachment G.

AREAS FOR OPPORTUNITY

Based on these assessments, a cross-departmental LHCC team identifies opportunities to improve performance and help meet the Quadruple Aim. Below we provide a *sampling* of identified areas of opportunity.

ED Super-utilizers. As of April 2019, 5.5% of LHCC enrollees meet the definition of ED Super-utilizer (4 ED visits in 12 months). Of those 35% are pediatrics 0-20 years old and 65% are adults 21+ years of age. The highest prevalence of ED Super-utilization is found in Region 4 (19%) followed by Region 1 (16%) and Region 9 (13%). See our response to Section 2.10.11.2.3 for a description of activities implemented based on this assessment.

BH Readmissions / Follow-Up After Mental Health Inpatient Stay. LHCC analysis of inpatient utilization reveals BH diagnoses as a key driver and evaluation of readmission data showed a similar trend. Root cause analysis revealed lack of step down levels of care for BH conditions and opportunities for a more hands on approach for discharge planning. See our response to Section 2.10.11.2.3 for a description of QI activities initiated and outcomes.

Chronic Disease. Detailed analysis of our Comprehensive Diabetes Care (CDC) HEDIS measure revealed hotspots of enrollees non-compliant with HbA1c testing residing in Orleans, East Baton Rouge, Calcasieu, Rapides, and Caddo Parishes. Further analysis identified specific providers within those parishes with a large volume of patients with CDC care gaps. See our response to Section 2.10.11.3.3 for description of QI activities initiated and program outcomes.

Health Disparities. LHCC's CLAS program utilizes a cross-departmental Task Force, which meets on a quarterly basis to ensure enrollees of all backgrounds have equal access to quality healthcare. In 2016, LHCC initiated a health disparity analysis on eight HEDIS measures based on region, age, language, and race/ethnicity. The most prominent disparities were present in measures for Adolescent Well Care, Childhood Immunizations, Chlamydia Screening, and Prenatal/Postpartum Care (PPC). In response, LHCC implemented a QI initiative to address postpartum care in Spanish speaking women. At baseline, the PPC for Spanish speaking women was 17.93% as compared to 30.75% for English speakers – a disparity of 41.7%. LHCC completed a root cause analysis (using barrier analysis, brainstorming, and the 5-Whys methods) to determine the drivers leading to the disparity. In response, LHCC initiated targeted educational campaigns to educate Spanish speaking mothers on the importance of the visit and available Healthy Rewards incentives; helped enrollees schedule appointments; and worked with providers to modify office hours to accommodate scheduling needs. At the end of the measure period, the disparity was reduced to only 4.2%, nearly a ***32% improvement*** from baseline.

2.10.11.2.2 A description of incentives that will be implemented for providers and enrollees to incentivize delivery of the right care in the right place at the right time; and

Our non-financial and financial incentives for both providers and enrollees are aligned and in compliance with applicable state and federal requirements as well as the Model Contract and MCO Manual requirements.

PROVIDER INCENTIVES

LHCC offers a package of non-financial and financial provider incentives to recognize and encourage evidence-based, quality health care, including appropriate delivery of preventive care and screenings and follow up treatment and services. LHCC makes a point to recognize our high performing providers to show our appreciation, learn from, and share their best practices.

Figure 2.10.11.2.a Physician Summit Award for Excellence in Care

Non-financial Incentives. LHCC's annual Physician Summit Award for Excellence in Care acknowledges health care professionals for the exemplary care they deliver compared to peers. LHCC named The Clinic of Welsh in Welsh, Louisiana, as the recipient of the 2018 Award for demonstrating a commitment to high quality, accessible care. Other non-financial incentives include recognition of PCMH status in our Provider Directory and preferential assignment of new enrollees who have not already selected their own PCP to higher quality providers.

[redacted]

ENROLLEE INCENTIVES

LHCC has had an enrollee incentive program since inception. Our program offers incentive dollars based on accessing appropriate screenings (e.g. well child visits, adult annual visit, cancer screenings, prenatal and postpartum care, and diabetes screenings). With LDH approval, we will be enhancing our enrollee Healthy Rewards program to better align with our Population Health strategy. In support of this, LHCC will offer enrollees a comprehensive Health and Wellness Platform (mobile app and web portal) to provide prevention and wellness resources, and additional customized activity-based incentives, complementing our existing clinically based incentives. Based on completion of an assessment in the Health and Wellness mobile app/web portal, enrollees will receive customized health and life skills education and opportunities to earn rewards for tracking activities such as exercise, diet, sleep, etc. Enrollees can use rewards received to purchase items from our online Reward Catalog and at local merchants such as Walmart and other recognized retail stores. This includes a variety of health-related items, such as some over-the-counter medication and health care products. We will also be exploring partnerships to address SDOH needs, such as partnering with bill payment/utility vendors to offer credits for utility bills. LHCC aligns our enrollee and provider incentive programs to promote the right care, in the right place, at the right time.

EVALUATING EFFECTIVENESS OF INCENTIVE PROGRAMS

Guided by CQI principles, we continually evaluate incentive program performance and at least annually evaluate

the impact of the incentive on the targeted outcome measure. We assess impact by comparing rates of individual incentive awarded to their compliance with the affiliated outcome measure. For example, the effectiveness of our well child incentives is affiliated with the HEDIS Well Child 15 Months of Life measure, which has shown sustained improvements over the past 3 years. If an incentive does not prove to affect an outcome measure, LHCC will begin a PDSA cycle to determine root causes and refine the incentive to better support healthy enrollee behaviors. For example, the incentive for Diabetes Screenings has a low rate of uptake. LHCC conducted a PDSA cycle to test the effectiveness of a Diabetes Health Fair that included an immediate incentive for enrollees who attended and received their diabetes screenings. The Diabetes Health Fair and incentive resulted in 53.48% of targeted enrollees obtaining their required diabetic screenings.

2.10.11.2.3 A description of evidence-based interventions and strategies that will be used to target super-utilizers and reduce potentially preventable events.

EVIDENCE BASED STRATEGIES TO TARGET SUPER-UTILIZERS AND REDUCE PPE

LHCC's Super-Utilizer Program aims to reduce inappropriate and duplicative use of health care services, including but not limited to potentially preventable hospital emergency departments visits and inpatient readmissions. LHCC defines super-utilizers as enrollees with complex physical, behavioral, and social needs who use or are at risk of using the ED more than four times in a 12-month period or who are at a high risk of admission/readmission. Super-utilizers often experience multiple chronic medical and/or BH conditions and face an array of SDOH such as joblessness or homelessness. LHCC's Super-Utilizer programs are founded on the evidence-based best practices of the Camden Coalition of Healthcare, Project BOOST, and Coleman Transitional Care. The Camden Coalition's model uses hot-spotting (use of data to allocate resources to a small subset of high-needs, high-cost enrollees) and a collaborative approach to help these enrollees better manage their physical and mental health while simultaneously addressing SDOH such as arranging for housing, food and transportation. Project BOOST involves discharge planning, medication reconciliation, patient and family community and primary care provider communication before discharge and a post discharge telephonic follow up. The Coleman Transitional model includes four pillars: medication self-management, personal health record, post-discharge follow-up and an alert and response system. These models also leverage community support services such as churches and faith-based organizations.

EVIDENCE BASED STRATEGIES FOR SUPER-UTILIZERS

- *Camden Coalition of Healthcare model*
- *Project BOOST*
- *Coleman Transitional Care model*

Data Analytics and Reporting. LHCC identifies, monitors, and trends potentially preventable events (PPEs) and other high-utilization trends through our Centelligence health informatics platform, which features 3M Clinical Related Group (CRG) software, enabling us to analyze claims data, to identify PPEs including avoidable ED visits, admissions and readmissions trends. We optimize the output of this software by transforming it into actionable internal performance dashboards for monitoring PPEs at a population and provider level. For example, our PPE dashboards are available to our leadership, who can conduct high-level provider network analysis, assessing potential areas for policy and administrative improvement, to reduce PPEs.

Real Time Notification. LHCC requires all EDs in its network to exchange admit discharge transfer (ADT) data with a Health Information Exchange (HIE) ED visit registry to aid in timely identification and assessment of enrollees with inappropriate ED utilization. The intent of the ED visit registry is to create a large network of interconnected EDs to identify complex needs of high-risk patients in real-time, allowing providers to see visit and care coordination information from any ED a patient has visited instantly upon patient registration. We partner with Louisiana Hospital Association to use LHIN-ENS, which provides current ED notifications.

Identification and Risk Stratification. Historical claims data serves as a foundation to our PPE analytics suite with the addition of alternative data sources such as real-time notification of ED and inpatient admissions, enrollee demographic, data from electronic health records, and Care Management (CM) assessment data. As further described below, we combine this information to generate hot-spotting reports and predictive modeling.

Person-Centered Care Management (CM). Our CM model places enrollees at the center of a multidisciplinary CM Team consisting of experienced nurses, licensed mental health professionals, social workers, and

Community Health Workers who are supported by our Medical Director, Pharmacist and other functional areas such as Network Management. The Case Manager also engages the PCP/medical home, BH provider (as appropriate), and other treating providers. With enrollee consent, the CM Team may also include the enrollee's family, caregivers and informal supports, and community providers. CM interventions will include:

- Timely outpatient follow-up post-discharge
- Linkage to a primary care provider/medical home and our 24/7 nurse advice line
- Extensive outreach and engagement strategies with priority placed on face-to-face contact
- Comprehensive medication reconciliation and management
- Health education/health coaching including management of chronic conditions (e.g., diabetes, asthma, pain)
- Linkage to community resources to address SDOH (e.g. housing, food insecurity, transportation and safety)

Our Case Manager works with the CM Team to complete a comprehensive assessment, close care gaps, and develop a care plan that incorporates all covered/non-covered services to meet enrollee goals addressing PH and BH needs as well as social service and community support needs.

Provider Engagement. Provider partnerships and the sharing of actionable clinical information is critical. By ensuring clinical decision-making is based on complete information such as care gaps, recently developed complications, and ED utilization, LHCC allows providers to see and act upon a complete picture of an enrollee's health, including conditions and treatments that occurred outside of the provider office. Our secure Provider Portal is a web-based platform supporting PH and BH provider administrative "self-service" capabilities, and a growing number of clinical applications including: online care gap notifications (alerting providers to health alerts and care gaps); ED high utilizer flag (alerting providers if an enrollee has had three or more emergency room visits in 90 days); the Online Member Health Record (delivering advanced capabilities for clinical care management); Patient Analytics (a population health analytics platform); Provider Analytics (a provider performance management analytic platform); and practice-level clinical quality and cost reports. In support of our Super-Utilizer program, we will also offer providers access to 3M's Provider Performance Dashboards, delivering 12 months of rolling data and year-to-date information at both the aggregate and enrollee-level on PPEs, utilization and cost data, and data on high-needs individuals.

Value-Based Payment (VBP) Programs. LHCC's strategy to reduce PPEs includes customized quality incentive programs that reward providers for administering accessible, quality health care to our enrollees. As described above and in our response to Section 2.10.12, LHCC uses VBP arrangements that incorporate quality measures and appropriate use of services to help drive provider performance and improve population health outcomes.

ED DIVERSION PROGRAM

Preventable ED visits significantly drive health care costs. LHCC has identified potential barriers as lack of knowledge about alternative resources, lack of a PCP, and the possible need for CM. In response, LHCC has developed a comprehensive program to educate on appropriate ED use, offer alternatives such as after-hours (encouraged through VBP) urgent care and 24/7 nurse triage services, and promote enrollee engagement with their PCP, assisting with selection and appointment scheduling. ED Diversion is a two-part strategy -- preventing high utilization before it occurs (as described), and identification and targeted mitigation of high utilization.

Identification. Our ED program begins with identification of enrollees who are or who are at risk of becoming an ED super-utilizer defined as four or more ED visits in a 12-month period. To date, LHCC staff have used an ED Trigger Report, identifying enrollees who have met this threshold. In 2019, we are deploying a predictive ED Super-utilizer model to support early identification and outreach to potential ED super-utilizers. Data elements used as part of the predictive model include demographics, medical history, area ED statistics, and SDOH data.

Targeted Outreach & Education. Our CM staff conduct outreach to identified at-risk enrollees to educate and redirect before they become super-utilizers, assisting with making appointments, arranging transportation, and facilitating referrals to community resources to address SDOH if needed. CM staff conduct face-to-face and telephonic outreach to enrollees identified as super-utilizers to assess the reasons for ED use; identify barriers to care and self-management, identify and address provider access issues, and coordinate follow-up care with the enrollee's PCP. If there is difficulty in contacting or locating the enrollee, a Community Health Worker (CHW) will do intensive research and field work to locate the enrollee and engage in our Care Management Program.

Telephonic Triage through 24/7 Nurse Advice Line. LHCC encourages enrollees to contact our 24/7 nurse advice line if they have any questions about appropriate access and potential need for ED services. Nurse advice line staff obtain information from the enrollee and using nationally-recognized algorithms, determine the best level of care based on presenting symptoms. If an enrollee's condition appears emergent, nurse advice line staff warm transfer the member to 911. Alternately, when the condition does not warrant ED care per the protocols, the nurse will advise the enrollee to seek urgent care, immediately contact the PCP, or schedule an appointment with the PCP the next business day. The nurse may also provide self-care alternatives to manage the symptoms at home such as increased fluids, fever reducing medicine or ice compress, as applicable. In 2017, **16.5% of calls to our 24/7 nurse advice line were redirected away from the ED to appropriate levels of care.**

Initiatives to Increase Access to Primary, Specialty and Urgent Care Services. [redacted] LHCC is also partnering with ***Lafayette General Hospital*** (LGH) who currently provides telemedicine clinics at Lafayette Parish School System and St. Martin Parish School System. LGH partnered with the American Well technology platform to provide health care services through home technology, such as a smartphone, computer or tablet. LGH telemedicine visits will cover non-emergency needs as well as ongoing chronic condition management, such as diabetes. [redacted]

REDUCING AVOIDABLE READMISSIONS: TRANSITIONAL CARE PROGRAM

We promote prevention, continuity of care, and coordination for all enrollees transitioning from one setting to another. For enrollees that are hospitalized, our enhanced, evidence-based Transitional Care Program assists with discharge planning to ensure a safe transition. This includes post-discharge follow-up and monitoring with special focus on co-morbidities, complex conditions, and coordination for high utilizers to identify and close care gaps. Our Transitional Care Program is inclusive of care transition and diversion activities and considers SDOH in evaluating risk to prevent unplanned or unnecessary readmission and adverse health outcomes. In addition to the ED diversion activities above, the following initiatives are key components of our readmissions program.

Concurrent Review. Part of our Transition of Care Team, our concurrent review staff work with enrollees and hospital staff to ensure each enrollee is receiving the appropriate level of care, ensure that the enrollee's discharge plan addresses all the enrollee's needs and identify potential risk factors for readmission.

11%

Readmission rates decreased by 11% from 2017 to 2018 with an estimated cost savings of $261,886 in 2018.

Identification and Stratification of Enrollees. Our Readmissions Program begins with early identification of enrollees with multiple readmission or at a high risk for readmission. Our readmission prevention model assigns a probability of readmission at the time of acute admission to prioritize post-hospitalization outreach. The score is reported on the Daily Inpatient Census Report allowing LHCC concurrent review staff, Transition Coordinators and Case Managers to maximize outreach effectiveness by targeting the enrollees most likely to readmit.

Post Discharge Outreach Program. LHCC CM staff initiate post-discharge outreach calls within 72 hours of discharge to enrollees identified as high risk for readmission. During the call, the Case Manager confirms that

the enrollee has all needed equipment, medications, in-home services, and reconfirms their understanding of their diagnosis, condition, and self-management plan. Enrollee and provider engagement and education, coordination of care and services and the promotion of self-management skills helps achieve the ideal transition and reduces readmission risk. Analysis of 2017 data, using propensity score matching, confirmed the intervention to be effective for preventable readmissions with statistically significant savings. Enrollees who received the intervention had 51% lower odds of readmission compared to those in the comparison group. In 2018, LHCC CM staff successfully contacted 84% of targeted enrollees.

Improving Access to BH Step-Down Services. [redacted]

26%

Readmission rate decreased 26% for enrollees receiving IOP

Increasing Access to Home Health and Post-Acute Care. [redacted] LHCC is contracted with Children's Hospital to provide eligible enrollees access to Children's Ventilator Assisted Care program. [redacted], to assess improved outcomes in readmissions, ED utilization and improved quality of life. Enrollees referred to this program will have access to a team of nurses, social workers and community support services to provide24/7 on-call services, care coordination, caregiver support, training and education, health management and crisis management and will supplement with in-home RN visits.

2.10.11.3 The Proposer should describe how the Proposer's Medicaid managed care Quality Assessment and Performance Improvement (QAPI) Program includes the following functions related to organization-wide initiatives to improve the health status of covered populations, and describe in detail at least one (1) data-driven clinical initiative that the Proposer initiated within the past twenty-four (24) months that yielded improvements in clinical care for similar populations. Functions include:

Based on the principles of CQI, LHCC's QAPI Program includes all of the stated functions, employing evidence-based methods such as the IHI Model for Improvement described in Section 2.10.11.1 above.

2.10.11.3.1 Analyzing gaps in delivery of services and gaps in quality of care, areas for improved management of chronic and selected acute diseases or conditions, and reduction in disparities in health outcomes;

Driven by our QI Director, LHCC takes a data-driven approach to identify gaps in delivery of service, gaps in quality of care, areas for improved management of chronic and selected acute diseases or conditions and reduction in disparities in health outcomes. Centelligence, our family of integrated decision support and health care informatics solutions, facilitates our use of data by collecting, integrating, storing, analyzing, and reporting data from all sources. We report on all datasets in our Centelligence platform, including those for HEDIS, EPSDT

services, utilization data, quality of care data, claims timeliness, grievance and appeals data, demographic information relevant to health risks or health disparities, and other critical aspects of our operations for all provider types, including PH and BH. This is combined with other quality and CM data such as access and availability audits, enrollee and provider satisfaction survey results, issues identified during CM, and referrals from any source indicating potential problems or suspected fraud or abuse. QI staff reviews this array of data using appropriate analytic tools to identify the most prevalent or persistent issues, including those that affect enrollees, providers and/or span multiple departments or otherwise indicate the need for improvement in a particular clinical or non-clinical area. Other initiatives may be selected to test an innovative strategy or as required by LDH or identified during monthly meetings, analysis and/or data drill down such as the Diagnosis, Race/Ethnicity, Age, Gender, Geography (DRAGG) analysis.

2.10.11.3.2 Identifying underlying reasons for variations in the provision of care to enrollees; and

LHCC staff use validated improvement science tools, founded in the PDSA and LEAN/Six Sigma models, when identifying underlying reasons for variations. Such tools include: Failure Modes and Effects Analysis, Root Cause Analysis, Five Why's, Driver Diagrams, Cause and Effect Matrices, Fishbone (Ishikawa) Diagram, Critical to Quality matrices, process mapping, value stream mapping, Pareto charts, histograms, scatterplots for cause and effect analyses, Voice of the Customer (stakeholder) feedback, and control plans.

2.10.11.3.3 Implementing improvement strategies related to analytical findings pursuant to the two (2) functions…

Based on analytical findings, LHCC's QAPI Committee and Performance Improvement Team (PIT) solicits input from all health plan departments and external subject matter experts, enrollees, providers, and community resources when considering interventions. With this input, QI and other staff identify barriers to performance and develop interventions that specifically addresses the identified barriers that are most likely to succeed. The PIT establishes implementation plans that include clearly defined, tasks to be accomplished by specific departments, accountability for each task, timelines for intervention, and a plan for how and when the effectiveness of the intervention will be measured. Though interventions may be coordinated by CM, UM or Network staff, QI staff coordinate most interventions, monitor for effectiveness, apply PDSA to test and modify, and provide progress reports to the PIT. The PIT tracks all interventions and reports to the QAPI Committee.

SAMPLE QAPI INITIATIVES

Below we provide a data driven example of how we have applied our process and improved health outcomes.

Table 2.10.11.3.3 Sample QAPI Initiative

	Increasing Compliance with Diabetic Screenings
Rationale	Detailed analysis of our CDC HEDIS measure revealed hotspots of members non-compliant with HbA1c testing with the highest concentrations residing in Orleans, East Baton Rouge, Calcasieu, Rapides, and Caddo parishes. Further analysis identified specific providers within those parishes with a large volume of patients with CDC care gaps.
Identifying Underlying Reasons for Variations (2.10.11.3.2)	Investigation into possible root causes included review of third-party research, which identified two key factors that aligned with our data around enrollees not seeking care and insights collected from unstructured interview research with FQHC staff: patient's health-related knowledge and beliefs and physician-patient interaction.
Implementing Improvement Strategies Related to Analytical Findings (2.10.11.3.3)	In November 2018, we partnered with Daughters of Charity (DoC), a large volume, multi-location FQHC in Orleans parish with a significant population of enrollees with diabetes non-adherence to sponsor a Diabetes Health Fair. We contacted DoC's panel of diabetic enrollees who had not been seen at the clinic for the past 12 months and used our Appointment Wizard technology to schedule appointments for these enrollees in order to establish (or re-establish) physician-patient interaction and engage in disease management to address health-related knowledge. We also did a month long outreach with the same clinic to get their DM patients in to have their HbA1c, eye exam and nephropathy labs completed.
Program Outcomes	The DoC Diabetes Health Fair resulted in 53.48% of targeted enrollees obtaining their required CDC screenings and establishing care with DoC.

LHCC has partnered with the Diabetes Assessment and Management Center (DiaMC) in Shreveport (Caddo Parish), through a customized VBP model related to comprehensive diabetes care. DiaMC treats the whole person, focusing on continuous glucose monitoring along with diabetes educators who teach self-care, and a nutritionist who provides face-to-face nutrition and health management services. Initial outcomes of the pilot are positive showing an increase in HbA1c screening by 12.90%, fundoscopic eye exams by 5.38%, and microalbuminuria screening by 36.39% compared to the control population.

2.10.11.4 The Proposer should submit an overview of its proposed approach to Quality Management and Quality Improvement (QM/QI). As part of its response, the Proposer should submit a description of:
2.10.11.4.1 The Proposer's current QM/QI organizational plan description, goals, quality committees, and schedule of QM activities;

QM/QI ORGANIZATIONAL PROGRAM DESCRIPTION

The scope of our QAPI Program is comprehensive and addresses quality and safety of clinical care and quality of services provided to all enrollees across all programs and benefits, as described in 2.10.11.1 through 2.10.11.3.

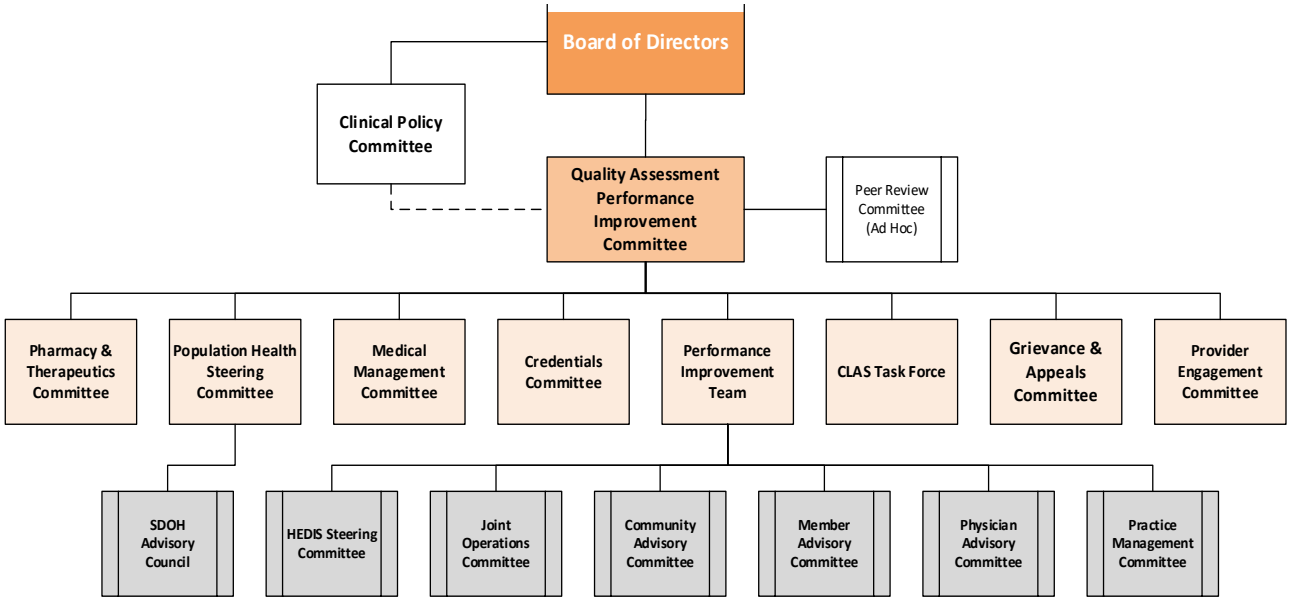
QM/QI Program Goals. LHCC's primary QAPI goal is to improve enrollees' health status through a variety of meaningful quality improvement activities and performance improvement projects implemented across all care settings and aimed at improving quality of care and services delivered. Founded on the Quadruple Aim, LHCC's QAPI goals include but are not limited to the following:

- A high level of health status and quality of life will be experienced by LHCC enrollees
- Network quality of care and service will meet industry-accepted standards of performance
- LHCC services will meet or exceed industry-accepted standards of performance
- Fragmentation or duplications of services will be minimized through integration of QI across functional areas
- Member satisfaction will meet LHCC's established performance targets
- Preventive and clinical practice guideline compliance will meet established performance targets

QM/QI QUALITY COMMITTEES

LHHC's Board of Directors (BOD) oversees the development, implementation and evaluation of the QAPI Program, providing strategic direction and ensuring that quality is incorporated into operations throughout LHCC. While the BOD maintains ultimate oversight of the QAPI Program, the BOD delegates operational authority to the QAPIC. LHCC's QAPI Program permeates the organization as depicted by our Quality Committee structure shown below.

Figure 2.10.11.4.a_LHCC QM/QI Committee Structure



Quality Assessment and Performance Improvement Committee (QAPIC). The QAPIC is our senior level committee, chaired by our Chief Medical Director and accountable directly to the BOD. The purpose is to

provide oversight and direction in assessing the quality and appropriateness of care and service delivered, including assessment of provider network performance and analysis of over- and under-utilization of services. This is accomplished through a plan-wide system of ongoing, objective, and systematic monitoring; identification, evaluation, and resolution of process problems; identification and implementation of actions to improve health outcomes; and education of enrollees, providers and staff regarding QAPI programs and activities. The QAPIC meets at least quarterly and includes at least four network physicians representing the range of practitioners within the network and across the regions in which it operates (i.e. Family Practice, Internal Medicine, OB/GYN, Pediatrics, BH and other high-volume specialties as appropriate). The BH Medical Director and Senior Director of QI are included as standing participants. Representation from LHCC senior management staff include leadership from key functional areas including but not limited to integrated Medical Management, Pharmacy, Network Development/ Contracting, Member and Provider Services, and Compliance. Delegate entity representatives may also attend as appropriate. Additionally, LHCC will include an enrollee advocate representative at the QAPIC meetings. LHCC provides LDH with a schedule of QAPIC meetings to send representatives to the meetings as appropriate. Similarly, an LHCC representative participates on LDH's Quality Committee.

Subcommittees. LHCC's QAPIC directs subcommittees/task forces to identify, review and address areas of concern. The following sub-committees report directly to the QAPIC: Pharmacy and Therapeutics Committee (P&T), Credentialing Committee, Medical Management Committee, Population Health Steering Committee, Performance Improvement Team, CLAS Task Force, Grievances and Appeals Committee, and Provider Engagement Committee.

LHCC's QAPI structure also includes several advisory councils/committees to ensure sufficient mechanisms to solicit feedback and recommendations from key stakeholders, enrollees and their families/caregivers and providers. These advisory groups include: SDOH Advisory Council, HEDIS Steering Committee, Joint Operations Committee, Community Advisory Committee, Member Advisory Committee, Physician Advisory Committee, and a Practice Management Committee. LHCC uses feedback from these groups to address population health needs and improve health outcomes. For example, LHCC's Community Advisory Committee participants in Region 1 and Region 2 identified HIV/AIDS as a major health concern for their communities. To assist with education and awareness and increase screening rates, LHCC collaborated with local FQHCs in each region to host an HIV/AIDS event aligned with National HIV/AIDS Awareness Day. LHCC partnered with CrescentCare and Walgreens to host a mobile testing event in a Medicaid-dense, high traffic area of New Orleans resulting in 100+ HIV screenings.

PROVIDER PARTICIPATION ON QUALITY COMMITTEES

Local Louisiana providers actively participate in all QAPI, P&T, Medical Management and Credentialing Committee meetings.

Schedule of QM Activities. The QAPI Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, identification of opportunities, action implementation, and evaluation, including our QAPA Program Description, Work Plan and Annual Evaluation.

QAPI Program Description. Outlines the structure and processes used to monitor and improve quality and safety of clinical care and services. The Program Description includes: specific roles, structure and function of the QAPIC and other committees; accountability to the BOD; a description of staff and technical resources that are devoted to the QAPI; BH care involvement; and patient safety. The Program Description is reviewed on an annual basis and will be submitted to LDH for written approval at the Readiness Review and annually thereafter. LHCC will submit requested revisions to LDH for approval prior to implementation of such revisions.

QAPI Work Plan. To implement the comprehensive scope of the QAPI Program, the Work Plan incorporates the strategic direction provided by the BOD and clearly defines the activities that must be completed by each department and all supporting committees throughout the measurement year. The Work Plan specifies the activities, the person(s) responsible for the activity, the date of expected task completion and the monitoring techniques that will be used to ensure completion within the established timeframe. The Work Plan is reviewed by the QAPIC on an annual basis and at regular intervals throughout the year.

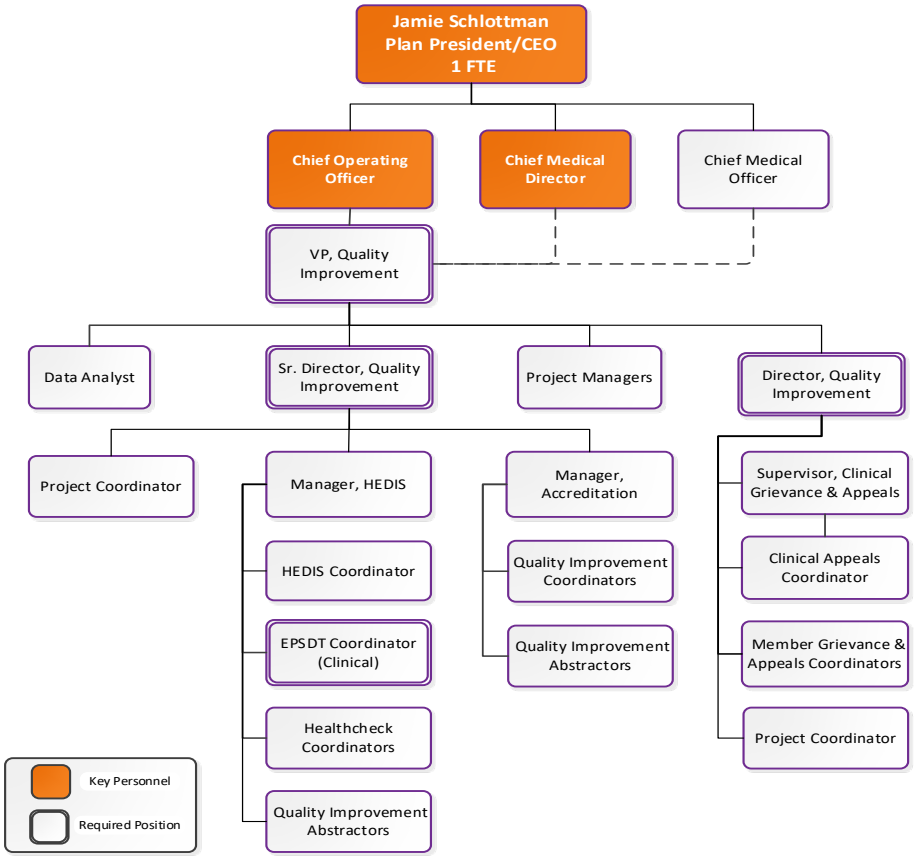
QAPI Program Evaluation. Our annual Program Evaluation includes a summary of all QI activities, the impact the program has had on enrollees' care, an analysis of the achievement of stated goals and objectives and the need for program revisions and modifications. Program Evaluation results are used in developing the QAPI Program Description and Work Plan for the subsequent year. LHCC's Chief Medical Director and Senior Director of QI are responsible for coordinating the evaluation process through the QAPIC and a written description is provided to the BOD for approval annually. The QAPI Evaluation is submitted to LDH following approval by the BOD.

Communicating QAPI Findings. LHCC disseminates information about QI actions taken and their effectiveness to key stakeholders, including enrollees and providers, through our website, newsletters and other direct mailings.

2.10.11.4.2 A description and organizational chart of its proposed QM/QI program, including a list of the Proposer's staff dedicated to and responsible for administering and operating the Proposer's QM/QI program as described in these sections, including the role of the QM Director and staff;

The LHCC Senior Leadership Team plays a key role in improving quality and fostering CQI as they set priorities for the organization and support the structure required to achieve sustainable improvements. The organizational chart depicted below, outlines the structure of our QM/QI department.

Figure 2.10.11.4.2 LHCC QI/QM Department Org Chart



STAFF RESPONSIBLE FOR ADMINISTERING QM/QI PROGRAM

Chief Medical Director (CMD) serves as our Senior Executive of Quality Improvement and is actively involved in LHCC's QAPI Program to include: recommending QI study methodology; formulating topics for QI studies; promoting participating providers' compliance with UM criteria and clinical practice guidelines; assisting in the development of guidelines for on-going patient care monitoring and other focused studies; and directing credentialing and re-credentialing activities in accordance with LHCC's policies and procedures. The CMD serves as the chair of the QAPIC and reports QAPI Program activities and outcomes to the BOD at least annually.

Vice President, Quality Improvement (VP QI) reports to the Chief Operating Officer (COO) and is responsible for directing the activities of LHCC's QI staff in monitoring and auditing LHCC's health care delivery system,

including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality. Additionally, the VP QI coordinates LHCC's QAPIC proceedings in conjunction with the CMD; reviews statistical analysis of clinical, service and utilization data, and recommends performance improvement initiatives while incorporating best practices as applicable.

Senior Director, Quality Improvement (Sr. Director QI) reports to the VP QI and is responsible for leading and collaborating with other applicable parties on NCQA Accreditation and HEDIS performance; organizing and controlling activities, methods, and procedures to achieve business objectives; and presenting results of efforts and ongoing performance measures to senior management.

Director, Quality Improvement (Director QI) reports to the VP QI and is responsible for the oversight of the review and analysis of reports and evaluation of procedures and practices related to the functions of grievances and appeals and implementation of improved procedures and practices to ensure compliance with required standards.

Manager, HEDIS reports to the Sr. Director QI and is responsible for overseeing activities, resources, methods and procedures to achieve improvement in HEDIS measures. The HEDIS Manager ensures compliance with HEDIS technical specifications, policies, operating procedures and goals in compliance with internal and external guidelines. The HEDIS Manager provides a comprehensive analysis of HEDIS measures, barriers, and opportunities and present results of improvement efforts and ongoing performance measures to senior management.

Manager, Accreditation educates LHCC staff on NCQA and CMS requirements and ensures compliance with such standards through routine operational assessments of policies and procedures and helps to oversee development of organization-wide initiatives to support accreditation.

Clinical Appeals & Grievances (A&G) Staff is led by the Supervisor of A&G who oversees day to day clinical operations and functions of the department, ensuring compliance with standards. The Clinical Appeals Coordinator (CAC) reviews clinical information for all appeals utilizing nationally recognized criteria to determine medical necessity of services requested. The CAC prepares response letters for enrollee and provider clinical appeals and ensures letters are compliant with State and NCQA standards while maintaining files and logs for all appeals. The Grievance & Appeal Coordinator (GAC) logs enrollee grievances and appeals and refers those pertaining to potential quality of care issues to a QI Coordinator (or Medical Director) for investigation and resolution. The GAC evaluates complaints and grievances by type, location, and region to identify trends indicating potential areas in need of further analysis and intervention and tracks and resolves all administrative provider complaints.

Quality Improvement Coordinators are highly trained clinical and non-clinical staff with significant experience in a health care setting and preferred experience with data analysis and/or project management. Their scope of work may include data collection for various QI studies and activities, data analysis and implementation of improvement activities and complaint response with follow up review of risk management and sentinel/adverse event issues. The QI Coordinator collaborates with other departments as needed to implement improvement initiatives as identified through QAPI Work Plan.

Quality Improvement Abstractors complete data collection and abstraction for company quality measures, including HEDIS, CMS, AHRQ, OHSU, PQA and any other custom measures in compliance with standards. The Abstractor tracks and reports on issues and outcomes related to abstractions and over-reads.

EPSDT Coordinator (Clinical) and Health Check Coordinators (HCC) report to the HEDIS Manager and coordinates preventive health care and promotes compliance with preventive care guidelines through enrollee outreach. The EPSDT Coordinator and HCC performs outreach via phone, mail, health fairs, and various events to educate enrollees on the importance and availability of health check services and assists enrollees with scheduling and follow up on appointments and transportation.

2.10.11.4.3 The Proposer should demonstrate its capacity to participate in LDH's annual HEDIS® performance measurement and reporting initiative and the proposed availability of resources dedicated to the initiative and other measurement and data-driven initiatives;

Capacity to Participate in Annual HEDIS Performance Measurement. LHCC has been reporting HEDIS for seven years. Our QAPI Program infrastructure, staffing, and approach enable us to continue to support the LDH annual HEDIS performance measurement and reporting initiative. LHCC collects and reports clinical and administrative performance measure data in accordance with the Quality Companion Guide and MCO BH Companion Guide as published by LDH, and in compliance with NCQA HEDIS Technical Specifications. LHCC leverages its parent company's national contract with an NCQA Certified HEDIS Engine to collect and report on all HEDIS and LDH custom performance measures. Rates are audited by Attest Health Care Advisors, our NCQA certified HEDIS auditor. LHCC's QI staff conduct outreach and retrieval of medical records for select measures, as required by HEDIS technical specifications, resulting in 97% of records retrieved. LHCC contracts with Change Health to perform abstraction, with LHCC's QI staff conducting 100% over-read to ensure accuracy.

Dedicated Staffing Resources. In addition to our QI leadership staff, the following QI staff are dedicated to supporting HEDIS activities and other measurement and data-driven initiatives and provide ongoing support to LDH on statewide HEDIS initiatives: HEDIS Manager, QI Abstractors, Project Coordinator, and Health Check Coordinators. LHCC is supported by its parent company's data analytics and HEDIS reporting team, which brings a wealth of knowledge and best practices from our affiliate health plans.

2.10.11.4.4 The Proposer should provide an example of a recent successful quality improvement activity; and

LHCC is committed to the continuous monitoring of its performance related to standards of care and service for enrollees. In 2018, LHCC participated in three state-led Performance Improvement Projects including: improving birth outcomes, improving treatment for children with ADHD and improving rate of Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET). Below we provide an example of a recent successful quality improvement activity.

Improving Prenatal and Postpartum Care to Reduce Preterm Births	
Topic/ Rationale	The State of Louisiana's premature birth rate was 15.1% in 2013, and the State pledged to reduce the preterm birth rate by 8% in 2014 (March of Dimes Foundation, 2014). Further, the Department of Health and Hospitals of the State of Louisiana targets a 15% reduction in the statewide prematurity rate by 2017. Early prenatal care is recommended by the Centers for Disease Control and Prevention (CDC) as a means for women to reduce the risk for preterm birth, yet HEDIS rates for Timeliness of Prenatal Care and Postpartum Care did not meet the NCQA 50th Percentile.
Study Aim	The aim of the PIP is to decrease the preterm birth rate by implementing a robust set of health plan, member and provider interventions to improve rates in various performance indicators as outlined below.
Population	Women age 15 – 45 who had a live birth during the measurement year
Quantifiable Measures / SMART Goal	1. Improvement from the baseline 2.16% to 17.5% in the percentage of women 15-45 years of age with evidence of a previous pre-term singleton birth event (<37 weeks completed gestation) who received one or more progesterone injections between the 16th and 21st week of gestation 2. An improvement from the baseline 70.29% to 87% in the percentage of women aged 16 years and older who delivered a live birth and had at least one test for Chlamydia during pregnancy 3. An improvement from the baseline 5.95% to 32% in the percentage of women who delivered a live birth and had at least one test for HIV during pregnancy 4. An improvement from the baseline 71.18% to 85% in the percentage of women who delivered a live birth and had at least one test for syphilis during pregnancy 5.a Adopt use of a most effective FDA-approved method of contraception, i.e., (i) female sterilization or (ii) Long-Acting Reversible Contraception (LARC), i.e., contraceptive implants, or intrauterine devices of systems (IUD/IUS) from a baseline of 19.56% to 30% 5.b. Adopt use of a moderately effective method of contraception, i.e., use of injectable, oral pills,

<table>
<tr><td></td><td>patch, ring or diaphragm from a baseline of 23.31% to 30%
5.c Adopt use of a LARC during delivery hospitalization from a baseline of 1.90% to 30%
5.d. Adopt use of a LARC in an outpatient setting within 56 days postpartum from a baseline of 6.86% to 30%
6. An improvement in the percentage of women with a postpartum visit as per the HEDIS PPC Postpartum Measure per the baseline administrative rate of 45.96% to 55% and the baseline hybrid rate of 58.23% to 70%</td></tr>
<tr><td>Data Sources, Data Collection Methodology & Plan</td><td>Data will be collected using the Centene-level corporate Quality Spectrum Insight (QSI-XL) database. All numerators and denominators for the annual performance measures come from this source. For this PIP we are utilizing data from the high risk registry and LEERS reports supplied by LDH. We are also utilizing QSI-XL for member and provider profile, HEDIS metrics report, Louisiana Healthcare Connections SharePoint for documentation, trending and tracking purposes, and NOP reports supplied by Centene Corporation. LHCC ensures the validity and reliability of the data through weekly meetings between plan data analytics and corporate analytics. In addition, reports go through test run for reliability. Data is compared to previous year's data when available, denominators and numerators will be checked for inclusion of all eligible populations and any discrepancies are investigated. Data is compared to all sources and histories available in an effort to produce the most valid answer possible.
<table>
<tr><th>Event</th><th>Timeframe</th></tr>
<tr><td>Baseline Measurement Period</td><td>November 6, 2104 –November 5, 2015</td></tr>
<tr><td>Interim Measurement Period</td><td>November 6, 2015 – November 5, 2016</td></tr>
<tr><td>Submission of Interim Report</td><td>June 30, 2017</td></tr>
<tr><td>Final Re-measurement Period</td><td>November 6, 2016 – November 5, 2017</td></tr>
<tr><td>Intervention Implementation</td><td>November 6, 2015 – November 5, 2017</td></tr>
<tr><td>Analysis of Project Data</td><td>Ongoing</td></tr>
<tr><td>Submission of Final Report</td><td>June 30, 2018</td></tr>
<tr><td>Extension Measurement Period</td><td>November , 2017- November 5, 2018</td></tr>
<tr><td>Submission of Extended PIP Report</td><td>June 30, 2019</td></tr>
</table></td></tr>
<tr><td>Barriers Identified</td><td>Lack of accurate/ complete data to identify high risk pregnant members; Lack of high risk member awareness of appropriate treatment and engagement with CM; Lack of accurate identification of high risk members with history of preterm birth</td></tr>
<tr><td>Interventions</td><td>(1) Notice of Pregnancy For (NOP): revised education to providers and added a P4P incentive for timely submission of the NOP; (2) Created High Risk Pregnancy registry; (3) Revised provider education (Medicaid 101); and (4) Enhanced outreach to targeted high risk pregnant members for enrollment in CM.</td></tr>
<tr><td>Results</td><td>1. 17P utilization rates increased from baseline of 2.16% to 15.84% in 2017*
2. Chlamydia screening increased from 70.29% at baseline to 85.71% in 2017*
3. HIV testing during pregnancy increased from baseline of 62.56% to 75.83% in 2017*
4. Syphilis testing during pregnancy increased from 71.28% at baseline to 77.67% in 2017*
5.a. Most effective method of contraception increased from 8.57% at baseline to 9.57% in 2017*
5.b Moderately effective method of contraception decreased from 23.65% to 21.90%
5.c Adoption of LARC during delivery remained relatively unchanged with slight decrease from baseline of 1.90% to 1.55% in 2017
5.d Adoption of LARC within 56 days of delivery increased from 6.86% at baseline to 8.02% in 2017*
6. Postpartum Care HEDIS measure increased from 58.23% at baseline to 63.42% in 2017.
At the end of the project, LHCC measured preterm birth rates noting a decrease of 8% (30.6% in 2015 to 28.1% in 2017)
*indicates statistically significant results with p-value less than 0.05.</td></tr>
</table>

2.10.11.4.5 The Proposer should describe how it will identify quality improvement plans and projects to put in place, what potential topics may be, and how the Proposer will monitor the implementation and outcomes of the activity.

Identifying QI Plans and Projects. Our QI staff present results of our Population Health Assessment, Utilization Assessment, and other data analyses (e.g. complaints, enrollee/provider input) to the PIT who identifies initiatives and makes recommendations to the QAPIC. The QAPIC assists to prioritize identified initiatives focusing on those with the greatest need or expected impact on the Quadruple Aim, utilizing measures as outlined in Attachment G of the Model Contract and traditional quality/risk/utilization management approaches

to identify activities based on observable, measurable and manageable issues. Most often, initiatives are identified through analysis of key indicators of care and service based on reliable data that indicates the need for improvement in a particular clinical or non-clinical area. Other baseline data may come from: performance profiling of contracted providers; provider site visits; focus studies; over- and under-utilization performance indicators; sentinel event monitoring; trends in enrollee complaints, grievances and/or appeals; issues identified during care management; and/or referrals from internal or external sources, including enrollees, providers, and quality subcommittees.

Potential Topic Areas. LHCC will perform at least three LDH-approved PIPs with at least one related to BH. LHCC acknowledges that LDH may require up to two additional projects for a maximum of five projects. Potential PIP and quality improvement plans and projects topic areas may include:

- Prematurity/Infant Mortality (e.g. safe sleep environment)
- Reducing low value care (e.g. use of imaging for low back pain)
- Substance Use Disorder and Treatment (e.g. peer support programs)
- Addressing SDOH (e.g. tracking and closing the loop on resource referrals)

Monitoring Implementation and Outcomes. PIPs, focused studies and other QI initiatives are designed to achieve and sustain significant improvement over time in accordance with principles of sound research design and appropriate statistical analysis. LHCC re-measures each project's established performance measures, compares them to the established benchmarks and goals at the intervals determined at the beginning of the project, and tests the comparisons for statistical significance. Intervals are based on the timeframe in which an anticipated improvement in performance is expected to occur. To ensure comparability, the re-measurement methodology is the same as that used for baseline measurement. We may also track additional measures related to the project, such as intermediate process indicators or enrollee or provider satisfaction, including monitoring the quality and appropriateness of care delivered to enrollees with special health care needs. If re-measurement does not demonstrate significant improvement or performance does not exceed established goals, the QI cycle begins again. In such cases, the PIT, in conjunction with the QAPIC, evaluates each intervention, identifies barriers that may be interfering with the achievement of performance goals, and revises the intervention, or replaces or supplements it with new interventions to address identified barriers.

2.10.11.5 The Proposer should submit a list of clinical practice guidelines relevant to the LDH Medicaid population that the Proposer proposes to use, a sample of one such guideline, and the following:

CLINICAL PRACTICE GUIDELINES (CPG)

LHCC adopts CPGs in consultation with network providers (including BH as indicated) and based on the health needs and opportunities for improvement identified as part of our QAPI Program; valid and reliable clinical evidence or a consensus of Health Care Professions in the particular field; and needs of the enrollees. CPG criteria is used to ensure consistency with all decisions relating to utilization management, enrollee education, and covered services. LHCC has adopted clinical practice and preventive health guidelines for:

ADHD*	Coronary artery disease*	Oppositional defiant disorder	Stress disorder
Adult preventive care	Diabetes*	Panic disorder	Substance use disorder*
Anxiety disorder*	High cholesterol	Pediatric preventive care	Tobacco cessation
Asthma*	Hypertension*	Perinatal care	Psychotropic medication use
Back pain*	Immunizations	Respiratory illness	Weight management*
Bipolar disorder	Lead screening	Schizophrenia	
COPD	Major depressive disorder*	Sickle cell anemia	

* CPGs related to disease management programs

For example, we have adopted the *Asthma Care Quick Reference: Diagnosing and Managing Asthma*, Guidelines from the National Asthma Education and Prevention Program (Expert Panel Report 3, Revised 2012) published by the U.S. Department of Health and Human Services; National Institute of Health; National Heart, Lung, and Blood Institute. See ***Attachment 2.10.11.5 LHCC Adopted CPGs and Sample*** for our adopted CPGs and sample CPG.

2.10.11.5.1 The proposed process for developing and disseminating clinical practice guidelines to participating providers and enrollees;

Process for Developing CPGs. LHCC's QI staff is responsible for researching evidence-based guidelines, including preventive care guidelines and CPGs. Guidelines are then presented to LHCC's new Clinical Policy Committee, with majority representation from Louisiana Medicaid providers, and subsequently to our QAPI Committee.

Disseminating CPGs to Providers and Enrollees. The QI department in collaboration with our Network Development department ensure guidelines are disseminated to all affected providers and upon request to enrollees and potential enrollees. Provider distribution is through Provider Manuals and orientations, Newsletters, LHCC website, emails or faxes. A listing of adopted clinical practice and preventive health guidelines is maintained in the Provider Manual, with links to the full guidelines or a notation that the links and/or full guidelines are available on the LHCC website or hard copy upon request. The distribution to enrollees is through the Member Handbook, Newsletters and the LHCC website or hard copy upon request.

2.10.11.5.2 How scientific evidence and the opinions of in-network and out-of-network experts and providers will be incorporated into such guidelines;

Incorporating Scientific Evidence. Clinical guidelines are intended to be reflective of current scientific research and evidence-based clinical standards. LHCC's QI staff conducts research to identify evidence-based guidelines developed by national organizations and recognized authorities including opinions and assessments by nationally recognized medical associations such as physician specialty societies, consensus panels, or government agencies such as the Food and Drug, Administration (FDA), Centers for Disease Control (CDC), or National Institutes of Health (NIH). If guidelines from a recognized source cannot be found, LHCC consults our parent company's policy department for assistance in guideline sourcing or development.

Incorporating Opinions of Experts and Providers. LHCC's new Clinical Policy Committee reviews proposed CPGs for adoption to determine relevance to the needs of our enrollees. LHCC's Clinical Policy Committee includes Louisiana practicing network primary care and specialty providers, who will provide input on current community clinical practices and provide guidance on how to maximize acceptance of evidence-based guidelines. For example, when there is a difference in policy between two national associations (e.g. mammograms) our Clinical Policy Committee will make the final determination on which guideline to adopt. LHCC refers CPGs involving a specialty not represented on the Clinical Policy Committee to a community specialist for input and recommendations. Before approval and distribution, QI staff review authorization criteria, UM policies, state coverage guidelines and enrollee education and benefit materials for consistency with our adopted CPGs.

2.10.11.5.3 How the Proposer plans to evaluate providers' adherence to clinical practice standards and evidence-based practice, and any interventions that the Proposer may take to encourage adherence; and

Evaluating Adherence to CPGs. As obligated by contract, providers are expected to adhere to LHCC's published guidelines and may be monitored for compliance through chart audits and monthly reporting. For example, for population based analysis, adherence is assessed via claims data or HEDIS rates. For practice-based, a sample of medical records may be evaluated for adherence to specific guidelines. If performance measurement rates fall below LHCC and/or State goals, we will implement corrective action plans and/or interventions for improvement, as applicable. LHCC will continue to promote CPG documentation and in 2019 will offer Continuing Medical Education to providers as appropriate.

Interventions to Encourage Adherence. Provider adherence to the CPG's is encouraged during routine education such as our new Provider Orientations, Provider Manual, Newsletters, and on the Provider Portal. Targeted mail outs that include CPGs relevant to specific providers underscore the importance of compliance. LHCC's Provider Incentive/VBP programs, as discussed above, also work to promote compliance with CPGs.

2.10.11.5.4 The ongoing evaluation process for updating and revising the Proposer's clinical practice guidelines to ensure consistency with medical practice standards.

Updating and Revising Guidelines. CPGs are updated based on significant new scientific evidence or change in national standards or at least every two years. At least annually, a multidisciplinary meeting to review CPGs is conducted which includes representation from subcontractors, Quality Improvement, Medical Management, Pharmacy, Medical Affairs, Provider Engagement and Member Services. The meetings are held to review the

CPGs and to ensure that decisions to which the guidelines apply are consistent. Further, the cross-departmental meetings review enrollee and provider documents to ensure distributed content and materials are consistent with the guidelines. If guidelines are changed between annual meetings, due to updates in the literature upon which they are based, an ad hoc meeting is held to review the specific guideline that changed. Recommendations for significant changes are presented to the Clinical Policy Committee for approval.

2.10.11.6 The Proposer should submit, as an attachment using the Quality Response Template provided in the procurement library, its NCQA Health Insurance Plan Ratings (2018-2019) for all of the Proposer's and its parent organization's (including affiliates). Medicaid managed care contracts with full NCQA accreditation…

Attachment 2.10.11.6 LHCC Quality Response Template has been provided as part of the electronic copy submission in lieu of hard copy.

SECTION 2.10.12

Value-Based Payment

Louisiana Healthcare Connections works together with us to improve care while saving costs, giving us data on utilization, care gaps, health risks and high ED usage, at both panel and member levels, to help us focus on both population and individual patient needs.

—Dr. Shahid Mansoor
Avoyelles Pediatrics, Rural Health Clinic

SECTION 2.10.13

Claims Management and Systems and Technical Requirements

We require fast claims processing for our Medicaid operations, and Louisiana Healthcare Connections' twice weekly payment cycle and free EFT payment service ensures smooth revenue flow and efficient payment posting.

—Donna Saterfiel
President and CEO
All Kids R Us Medical Clinic

2.10.13 CLAIMS MANAGEMENT AND SYSTEMS AND TECHNICAL REQUIREMENTS [10 PAGE LIMIT; DATA FLOWS AND CHARTS ARE EXCLUDED FROM SECTION-SPECIFIC AND TOTAL PAGE LIMIT]

2.10.13.1 The Proposer should demonstrate its understanding of the Louisiana Medicaid program, applicable state administrative rules, and statutes and describe in detail how it will apply this understanding in customizing a Louisiana-specific system for adjudicating claims.

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DEMONSTRATED EXPERIENCE IN LOUISIANA – "TRUSTED PARTNER"

Louisiana Healthcare Connections (LHCC) has successfully processed claims as part of the Louisiana Medicaid program since 2012, and we currently serve more than 475,000 enrollees.

> *"We require fast claims processing for our Medicaid operations, and LHCC's twice weekly payment cycle, along with free EFT payment service, ensures smooth revenue flow and efficient payment processing."*
> *– Donna Saterfiel, MSN, FNP-Certified, President & CEO All Kids R Us*

Demonstrated metrics. In 2018, LHCC processed 99.0% of clean claims within 15 days (exceeding the Louisiana Department of Health (LDH) requirement) and 99.7% of clean claims within 30 days.

National and Local Claims Expertise. LHCC's claims adjudication process is supported by our parent company, Centene Corporation (Centene) with 35 years of experience receiving, processing, and reporting claims data for our State partners, including LDH.

8.5 days

LHCC's average turnaround time for provider payment

We Understand the LA Medicaid Program. LHCC confirms we will adhere to requirements contained in Appendix B: Model Contract, Section 2.18 Claims Management, state or federal requirements including, 42 CFR 455.23, 42 C.F.R. §438.242(b)(3); *42 CFR 455.18 and 455.19,* La.R.S. 46:460.71, La R.S. 24:51 for claims processing and payment.

INTEGRATED CLAIMS PROCESSING SYSTEMS TAILORED FOR LOUISIANA

LHCC's Medicaid experience in Louisiana informs our customized claims operations, system design, processing, and reporting. Our HIPAA-compliant Claims Processing System is configured to adhere to LDH requirements outlined in Louisiana Medicaid fee schedules, Medicaid Provider Manuals, and all published Medicaid Health Plan Advisories, so we can process claims and pay providers efficiently and accurately. Also, our claims management system is integrated within our Management Information System (MIS) to share data seamlessly with enrollment, provider, authorization, care management, and reporting systems. See ***Attachment 2.10.13.1 Claims Processing System*** for a flowchart of the claims process.

Local Louisiana Claims Excellence

Local Expertise and Collaboration. Our Louisiana-based Claims Team oversees LHCC claims adjudication and payment operations, has over seven years' experience in claims processing for LDH programs, and consistently processes complex claims in an accurate, timely manner. LHCC's Claims Team is comprised of Claims Research Specialists, Claims Liaisons, and Contract Implementation Analysts, who collaborate to manage our claims operations. The Claims Research Specialists take the lead to assist providers in resolving claims submission and payment issues, while the Claims Liaisons analyze claim trends and resolve systemic provider claim issues. The Contract Implementation Analysts take care of system configurations, including those for benefits, fee schedules, and provider setup. Our Claims Teams also collaborates with LDH and our fellow MCOs to strategize about improvement opportunities. ***Process Excellence.*** LHCC's Management Team frequently reviews claims performance reports to identify high-level claims trends. Our Claims Team provides support by reviewing daily pend reports to identify aging claims, taking steps such as provider outreach to resolve any outstanding issues. ***Enterprise Support.*** LHCC is also supported by a Centene Medicaid Claims Support Team, knowledgeable on the LDH reimbursement guidelines, benefits plan and LDH-specific business processing rules, and quality monitoring. These additional staff resources ensure we exceed claims processing and provider payment Contract requirements, regardless of claims volume or staff variance.

Processing and Paying Claims for our Louisiana Providers

96%

of claims received were EDI in February 2019

Multiple Claim Submission Methods. LHCC takes a no-wrong-door approach to claims submission, offering providers multiple online claim submission options. We proactively encourage providers to file claims as soon as possible after the date of service to ensure timely payment, and we use that data to better serve enrollees. We support all HIPAA EDI required formats, including the 837 Health Care Claims (Institutional, Professional, and Dental) and NCPDP D.0 Pharmacy claims. For paper claims, we accept the UB-04, CMS 1500, and Dental ADA formats. Upon receipt, our MIS translates claims data, performs an initial screening, and either rejects the claim or assigns a unique control number for further processing. Our Claims Processing System verifies that claims comply with HIPAA syntax and data structure guidelines, validating against ANSI Accredited Standards Committee X12N and LDH's Systems Companion Guides. If a claim does not pass, a notification is triggered to the trading partners and providers (via ANSI TA1/999 Functional Acknowledgment or rejection letter). We promote electronic claims submission for our providers in an ongoing manner through provider training and education via outreach calls, in-person meetings, and webinars, and provide claims submission procedures in the Provider Manual, posted on our public website.

Claims System Adjudication Edits. Submitted claims are mapped, translated, and validated by our MIS against adjudication edits that a claim must pass to reach a "finalized" (paid or denied) or internally pended status. Our Claims Processing System identifies receipt date; adjudication status and dates; provider payment dates; encounter data elements; electronic and paper adjustments and voids; and zero pay claims. Other claims edits include validation of enrollee name and eligibility spans, CPT, HCPCS, ICD-10, age, gender, duplicate records, service quantity, attending and billing provider of each service, submitting provider's eligibility and network participation, prior-authorization during service date spans, and benefit management rules. The claim is then priced by applying enrollee TPL, coordination of benefits, copayments or deductible amounts, and provider-specific agreements. Providers can obtain claim status information online through our Provider Portal or by calling our Provider Call Center. We are enhancing our Provider Portal to allow providers to submit claim reconsideration and appeal requests online, and providers will receive emails updating them on any changes in request status. In addition, our enhancements will give providers an enhanced online view into their claims status, improving provider administrative simplification.

Provider Payment and Remittance. To support accurate provider payment, the integrated provider payment component of our Claims Processing System has an additional, customized layer of validation. We process provider payments two times weekly, exceeding the LDH requirement, and will be moving to three times weekly. We offer providers multiple payment options, including paper check and explanation of payment accuracy checks prior to payment, we created an additional, customized layer of validation within the (EOP) and Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) payment options which comply with CAQH CORE Operating Rules and the provisions in La. R.S. 46:460.71.

As with claim submission, we encourage our providers to utilize the ERA and EFT electronic payment options. Our ERAs/EOPs provide an itemized account of the claims included in the payment, with information such as enrollee's name, date of service, procedure code, service units, and reimbursement amount. Each ERA sent to providers includes statements in compliance with 42 C.F.R. §455.18 and §455.19 certifying the accuracy of information and payment is from Federal and State funds. The provider will receive an ERA or EOP even if a claim is denied, with the claim denial reason and instructions for correction and resubmission. We are also improving our denial code explanations, to improve our transparency with providers in the claims process.

Encounter Data Processing Customized for Louisiana

We submit weekly certified HIPAA-compliant encounter files to LDH according to specifications in the MCO Manual, including data elements and reporting requirements. The claims system electronically sends processed claims data to the Enterprise Data Warehouse (EDW), where that data is accessed by our Encounter Data System (EDS) to meet LDH encounter data submission requirements. EDS is a comprehensive encounters workflow system, which edits and validates claims data, creates encounter submissions files, loads inbound response files from LDH, and tracks and reports encounter data status. Louisiana-specific encounter rules and edits are set up in our EDS, to ensure encounters are HIPAA 837 compliant, and conform to LDH's content, format, and

transmission specifications. LHCC submits encounters to LDH for every paid, denied, adjusted, and voided claim for health plan and subcontractor services. Prior to submission to LDH, LHCC tests encounter data for accuracy, completeness, logic, and consistency, including for our subcontractors. Our CEO, CFO or their designee attest to the truthfulness, accuracy, and completeness of all encounter data submitted.

Ensuring Encounter Data Completeness. Our Claims Operations and Encounters Business Operations (EBO) Teams maintain rigorous processes for tracking encounter submission, error correction, resubmission, and contract compliance, using a variety of customized reports. The Teams complete a monthly reconciliation tying adjudicated claims to their current encounter status and evaluates functions associated with encounter rejections, to identify process or system changes needed to meet Contract completeness requirements.

Timely Error Resolution for Louisiana Encounters. EDS enables the EBO Team to research errors quickly, in accordance with LDH's requirement to remediate 90% of encounters within 60 calendar days and 99% of encounters within 90 days after notice for those failing repairable edits. Through our EDS, we can identify any encounter that need reprocessing, view encounter issues from the batch-level to the service line-level, and view the processing history of all encounters. We achieve timely error resolution by performing root cause analysis, and route the encounter record to the appropriate EBO, IT, Claims, or subcontractor teams for resolution. If an erred encounter record requires the claim to be reprocessed, corrections are made at the source, and the encounter is resubmitted through EDS and resubmitted to LDH, within the agreed upon timeframe.

Pharmacy Claims Processing – Envolve Pharmacy

Our affiliate, Envolve Pharmacy Solutions (EPS), has provided Pharmacy Benefit Management (PBM) services for nearly 20 years, and has the system in place to support automated claims and encounter processing of our pharmacy program. Through our Vendor Management program, LHCC oversees EPS performance and Contract requirements. EPS supports the current HIPAA-compliant NCPDP D.0 formats and National Drug Code file updates. This includes accurate pharmacy point of sale (POS) claims processing and payment, administration of drug coverage, enrollee eligibility processing, benefit limitations, prior authorization, claims history, drug package information, and drug utilization review.

Pharmacy Encounters Submission and Disputed Pharmacy Encounter Submissions. We currently provide pharmacy encounters with all claims-level detail information to LDH on outpatient drugs administered to our enrollees. Our pharmacy encounter submissions follow similar processes as our medical encounters. EDS receives processed pharmacy claims data every 24 hours, electronically from our affiliated PBM. EDS then creates HIPAA-compliant NCPDP pharmacy claim transactions, which we transmit to LDH for LDH's subsequent reporting of drug utilization information to CMS and quarterly rebate invoices to drug manufacturers. We review disputed encounters identified through the drug rebate invoicing process and correct and resubmit to LDH. LDH and EPS have the claims and encounter edits in place to support the 340B requirements. Our 340B provider contracts will contain billing instructions on how to identify 340B claims and encounters.

Claims Audit Division to Support Claims Accuracy and Quality Standards for Louisiana

Our Claims Audit Department (CAD) is responsible for the independent, objective evaluation of claims payment accuracy, per our policies and procedures. CAD operates independently of the Claims Department, and reports directly to the Senior Vice President, Internal Audit. CAD helps ensure that provider payment processing is in accordance with appropriate rates, and that all State and federal claim processing rules are followed. CAD issues monthly and quarterly reports to the LHCC Claims Team and Management, which summarize audit testing results. LHCC then submits a claims payment accuracy percentage report to LDH. CAD audits encompass claim entry, adjudication, and whether determinations on enrollment, benefit, and payment are accurate. CAD staff perform weekly and monthly statistically valid audits, based on a random sample of processed and paid claims, to assess claims for processing, and financial accuracy. CAD selects random samples of 200-250 claims per month, based on financial stratification from each check run, and assesses multiple attributes (e.g., correct data entry, correct provider, prior authorization, enrollee eligibility, payment amount, duplicates, denial reasons, co-payments, proper coding, and modifiers). LHCC also submits a monthly Claims Summary Report of paid/denied claims to LDH by claim type.

Enrollee Sampling for Service Verification. LHCC utilizes an automated process to survey a random enrollee sample, mailing an Explanation of Benefits (EOB) within 45 days from payment. The EOB states the document is not a bill, but is provided to verify rendered services. We ask enrollees to sign and return the EOB to our Baton Rouge office, and if they did not receive the services, contact our Member Services Department.

LaHIPP

LHCC continues to support the LaHIPP program for LDH qualified enrollees. For our enrollees that are part of the LaHIPP program, LHCC processes and pays the enrollee payment responsibility after the claim has been processed and paid by the primary payer. We pay as primary for mental health services and transportation services not covered by commercial insurance as primary payer. Enrollees follow the policies of the primary plan. LHCC only pays for services covered under the Louisiana Medicaid Fee Schedule.

2.10.13.2 The Proposer should describe in detail the Management Information System (MIS) it proposes to use in performance of its Contract obligations and how the MIS will comply with all of the requirements of the Model Contract.

LHCC, backed by Centene, uses a HIPAA-compliant enterprise MIS that supports physical and behavioral health administration on a unified platform, which complies with requirements contained in the Appendix B: Model Contract, Section 2.19 Systems and Technical Requirements, federal and State regulations and industry guidelines. Our MIS is grounded on four design principles: I*ntegration, Interoperability, Accessibility, and Scalability*, and is designed for health plan administration, including claims processing, clinical, service, analytics, and reporting functions needed to support our State partners. We employ administrative, physical, and technical controls such as facility monitoring, role- based access, audit trails, and encryption, and perform regular risk assessments, identify controls to reduce risk likelihood and impact, and ensure our MIS is kept secure. Additionally, we are implementing Application Program Interfaces (APIs) and automation controls, ensuring that data flows seamlessly between our MIS, and that users of our MIS have access to the most relevant data available. See ***Attachment 2.10.13.2 IT Systems Landscape*** for an overview of our MIS.

2.10.13.2.1 The length of time the Proposer has been utilizing the MIS proposed for the Contract; if for fewer than two (2) years, the Proposer should describe how it will assure system stability;

LHCC leverages an enterprise MIS supplied to us by Centene, which has been in use longer than two years and established before and used continuously to support our operations in Louisiana.

MIS Architecture to Assure System Stability

Data Centers Assure System Stability. Centene operates a nationwide network of data centers, including redundancy to our secure private cloud environment, which includes our LEED certified, Tier 3 primary facility, supported by additional, geographically dispersed data centers. Our data center facilities have redundant environmental, power, networking systems, and backup capability, and if a disabling event occurred in our primary datacenter, critical voice and networking processes would redirect to the secondary datacenters in near-real-time. The secondary datacenters can resume essential functions for enrollee care and provider payment services, ensuring limited or no disruption. The data centers are connected by our redundant Wide Area Network (WAN), to ensure any telecommunication provider's outage will not result in unavailability. This strategy was successful in enabling our systems to maintain business continuity, with no service disruptions, during hurricanes in our affiliate states. See ***Attachment 2.10.13.2.1 Contingency Plan*** for additional details on our data center backup and recovery capabilities. ***Systems Quality Assurance Plan***. We maintain, and provide to LDH, a Systems Quality Assurance Plan, which includes our system processes, design, procedures, and user manuals of our MIS. LHCC will also complete an Information Systems Capability Assessment (ISCA) at LDH's request. ***Change Management to Support System Stability***. We use a structured best practices Change Management approach, utilizing Agile and the Information Technology Infrastructure Library (ITIL) process framework, to ensure any system changes maintain stability and avoid disruptions.

2.10.13.2.2 Hardware and system architecture specifications for all systems that would be used to support the Contract (including enrollment, claims processing, customer service systems, utilization management/service authorization, care management/care coordination, and financial systems);

Hardware and System Architecture of Core Systems

We maintain hardware and software compatible with current LDH requirements, in accordance with the MCO Manual. Our MIS is designed for interoperability via a Service Oriented Architecture (SOA) with microservices accessible via open APIs to deliver system functions in a scalable manner. Our MIS is informed by CMS' Medicaid Information Technology Architecture (MITA) 3.0 standards, with integrated and industry-standard interfaces. Our flexible, standards-based approach also ensures that our systems are scalable and agile, such that we can easily incorporate innovative technologies like real-time analytics and artificial intelligence, as they become available. Our SOA is multi-tiered, and data is stored on a Storage Area Network (SAN), supported by Storage Arrays featuring RAID 6 configurations. Unix databases run on 308 Central Processing Units (CPU) and 11 TB of memory, running Oracle Real Application Clustering for high availability, and Windows applications run on blade servers in virtualized environments. LHCC applications run at our datacenters, and our virtual desktops connect to centralized data via a WAN. Virtual desktops run Windows applications via Citrix XenApp for thin clients, and we use JBOSS portal platforms operating on Red Hat Enterprise Linux for maximum interoperability. All staff connect to applications via our full-mesh, IP Multiprotocol Layer Switching WAN, and internet access is through burstable circuits and redundant firewalls. Intrusion Prevention System (IPS) technology protects against known vulnerabilities, and remote access is via a Virtual Private Network using Cisco's VPN Concentrator and encrypted sessions with Citrix NetScaler Controllers. Our data network connects our offices and affiliate subcontractor telephone systems through VOIP, with multiple paths for instant call routing, if a call center becomes disabled. We support our operations with the core systems described below.

2.10.13.2.3 All proposed functions and data interfaces;

Enrollment System - Unified Member View

The Unified Member View (UMV) component of our MIS provides the single source of truth for all informational aspects of our enrollees' relationship with LHCC, including enrollee demographics, current and historic benefit plan eligibility, contact information, communication preferences, and a history of changes to data. UMV employs a master data management approach to collecting, matching, quality-assuring, storing, and distributing enrollee enrollment data we receive from the enrollment broker to the components of our MIS needing that data. UMV automatically links individual enrollee identifiers to a unique master member index, enhancing our ability to maintain historic enrollee data and result in a unified view of an enrollee's enrollment history. See ***Attachment 2.10.13.2.3.A Enrollment System*** for data interface details.

LHCC has an API in place between our Enrollment System and our Member and Provider Portals, delivering eligibility data to our Portals faster and ensuring updates display timely.

Claims Processing System

We employ one of the health care industry's premier Claims Processing System, to efficiently support accurate claim adjudication for complex benefit plans and provider reimbursement models. We use our Claims Processing System for medical and behavioral health claims processing, enabling a uniform approach to coordinated benefits administration. Our Claims Processing System fully supports HIPAA standard EDI and EFT capabilities, as well as detailed, real-time clinical edits and advanced Fraud Waste and Abuse detection. Our integrated claims workflow software manages any pended claim in real time, meaning if a claim pends, it is electronically routed to a claims processor skilled in the specific pend type, for efficient resolution and re-adjudication. See ***Attachment 2.10.13.1 Claims Processing System*** for additional data interface details.

Customer Service System

Our **Customer Service System (CSS)** enables us to identify,serve, and engage LDH, our enrollees and providers in a coordinated fashion across wellness, clinical, administrative, and financial matters. See ***Attachment 2.10.13.2.3.B_Customer Service Systems*** for data interface details.	Provides a 360-degree view of our relationship with enrollees and providers for our Customer and Provider Service Representatives (Representatives).
	Allows our Representatives to route any inquiry-related task requiring follow up to appropriate staff, while also enabling them to manage all tasks to successful completion.
	Features task lists and work queues that communicate to all Representatives, and supporting staff, on the prioritization and urgency of follow-up actions.
	Tracks inquiries to enable unified communications, and all inquiries become part of that enrollee or provider's online CSS record.
	Allows us to capture, track, report, and manage complaints, grievances, and appeals as well as reasons for termination of enrollment other than loss of eligibility.

Our Customer Service System integrates with our Enrollment and Provider Lifecycle Management Systems, delivering the most up-to-date information to our CSRs, enabling quick resolution to enrollee and provider inquiries.

Utilization Management and Service Authorizations

LHCC's integrated family of tools to support administrative productivity and clinical quality, enables us to simplify the utilization management (UM) process for providers and staff. We use TruCare as our Care and Utilization Management System, to maintain UM and Service Authorization (SA) information. We also offer providers the ability to look up whether a SA is required on our public website. Providers can submit SA requests through our secure Provider Portal, by phone, or fax, and can also check the status of SA requests. *InterQual Connect™.* LHCC will enhance our web-based authorization capability through the implementation of InterQual (IQ) Connect point-of-care solution, which incorporates InterQual Medical Necessity Criteria in a fully automated, interactive workflow, supporting real-time medical appropriateness review and determination for key services. Using IQ Connect allows providers to track their SA submissions, enabling enhanced practice management and better care for our enrollees. See ***Attachment 2.10.13.2.3.C Care and Utilization Management System*** for additional data interface details.

Care Management and Care Coordination

TruCare enables us to deliver collaborative care management and care coordination. See ***Attachment 2.10.13.2.3.C_Care and Utilization Management System*** for additional data interface details.	Our system used to help enrollees develop and maintain care plans. The TruCare Plan of Care displays the enrollee's identified health problems, treatment goals and objectives, and milestone dates.
	Supports a unique profile for each enrollee, including enrollee demographics, initial Health Needs Assessment (HNA), comprehensive assessment, POC, enrollee case notes, and enrollee preferences, such as language and communication preference.
	Integrated with our Centelligence health informatics platform and EDW, enabling access to unified data from a variety of sources to better risk stratify, identify, and monitor enrollees.
	Data includes, eligibility and benefit information, care gaps, care opportunities, and emergency department (ED) alerts, diagnoses, medications, disease management information, inpatient utilization data, access to an enrollee's risk score, among others.

We are in the process of applying Human-Centered Design (HCD) principles to TruCare, including using a simple and natural design that presents information clearly, reducing the amount of mental effort required by users, and maintaining consistency throughout design.

Financial Management System

LHCC uses an enterprise Financial Management System (FMS) to record financial data, integrating data from our core systems and FMS to produce our Financial Statistical Reports for LDH. All financial

transactions are auditable per GAAP guidelines**.** See ***Attachment 2.10.13.2 IT Systems Landscape*** for data interface details on the FMS.

Provider Lifecycle Management System

The Provider Lifecycle Management System (PLMS) component of our MIS includes a single repository for LHCC's core provider functions including provider prospecting, contracting, credentialing, data administration, and engagement. Our Provider Data Management Department enters and updates provider data in PLMS, ensuring that all provider data comes from one governing source for complete data integrity. PLMS stores and indexes multiple providers' numbers, provider types, specialty, and sub-specialty codes, provider's language information, locations, office hours, ADA accessibility, etc. PLMS is integrated with our Customer Service System (CSS) platform, enabling enterprise-level call center support for provider inquiries, outbound campaigns, and unified provider contact management and communications. We will be enhancing our PLMS with additional provider engagement functionality, to improve provider partnerships and satisfaction. See ***Attachment 2.10.13.2.3.D Provider Lifecycle Management System*** for additional details.

2.10.13.2.4 Data and process flows for all key business processes; and

See the following attachments for details on the data and process flows for our core systems, which support our key business processes: ***Attachment 2.10.13.1 Claims Processing System; Attachment 2.10.13.2 IT Systems Landscape; Attachment 2.10.13.2.3.A Enrollment System; Attachment 2.10.13.2.3.B Customer Service Systems; Attachment 2.10.13.2.3.C Care and Utilization Management System; and Attachment 2.10.13.2.3.D Provider Lifecycle Management System.***

2.10.13.2.5 Proposed resources dedicated to Medicaid Management Information System (MMIS) exchanges.

Our HIPAA-compliant MIS employs relational database management systems for all production data (claims, enrollee eligibility, provider data, authorizations, etc.). We support real-time, industry standard APIs for multiple transaction types, and Open Database Connectivity (ODBC) compliant software for data access in conjunction with industry standard ETL tools. This standards-based MIS design ensures that all data elements are available for MMIS exchanges. In addition, our MIS receives and transmits data using HIPAA transaction codesets wherever applicable, including support for outbound transmission of eligibility data in HIPAA 834 format, authorizations as HIPAA 278 data, encounters in HIPAA 837 and NCPDP D0 formats, etc. Our MIS supports all LDH proprietary formats for provider data, reference files, and care plans. Our Louisiana team of claims, analytics, and reporting staff are supported by Centene's 2,000 MIS and 1,700 claims professionals.

2.10.13.3 The Proposer should attest to the availability of the data elements required to produce required management reports;

Our Centelligence health informatics and reporting platform is powered by our EDW and is the foundation of our reporting strategy. We take a data-driven, evidence-based, and local approach to data collection and report development. From ensuring quality data enters our EDW, to using stakeholder input when designing dashboards and reports, we ensure Centelligence produces quality reports, while adhering to LDH requirements.

Seamless Data Flow Between MIS. LHCC's integrated MIS ensures that data flows seamlessly between our core systems, and that we have all data elements necessary to produce required reports.

Integrating Data. Our EDW systematically receives, integrates, and transmits internal and external administrative, clinical, and population health data, including medical, behavioral, and pharmacy claims data, as well as lab test results, health assessment data, and social determinant of health data. See ***Attachment 2.10.13.3 Centelligence Platform*** for examples of data collected in the EDW.

Up-to-date Data. Our MIS refreshes all data elements across applications within appropriate business cycles, including our EDW, which is updated nightly, to ensure reports data are clinically and administratively relevant.

Standard and Ad Hoc Reporting Tools. Our EDW data feeds our Centelligence health informatics and reporting platform, enabling us to generate standard and ad-hoc reports from a single data repository. Centelligence's reporting layer accommodates skill levels ranging from basic to advanced data and coding experience.

Report Lifecycle Management. Centelligence enables our staff to effectively manage every aspect of reporting from report design, testing, scheduled production and submission, as well as rapid development of ad-hoc reports. LHCC supports LDH standards for data element capture and availability, transmission, and reporting

schedules, as outlined in the Managed Care Reporting Guide, MCO Manual and the LDH Managed Care Reporting Deliverables list, and we use a compliance management system to track adherence to LDH reporting schedules. LHCC's Chief Executive Officer and Chief Financial Officer, or persons in equivalent positions, will certify that the enrollment information, financial reports, encounter data, and other information reported to LDH has been reviewed and is true and accurate to the best of the certifying person's knowledge.

2.10.13.4 The Proposer should describe in detail any system changes or enhancements that the Proposer is contemplating making during the term of the Contract, including subcontracting all or part of the system to an existing material…

LEVERAGING LHCC'S LONGSTANDING EXPERIENCE MAINTAINING SYSTEMS AND SYSTEM CHANGES

LHCC has been maintaining systems for its Contracts with LDH that conform with federal and State specific standards since 2012, and we continually assess opportunities to improve our core systems. We notify LDH of major system changes at least 90 calendar days prior to making major changes or upgrades to our core production systems, and define a major system change as a new software version or significant enhancements, rather than routine maintenance changes. As part of any major system change, we update system documentation and deliver it to LDH for review and approval. We will continue to work with LDH as we evaluate (through our Systems Refresh Planning) and consider enhancing any of our systems. In 2017, LHCC updated and provided LDH with a Systems Refresh Plan, outlining how our systems are assessed for versions, upgrades, releases, modifications, systems support. We will provide LDH with an updated Systems Refresh Plan as part of Readiness Review and 60 days prior to implementation of revisions and ensure system components remain formally supported by the original equipment manufacturer (OEM) or authorized vendor. Centene undergoes a detailed ISO 27001 re-certification audit, every 3 years, conducted by an ISO Certified external firm that performs an in-depth assessment of our systems. We also have a planned implementation of SOC 2 Type II reporting in 2020 and will provide a copy of the audit to LDH.

2.10.13.4.1 Enrollment;

We do not have any major system changes, upgrades, or enhancements currently scheduled for the Enrollment System. The flexible Big Data design of our UMV allows us to introduce the capture of new data elements (such as those related to Social Determinants of Health) without introducing major system changes. We do not have plans to subcontract any part of the Enrollment system for the new Contract term.

2.10.13.4.2 Claims processing;

We do not have any major system changes, upgrades, or enhancements currently scheduled for our Claims Processing System. Our configurable Claims Processing System already accommodates the increasing number of Value Based Purchasing (VBP) arrangements that we administer with our providers. We do not plan to subcontract the Claims Processing System for the new Contract term.

2.10.13.4.3 Utilization Management/service authorization; or

We do not have any major system changes or upgrades currently scheduled for the Utilization Management/ service authorization system components of TruCare. As described above, LHCC and Centene will be enhancing our web-based authorization capability through the implementation of InterQual (IQ) Connect point-of-care solution during the term of the new Contract.

2.10.13.4.4 Care Management/disease management.

We do not have any major system changes, upgrades, or enhancements currently scheduled for the TruCare Care Management/disease management system components. We do plan to subcontract the Care Management/disease management system components for the new Contract term.

ENSURING CONTINUITY OF SYSTEMS AND OPERATIONS THROUGH CONTINGENCY PLANNING

Maintaining continuity of operations is critical to service excellence for providers and enrollees.

Best Practices Approach. We follow best practices by maintaining a Contingency Plan, which includes our Business Continuity Plan (BCP) and Disaster Recovery Plan (DRP), to protect the availability, security, and integrity of our systems in the event of a disaster or failure. LHCC develops and maintains our Contingency Plan through LHCC experience, Centene's nationwide expertise and support, and a resilient IT architecture.

Focus on Restoration. Our Contingency Plan accounts for anticipated and unplanned disruption in service and focuses on restoring our operational functions including systems and employee notification processes and addresses all scenarios outlined in the Model Contract.

In 2016, we activated our Contingency Plan due to historic flooding in Baton Rouge and maintained operations with no disruption in service for our enrollees and displaced staff.

Ongoing Review and Testing. We review, update, and test our Contingency Plan annually, and will submit it as part of readiness review. See ***Attachment 2.10.13.2.1 Contingency Plan*** for additional details on our processes.

ENSURING INFORMATION SYSTEM AVAILABILITY

Secure Systems and Data. LHCC's core systems and data are securely housed in Centene-enterprise remote data centers. Centene's data centers support all core systems and applications, which are replicated between our primary and secondary data centers every four hours. This ensures users have access to system functions and information 24/7, except in the case of scheduled downtime, or in the event of a declared major failure or disaster. Both facilities employ redundant environmental, power, and networking systems; backup capability; and are hardened to withstand natural disasters. All data is backed up daily in our primary data center, to ensure data can be recovered and accessible to providers, enrollees, and staff.

Dedicated Staff and Proven Processes. Our Incident Response Operations Center (IROC), a team of systems analysts, engineers, and LHCC Management, monitors all our systems 24/7 for service availability. If an emergency event disables our operations, IROC immediately invokes response and restoration procedures, and activates a temporary Command Center, with a pre-designated Crisis Management Team, inclusive of our Management. Our Compliance Department will notify LDH of any System problems, resulting in system unavailability, within the timeframes outlined in the Model Contract. If the IROC identifies a systems function, data exchange availability, report distribution, or on-line systems access issue, our Compliance Department will promptly notify the designated LDH staff, via phone, fax, or email, within the required timeframe, including the impact to critical path processes. We will keep in contact with LDH via phone or email, providing hourly updates on status and problem resolution.

2.10.13.5 The Proposer should describe the capability and capacity of the Proposer's Information Technology (IT) system to interface with LDH's system and that of its network providers and material subcontractors.

SCALABLE ARCHITECTURE TO MEET CAPABILITY AND CAPACITY DEMANDS ON AN ONGOING BASIS

We are capable of interfacing with LDH's systems, our network providers, and our material subcontractors. Our MIS is engineered for hardware, software, and communications scalability for granular, low risk, and rapid capacity enhancement, without onerous development or changes in our overall IT architecture. Our MIS has internal capacity to quickly process transactions, to ensure we have timely data available for LDH via our LDH-LHCC interfaces. We incorporate scalability through the careful deployment of proven technologies, such as automated systems capacity measurement, virtualization, SAN, server clustering, hardware and software redundancy, and use of rack mounted, CPU blade technology.

Capacity Management Approach.

- Our Capacity Solutions Team:
  - Monitors system and interface metrics (e.g. network bandwidth and transaction times) crucial to maintaining interfaces and connectivity
  - Schedules MIS resources to ensure a consistent level of service for current and future business needs
  - Evaluates our capacity "profile" by translating business needs into interface needs, resource utilization, and future interface capacity requirements.
- The Network Operations Center manages the end-to-end capacity and operations of interfaces to our State partners, network providers, and material subcontractors.
- Centene's technical Help Desk provides 24/7 technical support to all users, including LDH.

The Capacity Solutions Team, Network Operations Center, and Help Desk use MIS capacity measurement tools to capture interface performance data, maintain a repository of data for trending, analyze the data to determine accurately existing capacity, and equip our IT Management with an online capacity dashboard for real time monitoring. We also use performance measurement software to monitor our web application servers and web response time, and we use system monitoring tools to automatically monitor overall MIS performance and interface connectivity, forecast growth, and schedule additional capacity implementation accordingly.

Interfaces with LDH Systems, Network Providers, and Material Subcontractors

Interfacing with LDH Systems. LHCC currently provides electronic data interfaces through Secure File Transfer Protocol (SFTP) and APIs to LDH systems, including the MMIS, LaMEDS, and Enrollment Broker, and we can connect to other State agencies as needed. These data interfaces support the transmission of required reports, enrollment data, client/episode level recipient, assessment, service, and provider data. We will offer OJJ and DCFS access through our Community Partner Portal to obtain enrollee eligibility information, and view referrals and services authorizations. LHCC can support a secure Virtual Private Network (VPN) connection, if requested by LDH, for other communication. ***LDH Access to LHCC.*** LHCC will work with LDH on approaches and solutions to accessing LHCC systems. We will offer a multi-pronged technology approach for providing IT system access to LDH, and will continue to share data directly with LDH, no less than weekly, for specified systems through SFTP. We will provide LDH with access to our Centelligence External Reporting Suite, a cloud-based reporting platform, in addition to "Concierge" access services, where an experienced LHCC professional can assist select LDH staff with facilitated, in-person access to our MIS.

Interfacing with Network Providers Through HIE Connections and Other Interfaces. LHCC securely receives admission, discharge and transfer data (ADT) daily from LaEDIE. This ADT and ED Registry information is then available for use in our Centelligence health informatics platform. For example, enrollees with ED visits, as represented in the ADT data, are matched with data in our MIS to identify enrollees who need to be assigned and contacted by a Case Manager (CM), or contacted via our predictive dialing system, to connect the enrollee with their already assigned CM. We will continue supporting ADT connections and require our network EDs to participate so that we employ ADTs impactfully. We are expanding HIE connectivity by participating in the Louisiana Health Information Network – Encounter Notification Service (LHIN-ENS). Other Interfaces. We support interfaces for our providers to all major EDI claim clearinghouses. Through our Provider Portal, we offer direct submission of claim and other files, and online claim and authorization entry/inquiry. In addition, we can send large data files via SFTP to providers who have the capacity to accept that level of data.

We will provide transformation grants for providers looking to advance onto an EMR system to facilitate additional interface capabilities with us.

Interfacing with Material Subcontractors. Our affiliated material subcontractors, Envolve Pharmacy Solution, Envolve Dental, Envolve Vision, and Envolve PeopleCare, share a common voice and data network. LHCC, Envolve Vision, and Envolve PeopleCare share a common hosting environment in Centene's enterprise data centers. In addition, all four subcontractors are integrated with our MIS through bi-directional network linkages and have remote access through our Citrix VPN Gateway. For our non-affiliated and provider material subcontractors, such as LogistiCare and National Imaging Associates, we support interface data exchange through SFTP and secure email.

SECTION 2.10.14

Program Integrity

Dear Linda, Thank you for helping my son, Ryan. Sharing your personal battle with health and steadily checking in on us while we were in the hospital, showed me your genuine concern [for] my son's health. I know our paths crossed due to your profession but it is truly refreshing you taking the time to hear his story.

—Amanda Reeves
Member, via a card to her son's Care Manager

2.10.14 PROGRAM INTEGRITY [10 PAGE LIMIT]

2.10.14.1 The Proposer should describe its fraud, waste and abuse program and how it addresses the requirements in the Model Contract, Part 2, Fraud, Waste, and Abuse Prevention. The description should include:

LOUISIANA HEALTHCARE CONNECTIONS'S (LHCC) COMPREHENSIVE PROGRAM INTEGRITY PROGRAM TO PREVENT AND DETECT FRAUD, WASTE AND ABUSE (FWA)

LHCC is committed to the prevention, reduction, detection, and reporting of known or suspected FWA while preventing potential enrollee health risks. Through our Compliance Committee and provider-led Board of Directors (BOD), we maintain successful Program Integrity (PI) with our comprehensive Compliance and FWA Program, including procedures to prevent and detect FWA. In addition, we will implement a task force comprised of local providers from multiple disciplines to better identify and address FWA. Our FWA Program complies with all applicable federal and state standards and includes effective internal and external controls to safeguard Medicaid funds against unnecessary or inappropriate use of services and against improper payments. We also designed our FWA Program to put enrollees' healthcare needs first. Our parent company, Centene Corporation (Centene), supports our FWA Program built on the following Louisiana Department of Health (LDH) provisions:

- Staffing model to support the FWA Program and LDH
- Comprehensive Fraud, Waste, and Abuse Compliance Plan
- Monitoring of Prohibited Affiliations and Excluded Providers
- Reporting FWA to LDH
- Review and Investigation of Potential FWA

$25 Million

LHCC's FWA practices resulted in approximately $25 million in savings through prepay reviews, cost avoidance, and recovery activities during 2018. Recoveries include $7.5M NCCI Edits; $4M Clinical Payment Policies; $14M Prior Authorization Denials.

LHCC uses prospective and retrospective criteria to monitor and detect potential FWA by providers, subcontractors, and enrollees. Our provider agreements require that the provider complies with the FWA provisions as a condition of receiving Medicaid payment. Further, we raise awareness across our organization and our provider network about methods to prevent, detect, and report FWA, while also preventing potential enrollee health risks, through compliance with all applicable federal and state standards. We will adhere to requirements contained in Appendix B: Model Contract, Section 2.3.8.2 Program Integrity, Section 2.20 Fraud, Waste and Abuse Prevention and federal and state requirements, including but not limited to, 42 C.F.R. Part 438, Subparts A, and H; 42 C.F.R. Part 455, Subparts A and B; La. R.S. 46:437.1 through 437.14; LAC 50:I, Subpart 5; and 42 U.S.C. §1320a-7, §1320c-5, and §1396a(a)(68).

Staffing Model that Supports the FWA Program and LDH

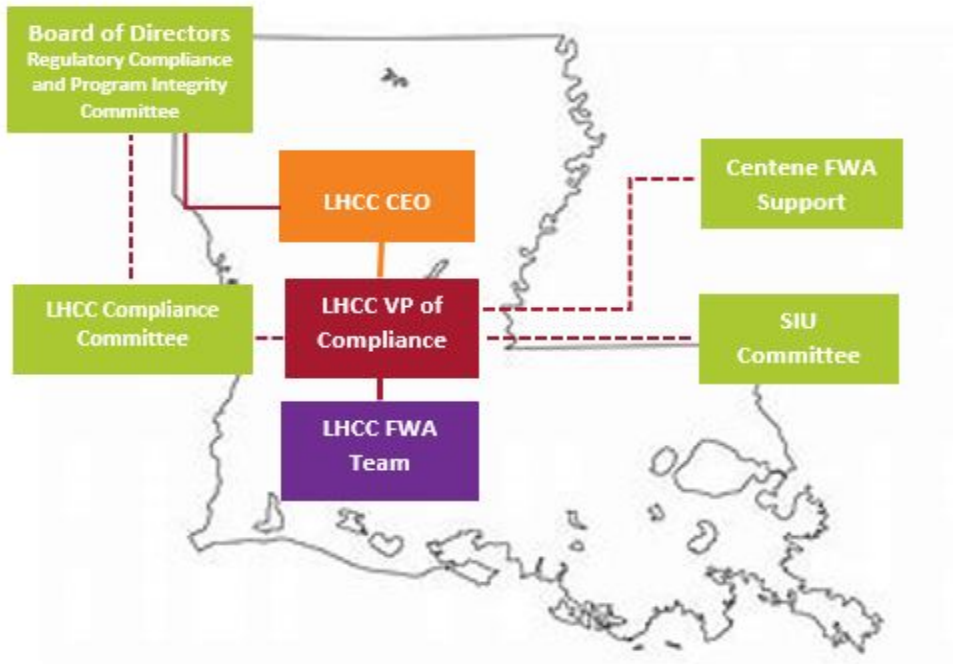
Our Chief Executive Officer (CEO) is responsible for all FWA activities and delegates daily oversight to the LHCC Vice President of Compliance (VP of Compliance) and Director, Special Investigations Unit (SIU Director). Our VP of Compliance reports to the CEO and Board of Directors and serves as the Contract Compliance and Program Integrity Officer responsible for developing and implementing policies, procedures, and practices designed to ensure FWA Program compliance.

Louisiana-Based FWA Program Staff. Our Louisiana-based FWA Team is comprised of our Program Integrity leadership (VP of Compliance, Director of Program Integrity, Program Integrity Manager), State Reporting Managers, SIU Investigators, Clinical Investigators, and an SIU Analyst dedicated to FWA activities in Louisiana. We have the staff and resources to investigate incidents and develop and implement corrective action plans to prevent and detect FWA. Our FWA Team is physically located within Louisiana and we maintain one full-time investigator for every 50,000 enrollees according to LDH requirements. The FWA Team is responsible for cooperating with LDH, and any State or federal agency on any investigations, and are available for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes. In 2019, we will add a Director of Program Integrity (PI Director) to our staff whose primary focus will be oversight of all program integrity functions. The PI Director will coordinate local SIU activities across LHCC departments, subcontractors, and LDH, ensuring that all cases are completed in 240 days. VP of Compliance Responsibilities. LHCC's VP of Compliance, with the assistance of the PI Director, will serve as the lead for our

Compliance Committee and SIU Committee. The VP of Compliance is the primary point of contact for communicating with regulatory authorities, including the LDH Medicaid Fraud Control Unit (MFCU), the Department of Insurance, and LDH. The VP of Compliance provides quarterly reports to the LHCC Board of Directors, including an SIU activity summary. SIU Committee. The SIU Committee advises and assists the VP of Compliance in developing policy and program implementation oversight. Staff from key operational areas comprise the workgroup with authority to commit resources to remedy any issues of noncompliance. Committee membership includes, but is not limited to Claims, Compliance, Finance, Provider Contracting, Medical and Care Management, SIU Legal Counsel, Network Administration, and Operations staff. The SIU Committee meets monthly and provides quarterly reports to LHCC's Compliance Committee.

LHCC Compliance Committee. Our LHCC Compliance Committee reports directly to our LHCC BOD and is responsible for overseeing LHCC's Compliance and FWA Programs. The VP of Compliance chairs the Compliance Committee. They meet quarterly to discuss standing FWA agenda topics, updates on the FWA Program, compliance training, and Contract compliance. To support additional BOD oversight of the FWA Program, in 2019 we will establish a Regulatory Compliance and Program Integrity Committee on the LHCC BOD to help shape and further define our FWA and PI program. The figure below overviews the staffing structure of our FWA Program.

Figure 2.10.14.1: FWA Team Structure



Centene Staff Supporting the FWA Program. The LHCC PI Director will ensure collaboration with Centene's SIU, Payment Integrity, Claims, and Provider Contracting departments, providing support and analytical services from a team of over 120 analysts and Louisiana-based clinical and non-clinical investigators. These support services include provider data mining, monitoring providers placed on prepayment review, and evaluating FWA referrals. Every Centene FWA Team member possesses expertise and experience relating to healthcare law, loss prevention, law enforcement, and nursing to effectively carry out their duties and responsibilities. The SIU staff are professionally credentialed by accredited organizations, such as the National Healthcare Anti-Fraud Association, the Association of Certified Professional Coders, and the Association of Certified Fraud Examiners.

FWA Compliance Plan

LHCC currently submits a copy of our FWA Plan, compliant with the 13 elements described in Model Contract 2.20.2.2, to LDH annually and whenever there are updates or modifications. We will also submit our FWA plan as part of Readiness Review upon contract award.

LHCC maintains a comprehensive FWA Plan and program, including the Contract components in line with 42 C.F.R. §438.608(a) and LDH requirements.	Written policies, procedures, and standards of conduct compliant with state and federal requirements, including disciplinary guidelines, enforcement, and corrective actions.
	Designation of a Compliance Officer that reports to the CEO and Board of Directors.
	Training and education for employees, providers, and enrollees, and open lines of communication between the Compliance Officer, other LHCC employees, and stakeholders.
	Procedures for monitoring, auditing, investigating, reporting, and whistleblower protections.
	Notifications to LDH related to enrollee or provider eligibility for program participation.
	Procedures for reporting and recovery of provider overpayments.

Adhering to Prohibited Affiliations and Payments to Excluded Providers

LHCC complies with the requirements set forth in 42 CFR § 438.610 regarding prohibited affiliations in Section 2.20.3 of the Model Contract. We do not intentionally have relationships or contracts for services with individuals or entities that are debarred, suspended, or otherwise excluded from participation under Federal Acquisition Regulations or Social Security Act, or convicted of crimes such as kickbacks, bribes or rebates. We also acknowledge the prohibited affiliation relationships in the Contract.

Screening Employees, Contractors, and Network Providers – Review of Exclusion Lists. LHCC screens all employees, contractors, and network providers to determine if they have been excluded from participation in Medicare, Medicaid, the Children's Health Insurance Program, and any federal healthcare programs. Our monthly screen includes queries to the Office of Inspector General (OIG) List of Excluded Individuals/Entities (LEIE), Social Security Administration Death Master File, National Plan and Provider Enumeration System (NPPES), Excluded Parties List System (EPLS), Louisiana Adverse Actions List Search, System of Award Management (SAM) and other applicable sites as determined by LDH. We check the exclusion status of persons with an ownership or controlling interest in LHCC, LHCC staff, network providers, delegated entities, and subcontractors against the exclusion lists at least monthly to ensure LHCC does not pay federal funds to excluded persons or entities. We subscribe to ongoing monitoring services to ensure that any OIG listing, National Practitioner Data Bank, license revocation or relevant criminal conviction is brought to our attention. We report all exclusion information discovered to LDH within three business days. We require employees to self-report either anonymously to the Ethics and Compliance Helpline or the FWA Hotline or to their immediate supervisor, the Compliance Officer, the Human Resource Manager, or the CEO when they believe they have been personally involved in, witness, or suspect a policy violation, misconduct, or issue of non-compliance. Our Compliance Officer attests to LDH monthly that all employees and subcontractors are screened to capture all debarment, suspension, and exclusions.

Reporting Suspected FWA to LDH

A crucial part of our FWA Program is to promptly report any suspected fraud, abuse, or waste to LDH and the Louisiana Office of the Attorney General MFCU upon discovering suspected incidents. We notify LDH in instances where we receive notice that an action is being taken against one of our employees, subcontractors, or network providers that could result in exclusion, debarment or suspension. See response below within Section 2.10.14.2 for additional details on our approach to reporting FWA to LDH.

Review and Investigation of Suspected Fraud and Abuse

Our FWA Team supports the identification, investigation, and referral of suspected FWA cases .

Identification of Suspected FWA. We encourage providers, enrollees, employees, and others to report any potential FWA cases. In support of this initiative, we prominently post our toll-free, confidential FWA Hotline number, which LHCC includes in all Provider Manuals, Member Handbook, Member ID cards, and on our public website. We also publicize our email address for reporting FWA on our website, which goes directly to Compliance leadership.

***Review and Investigation of Suspected FWA*.** We evaluate all FWA referrals and perform a preliminary review and investigation of all incidents of suspected or confirmed FWA according to state, federal, and Contract guidelines. Our SIU investigates all FWA referrals received by the LHCC Compliance Officer or the SIU.

The LHCC SIU uses a risk assessment tool to evaluate and determine a lead or referral's priority by scrutinizing the provider's financial exposure, enrollee vulnerability, risk of reoccurrence, and possible regulatory violations. The tool also determines if a full investigation is warranted, if provider education is required, or closure of the case for future review is recommended. An investigator has the discretion to open a full investigation/review regardless of the risk assessment score. Our SIU may request medical records from the provider to determine if the potential fraud extends beyond what was initially identified. The SIU staff prepares a preliminary report, which may include a recommendation to review additional medical records, onsite investigation, interview enrollees or providers, educate or recover payments. Upon notification or knowledge of suspected FWA, we immediately inform the LHCC Compliance Officer. We confer with LDH before initiating a post-payment review to ensure that review and recovery are permissible.

Example of Fraud Investigation and Outcome. In 2017**,** LHCC investigated eight behavioral health providers owned by a group of extended family members. Our SIU subsequently reviewed the providers' claims records, revealing aberrant billing practices: billing for services not rendered, billing for an excessive number of units, and excessively billing crisis intervention per diem and follow-up services. SIU referred these providers to the MFCU for investigation and prosecution. The aberrant billing practices committed by these providers extended beyond LHCC, including four other Louisiana MCOs. We presented this case at a quarterly MFCU BH Task Force meeting.

$700,000

LHCC identified overpayments in BH providers fraud case

Referrals to LDH. Our Compliance Officer, or her designee, uses the Fraud Referral Forms to report all tips of confirmed or suspected FWA to LDH and other applicable agencies in the required timelines , and LDH recognized us for "exceeding the LDH target for referrals using the Fraud Referral Form". On an ongoing basis, we report any provider to LDH if we suspect they are submitting claims that are coded incorrectly or not supported by documentation, we receive a credible report of FWA, or we have requested recoupment that is not received. In these cases, our VP of Compliance, or designee, forwards all relevant information to LDH and appropriate state agencies. We suspend network provider payments when LDH determines there is a credible allegation of fraud. We immediately notify LDH if a delay in reporting could result in harm to a patient. We expedite referrals if there is possibility of loss, destruction, or alteration of evidence; if there is an unrecoverable monetary loss; or there is hindrance of an investigation or criminal prosecution of the alleged offense.

Coordinating FWA Efforts with LDH. Our FWA Team has regular interaction with the State's staff, including ongoing collaboration, routine meetings, reporting and updating LDH, maintaining and submitting our FWA Plan, and seeking and implementing best practices. LHCC Program Integrity leadership meet regularly with state partners through monthly conference calls, quarterly in-person meetings, and other ad hoc discussions relating to potential FWA investigations.

Leveraging the LDH TIPS Report. LHCC supports the best practice systems implemented by LDH, such as the state TIPS report to track, investigate, and report on FWA allegations. For example, our SIU Senior Investigator collaborated with our Medical Management Department to open an investigation after a nurse in the department discovered a discrepancy in a DME prior authorization request. We reported our concern to LDH on the TIPS Report. The investigation uncovered fraudulent prior authorization requests, misrepresentation of services rendered, billing for non-covered services and services not rendered, and billing claims using a Medicaid recipient's stolen Protected Health Information (PHI). We review every item on the TIPS Report and may take action depending on provider status and allegation. LHCC and our subcontractors will cooperate fully with LDH, as well as with other State and federal agencies, in any investigations and subsequent legal actions.

Once we report a case of suspected FWA to LDH, we suspend all LHCC efforts to take further action pending approval from LDH, to ensure we do not interfere with any ongoing state investigation or enforcement. If LDH provides the approval to complete our own investigation, our VP of Compliance immediately notifies the Louisiana SIU to proceed with the investigation following LDH requirements.

LHCC is dedicated to local engagement and participates in the Louisiana Medicaid Fraud and Prevention Task Force, comprised of voting representatives from the House, Senate, Governor, Attorney General, Legislative

Auditor, Inspector General, and LDH. This Task Force provides a forum to discuss SIU processes, focusing on eligibility as well as Department of Revenue tax records. The Task Force reviews FWA from both a provider and enrollee standpoint and from a legislative perspective. We regularly monitor Task Force meetings for significant issues or concerns. In 2017, our VP of Compliance, the SIU Director, and SIU Manager provided an overview of our FWA investigation processes during a Task Force meeting.

2.10.14.1.1 Any training programs that the Proposer uses to train employees, subcontractors, and providers on federal and state laws related to Medicaid program integrity and prevention of fraud, waste and abuse;

Training Programs for Employees, Subcontractors, and Providers

LHCC's Connections Academy contains locally developed information specific to state laws and contract requirements, and is supplemented by Centene's national compliance training program. In 2018, Centene initiated a compliance summit in which more than 20 health plan compliance officers gathered at Centene corporate offices in St. Louis to share best practices and the latest developments from around the country. Regular, effective education and training of our employees, providers, and subcontractors are ingrained in our culture and a key element to our FWA prevention plans.

Employee Training and Education. We educate all employees, including our Compliance Officer and senior management, on the processes for identifying and reporting issues outlined in our FWA Plan. Mandatory training occurs upon hire, annually, and on an ad hoc basis when circumstances warrant (e.g., in response to identified risks; as required by legislative mandate or other material changes in the law, policy, or procedure). Our online FWA training programs include modules on the Code of Conduct; HIPAA Privacy and Security; FWA identification and reporting, False Claims Act and employee whistleblower protections; procedures for timely consistent exchange of information and collaboration with LDH; our FWA Program organizational structure; and other practices that reflect current state and federal laws. With Connections Academy, we can monitor the progress and completion of required FWA program training, to ensure our staff has completed the modules. We provide LDH an update on all staff that has completed the required FWA compliance training, as requested.

Ad Hoc FWA Education and Training. As needed, we can configure timely, structured learning modules related to our FWA Program, deploy that training to staff (e.g., by job hierarchy, by job role), and monitor who has viewed the content. Connections Academy allows us to see any FWA content that our staff is not understanding (via quiz results and course feedback) and adjust module content as needed. We will launch FWA Lunch and Learn sessions in 2019 to facilitate further discussion between the FWA Team and LHCC employees regarding the detection and reporting of suspected FWA.

Compliance Week. Each year, LHCC launches a *Compliance Week* campaign to further engage our employees in FWA compliance. As part of Compliance Week, we kick off the annual FWA training program. Employees have the chance to win Visa gift cards by completing quizzes and trivia contests. We post daily compliance videos and activities on our company intranet, each LHCC office has posters placed in high-traffic areas about detecting and reporting FWA, and employee computers have screen savers displaying the Ethics and Compliance Helpline and FWA Hotline numbers.

SIU Staff Training. All SIU staff members, including the VP of Compliance, participate in FWA training provided by LDH, and SIU staff are responsible for attending at least 40 hours of training per year. We provide training in person, through written publications, and web-based modules. Training topics include identifying FWA, common FWA schemes, mechanisms to report FWA, role of the SIU, the Business Ethics and Conduct policy, and rights of employees to be protected as whistleblowers. The SIU presents training sessions on the detection and deterrence of fraud to employees whose work duties allow a greater ability to identify and refer suspected incidents of fraud (e.g., claims analysts, provider relations, call center). The SIU sends the team to training seminars that address topics such as overutilization, behavioral health trends, and emerging billing schemes.

Subcontractor Training. We educate our subcontractors during their initial orientation and mandatory annual training sessions. In addition, our FWA team provides ad hoc FWA training to subcontractors. For example, our PI Manager provided training to LogistiCare, our non-emergency medical transportation material subcontractor on the FWA investigation process used by LHCC and LDH investigation and reporting requirements.

Provider Training. LHCC educates providers about our FWA Plan through our Provider Manual, newsletters, Connections Academy, new provider orientations, and provider workshops. The face-to-face provider workshops and webinars include FWA education and information on how to report FWA. We employ Coding Analysts who educate provider billing staff on proper capture of codes to ensure accurate and complete billing, critical to detecting potential FWA.

We post telephone, email, and address information for reporting suspected FWA on our public website. The SIU team conducts provider education calls upon completion of investigations and provider notification of investigation findings. During educational calls, SIU Investigators outline billing aberrancies found in the medical record review. SIU refers providers to the applicable LHCC, LDH, and CMS policies and procedures, laws, rules and regulations as a resource for gaining additional information on billing requirements.

2.10.14.1.2 How the Proposer engages enrollees in preventing fraud, waste and abuse;

Engaging and Informing Enrollees

LHCC engages enrollees and informs them about how to report fraud issues in our enrollee materials, such as the Member Handbook, New Member Orientation, Member ID cards, and other periodic communications and enrollee newsletters. Our Member Handbook advises enrollees to report persons suspected of misusing Medicaid benefits to LHCC or LDH and includes the phone numbers for the LHCC Compliance Department and the LDH number to report Medicaid fraud. The Member ID card includes telephone numbers for the LDH Medicaid fraud line and LHCC Member Services. Our public website contains Member Resources specific to reporting FWA. These resources include enrollee rights specific to FWA; definitions of neglect, abuse, and fraud; information needed when reporting suspected FWA; LHCC and LDH phone numbers; and a link to LDH for additional resources such as the Provider and Recipient Fraud Forms.

Our Customer Service Representatives are trained to address and assist enrollees with questions related to reporting suspected FWA. In March 2019, we piloted a program with our Community Health Workers to conduct new enrollee orientation which includes information on reporting suspected FWA.

In February 2019, we conducted an enrollee outreach campaign in support of LDH's enrollee wage eligibility audit. LHCC launched a robust social media, print, and text campaign asking enrollees to make necessary updates to their financial and employment information, with a link to LDH, to assure continued Medicaid coverage. We also offered our call center services to LDH.

As part of the February 2019 campaign, we notified all 10,628 of our affected enrollees. On our public website, we posted an alert on the homepage and a blog article. We posted messages on Facebook, reaching over 54,000 individuals, and sent notices to our providers.

Enrollee Validation of Paid Claims

LHCC currently utilizes an automated process to survey a random sample of enrollees by mailing them an Explanation of Benefits (EOB) within 45 days from date of payment. The EOB notice clearly states the document is not a bill but is provided to verify the rendered services. We ask the enrollee to sign and return the EOB to our Baton Rouge office. The EOB notice includes a description of the services provided, the name of the provider furnishing the service(s), date on which the service was furnished, the amount paid for the service, and the method to inform LHCC of services not rendered. In the event an enrollee did not receive the services, we request that they contact the Member Services Department. We track which enrollees have been sent an EOB notice and enrollee responses in our management information system (MIS) for reporting purposes . Our random sampling methodology for EOBs assures that enrollee surveys are reflective of all provider types and billed services of our enrollee population to monitor our program with statistical confidence.

Our call center and Special Investigation Unit (SIU) maintain Louisiana-specific policies and procedures for when an enrollee responds to us on an EOB notice. Our resolution may be enrollee education, provider education, payment recovery, or referral to LDH. We refer any results indicating paid services may not have been received to our SIU and the LDH Program Integrity contact within three business days. In addition, we submit to the State a quarterly report that details the number of enrollee verified services.

2.10.14.1.3 The data analytic algorithms that the Proposer will use for purposes of fraud prevention and detection;

Detection and Prevention Through Data Analysis

LHCC uses several FWA data analytic algorithms to prevent and detect fraud. These tools perform data matching, trending, statistical analysis, monitoring service and billing patterns, monitoring claims edits, and other data mining techniques, enabling us to reduce prospective financial loss and prevent payment on potentially miscoded claims. Our retrospective data analytics enable us to detect potentially fraudulent billing practices for review.

Prospective Data Analytic Tools

Claims Processing System. Our Claims Processing System scans for potential duplicate claim submissions ("double bills") by identifying claims with the same information, which can include service dates, procedure codes, modifiers, diagnosis codes, provider identification numbers, such as NPI and Tax ID, charged amounts, enrollee information, and potential bundling/unbundling of services.

Claims Xten (CXT). We use CXT, integrated with our Claims Processing System, for claim code editing. Following adjudication, claims are analyzed in real-time by CXT for coding appropriateness and fraudulent billing practices. CXT reviews claims against Current Procedural Technology (CPT) as well as codes from CMS and several medical specialty societies. CXT identifies FWA triggers such as unbundling, duplicates, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies.

Physician Claim Insight (PCI). Our secondary claim code editing software, PCI compares submitted claims to correct coding rules/guidelines but also includes a clinical review component. Edits are based on CMS, AMA/CPT, and specialty society codes. PCI also reviews most commonly-abused modifiers which might otherwise escape the edits of Claims Xten. A nurse reviews the claim and compares services to the enrollee's history to determine if the service is medically likely, and if potential FWA exists.

Retrospective Data Analytics

Cotiviti Fraud Detection Platform. The FWA team uses Cotiviti's Fraud Detection platform Nucleus to identify aberrant billing patterns. By using more than 75 algorithms in its fraud detection methodology, Nucleus identifies if providers are billing more than 2.5 standard deviations from their peers. Some examples of patterns detected by Cotiviti's algorithms include providers who are submitting services for 30 or more consecutive days; services on a high percentage of patients; an increase in billed services based on the provider's historical claims; services billed at a higher frequency than peers; excessive units; or patterns of overlapping services.

PostShield. We also use PostShield, which systematically identifies billing irregularities based on industry standards. PostShield continuously updates the fraud rules, predictive analytic models, and algorithms to produce more accurate results with less false positives. Claims data is loaded monthly and scored against PostShield's 1,500+ algorithms which identify overpayments and potentially inappropriately paid services. Fraud rules and algorithms for medical, dental, vision and pharmacy data are designed to detect suspicious claims and behavior patterns. Algorithms include targeted suspect code identification, peer comparison outliers, high dollar alerts, providers rendering services in a foreign country, payment spikes and procedure code spikes, and changes in trends. We can catch suspicious billing patterns, coding errors, policy and contract violations, collusion, and ineligible providers and enrollees.

RxShield. RxShield monitors pharmacy expenditures with cross-claim analysis of pharmacy and medical claims, and identifies suspicious prescription drug billing patterns, detects medications that are inappropriate for the stated diagnoses or outside the standard of care, and enrollees who may be abusing prescription opioids.

2.10.14.1.4 Methods the Proposer will use to identify high-risk claims and its definition of "high-risk claims"; and

Definition of High-Risk Claims

We apply several criteria to define and evaluate high-risk claims indicating potential FWA, including inappropriately billed claims, claims from providers with a previous history of billing abnormalities as compared to peers, claims not following National Correct Coding Initiative (NCCI) guidelines, claims in which the total amount paid is over $60,000, claims relating to allegations from more than ten enrollees, claims related to previous cases that have confirmed overpayment or potential fraud, and claims with evidence of regulatory noncompliance. Claims found to be billed inappropriately by any of our program integrity and FWA programs are considered high-risk.

Methods to Identify High-Risk Claims

System Tools to Identify High-Risk Claims. LHCC uses several system tools described above in 2.10.14.1.3 to identify high-risk claims, determine clinical claims coding appropriateness, inaccuracies, aberrant billing patterns, and fraudulent billing practices.

- Claims Xten – Reviews claims against common coding standards and identifies high-risk triggers
- Physician Claim Insight – Incorporates processing against (NCCI) edits through prepay code editing
- Cotiviti: Nucleus – Flags claims for review from providers who bill differently from their peers

FWA Investigative Leads to Identify High-Risk Claims. There are two types of FWA leads – reactive referrals and proactive leads – that can also serve as a source for identifying potential high-risk claims. A reactive referral is defined as a person or agency, outside of the SIU or LHCC, who forwards information to the SIU for further review. A proactive lead is defined as the identification of a suspicious provider billing pattern or patterns through data mining or independent research.

Reactive Referrals are often identified through calls to the hotline or through state and federal notifications. FWA Hotline Number. We have an established toll-free FWA Hotline to report potential FWA activities. An independent third party operates the hotline. All referrals are sent directly to a member of the SIU management and analyst team. All referrals are logged for tracking purposes. Federal and State Notification. During the quarterly MCO meeting, we commonly receive federal and State notifications. During these meetings, other MCOs and State or federal employees may provide information regarding a provider which could result in the SIU team conducting an exploratory review.

Proactive leads involve several different types of software and tactics to help identify potentially fraudulent, wasteful, or abusive patterns, including high-risk claims. Cotiviti: Nucleus. Nucleus is the platform for Cotiviti's Fraud Detection software described in 2.10.14.1.3. This software profiles providers with aberrant coding practices prior to payment. Cotiviti detects multiple conditions including, but not limited to, billing spikes, up-coding, and excessive services. These conditions could indicate a high-risk claim. Ad-Hoc Data Mining and Reporting. The SIU uses our Centelligence© Enterprise Reporting Suite to conduct ad-hoc data mining efforts to identify potential FWA and high-risk claims. Issues may include the dates on which the services and treatments were rendered; misrepresentation of the nature of the services, procedures and supplies provided; the diagnosis or condition treated; the charges for the service, procedure, and supplies provided; or the identity of the provider or recipient of services and procedures. The SIU focuses on detecting and investigating the most common and prevalent FWA schemes as shown in the table below.

Table 2.10.14.1.4 Examples of Common FWA Schemes

Common FWA Schemes Potentially Resulting in High-Risk Claims	
Billing for a non-covered service as a covered service	Billing for services not rendered
Misrepresenting dates of services	Overutilization of services
Misrepresenting locations of services	Upcoding
Misrepresenting provider of services	Corruption (kickbacks and bribery)
Incorrect reporting of diagnoses or procedures (includes unbundling)	False or unnecessary issuance of prescription drugs

2.10.14.1.5 The Proposer's experience with provider recovery collection.

Experience with Provider Recovery Collection

Through the use of our system capabilities and on-going provider FWA education, we try to limit the amount of funds we must recover and collect from providers. We may identify providers where the most appropriate action is to educate them regarding their patterns of possible incorrect billing. Education enables the providers to improve or correct issues identified through system edits and other cost avoidance activities. For example, our staff worked with one of our largest PCP practices when our analytics identified a provider in the group as a peer outlier for potential upcoding. Once the practice understood the coding guidelines, we observed improved coding practices. LHCC ensured services were not disrupted for our enrollees during the process.

LHCC's Provider Engagement and SIU teams worked together with the practice and individual provider to provide references for current coding practices and assisted the practice in identifying the proper clinical documents needed to address the SIU concerns.

We engage recovery partners to review paid claims data monthly and identify improper payments. These partners conduct programs such as DRG coding/clinical validation, credit balance audits, and facility and service billing audits. LHCC seeks to recover any funds paid out resulting from inappropriate actions. We notify LDH of all overpayments related to fraud or abuse. Cases which result in a recoupment recommendation are reviewed and approved or denied according to our FWA Plan policies.

Provider Recovery Processes. Our FWA Plan and policies provide a process to oversee and effectuate provider recoveries. When our FWA Team discovers FWA, our SIU investigators prepare a report for all retrospective cases. The SIU Workgroup is presented cases that result in a recoupment recommendation. Upon approval of an SIU recovery, we send providers a recoupment letter and audit sheet detailing the recovery, and the provider has the option to appeal an SIU review. When we receive an appeal notice, the SIU reviews the appeal within 30 calendar days. Depending on the results of the SIU review, recovery efforts are either continued or stopped.

We notify the provider in writing of the appeal determination and results and end recovery efforts for overturned appeals. We continue recovery efforts for those claims not overturned on appeal. Providers have 15 days to refund the overpayment. Our Claims Department implements a negative balance for the provider, recovering funds from the next provider payment if the provider does not refund the overpayment or request approval of a payment plan within 15 days. LHCC SIU has implemented investigative workflow policies consistent with the contractual requirement to complete complex case reviews within 240 days. The policies are designed to reduce the number of cases managed by every SIU investigator, improve the quality and timeliness of investigative reporting, and ensure recovery of identified overpayments.

Credit Balance Recoveries. Our FWA Team partners with vendors to collect credit balances on behalf of hospitals, which are required to refund any overpayments within 60 days. To assist these hospitals, our vendor partners review the hospital's open accounts receivable for credit balances. Once identified, the vendor works with the hospital to obtain approval and forwards the refund to LHCC.

Coordination of Benefit (COB) Recoveries. Our FWA Team oversees the billing and collection of other liability when other benefits are detected. Our vendor partner assists in identifying COB by reviewing weekly claims information. The vendor sends a recoupment request when Medicaid is incorrectly paid as primary.

2.10.14.2 The Proposer should provide a detailed description of its capability to produce the required reports included in the Fraud, Waste, and Abuse Prevention section of the Model Contract and any proposed innovations for reporting data related to Program Integrity.

Capability to Produce Required Reports

LHCC has developed and maintained streamlined reporting processes, driven by Louisiana-based staff to meet LDH reporting requirements in the timeframes and formats set forth by the State and federal guidelines.

We currently provide the following required reports to LDH:

- Number of complaints of FWA requiring preliminary investigation
- Actions that could result in exclusion, debarment, or suspension
- Number of complaints reported to our Compliance Officer
- Monthly audits performed, and overpayments identified and recovered
- Unsolicited provider refunds

Compliance State Reporting Workflow and Management. Our State Reporting Manager (Report Manager) is responsible for tracking report deliverables listed in LDH's MC Reporting Deliverables Schedule. LHCC uses our Customer Support System for report deliverable workflow management and storage. Preparing and Submitting Monthly LHCC Reports. At the beginning of each month, we retrieve a list of LDH MCO report deliverables from the LDH website and disseminate it to the LHCC designated report owners, including the report name, number, submission frequency and due date for each report. Tracking Reports submitted to the State Reporting Manager. The Report Manager sends an email to the designated report owner confirming report receipt. The Report Manager reviews the report to ensure it is complete, accurate, and compiled according to LDH's report definitions. Approving Reports Before Submission to LDH. After the compliance review, the Report Manager emails each report to the report owner for final review and approval. Upon certification by the CEO or COO, the Report Manager uploads the report to the LDH Reporting 2.0 site and sends an email to the report owner confirming that the report has been uploaded. Tracking Report Submissions and Template Revisions. The Report Manager tracks report submissions, resubmissions, and replacements and assists in reviewing LDH requests to ensure report resubmissions correct issues identified by LDH. In the event we identify an issue with report submission, we reach out to LDH to determine an appropriate course of action to resolve the issue in an expeditious manner. We track report template revisions identified on the LDH website. The Report Manager informs designated report owners of report template revisions implemented by LDH.

Innovations to Automate Reporting

In 2019, we will implement an automated data retrieval that will systematically extract FWA case data and prepare it in the required LDH report format. Case data will be retrieved from our Healthcare Fraud Shield application. We will pull additional information from our Enterprise Data Warehouse to ensure that all required data elements are included in the reports. We will schedule the automated report data retrieval process based on the report due date (monthly, quarterly, annually), or on an ad hoc basis as requested by LDH. We expect that automating the reporting process will reduce data entry errors that have previously resulted from a manual process. LHCC's affiliate in Indiana recently implemented the automated reporting process planned for LHCC. Because of automating their reporting processes, SIU Investigators in Indiana report a savings of 30 staff-hours per month.

Centelligence External Reporting Suite. In addition, we will make FWA reports available to authorized LDH staff via our Centelligence External Reporting Suite, an integrated, interactive set of configurable dashboards organized by subject matter, allowing LDH to view, filter, sort, drill down and extract to Excel data and information to serve LDH's monitoring and decision support needs.

SECTION 2.10.15

Veteran and Hudson Initiatives Programs Participation

Since Healthy Louisiana launched, Louisiana Healthcare Connections has worked closely with my company to communicate to its members across the state through printed material. We have seen the impact of your commitment to better health. As the owner of a small business, I understand how difficult it is to provide adequate and affordable healthcare for my employees in today's healthcare environment. Louisiana Healthcare Connections plays a critical role in bridging the healthcare disparity gap present in our state as well as in the entire country today.

Louisiana Healthcare Connections is undoubtedly the premier leader in the Medicaid managed care program in our state and has a proven record of success. We are proud to be associated with Louisiana Healthcare Connections.

—Kevin Bankston
President
Baton Rouge Printing Company

2.10.15 VETERAN-OWNED AND SERVICE-CONNECTED DISABLED VETERAN-OWNED SMALL ENTREPRENEURSHIPS (VETERAN INITIATIVE) AND LOUISIANA INITIATIVE FOR SMALL ENTREPRENEURSHIPS (HUDSON INITIATIVE) PROGRAMS PARTICIPATION

2.10.15.1 Twelve percent (12%) of the total evaluation points in this RFP are reserved for Proposers…

Louisiana Healthcare Connections (LHCC) understands that up to 12% of the total evaluation points in this RFP are reserved for Proposers who are certified small entrepreneurships. While we are not a certified small entrepreneurship, we are actively partnering with certified Veterans Initiative and Hudson Initiative small entrepreneurships for subcontracted services throughout Louisiana. Further, we have actively educated dozens of Louisiana small entrepreneurships on the qualification requirements and steps to become certified through the program. **LHCC anticipates our total subcontracted spend with Veterans Initiative and Hudson Initiative small entrepreneurships will be nearly $30 million over the three-year contract period**.

2.10.15.1.1 If the Proposer is a certified Veterans Initiative small entrepreneurship, the Proposer shall receive points equal to twelve percent (12%) of the total evaluation points in this RFP.

LHCC is not a certified Veterans Initiative small entrepreneurship.

2.10.15.1.2 If the Proposer is a certified Hudson Initiative small entrepreneurship, the Proposer shall receive points equal to ten percent (10%) of the total evaluation points in this RFP.

LHCC is not a certified Hudson Initiative small entrepreneurship.

2.10.15.1.3 If the Proposer demonstrates its intent to use certified small entrepreneurship(s)...

LHCC is committed to not only the success of the Healthy Louisiana program but to the continued economic vitality of Louisiana. This commitment is deeply rooted in one of LHCC's key philosophies, that quality healthcare is best delivered locally. We anticipate 0.4% of our work under the Contract, based on the estimated value of $7.4 billion, to be performed by certified small entrepreneurships, as detailed in the tables at the end of this section.

2.10.15.1.4 The total number of points awarded pursuant to this section shall not exceed twelve percent (12%) of the total number of evaluation points in this RFP.

LHCC understands the total number of points awarded pursuant to Section 2.10.15 will not exceed 12% of the total RFP evaluation points.

2.10.15.2 If the Proposer is a certified Veterans Initiative or Hudson Initiative small entrepreneurship, the Proposer must note this in its proposal in order to receive the full amount of applicable reserved points.

LHCC is not a certified Veterans Initiative or Hudson Initiative small entrepreneurship.

2.10.15.3 If the Proposer is not a certified small entrepreneurship, but has engaged one (1) or more Veterans Initiative or Hudson Initiative certified small entrepreneurship(s) to participate as subcontractors, the Proposer shall provide the following information for each certified small entrepreneurship subcontractor in order to obtain any applicable Veterans Initiative or Hudson Initiative points:
2.10.15.3.1 Subcontractor's name;
2.10.15.3.2 A detailed description of the work to be performed; and
2.10.15.3.3 The anticipated dollar value of the subcontract for the three-year contract term…
2.10.15.4 If multiple Veterans Initiative or Hudson Initiative subcontractors will be used...

LHCC will engage more than 75 certified small entrepreneurships across Louisiana to participate as subcontractors supporting the Healthy Louisiana program. Please see the following table for a list of our proposed subcontractors, their detailed descriptions of work to be performed, and LHCC's anticipated dollar value over the three-year contract term for each respective subcontract.

Additionally, we have reached an agreement with our transportation subcontractor to perform no less than 20% of transportation services during the contract term using Hudson Initiative or Veteran Initiative small entrepreneurships, at an estimated value over three years of more than $11.3 million. This amount is not included in the total or calculation above or on the following pages.

2.10.15.5 For additional information, see Appendix G, Veteran and Hudson Initiatives.

Please see the following tables for LHCC's proposed Veteran and Hudson Initiative subcontractors.

ATTACHMENTS AND APPENDICES

I enjoy helping members in need connect with physicians and resources they have no idea how to connect with. Setting people on the pathway to disease management empowers them to be proactive in their own care.

—Sonya D. Ortego
Care Management
Louisiana Healthcare Connections

ATTACHMENT 2.3.3
Louisiana Healthcare Connections
Board Resolution

Transforming Louisiana's health,
one person at a time.

CERTIFICATE OF AUTHORITY

I, Keith H. Williamson, hereby certify that I am Secretary of Louisiana Healthcare Connections, Inc., a corporation organized and existing under the laws of the State of Louisiana (the "Corporation").

I further certify that James Elliott Schlottman, President & CEO of the Corporation, is authorized to sign the Request for Proposal (RFP#:3000011953) from the Louisiana Department of Health on behalf of the Corporation.

I further certify that the authority given to the individual named above shall remain in full force and effect until this Certificate of Authority is amended by the Corporation.

IN WITNESS WHEREOF, I have subscribed my name as Secretary of the Corporation on this 16th day of April, 2019.

Keith H. Williamson, Secretary

State of Missouri

County of St. Louis

On this 16th day of April, 2019, before me, Rosemarie Bayes, the undersigned Notary Public, personally appeared Keith H. Williamson, personally known to me, to be the person whose name is subscribed to within the instrument, and acknowledged to me that he executed the same for the purposes therein stated.

ROSEMARIE BAYES
Notary Public - Notary Seal
STATE OF MISSOURI
St. Louis County
My Commission Expires: June 3, 2020
Commission # 12567879

Signature of Notary Public

RECORD OF ACTION
BY UNANIMOUS CONSENT
OF THE BOARD OF DIRECTORS OF
LOUISIANA HEALTHCARE CONNECTIONS, INC.

The undersigned, being all the directors of Louisiana Healthcare Connections, Inc., a Louisiana corporation (the "Corporation"), do hereby consent that the following action be taken without a meeting pursuant to LA Rev Stat 12: 1-704 and shall have the same force and effect as an action taken by the unanimous vote of the Board of Directors at a meeting duly called and held.

RESOLVED, that the Board of Directors do hereby authorize James Elliott Schlottman, CEO and Plan President, to sign and execute the Request for Proposal (RFP#:3000011953) from the Louisiana Department of Health on behalf of the Corporation, and further we do hereby give him the power and authority to do all things necessary to implement, maintain, amend or renew said RFP.

IN WITNESS WHEREOF, the undersigned have executed this Consent as of the 16th day of April, 2018.

James Elliott Schlottman

William Brent, III, M.D.

Michael Fleming, M.D.

Christopher Leumas, M.D.

Thomas Wise

Terrie R. Thomas, M.D.

Dawn R. Vick, M.D.

I hereby certify this to be a true copy of the original of this document given to me for copying and certifying on April 23, 2019.

Christopher D. Adams
Notary Public
La Notary No. 85969
La Bar No. 31008

ATTACHMENT 2.9.1.4
Certificate of Authority

Transforming Louisiana's health,
one person at a time.

LOUISIANA DEPARTMENT OF INSURANCE
JAMES J. DONELON
COMMISSIONER

September 13, 2010

Mr. Errol King
450 Laurel St.,
Chase Tower North, 20th Floor
Baton Rouge, LA 70801

RE: Louisiana Healthcare Connections, Inc.

Dear Mr. King:

This letter is to officially notify you that the application for Certificate of Authority as a health maintenance organization in the State of Louisiana for the above referenced company has been approved effective September 10, 2010.

Please note that the issuance of the Certificate of Authority is not intended as and should not be construed as an approval of any contract forms submitted in association with the application package. You will receive a separate notice regarding the forms as soon as they are in compliance with all applicable Louisiana laws.

The company is approved with a service area as indicated in the submitted application.

I am pleased that you have requested license in Louisiana and am confident that your company will recognize and be responsive to the laws of this State regulating the business of insurance.

I wish you success in the conduct of business in Louisiana and invite you to contact this Department should you have any questions or concerns.

Sincerely,

James J. Donelon
Commissioner of Insurance
State of Louisiana

JD/cs

P. O. BOX 94214 • BATON ROUGE, LOUISIANA 70804-9214
PHONE (225) 342-5900 • FAX (225) 342-3078
http://www.ldi.state.la.us

State of Louisiana

UNION JUSTICE AND CONFIDENCE

JAMES J. DONELON

COMMISSIONER OF INSURANCE

I, THE UNDERSIGNED **COMMISSIONER OF INSURANCE** OF THE STATE OF LOUISIANA,

DO HEREBY CERTIFY THAT

Louisiana Healthcare Connections, Inc.

has complied with all requirements and is hereby licensed to act as a
HEALTH MAINTENANCE ORGANIZATION
in the State of Louisiana
This license shall remain in effect until canceled, suspended, revoked or the renewal thereof refused.

Given Under my signature, authenticated with the impress of my Seal of office, at the City of Baton Rouge, this 10th day of September A.D. 2010

James J. Donelon
Commissioner of Insurance

2.9.5.1.2 Attachments

2.9.5.1.2.A LHCC Tax Clearance
2.9.5.1.2.B Centene Tax Clearance
2.9.5.1.2.C Envolve Dental Tax Clearance
2.9.5.1.2.D Envolve PeopleCare Tax Clearance
2.9.5.1.2.E Envolve Pharmacy Tax Clearance
2.9.5.1.2.F Envolve Vision Tax Clearance
2.9.5.1.2.G AdhereHealth Tax Clearance
2.9.5.1.2.H LogistiCare Tax Clearance
2.9.5.1.2.I NIA Tax Clearance

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health,
one person at a time.

LOUISIANA Post Office Box 66658
DEPARTMENT of REVENUE Baton Rouge, LA 70896-6658

LOUISIANA HEALTHCARE CONNECTIONS INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

Date of Notice: 27-Mar-2019
Letter ID: L0694184160
Account ID: 6152516-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
LOUISIANA HEALTHCARE CONNECTIONS INC

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Reva Williams
Tax Officer
Collections Division
(225) 219-7448

TAXATION DIVISION
PO BOX 3666
JEFFERSON CITY, MO 65105-3666

Missouri
DEPARTMENT OF REVENUE

Telephone: 573-751-9268
Fax: 573-522-1265
E-mail: taxclearance@dor.mo.gov

CENTENE CORPORATION
7700 FORSYTH BLVD STE 800
CLAYTON, MO 63105-1849

April 23, 2019

CERTIFICATE OF TAX CLEARANCE

RE: CENTENE CORPORATION
MISSOURI ID 16668952
Notice Number 2005639915

Dear Sir or Madam:

The Department of Revenue received your request for tax clearance and reviewed your account. There are no delinquencies at this time.

This statement is not to be construed as limiting the authority of the Director of Revenue to assess, or pursue collection of liabilities resulting from final litigation, default in payment of any installment agreement entered into with the Director of Revenue, any successor liability that may become due in the future, or audits or reviews of the taxpayer's records as provided by law.

THIS CERTIFICATE REMAINS VALID FOR 90 DAYS FROM THE ISSUANCE DATE.

If you require additional information, contact the Taxation Division at the above address, telephone number, fax number, or e-mail.

TAXATION DIVISION

LOUISIANA
DEPARTMENT *of* REVENUE
Post Office Box 66658
Baton Rouge, LA 70896-6658

ENVOLVE DENTAL INC.
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

Date of Notice: 22-Apr-2019
Letter ID: L0907363552
Account ID: 1890618-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
ENVOLVE DENTAL INC.

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Robert Williams
Revenue Tax Specialist
Collections Division
(225) 219-7448

Post Office Box 66658
Baton Rouge, LA 70896-6658
(855) 307-3893 • (225) 219-0864 Fax
www.revenue.louisiana.gov

LOUISIANA
DEPARTMENT *of* REVENUE
Post Office Box 66658
Baton Rouge, LA 70896-6658

TISHA DINKLEMAN
ENVOLVE PEOPLECARE INC
7711 CARONDELET AVE STE 800
SAINT LOUIS MO 63105-3389

Date of Notice: 22-Apr-2019
Letter ID: L1444234464
Account ID: 2511905-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
ENVOLVE PEOPLECARE INC

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Robert Williams
Revenue Tax Specialist
Collections Division
(225) 219-7448

LOUISIANA
DEPARTMENT *of* REVENUE
Post Office Box 66658
Baton Rouge, LA 70896-6658

ENVOLVE PHARMACY SOLUTIONS INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

Date of Notice: 23-Apr-2019
Letter ID: L0167314656
Account ID: 1442392-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
ENVOLVE PHARMACY SOLUTIONS INC

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Robert Williams
Revenue Tax Specialist
Collections Division
(225) 219-7448

Post Office Box 66658
Baton Rouge, LA 70896-6658
(855) 307-3893 • (225) 219-0864 Fax
www.revenue.louisiana.gov

LOUISIANA
DEPARTMENT *of* REVENUE
Post Office Box 66658
Baton Rouge, LA 70896-6658

ENVOLVE VISION, INC.
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

Date of Notice: 22-Apr-2019
Letter ID: L1981105376
Account ID: 6916266-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
ENVOLVE VISION, INC.

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Robert Williams
Revenue Tax Specialist
Collections Division
(225) 219-7448

Tre Hargett
Secretary of State

Division of Business Services
Department of State
State of Tennessee
312 Rosa L. Parks AVE, 6th FL
Nashville, TN 37243-1102

GREGG HADDAD
200
5200 MARYLAND WAY
BRENTWOOD, TN 37027

April 22, 2019

Request Type: Certificate of Existence/Authorization
Request #: 0313422

Issuance Date: 04/22/2019
Copies Requested: 1

Document Receipt

Receipt # : 004769482 Filing Fee: $20.00

Payment-Credit Card - State Payment Center - CC #: 3756181898 $20.00

Regarding: **AdhereHealth LLC**

Filing Type: Limited Liability Company - Domestic
Formation/Qualification Date: 03/30/2006
Status: Active
Duration Term: Perpetual
Business County: WILLIAMSON COUNTY

Control # : 517125
Date Formed: 03/30/2006
Formation Locale: TENNESSEE
Inactive Date:

CERTIFICATE OF EXISTENCE

I, Tre Hargett, Secretary of State of the State of Tennessee, do hereby certify that effective as of the issuance date noted above

AdhereHealth LLC

* is a Limited Liability Company duly formed under the law of this State with a date of incorporation and duration as given above;

* has paid all fees, interest, taxes and penalties owed to this State (as reflected in the records of the Secretary of State and the Department of Revenue) which affect the existence/authorization of the business;

* has filed the most recent annual report required with this office;

* has appointed a registered agent and registered office in this State;

* has not filed Articles of Dissolution or Articles of Termination. A decree of judicial dissolution has not been filed.

Tre Hargett
Secretary of State

Processed By: Cert Web User

Verification #: 032907325

Georgia Department of Revenue
TAXPAYER SERVICES DIVISION
P.O. BOX 105499
ATLANTA, GA 30348-5499
Telephone: (877) 423-6711

aL020

Ronald Johnson Jr., Director, Taxpayer Services Division **Lynnette T. Riley, State Revenue Commissioner**

LOGISTICARE SOLUTIONS LLC
1275 PEACHTREE ST NE STE 600
ATLANTA GA 30309-7517

Letter ID: **L1514340720**
Issued Date: **17-Apr-2019**

TAX CLEARANCE CERTIFICATE

The Georgia Department of Revenue certifies that LOGISTICARE SOLUTIONS LLC is in compliance with the Georgia Public Revenue Code and there are no known liabilities due to the State of Georgia for the tax type(s) below as of 04/17/2019.

ACCOUNT TYPE	ACCOUNT ID
Withholding	2250302IU
Sales & Use	308104752
Corporate	70840312200

Georgia Department of Revenue

(877) 423-6711

LOUISIANA Post Office Box 66658
DEPARTMENT *of* REVENUE Baton Rouge, LA 70896-6658

NATIONAL IMAGING ASSOCIATES INC
PO BOX 28737
MACON GA 31221-8737

Date of Notice: 16-Apr-2019
Letter ID: L0244381920
Account ID: 2106946-001-200
Tax Type: Corporation Income & Franchise

Re: Letter of Good Standing
NATIONAL IMAGING ASSOCIATES INC

Dear Louisiana Taxpayer:

This letter is to certify that as of this date, the above referenced taxpayer is in good standing for business taxes collected by the Louisiana Department of Revenue.

Please contact us if you have any questions.

Sincerely,

Melvin Beasley
Revenue Tax Specialist
Collections Division
(225) 219-7448 xOpt 2

ATTACHMENT 2.9.6.1
Appendix C
Proposal Compliance Matrix

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health, one person at a time.

Appendix C: Proposal Compliance Matrix

RFP #3000011953		Proposer: LOUISIANA HEALTHCARE CONNECTIONS, INC.		
RFP Section	**RFP Page(s)**	**Requirement**	**Proposal Section**	**Proposal Page(s)**
2.2.1	9	Table of Contents	2.2.1	1
2.2.2	9-10	Cover Letter	2.2.2	2
Business Proposal				
2.9.1	14-15	Mandatory Qualifications	2.9.1	7
2.9.2	15-16	Conflict of Interests	2.9.2	8
2.9.3	16	Moral or Religious Objections	2.9.3	9
2.9.4	16	Material Subcontractors	2.9.4	10
2.9.5	16-17	Financial Condition	2.9.5	Tab 2.9.5-Exempt from page limits
2.9.6	17	Required Forms and Certifications:		
2.9.6.1	17	✓ Proposal Compliance Matrix	2.9.6	Att.2.9.6.1-Exempt from page limits
2.9.6.2	17	✓ Certification Statement	2.9.6	Att.2.9.6.2-Exempt from page limits
2.9.6.3	17	✓ Medicaid Ownership and Disclosure Form	2.9.6	Att.2.9.6.3-Electronic only
Technical Proposal				
2.10.1	18	Executive Summary	2.10.1	11
2.10.2	18	Organizational Experience:		
2.10.2.1	18	✓ Proposal Experience	2.10.2.1	16
2.10.2.2	18-19	✓ Staff Experience and Organizational Structure	2.10.2.2	18
2.10.2.3	19	✓ Material Subcontractors	2.10.2.3	24
2.10.2.4	19	✓ Proposal Reference Contact Information	2.10.2.4	25
2.10.2.5	19-20	✓ NCQA Accreditation	2.10.2.5	54
2.10.3	20-21	Enrollee Value-Added Benefits	2.10.3	55
2.10.4	21-22	Population Health	2.10.4	69
2.10.5	22-23	Care Management	2.10.5	82
2.10.6	23-24	Case Scenarios	2.10.6	97
2.10.7	24	Provider Network	2.10.7	Att.2.10.7-Electronic only
2.10.8	25	Network Management	2.10.8	112
2.10.9	26-27	Provider Support	2.10.9	127
2.10.10	27-28	Utilization Management	2.10.10	141
2.10.11	28-29	Quality	2.10.11	156
2.10.12	29-30	Value-Based Payment	2.10.12	176
2.10.13	30-31	Claims Management and Systems and Technical Requirements	2.10.13	191
2.10.14	31-32	Program Integrity	2.10.14	201
2.10.15	32-33	Veteran and Hudson Initiatives Programs Participation	2.10.15	211

ATTACHMENT 2.9.6.2
Appendix D
Certification Statement

Per the RFP, This information is exempt from section-specific and total page limits

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Appendix D: Certification Statement

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Louisiana Medicaid Managed Care Organizations Request for Proposals (RFP), including attachments and appendices.

OFFICIAL CONTACT: The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below:

PROPOSER	Louisiana Healthcare Connections, Inc.
VENDOR NUMBER	6152516
DATE	04/29/2019
LDR NUMBER	V31006667001
OFFICIAL CONTACT NAME	James Schlottman, Plan President and CEO
EMAIL ADDRESS	jschlottman@centene.com
FAX NUMBER	866-700-6765
PHONE NUMBER	225-201-8477
STREET ADDRESS	8585 Archives Avenue, Suite 310
CITY, STATE, ZIP	Baton Rouge, Louisiana 70809

Proposer certifies that the above information is true and grants permission to the Department to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, Proposer certifies that:

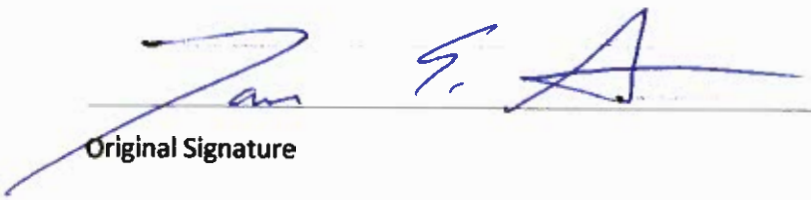
1. The information contained in its response to this RFP is accurate.
2. Proposer complies with each of the mandatory requirements listed in the RFP and will meet or exceed the business and technical requirements specified therein.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's response is valid for at least one hundred and twenty (120) days from the date of Proposer’s signature below.
5. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) calendar days from the date of delivery of initial contract in which to complete contract negotiations, if any, and execute the final contract document. The Department has the option to waive this deadline if actions or inactions by the Department cause the delay.

6. Proposer certifies by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in 2 C.F.R. §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)

7. Proposer understands that, if selected as a contractor, the Louisiana Department of Revenue must determine that it is current in the filing of all applicable tax returns and reports and in payment of all taxes, interest, penalties, and fees owed to the State and collected by the LDR. Proposer shall comply with R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.

8. Proposer further acknowledges its understanding that issuance of a tax clearance certificate by LDR is a necessary precondition to the approval of any contract by the Office of State Procurement. The contracting agency reserves the right to withdraw its consent to any contract without penalty and proceed with alternate arrangements, should a prospective contractor fail to resolve any identified outstanding tax compliance discrepancies with the LDR within seven (7) days of such notification.

9. Proposer certifies and agrees that the following information is correct: In preparing its response, the Proposer has considered all proposals submitted from qualified, potential subcontractors and suppliers, and has not, in the solicitation, selection, or commercial treatment of any subcontractor or supplier, refused to transact or terminated business activities, or taken other actions intended to limit commercial relations, with a person or entity that is engaging in commercial transactions in Israel or Israeli-controlled territories, with the specific intent to accomplish a boycott or divestment of Israel. Proposer also has not retaliated against any person or other entity for reporting such refusal, termination, or commercially limiting actions. The State reserves the right to reject the response of the proposer if this certification is subsequently determined to be false, and to terminate any contract awarded based on such a false response.



Original Signature

James E. Schlottman, Plan President and CEO

Printed Name

4/22/19

Date

ATTACHMENT 2.10.2.2.1
Key Personnel Resumes

Per the RFP, This information is exempt from section-specific, but not total page limits

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ATTACHMENT 2.10.2.2.2.2
Organizational Charts

Per the RFP, This information is exempt from section-specific, but not total page limits

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ATTACHMENT 2.10.2.3
Appendix F
AdhereHealth, LLC

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health, one person at a time.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Louisiana Healthcare Connections, Inc. (LHCC)
Material subcontractor name:
AdhereHealth, LLC (AdhereHealth)
Description of the Proposer's role and material subcontractor's role:
Proposer's role: LHCC is responsible for evaluating the material subcontractor's ability to perform all activities to be subcontracted, and will request prior approval from LDH for all amendments and substitutions. Any additional information requested by LDH will be provided by LHCC. LHCC will monitor the material subcontractor's performance on an ongoing basis and perform a formal review annually. LHCC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. **Subcontractor's Role:** AdhereHealth will provide comprehensive medication therapy management (MTM) services.
Explanation of why the Proposer plans to subcontract this service and/or function:
For more than a decade, AdhereHealth has helped Medicare Advantage, managed Medicaid, and Commercial plans improve health outcomes. AdhereHealth includes powerful analytics, a nationwide licensed clinical network, and pharmacy home delivery to improve value-based care. Social determinants of health create barriers to care that significantly impede quality improvements and AdhereHealth's innovative focus on medication adherence enables a unique pathway to achieve outcomes for population health. Adhere provides a medication-focused solution platform that uses advanced analytics to stratify consumer populations, prioritize interventions, and resolve gaps in care.
A description of the material subcontractor's organizational experience:
AdhereHealth is a technology solutions leader supporting health plans, self-insured employers and other risk-bearing entities for medication adherence insights and healthcare outcomes. AdhereHealth's Adhere platform touches nearly 10 million consumers through its disruptive technologies, engagement services and home-delivered pharmacy. AdhereHealth addresses the challenge of $300 billion of annual unnecessary medical costs due to medication adherence issues, representing 10% of the United States healthcare spend. Headquartered in the Nashville suburb of Brentwood, Tennessee, AdhereHealth has been in business for more than a decade. They employ hundreds of dedicated professionals across the nation who are focused on the mission of providing solutions that improve consumer adherence.
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
LHCC monitors subcontractors through compliance and financial reporting, review of financial data, communications from our member and provider communities, and through Vendor Oversight Committee monthly and quarterly meetings. A review of activities and information from data sources may trigger the need for additional financial monitoring. LHCC's Compliance Management System supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities. Any Contract compliance issue identified with a subcontractor is tracked within the Compliance Management System along with progress on any identified issues.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Agreement, Page 15, Section 3
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).	Agreement, Page 8
3	Specify the effective dates of the subcontract agreement.	Agreement, Page 1
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Agreement, Page 15, Section 4
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Agreement, Page 15, Section 5
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Agreement, Page 15, Section 6
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	Agreement, Page 15, Section 7
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Agreement, Page 15, Section 8
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Agreement, Page 15, Section 9
10	Identify the population covered by the subcontract.	Agreement, Page 11, Exhibit A
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.	Agreement, Page 15, Section 10
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Agreement, Page 15, Section 11
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.	Agreement, Page 11, Exhibit A

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Agreement, Page 16, Section 12
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.	Agreement, Page 16, Section 13
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.	Agreement, Page 16, Section 14
17	Include record retention requirements as specified in the contract between DHH and the MCO.	Agreement, Page 16, Section 15
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Agreement, Page 16, Section 16
19	INTENTIONALLY LEFT BLANK	N/A
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.	Agreement, Page 16, Section 18
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.	Agreement, Page 16, Section 19
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.	Agreement, Page 17, Section 20
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Agreement, Page 17, Section 21

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.	Agreement, Page 18, Section 22
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.	Agreement, Page 17, Section 23
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Agreement, Page 11, Section VII
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.	Agreement, Page 17, Section 24
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.	Agreement, Page 17, Section 24
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.	Agreement, Page 17, Section 25
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Agreement, Page 17, Section 26
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	Agreement, Page 17, Section 27
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Agreement, Page 17, Section 28
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.	Agreement, Page 18, Section 29
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Agreement, Page 18, Section 30
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Agreement, Page 18, Section 31
36	Include a conflict of interest clause as stated in the contract between DHH and the MCO.	Agreement, Pages 14-15, Section 2

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Agreement, Page 18, Section 32
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Agreement, Page 18, Section 33
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Agreement, Page 18, Section 34
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Agreement, Page 18, Section 35
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Agreement, Page 18, Section 36
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Agreement, Page 18, Section 37
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Agreement, Page 18-19, Section 38

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
44	Contains the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Agreement, Page 19, Section 39

ATTACHMENT 2.10.2.3
Appendix F
Envolve Dental, Inc.

Per the RFP, This information is exempt from section-specific and total page limits

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Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Louisiana Healthcare Connections, Inc. (LHCC)
Material subcontractor name:
Envolve Dental, Inc.
Description of the Proposer's role and material subcontractor's role:
Proposer's role: LHCC is responsible for evaluating the material subcontractor's ability to perform all activities to be subcontracted, and will request prior approval from LDH for all amendments and substitutions. Any additional information requested by LDH will be provided by LHCC. LHCC will monitor the material subcontractor's performance on an ongoing basis and perform a formal review annually. LHCC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. **Subcontractor's Role:** Service include dental provider recruitment; credentialing; contracting; provider services and training; utilization management/prior authorization; dental claims processing; first level review of claims disputes; and provider complaints.
Explanation of why the Proposer plans to subcontract this service and/or function:
Envolve Dental's industry-leading experience, clinical expertise, and breakthrough technology fuel a unique approach that can significantly improve the oral health of members while lowering total program costs. Their managed dental care solutions are driven by a large network of dental service providers, and are designed to cut costs without sacrificing service or quality.
A description of the material subcontractor's organizational experience:
Envolve Dental serves approximately 2.5 million members across 13 state Medicaid/CHIP, Medicare, and Health Insurance Marketplace programs across the country. Within those states, they currently support 13 Medicaid health plans through the provision of dental management services. Envolve Dental knows that excellent dental health and wellness along with timely dental check-ups are an essential part of a healthy lifestyle. Whether administering government programs directly with states or with its health plan partners across the country, Envolve Dental is committed to delivering outstanding dental programs that achieve its clients' objectives. Their managed dental Care Plans help maximize members' oral health.
The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
LHCC monitors subcontractors through compliance and financial reporting, review of financial data, communications from our member and provider communities, and through Vendor Oversight Committee monthly and quarterly meetings. A review of activities and information from data sources may trigger the need for additional financial monitoring. LHCC's Compliance Management System supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities. Any Contract compliance issue identified with a subcontractor is tracked within the Compliance Management System along with progress on any identified issues.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Amendment 1, Attachment C-1, Page 21, Section 3
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).	Envolve Dental Agreement, Page 19
3	Specify the effective dates of the subcontract agreement.	Envolve Dental Agreement, Page 1
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Amendment 1, Attachment C-1, Page 21, Section 4
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Amendment 1, Attachment C-1, Page 21, Section 5
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Amendment 1, Attachment C-1, Page 21, Section 6
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	Amendment 1, Attachment C-1, Page 21, Section 7
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Amendment 1, Attachment C-1, Page 21, Section 8
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Amendment 1, Attachment C-1, Page 21, Section 9
10	Identify the population covered by the subcontract.	Envolve Dental Agreement, Exhibit 1, Page 20; Amendment 1, Page 3, First Paragraph
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.	Amendment 1, Attachment C-1, Page 21, Section 10

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Amendment 1, Attachment C-1, Page 21, Section 11
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.	Envolve Dental Agreement, Exhibit 1, Page 20; Amendment 1, Exhibit 1-B, Page 3
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Amendment 1, Attachment C-1, Page 22, Section 12
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.	Amendment 1, Attachment C-1, Page 22, Section 13
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.	Amendment 1, Attachment C-1, Page 23, Section 14
17	Include record retention requirements as specified in the contract between DHH and the MCO.	Amendment 1, Attachment C-1, Page 23, Section 15
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Amendment 1, Attachment C-1, Page 22, Section 16
19	INTENTIONALLY LEFT BLANK	

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.	Amendment 1, Attachment C-1, Page 22, Section 18
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.	Amendment 1, Attachment C-1, Page 22, Section 19
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.	Amendment 1, Attachment C-1, Page 22, Section 20
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Amendment 1, Attachment C-1, Page 23, Section 21
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.	Amendment 1, Attachment C-1, Page 23, Section 22
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.	Amendment 1, Attachment C-1, Page 23, Section 23
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Envolve Dental Agreement, Exhibit 2, Page 21; Amendment 1, Exhibit 2, Page 4
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.	Amendment 1, Attachment C-1, Page 23, Section 24
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.	Amendment 1, Attachment C-1, Page 23, Section 24
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.	Amendment 1, Attachment C-1, Page 23, Section 25

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Amendment 1, Attachment C-1, Page 23, Section 26
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	Amendment 1, Attachment C-1, Page 23, Section 27
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Amendment 1, Attachment C-1, Page 23, Section 28
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.	Amendment 1, Attachment C-1, Page 23, Section 29
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Amendment 1, Attachment C-1, Page 24, Section 30
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Amendment 1, Attachment C-1, Page 24, Section 31
36	Include a conflict of interest clause as stated in the contract between DHH and the MCO.	Amendment 1, Attachment C-1, Page 15, Section 3.33
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Amendment 1, Attachment C-1, Page 24, Section 32
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Amendment 1, Attachment C-1, Page 24, Section 33

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Amendment 1, Attachment C-1, page 24, Section 34
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Amendment 1, Attachment C-1, Page 24, Section 35
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Amendment 1, Attachment C-1, Page 24, Section 36
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Amendment 1, Attachment C-1, Page 24, Section 37
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Amendment 1, Attachment C-1, Page 24, Section 38

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
44	Contains the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Amendment 1, Attachment C-1, Page 24-25, Section 39

ATTACHMENT 2.10.2.3
Appendix F
Envolve Pharmacy Solutions, Inc.

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health,
one person at a time.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Louisiana Healthcare Connections, Inc. (LHCC)
Material subcontractor name:
Envolve Pharmacy Solutions, Inc.
Description of the Proposer's role and material subcontractor's role:
Proposer's role: LHCC is responsible for evaluating the material subcontractor's ability to perform all activities to be subcontracted, and will request prior approval from LDH for all amendments and substitutions. Any additional information requested by LDH will be provided by LHCC. LHCC will monitor the material subcontractor's performance on an ongoing basis and perform a formal review annually. LHCC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. **Subcontractor's Role:** Envolve Pharmacy will provide pharmacy benefit management services on behalf of LHCC, including administration of a Preferred Drug List (PDL), pharmacy network contracting and management, rebate administration, reporting, claims adjudication, account management, pharmacy provider Call Center services, pharmacy and therapeutics support, pharmacy auditing, and selected drug utilization review and quality improvement functions.
Explanation of why the Proposer plans to subcontract this service and/or function:
Because of Envolve Pharmacy's extensive experience with managed Medicaid plans, they understand the nuances of Medicaid populations. From eligibility to provider access, Envolve Pharmacy is experienced and flexible in developing unique benefit designs that align with the current practices of local communities. Envolve Pharmacy's analytical approach to managing the pharmacy network has resulted in a robust pharmacy network portfolio ensuring compatibility with a client's product offering and strategic initiatives without sacrificing member access to network pharmacies.
A description of the material subcontractor's organizational experience:
Medicaid health plans represent a significant portion of Envolve Pharmacy's client portfolio. Envolve Pharmacy, URAC accredited in Pharmacy Benefit Management (PBM), operates as a full-service PBM for 18 state-sponsored health plans (which includes Medicaid, CHIP, Medicare, and Health Insurance Exchange). This represents over 6.8 million low-income members and their families who span age and program categories. Envolve Pharmacy has a proven track record of working with national Pharmacy providers as well as independent Pharmacy providers and Pharmacy Service Administrative Organizations (PSAOs) representing independent pharmacy providers, to meet the needs of the client and member, regardless of geographic limitations. From specialized networks such as an Extended Day Supply (90 day supply) network and the Flu Vaccine network to national networks or client specific networks, Envolve Pharmacy is experienced in the regulatory dynamics of Medicaid, Medicare Part D and the evolving changes affecting the health care industry.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
LHCC monitors subcontractors through compliance and financial reporting, review of financial data, communications from our member and provider communities, and through Vendor Oversight Committee monthly and quarterly meetings. A review of activities and information from data sources may trigger the need for additional financial monitoring. LHCC's Compliance Management System supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities. Any Contract compliance issue identified with a subcontractor is tracked within the Compliance Management System along with progress on any identified issues.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 3, Page 71
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).	Envolve Pharmacy Solutions New PBM Agreement, Page 34
3	Specify the effective dates of the subcontract agreement.	Envolve Pharmacy Solutions New PBM Agreement, Page 1
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 4, Page 71
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 5, Page 71
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 6, Page 71
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 7, Page 71
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 8, Page 71
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 9, Page 71

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
10	Identify the population covered by the subcontract.	Envolve Pharmacy Solutions New PBM Agreement, Attachment A, Page 34-35
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 10, Page 71
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 11, Page 71
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.	Envolve Pharmacy Solutions New PBM Agreement, Attachment A, Page 34-35
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 12, Page 72
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 13, Page 72
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 14, Page 72
17	Include record retention requirements as specified in the contract between DHH and the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7 Section 15, Page 72

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 16, Page 72
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 18, Page 72
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 19, Page 72-73
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 20, Page 73
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 21, Page 73
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 22, Page 73
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 23, Page 73

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit A, Page 38
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 24, Page 73
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 24, Page 73
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 25, Page 73
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 27, Page 73
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 28, Page 73-74
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 29, Page 74
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 30, Page 74

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 31, Page 74
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 32, Page 74
36	Include a conflict of interest clause as stated in the contract between DHH and the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 2, Page 70-71
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 33, Page 74
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 34, Page 74
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 35, Page 74
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 36, Page 74-75
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 37, Page 75

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 38, Page 75
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 39, Page 75
44	Contains the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Envolve Pharmacy Solutions New PBM Agreement, Exhibit 7, Section 40, Page 75

data fields provided to US Script by MediSpan (or another nationally available reporting source that may be selected by US Script).

1.4 **"Claims"** shall mean those claims processed through the US Script Claims System or otherwise transmitted or processed in accordance with the terms of this Agreement and the Payor Contract.

1.5 **"Co-Payment"** shall mean any monetary amounts (including for the purpose of this Agreement any deductibles, if applicable) that a Covered Person may be required to pay the Pharmacy for Covered Pharmacy Services at the time the Covered Pharmacy Services are provided by the Pharmacy pursuant to the applicable Payor Contract.

1.6 **"Covered Persons"** shall mean all individuals eligible to receive Covered Pharmacy Services.

1.7 **"Covered Pharmacy Services"** shall mean those retail and mail order pharmaceutical products and/or medical items, including prescription drugs that are reimbursable under the terms of the applicable Payor Contract.

1.8 **"Generic Drug"** shall mean a multisource generic drug as determined by US Script's proprietary algorithm using a combination of data fields provided to US Script by MediSpan (or other nationally available reporting source selected by US script).

1.9 **"Law"** shall mean any federal, state, local, or other constitution, charter, act, statute, law, ordinance, code, rule, regulation, order, specified standards or objective criteria contained in any applicable permit or approval, or other legislative or administrative action of the United States of America, any state, or any agency, department, authority, political subdivision, or other instrumentality thereof, or a decree or judgment or order of a court, and all applicable provisions of any Payor Contract between HMO and any State or federal government agency.

1.10 **"Maximum Allowable Cost" or "MAC"** shall mean the highest ingredient cost payable by HMO for certain Generic Drugs as specified on a list developed or selected by US Script. New Generic Drugs will be added to the MAC list within the later of (i) six (6) month of coming to market, or (ii) when readily available by multiple vendors.

1.11 **"Network Pharmacy(ies)"** shall mean a pharmacy or group of pharmacies that has/have agreed to provide Covered Pharmacy Services to Covered Persons under an agreement with US Script or HMO. "**Network**" shall mean the collection of Network Pharmacies.

1.12 "**Payor**" shall mean HMO or other entity that is responsible for funding Covered Pharmacy Services to Covered Persons.

1.13 "**Payor Contract**" shall mean HMO's contract with any Payor that governs provision of Covered Pharmacy Services to Covered Persons. Where HMO is the Payor, "Payor Contract" means HMO's contract with the State or federal agency or other entity that has contracted with HMO to arrange for the provision of Covered Pharmacy Services to eligible individuals.

1.14 "**State**" shall be defined as the state set forth in the Attachment(s) attached hereto.

1.15 "**State Agency**" means any applicable State governmental agency or division, including but not limited to the applicable State Medicaid agency and State Department of Insurance.

1.16 "**US Script Claims System**" shall mean US Script's proprietary on-line claims adjudication system.

2. RESPONSIBILITIES OF US SCRIPT.

2.1 **General**. US Script will provide HMO the services set forth in this Section 2 and Exhibits B, C and D to this Agreement, and any other attachment, addendum or amendment hereto (collectively, the "Services"). US Script may make enhancements to the Services from time to time and may use Claims information and other Protected Health Information to improve or recommend additional Services to HMO, so long as such changes are consistent with applicable Laws and do not materially alter any of the provisions of this Agreement. US Script shall perform the Services in accordance with the standards, policies, procedures, and requirements established by HMO for such activities and in accordance with applicable state and federal law. Such policies and procedures are subject to modification by HMO at its discretion, provided that HMO shall provide US Script with prior written notice of material modifications to these policies and procedures.

2.2 **Eligibility and Claims Processing**. US Script shall provide eligibility and claims processing services as set forth below and at Exhibits B and C, attached hereto.

2.2.1 **Eligibility**. US Script shall administer the eligibility of Covered Persons according to eligibility information provided by HMO via tape or telecommunication or such other reasonably practicable method in a mutually acceptable format. US Script shall load eligibility tapes within one (1) business day and inform HMO upon completion. US Script shall notify HMO immediately upon becoming aware of any discrepancies in the eligibility information.

2.2.2 **Claims Processing**. Subject to applicable Regulatory Requirements, US Script will use the US Script Claims System to adjudicate all Claims submitted by Network Pharmacies based on the pharmacy benefit parameters set forth in the Payor Contract, the requirements contained in the US Script Provider Manual, the terms of this Agreement, and all applicable Laws, as applicable. US Script will accept direct Claims submitted by Covered Persons on properly completed standard claim forms together with proof of payment ("Direct Claims") and will adjudicate such Direct Claims pursuant to the terms of the Payor Contract and this Agreement.

2.2.3 **Coordination of Benefits and Record Keeping.** US Script will reasonably cooperate with HMO in its claims payment administration including, but not limited to, its coordination of benefits, verification of coverage, and record keeping procedures. HMO acknowledges and agrees that US Script may contract with a third-party vendor to conduct coordination of benefits activities, and US Script may compensate such vendor up to twenty percent (20%) of any amounts recovered in connection therewith. US Script shall charge HMO an additional collection fee equal to five percent (5%) of any amounts recovered from coordination of benefits activities outside of point-of-sale coordination of benefits activities. US Script's efforts under this paragraph shall be deemed to be made on HMO's behalf and the balance of any collected amounts will be paid to HMO. US Script shall not be required to institute any litigation to collect any amounts in connection with coordination of benefits. US Script's obligations to attempt collection shall be US Script's sole obligation and liability with respect to remedying such overpayments. US Script acknowledges and agrees that nothing in this Agreement shall be construed as prohibiting HMO from seeking collection of overpayments from third parties in addition to the efforts set forth in this Agreement so long as US Script is not also pursuing the overpayment at issue.

2.3 **Network Pharmacies**. US Script shall maintain a network of Network Pharmacies to

dispense Covered Pharmacy Services to Covered Persons as set forth herein ("Network"). .

2.3.1 **Network Participation Agreement.** US Script shall enter into an agreement with each Network Pharmacy which shall require that such Network Pharmacy shall: (i) provide Covered Pharmacy Services consistent with the terms of this Agreement, the applicable Payor Contract and all applicable Laws; (ii) meet all credentialing requirements of HMO, as applicable; and (iii) provide all Covered Pharmacy Services hereunder in accordance with the standard of pharmaceutical care, skill and diligence applicable in the Network Provider's community, including but not limited to the code of ethics as adopted by the state pharmaceutical association and/or pharmacy board in the state in which Network Pharmacy is located. US Script shall further require Network Providers to comply with all HMO policies, procedures, rules and regulations, including but not limited to any applicable policies set forth in HMO's Provider Manual. US Script shall direct the Network Pharmacy to charge and collect the applicable Co-Payment from Covered Persons for each Covered Pharmacy Service provided.

2.3.2 **Credentialing.** US Script shall credential Network Pharmacies in a manner consistent with industry standards and HMO's policies and procedures. The credentialing process of Network Pharmacies will be provided to HMO upon request. At a minimum, US Script shall: (i) require pharmacies requesting participation in the Network to be credentialed; (ii) re-credential Network Pharmacies at least every three (3) years; and (iii) review on a quarterly basis the OIG and GSA websites, to identify Network Pharmacies that have received sanctions, been excluded, or received other disciplinary action.

2.3.3 **Accessibility of Network Providers.** US Script shall select Network Pharmacies at such locations and in such numbers as will ensure reasonable access to Covered Pharmacy Services by Covered Persons, provided such access meets or exceeds that required under the applicable Payor Contract. US Script agrees to provide to HMO, any communications that US Script intends to provide to the Network Pharmacies regarding Covered Pharmacy Services in advance of the dissemination of such communication. US Script will notify HMO in the event that there is a material reduction in Network Pharmacy coverage available to HMO's Covered Persons. US Script will ensure that retail Network Pharmacies will be open during normal retail hours at least five (5) days per week and a minimum of eight (8) hours per day. Legal Federal and State holidays will not be counted against the availability of retail hours.

2.3.4 **Network Participation.** US Script shall provide HMO with a complete list of the names, addresses, license numbers, and normal hours of operation of the Network Pharmacies, together with the provider-specific information required by HMO, upon execution of this Agreement and on a monthly basis thereafter. HMO hereby acknowledges and agrees that additions or deletions to the Network shall be in US Script's sole discretion, except that US Script shall remove a Network Pharmacy from the Network upon the request of HMO based on reasonable cause. US Script shall notify HMO of any terminations of Network Pharmacies from the Network on a weekly basis or as otherwise agreed by the parties. Prior to the effective date of any such termination, or as soon as possible following the effective date of such termination if prior notice is not practicable, US Script shall send letters (the text of which has been approved in writing by HMO) to affected Covered Persons (as agreed upon by the parties) notifying them of significant changes to the Network. HMO shall be responsible for postage costs for any mailings to Covered Persons pursuant to this Section. For the purposes of this Section, "significant changes to the Network" shall be defined as the termination of five percent (5%) or more of Network Pharmacies from the Network, or other change in the Network as requested by HMO.

2.3.5 **Network Pharmacy Audits.** US Script shall maintain criteria, which may be amended from time to time, to establish when and how a Network Pharmacy may be audited to verify compliance with its agreement with US Script. HMO acknowledges and agrees that US Script may

contract with a third-party auditor to conduct such periodic on-site and off-site audits, and US Script may compensate such auditor up to thirty percent (30%) of any overpayments recovered from Network Pharmacies. US Script shall charge HMO an additional audit and collection fee equal to 5% of any overpayments recovered from Network Pharmacies. US Script's efforts under this paragraph shall be deemed to be made on HMO's behalf and the balance of any collected overpayments will be paid to HMO. US Script shall not be required to institute any litigation to collect any overpayments. US Script's obligations to attempt collection of such overpayments shall be US Script's only obligation with respect to remedying such overpayments, and US Script shall not be obligated to repay such overpayments. US Script acknowledges and agrees that nothing in this Agreement shall be construed as prohibiting HMO from seeking collection of overpayments from Network Pharmacies in addition to the efforts set forth in this Agreement so long as US Script is not also pursuing the overpayment at issue.

2.4 **Mail Order Pharmacy Services.** The following shall apply to the extent mail order pharmacy is included as a Covered Pharmacy Service:

2.4.1 **General.** US Script will provide mail order pharmacy services to Covered Persons through US Script's mail order pharmacy ("Mail Order Pharmacy"). In the event HMO requests US Script to add mail service providers in addition to the Mail Order Pharmacy, the fees and rates under this Agreement in connection with Covered Pharmacy Services obtained through such alternative mail order pharmacy shall be negotiated by the parties. Consistent with the terms of this Agreement, the Payor Contract, and all applicable Laws, US Script will cause its Mail Order Pharmacy to dispense new or refill prescription orders upon receipt from a Covered Person of (i) a valid prescription order or a completed refill order form (via internet or telephone interface), and (ii) the applicable Co-Payment.

2.4.2 **Shipment.** US Script's liability for pharmaceuticals lost in shipment shall be limited to the replacement of the lost product, and HMO and Covered Person shall have no right to any other remedy. Shipment of pharmaceutical products will be to the Covered Person at the address set forth in the eligibility file or as appearing on the face of the prescription so long as such address in the continental United States, and will be by first class mail or, in the case of controlled substances as defined by the Drug Enforcement Administration, registered mail or express shipper such as UPS. All shipping, freight and other costs associated with the delivery of pharmaceuticals by the Mail Order Pharmacy are included in the Mail Order Pharmacy Fees set forth on Exhibit 1.

2.4.3 **Application of Professional Judgment.** The Mail Order Pharmacy shall dispense only those prescription drugs that, in its sole discretion, comply with applicable law. The Mail Order Pharmacy shall have the right to refuse to fill or renew a prescription for any Covered Person if, in the pharmacist's professional judgment, the filing or renewing of such prescription is not in the best interest of the Covered Person or the pharmacist has reason to doubt the authenticity of the prescription. Notwithstanding the foregoing, nothing in this Agreement shall be construed as acceptance by the Mail Order Pharmacy of liability in connection with the filling of a prescription that the Mail Order Pharmacy does not know, or has no reason to believe, was not validly prescribed.

2.4.4 **Timeframe for Mail Order Delivery.** US Script will use reasonable efforts to cause all Covered Pharmacy Services ordered through the Mail Order Pharmacy to be received by the Covered Person within fourteen (14) days after the prescription has been received by the Mail Order Pharmacy, provided that the medication required by the physician's prescription is available. If the medication is not available from the Mail Order Pharmacy's standard suppliers, the Mail Order Pharmacy will make commercially reasonable efforts to obtain the medication as quickly as possible. The Mail Order Pharmacy shall contact the Covered Person directly to notify him or her of such delay.

2.5 **Utilization Review and Quality Improvement.**

2.5.1 **Utilization Review**. In accordance with the terms and conditions of the delegation standards attached at Exhibit 3, US Script shall, for and on behalf of HMO, establish and administer a utilization review program in connection with the Covered Pharmacy Services provided to Covered Persons hereunder, utilizing the standards, criteria, protocols and procedures established by HMO and in accordance with applicable Laws, this Agreement, and applicable accreditation standards.

2.5.2 **DUR**. US Script will apply its automated concurrent drug utilization review ("DUR") services with respect to Claims that are submitted for adjudication at the point-of-sale. Quantity limitation edits made in connection with such DUR services will result in non-payment of a Claim unless the dispensing pharmacist requests an override from US Script (which override will be granted if, in the dispensing pharmacist's professional opinion, an early refill is necessary). Other DUR edits may result in the transmission of an alert message to the dispensing pharmacist, but do not affect Claim payments. Network Pharmacies are directed to review such alerts and to use their professional judgment as to whether action is required. HMO acknowledges that the DUR system: (i) is a highly automated system, without individual review in most circumstances, and (ii) is necessarily limited by the amount, accuracy, and completeness of data inputs concerning Covered Persons that are obtained from Claims or from information provided by HMO. The DUR program is intended as a supplement to, and not a substitute for, the knowledge, expertise, skill, and judgment of physicians, pharmacists, or other health care providers in providing patient care. In connection with the DUR program, US Script will have no obligation to acquire information concerning any Covered Person beyond the information that is included in US Script's eligibility or claims databases. Pharmacists are individually responsible for acting or not acting upon information generated and transmitted through the DUR services, and for performing services consistent with the scope of their licenses. In performing DUR services, US Script will not, and is not required by this Agreement, to deny Claims, or require compliance on the part of any prescriber, pharmacist, or Covered Person with any norm or suggested drug regimen, or in any way substitute US Script's judgment for the professional judgment or responsibility of the prescriber or pharmacist. The absence of an alert for a given drug or drug combination shall not be construed to indicate that the drug or drug combination is safe, appropriate, or effective for any Covered Person. Accordingly, US Script assumes no liability vis-à-vis HMO, any Covered Person, or any other person in connection with the DUR services, including, without limitation, the failure of the DUR services to identify a prescription that results in injury to a Covered Person. US Script will update its DUR databases on a reasonable basis to reflect changes in available standards for pharmaceutical prescribing; however, no database will contain all available information or accepted medical practices or prescribing practices.

2.5.3 **Prior Authorization and Step Therapy**. US Script shall provide HMO with its standard Prior Authorization and Step Therapy Program, as set forth herein. US Script shall, at HMO's request, supply to HMO a list of suggested prior authorization and/or step therapy criteria for review, modification, and/or adoption by HMO. HMO will have final approval over the authorization and/or step therapy criteria to be utilized by HMO, which will be evidenced in writing by HMO. US Script will administer the criteria as approved by HMO. No changes will be made to the criteria except upon HMO's approval. US Script will notify HMO of proposed changes to the criteria. If HMO does not wish to accept the proposed changes to the prior authorization or step therapy criteria, HMO agrees to notify US Script in writing within ten (10) business days and adopt customized criteria for a mutually agreed upon fee. After ten (10) business days, HMO will be deemed to have approved any proposed changes to the criteria unless it has notified US Script in writing of its objection as described herein. All prior authorization and/or step therapy criteria proposed by US Script hereunder shall at all-time be in compliance with applicable Laws and applicable accreditation standards. In determining whether to authorize coverage of a drug under the Prior Authorization and Step Therapy Program, US Script may rely entirely upon information about the Covered Person and the diagnosis of the Covered Person's condition provided to it by the prescriber or HMO. HMO acknowledges that the Prior Authorization and Step

Therapy Program is a nondiscretionary processing technique intended to provide better management of the prescription drug program based on objective criteria and the limited amount of information available to US Script. Beyond the application of criteria provided by the HMO, US Script shall not undertake, and is not required hereunder, to determine medical necessity or appropriateness of therapies, to make diagnoses, or substitute US Script's judgment for the professional judgment and responsibility of the prescriber. HMO shall indemnify and hold harmless US Script, its employees, directors, officers, and agents from and against any and all awards, losses, claims, suits, damages, liability, judgments, fines, penalties, settlement amounts, and expenses, including reasonable attorney's fees (collectively "Damages") arising from or as a result of US Script's decision to authorize or initially deny coverage of any such drug in accordance with HMO's adopted criteria, except to the extent that any such Damages arise from US Script's negligence or willful misconduct.

2.5.4 **Compliance with Applicable Accreditation Standards.** In connection with all utilization review services provided by US Script hereunder, US Script agrees to abide by, and shall have each of its employees or contracted providers performing utilization review services under this Agreement sign a written statement agreeing to abide by, the following accreditation standards: (1) any and all utilization review decisions made under this Agreement shall be based only on the appropriateness of the proposed prescription drug services and the existence of coverage for such services; (2) neither contracted providers nor US Script's staff or other individuals conducting utilization review are rewarded for issuing denials of coverage; and (3) financial incentives provided to persons conducting utilization review are not used to encourage decision-making that results in under-utilization of Covered Pharmacy Services.

2.5.5 **Quality Improvement.** US Script shall provide such quality improvement services as are set forth at Exhibit 3 hereto.

2.6 **Compliance with Grievance System.** Grievances and appeals may or may not be delegated to US Script. If not delegated, US Script shall require Network Providers to cooperate with HMO's Covered Person and Provider grievance and appeals procedures, and shall require Network Providers to agree that all communications and documents relating to benefit determinations, complaints, and grievances and records relating to such problems shall be referred to HMO in accordance with the grievance procedures.

2.7 **Call Center Services.** US Script, through its own and subcontracted call centers, will provide a toll-free telephone line 24 hours a day, seven days a week for inquiries from HMO, pharmacies and prescribers regarding the services provided by US Script under this Agreement. Services to be provided via the toll-free number include answering questions regarding Claims, Covered Person eligibility, covered benefits, deductible status and required Co-Payments, if any, Claims submission, Claims payment, instructions for completing a claim form, and location of Network Pharmacies. Call center services provided hereunder shall meet the requirements set forth at Exhibit 3 to this Agreement.

2.8 **Rebates and Formulary Management.**

2.8.1 **Formulary Manager.** US Script may contract with a third-party formulary manager (the "Formulary Manager") to manage US Script's prescription drug formulary and collect rebates from pharmaceutical manufacturers on behalf of HMO (such contract to be referred to herein as the "Formulary Management Services Agreement"). US Script shall ensure that at any Formulary Manager hereunder shall not itself be an entity, or employ an individual, that is excluded from participation in the Medicaid, Medicare or any other federal or state government health care program. HMO agrees to accept Formulary Manager as its exclusive agent for negotiating and arranging for rebates on Covered Pharmacy Services provided under this Agreement, except as otherwise permitted under the Formulary Management Services Agreement or as agreed by US Script and HMO. US Script shall ensure

that any Formulary Manager shall comply with all terms and conditions of this Agreement relating to formulary management, rebate services and Covered Person hold harmless. US Script shall ensure that the Formulary Manager complies with all applicable Laws. US Script will defend, indemnify, and hold the HMO and its respective officers, directors, employees, contractors and agents harmless against all costs, fees, expenses, damages and liabilities, including reasonable attorneys' fees and costs, (collectively, "Liabilities") to the extent such Liabilities relate to or arise as a result of the negligence, intentional misconduct or non-compliance with the applicable terms and conditions of this Agreement on the part of the Formulary Manager or its personnel, agents or subcontractors. A Formulary Manager shall not be considered a party or third party beneficiary to this Agreement.

2.8.2 **Formulary**. The HMO formulary ("Formulary") is a list that identifies those FDA approved prescription drug products and those over-the-counter products included in Payor Contract that are preferred by HMO for dispensing to Covered Persons. US Script shall administer the Formulary or other formularies as developed by HMO from time to time pursuant to the Benefit Contracts. US Script acknowledges and agrees that HMO and its Pharmacy and Therapeutics ("P&T") Committee shall have complete control in deciding what prescription drugs are placed on the Formulary from time to time, and that US Script shall have the right to present clinical data and rationale to the P&T Committee in conjunction with its evaluation of prescription drugs, but shall not be a voting member of the P&T Committee.

2.8.3 **Formulary Compliance and Promotion Programs.** HMO may have in effect a Formulary compliance program designed to promote the prescribing of Formulary drugs by Participating Providers, the dispensing of Formulary drugs by Network Pharmacies, and the awareness of the advantages of the Formulary by Covered Persons. HMO shall notify US Script, in advance, of any proposed material Formulary compliance program modifications. Additionally, HMO may, at its option, participate in US Script's formulary compliance programs, which may include communications with Covered Persons, Network Pharmacies and/or Participating Providers, as well as financial incentives to Network Pharmacies for their participation in the Formulary. HMO shall approve and may make reasonable changes to the content of Formulary communications before distribution..

2.8.4 **Effect of Termination of this Agreement**. In case of expiration or termination of this Agreement or the Formulary Management Services Agreement for any reason, any rebate amounts owed by US Script hereunder will remain due and payable to HMO; provided, US Script will not be responsible for payments of any rebate amounts unless such rebates are first received from the Formulary Manager.

2.8.5 **Rebates**. At all times hereunder, any Formulary Manager hereunder may retain an administrative fee not to exceed five percent (5%) of the rebates collected on behalf of HMO, which may change subject to prior written approval by HMO. US Script will pay to HMO all rebates received by US Script on behalf of HMO during a quarter within thirty (30) days of the close of such the quarter in which rebates were received, net of the fees retained by the Formulary Manager. HMO acknowledges and agrees that it shall not have a right to interest on any rebate or other payments received by US Script under this Agreement, provided such rebate payments are forwarded to HMO within the timeframe set forth herein. HMO acknowledges that whether and to what extent manufacturers are willing to provide rebates to HMO will depend upon the benefit design adopted under the Payor Contract, as well as US Script's receipt of sufficient information regarding each Claim that is submitted to manufacturers for rebates. HMO waives, releases, and forever discharges US Script from any claims or liabilities on the part of HMO arising from a manufacturer's failure to pay any rebate, breach of its agreement with the Formulary Manager, or negligence or misconduct. US Script shall require the Formulary Manager to use reasonable efforts to enforce its agreements with pharmaceutical companies. US Script and/or the Formulary Manager may receive compensation other than rebates from pharmaceutical manufacturers which may

include, without limitation, administrative fees not exceeding three percent (3%) of the aggregate cost of the Covered Pharmacy Services dispensed to Covered Persons, and fees for services rendered to a pharmaceutical manufacturer.

2.8.6 **Pharmaceutical Agreements.** At any time during each year of this Agreement, HMO may conduct such rebate audits as may be permitted pursuant to the Formulary Management Services Agreement. In the event US Script provides formulary management functions in lieu of a Formulary Manager, HMO may conduct an annual rebate audit for the prior twelve-month period, which shall be limited to a review of up to ten (10) pharmaceutical company contracts (or other number as required by Law or applicable State Agency) directly related to HMO's rebates as selected by HMO. Any audit of US Script's agreements with pharmaceutical manufacturers conducted pursuant to this Agreement shall be conducted by a mutually agreeable independent third party or a certified public accounting firm reasonably acceptable to US Script, subject to execution of a confidentiality agreement, and shall include only those portions of such pharmaceutical manufacturer agreements as necessary to determine Manager's compliance with this Agreement.

2.9 **Reporting.** US Script will provide HMO such records and reports relating to Covered Pharmacy Services provided hereunder as set forth at Exhibit 3 hereto, as well as all standard reports currently produced by US Script's computer system, all reports and documentation necessary to support all Fees incurred hereunder, and any other reports that are required under applicable Laws. In such cases where HMO requests additional reports than those set forth herein, US Script may charge a reasonable fee to program and produce the requested additional reports, except where such additional reports are required by any applicable State Agency. If a state fine or penalty is imposed upon HMO due to US Script's failure, after receiving adequate notice of the need for a report, to provide such report on the required due date, then US Script shall reimburse HMO for the full amount of the fine and any incidental expenses.

2.10 **Service Performance Standards.** US Script will perform the Services under this Agreement in a good and workmanlike manner in accordance with the customs, practices, and standards of the prescription benefit management industry, and shall provide sufficient dedicated personnel, information systems support, and other resources, as reasonably required to successfully provide high-quality, cost-effective Services for HMO pursuant to this Agreement. HMO and US Script shall each use good faith and reasonable commercial efforts to perform their respective duties and obligations under this Agreement in a diligent, professionally responsible, and efficient manner. The parties agree to cooperate with and assist each other as reasonably necessary in the performance of their respective duties and in developing timely responses to the needs of HMO's business. US Script shall comply with the service performance standards set forth in Exhibit 3 hereto. US Script shall provide to HMO monthly or quarterly reports, as applicable, with respect to US Script's performance, and annual statistics, within ninety (90) days of the end of the calendar year, demonstrating whether US Script met the service performance standards described in Exhibit 3. On a monthly basis, US Script shall submit electronic files of data maintained pursuant to this Agreement directly to HMO's database contractor. In the event that sanctions or penalties are assessed on HMO by an applicable State Agency solely as a result of the acts or omissions of US Script, US Script shall reimburse HMO the full amount of such sanction or penalty.

2.11 **Information Data Systems.** US Script shall maintain information data systems that meet the requirements of the State Contract and that interface with HMO's information systems. This includes HIPAA transaction code set requirements for electronic health information data exchange, National Provider Identification requirements and Privacy and Security Rule standards. US Script shall notify HMO of any disruption in information and data systems within three (3) hours of outage. US Script shall be responsible for the costs and expenses it incurs in relation to the establishment and maintenance of such interface. US Script shall notify HMO of material changes to its information data systems at least

one hundred eighty (180) days in advance of such changes, or within such timeframe as otherwise agreed by the parties.

3. RESPONSIBILITIES OF HMO.

3.1 **General.** HMO shall be responsible for administrative activities necessary or required to fulfill its obligations under this Agreement. Such activities may include, but are not limited to, quality improvement processes, utilization management, marketing, customer service, claims processing, benefits and eligibility verification, accounts receivable collection, maintenance of provider directory and records, and development of contracts with providers of covered services. HMO agrees to delegate to US Script the responsibility to perform certain administrative services relating to the Covered Pharmacy Services provided by US Script pursuant to this Agreement, subject to the continuing oversight of HMO, as referenced in Attachment D. The terms of this delegation, including a description of the administrative services to be provided by US Script, are set forth at Exhibit 2 hereto. HMO shall provide a Medical Director to be responsible for the professional and administrative medical affairs of HMO.

3.2 **Benefit Design and Eligibility File.** Within a reasonable time prior to the implementation of the Services under this Agreement, HMO shall furnish US Script the details of the benefit design and a complete listing of all Covered Persons. This information must be complete and accurate and in an industry standard or other mutually agreed-upon format. US Script and the Network Pharmacies are entitled to rely on the accuracy and completeness of this information. HMO is responsible for notifying US Script immediately by written notice of any changes or updates in the benefit design.

3.3 **Eligibility Updates.** During the term of this Agreement, HMO will provide US Script with a complete updated listing of all Covered Persons who are eligible for that month. Such listing will be provided in an industry standard or other mutually agreed-upon format. The eligibility information will be updated as reasonably required by the HMO. HMO will bear the risk of mistakes in eligibility determinations caused by material inaccuracies in the information provided by HMO to US Script, including payment of Claims adjudicated and verified as eligible which are later found to be not eligible.

3.4 **Identification Cards.** HMO or State shall issue Covered Persons an identification card, which shall bear the name of the Covered Person and a Covered Person identification number.

3.5 **Covered Person/Network Pharmacy Communication**. All communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons in HMO shall be made by HMO, unless otherwise expressly delegated to US Script hereunder. US Script agrees that all written communications sent to Covered Persons, Network Pharmacies, or facilities that relate specifically to the provision of Covered Pharmacy Services hereunder must be reviewed and approved in advance by HMO, which review and approval shall be completed within a reasonable time period following submission by US Script.

4. TERM AND TERMINATION.

4.1 **Term**. The term of this Agreement shall be one year and shall commence on the Effective Date. This Agreement shall automatically renew each year for an additional one-year period, unless otherwise terminated in accordance with the provisions of this Agreement.

4.2 **Termination.** This Agreement may be terminated as follows:

i. By either party at the end of any term, without cause, by providing at least ninety (90) days prior written notice of termination to the other party.

ii. At any time by the mutual written consent of the parties.

iii. By either party at any time, for cause, by providing sixty (60) days prior written notice to the other party upon the breach by such party of any material term, covenant, or condition of this Agreement, unless such breach is cured to the reasonable satisfaction of the terminating party within such sixty (60) day notice period.

iv. Immediately by HMO, by providing notice to US Script, upon the expiration, non-renewal, or revocation of any license, certificate, approval, or authorization of US Script to perform any or all of the PBM Services.

v. By either party, effective immediately upon provision of written notice to the other party, if the other party has become insolvent or has been dissolved or liquidated, makes a general assignment for the benefit of creditors, or has a receiver appointed for a substantial portion of its assets.

vi. Automatically and without any notice or other action on the part of either party if either party files, or has filed against it, a petition in bankruptcy and such petition is not dismissed within 60 days of the filing, unless the party which is not subject to such petition elects to waive such termination prior to the expiration of such 60 day period.

vii. By either party immediately due to loss of insurance or inability to self-insure as required under this Agreement.

viii. Upon termination of the Payor Contract.

ix. By either party in the event that the parties fail to mutually agree upon the modified pricing terms before the effective date of a Material Pricing change as defined in Section 1.2 hereof.

x. By either party pursuant to Section 12.8 hereof.

4.3. **Information to Covered Persons.** US Script acknowledges the right of HMO to inform Covered Persons of US Script's termination.

4.4. **End of Term or Termination.** Upon termination of this Agreement, if applicable, US Script and HMO shall cooperate reasonably with each other for up to a six (6) month period following such termination or expiration to effect a quality, cost-effective and smooth transition of HMO's business previously operated or managed by US Script to HMO or HMO's designee.

4.5. **Effect of Termination.** Any termination of this Agreement shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Termination of this Agreement shall not release US Script or the Network Pharmacies from their obligations to continue to provide Services and Covered Pharmacy Services hereunder for which compensation has been received prior to the effective date of termination.

4.6. **Continuity of Care.** Upon termination of this Agreement for any reason other than a quality of care issue, US Script and HMO shall comply with any applicable requirements for continuity of care as set forth in the Payor Contract.

5. COMPENSATION, BILLING, AND PAYMENT. As compensation for the Services provided by US Script under this Agreement, HMO will pay the fees specified in Exhibit 1 (the "Fees"). In addition,

HMO will pay US Script for all Covered Pharmacy Services based upon the rates set forth in Exhibit 1 of this Agreement. US Script will be responsible for payment to the Network Pharmacies for Covered Pharmacy Services solely to the extent it has received funds provided by HMO for payment of such services. US Script shall not be required to render payments to Network Pharmacies or Covered Persons unless and until US Script has received payment for the Claims from HMO. All payments of Fees to US Script shall be deemed final unless adjustment is requested within ninety (90) days of US Script's receipt of payment. HMO's request to recoup overpayments made to US Script, including overpayments made because of erroneous eligibility information, shall not be subject to such 90-day deadline. HMO shall remit payment of Fees to US Script on a monthly basis, by the 10th business day of each month or as otherwise mutually agreed upon by the parties. Such payments shall be remitted via wire transfer to the account(s) designated by US Script or by other means as mutually agreed upon, provided such invoices contain all information necessary for HMO to determine its liability. US Script shall invoice such Fees by the third (3rd) business day of each calendar month or more frequently as mutually agreed upon, and shall provide written detail for adjustments of Fees assessed in prior months due to all eligibility status changes.

6. CONFIDENTIALITY.

6.1 **Definition of "Confidential Information."** Each party acknowledges that during the performance of its obligations hereunder, it has received or will receive confidential information from the other party. As used herein, "Confidential Information" includes, but is not limited to, proprietary business and technical information, patient and third party payor lists, statistical data, computer programs, pricing information, Network Pharmacy coverage information, trade secrets and innovations, and other information of similar nature obtained by either party. Confidential Information will not include information that is a) generally known to the public at the time of disclosure; b) rightfully received by either party from a third party not under obligation of confidentiality with respect to such information; c) becomes publicly available through no act or omission of either party or its agents or employees; d) information which a party had in its possession prior to receiving Confidential Information from the disclosing party; or (d) information which is independently developed by a party without reference to the Confidential Information disclosed by the other party.

6.2 **Duty of Confidentiality**. Each party covenants and agrees that, without the prior written consent of the other party, neither it nor its directors, officers, employees or agents shall use or disclose any Confidential Information for purposes other than set forth herein. A party may disclose the other party's Confidential Information only to the receiving party's directors, officer, employees, agents and representatives (collectively, the "Representatives"), but only if a Representative needs to know the Confidential Information in order for the receiving party to perform under this Agreement. Each party shall direct its Representatives to treat the other party's Confidential Information confidentially and not to use it other than to perform under this Agreement. Each party shall be responsible for its Representatives' use and disclosure of the other party's Confidential Information.

6.3 **In the Event of a Subpoena**. Confidential Information may be disclosed pursuant to a bona fide subpoena or other compulsory disclosure if the party receiving the bona fide subpoena or other compulsory disclosure order has given the other party timely written notice of such subpoena or order so that the other party can object or otherwise intervene as it deems proper. In such event, the parties agree to make commercially reasonable efforts to assist each other in obtaining a protective order or other reliable assurance that confidential treatment will be accorded the Confidential Information.

6.4 **Upon Termination**. Upon termination of this Agreement, each party will immediately discontinue use of the other party's Confidential Information, and shall return the other party's Confidential Information to it, or destroy the other party's Confidential Information in its possession or

control. All Confidential Information will remain the property of the disclosing party. Each party may retain the other party's Confidential Information to the extent such Confidential Information has been used in or integrated into reports, studies, analyses, compilations or other documents in the receiving party's possession or control. Any oral Confidential Information will continue to be subject to the terms of this letter agreement. The parties agree that the Confidentiality obligations of this Section shall survive termination of this Agreement.

6.5 **Injunctive Relief.** Each party acknowledges that damages alone will be an inadequate remedy for a breach of the provisions of Section 6 of this Agreement and that the party seeking enforcement thereof, in addition to all other remedies, will be entitled as matter of right to equitable relief, including injunctive relief or specific performance in any court of competent jurisdiction.

6.6 **HIPAA Compliance.** Each party represents and warrants that it will comply with the provisions of the Health Insurance Portability and Accountability Act ("HIPAA") and all regulations promulgated thereunder. US Script further agrees to comply with the terms and conditions of the Business Associate Agreement attached hereto at Exhibit 7 and incorporated herein by this reference.

7. INTELLECTUAL PROPERTY.

7.1 **Use of Name.** Each party will have the right to use the name of the other party to inform existing or potential clients that US Script supplies Covered Pharmacy Services to HMO. Neither US Script nor HMO will otherwise use the other party's name, symbols, trademark, or service marks without the prior written consent of the other party, and both parties will cease any such use upon termination of this Agreement. Notwithstanding the above, US Script agrees HMO may use the name, address, and phone numbers and descriptions of the Network Pharmacies in HMO's directories.

7.2 **US Script Intellectual Property.** HMO acknowledges that all US Script's databases, as well as the software, hard-coding, and logic used to generate the compilations of information contained in US Script's adjudication system and in all other databases developed by US Script or its designees in connection with performing services, and the format of all reports, printouts, and copies thereof developed by US Script, and any prior and future versions thereof by any name, are the property of US Script and are protected by copyright which shall be owned by US Script. US Script acknowledges and agrees that the contents of any reports prepared or submitted by US Script hereunder and any data generated by US Script or HMO relating to Covered Persons shall not be considered the property of US Script.

8. INSURANCE AND INDEMNIFICATION.

8.1 **Required Insurance.** US Script shall procure and shall maintain, at its own expense: (a) professional liability insurance in the amount of $5,000,000.00 per occurrence and $10,000,000.00 annual aggregate, including coverage for errors and omissions; (b) general liability insurance in the amount of $1,000,000.00 per each occurrence and $2,000,000.00 annual aggregate; and (c) umbrella/excess liability insurance in the amount of $10,000,000.00 each occurrence and aggregate. HMO agrees to maintain adequate insurance related to the operation of its business and its obligations under the Agreement. All policies maintained hereunder shall: (i) be issued by companies that are admitted insurers in the jurisdiction in which all or a majority of the services or products are being provided, that have an A.M. Best rating of not less than "A-", and are in a size category which is not lower than "VIII"; (ii) be primary and noncontributory with any of HMO's insurance or self-insurance; (iii) name HMO as an additional insured; and (iv) not be cancelable, non-renewable or materially changed except after not less than thirty (30) days written notice to HMO. Upon request, US Script shall provide to HMO certificates of insurance evidencing the insurance coverage required by this Section.

8.2 **Disclaimers.** Except as provided in this section, US Script disclaims all express and all implied warranties of any kind, including the suitability for any particular purpose of the data generated through the US Script Claim System. US Script relies on MediSpan or comparable databases in providing HMO and Covered Persons with DUR services. US Script has utilized due diligence in collecting and reporting the information contained in the databases and has obtained such information from sources believed to be reliable. US Script, however, does not warrant the accuracy of reports, alerts, codes, prices or other data contained in the databases. US Script does not warrant that its services will be uninterrupted or error free. Other than the Mail Order Pharmacy, US Script does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services. Network Pharmacies (other than the Mail Order Pharmacy) are independent contractors of US Script, and US Script shall have no liability to HMO any Covered Person, or any other person or entity for any act or omission of any Network Pharmacy or its agents or employees; provided, however, that this limitation on liability shall not apply to the actions or omissions of the Mail Order Pharmacy and its agents or employees. Neither party will be liable to the other for indirect, incidental, consequential, punitive, special, or exemplary damages, arising out of or related to this Agreement, even if advised of the possibility of such damages.

8.3 **Indemnification.** HMO shall be indemnified and held harmless by US Script for the amount of any and all liabilities, losses, damages, claims, costs and expenses, interest, awards, judgments, and penalties (including, without limitation, attorneys' fees and expenses) (each, a "Loss"), arising out of or resulting from the breach of any of US Script's obligations under this Agreement or the negligence or willful misconduct of US Script or the Network Pharmacies. US Script shall be indemnified and held harmless by HMO for the amount of any Loss arising out of or resulting from the breach of any of HMO's obligations under this Agreement or the negligence or willful misconduct of HMO.

9. EXCLUSIVE AGREEMENT. US Script shall be HMO's exclusive provider of pharmacy benefit management services, and HMO may not contract with other organizations for any services relating to the subject matter of this Agreement. This provision, however, shall not prohibit US Script from entering into agreements with other potential clients, including competitors of HMO, and other providers of pharmaceutical services, either directly or indirectly.

10. INSPECTION OF FACILITIES AND RECORDS. US Script shall maintain adequate medical, financial, and administrative records related to the Services provided hereunder in a manner consistent with all applicable statutes and regulations and industry standards. HMO shall have the right to review such data at reasonable times and upon reasonable notice. If any audit reveals an underpayment or overpayment by HMO to US Script, such discrepancy shall be reported to US Script, and US Script shall respond within forty-five (45) days. Any amounts deemed payable as a result thereof shall be promptly repaid to the appropriate party with accrued interest. This obligation shall survive the expiration or earlier termination of this Agreement.

11. DISPUTE RESOLUTION. The Parties recognize that a *bona fide* dispute as to certain matters may rise from time to time relating to this Agreement. In the event of such a dispute, either party may, by giving written notice to the other party, request a meeting of authorized representatives of the parties for the purpose of resolving the dispute. Each party agrees to negotiate in good faith to resolve the dispute in a mutually acceptable manner.

12. MISCELLANEOUS.

12.1 **Governing Law.** This Agreement will be governed and construed according to applicable State law without reference or regard to its choice of law.

12.2 **Notices**. All notices, requests, demands and other communications provided for hereunder shall be in writing and shall be deemed duly given: (i) on the date of receipt if delivered in person; (ii) on the date of receipt if sent by facsimile transmittal; (iii) on the date of receipt if sent by commercial overnight delivery service, charges paid by the sender, (iv) on the date of receipt of electronic mail if sent by electronic mail, provided such transmission is followed by written notice of the same, or (v) on the date of deposit in the United States mail, first class, registered or certified, return receipt requested, with proper postage prepaid as follows:

If to HMO:	**If to US Script**:
President / CEO Louisiana Healthcare Connections, Inc.	US Script, Inc. President 2425 W. Shaw Avenue Fresno, California 93711 Fax: 559-244-3793

Any party may change its address for such communications by giving notice to the other in conformity with this section.

12.3 **Further Assurances**. Each party agrees to cooperate fully with the other party and to execute such further instruments, documents, and agreements and to give such further written assurances, as may be requested by any other party, to better evidence and reflect the transactions described herein and contemplated hereby, and to effect the intents and purposes of this Agreement.

12.4 **Severability**. In the event any term or provision of this Agreement is declared to be invalid or illegal for any reason, this Agreement will remain in full force and effect and will be interpreted as though such invalid or illegal provision were not a part of this Agreement. The remaining provisions will be construed to preserve the intent and purpose of this Agreement and the parties will negotiate in good faith to preserve the intent and purpose of this Agreement and the parties will negotiate in good faith to modify any invalidated provisions to preserve each party's anticipated benefits.

12.5 **Relationship of the Parties**. Nothing in this Agreement will be construed to create a relationship of employer-employee, partner, agent, or any other relationship between US Script and HMO except that of independent contractors.

12.6 **Execution in Counterparts**. This Agreement may be executed in two or more counterparts, each of which will be deemed an original agreement, but all of which together will constitute the same instrument.

12.7 **Amendments and Modifications**. Except as otherwise set forth herein, this Agreement may be amended only by mutual agreement of the parties.

12.8 **Compliance with Law; Change in Law**. Each party shall maintain all federal, state, and local licenses, certifications and/or permits necessary to provide Services under this Agreement, and each party shall at all times hereunder comply with all applicable Laws. HMO and US Script acknowledge and agree that each is subject to, and shall comply with, the State-mandated provisions set forth in Attachment A to this Agreement. Each party further represents and warrants that it will comply with the provisions of the federal Health Insurance Portability and Accountability Act ("HIPAA") and shall execute a Business Associate Agreement substantially in the form set forth at Exhibit 7 to this Agreement. The parties shall attempt to equitably adjust the terms of this Agreement to take into account any Change in Law that materially alters the rights or obligations of either party under this Agreement. If the parties are unable to

agree upon an equitable adjustment within sixty (60) days after either party notifies the other of such a Change in Law, then either party may terminate this Agreement upon written notice to the other party. For purposes of this provision, a "Change in Law" shall mean any (i) change in or adoption of any Law, (ii) change in the judicial or administrative interpretation of any Law, or (iii) change in the enforcement of any Law, occurring after the Effective Date. Each party shall, within ten (10) days of receipt of the same, provide information to the other regarding all non-routine inquiries by regulatory departments relating to the performance of Services under this Agreement. US Script shall provide HMO with reasonable assistance and cooperation in meeting all accreditation standards, including but not limited to applicable accreditation standards, applicable to the Services provided under this Agreement.

12.9 **Assignment**. No party may assign its rights or obligations under this Agreement to a third party without the prior written consent of the other party, which consent shall not be unreasonably withheld. Assignments by a party to a wholly-owned or controlled subsidiary, or to a successor entity under common control with a party, shall not constitute assignment to a third party.

12.10 **Third Party Beneficiary**. This Agreement is not intended to create, nor will it be deemed to create, any third party beneficiary rights in any third party.

12.11 **Entire Agreement**. This Agreement is the entire agreement between the parties with respect to the matters covered hereby and will supersede all previous written, oral or implied understandings between them with respect to such matters.

12.12 **Force Majeure**. If either party is prevented from carrying out its obligations under this Agreement for sixty (60) or more days by acts of war, civil unrest, riots, fire, labor actions, earthquakes or other acts that by their nature are beyond the reasonable control of either party, then such party will be relieved of its obligations under this Agreement, unless otherwise agreed upon by the parties.

12.13 **Waivers**. The waiver by either party of one or more defaults on the part of the other party in the performance of any obligations under this Agreement will not be construed to operate as a waiver of any subsequent defaults.

12.14 **Covered Person Hold Harmless.** US Script agrees that it shall look only to HMO and agrees to hold Covered Persons harmless for compensation for all Covered Pharmacy Services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to nonpayment by HMO, HMO's insolvency, or HMO's breach of this Agreement, shall US Script or any Network Pharmacy bill, charge, collect a deposit or surcharge from or seek compensation, remuneration, or reimbursement from, or have any recourse against, Covered Person or persons acting on the Covered Person's behalf for Covered Pharmacy Services provided pursuant to this Agreement. This provision shall not prohibit collection of Copayments. US Script further agrees that this provision shall: (i) survive the termination of this Agreement, regardless of the reason for termination, and shall be for the benefit of the Covered Person; (ii) supersede any oral or written agreement now existing or hereafter entered into between US Script and a Covered Person or persons acting on the Covered Person's behalf; and (iii) be construed to inure to the benefit of Covered Persons and persons acting on the Covered Person's behalf.

Intending to be legally bound, the parties have duly executed this agreement as of the Effective Date.

US Script, Inc.	HMO
Signature	Signature
Pete Clagett	James E. Schlottman
Print Name	Print Name
President	CEO
Office or Title	Office or Title
11/27/12	11/30/12
Date	Date

ATTACHMENT A

LOUISIANA COORDINATED CARE NETWORK – PREPAID PROGRAM PRODUCT ATTACHMENT

This Louisiana Medicaid Coordinated Care Network – Prepaid Program Product Attachment (the "***Product Attachment***") is incorporated into the Pharmacy Benefit Management Services Agreement (the "***Agreement***") entered into by and between US Script, Inc. ("***US Script***") and Louisiana Healthcare Connections, Inc. ("***CCN***").

ARTICLE I
RECITALS

1.1 CCN has contracted with the Louisiana Department of Health and Hospitals ("***DHH***") to arrange for the provision of medical services to Covered Persons under the Coordinated Care Network – Prepaid Program, as defined herein.

1.2 US Script has entered into this Agreement with CCN. This Product Attachment is intended to supplement this Agreement by setting forth the parties' rights and responsibilities related to the provision of Covered Services to Covered Persons as it pertains to the Coordinated Care Network – Prepaid Program. In the event of a conflict between the terms and conditions of this Agreement and the terms and conditions of this Product Attachment, this Product Attachment shall govern.

1.3 US Script agrees and understands that Covered Services shall be provided in accordance with the contract between DHH and CCN ("***Medicaid CCN Contract***"), the Provider Manual, any applicable State handbooks, and all applicable State and federal laws and regulations. To the extent US Script is unclear about US Script's duties and obligations, US Script shall request clarification from CCN.

ARTICLE II
DEFINITIONS

The definitions listed below will supersede any meanings contained elsewhere in this Agreement with regard to this Product Attachment.

2.1 ***Claim*** means a request for payment for benefits received or services rendered.

2.2 ***Clean Claim*** means (1) a bill for services, (2) a line item of service or (3) all services for one recipient within a bill. Clean Claim means one that that can be processed without obtaining additional information from Provider or from a third party. It includes a Claim with errors originating in a State's claims system. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity.

2.3 ***Co-payment*** means any cost sharing payment for which the Covered Person is responsible in accordance with 42 C.F.R. §§ 447.40 and 5006 of the American Recovery and Reinvestment Act (ARRA) or Indian Covered Persons.

2.4 ***CommunityCARE*** means the Louisiana Medicaid Primary Care Case Management program which links Medicaid/CHIP eligibles to a PCP as their medical home.

2.5 ***Coordinated Care Network — Prepaid Program (CCN-P)*** means any prepaid entity that participates in the State Medicaid Program and is regulated by the State Department of Insurance with respect to licensure and financial solvency pursuant to Title 22 of the Louisiana Revised Statutes, but shall solely with respect to its products and services offered pursuant to the State Medicaid program be regulated by the DHH.

2.6 ***Covered Person*** means an individual enrollee of CCN's Coordinated Care Network—Prepaid health plan.

2.7 ***Covered Services*** means those Medically Necessary health care services to which a Covered Person is entitled under the Louisiana Medicaid State Plan.

2.8 ***Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*** means a federally required Medicaid benefit for individuals under the age of twenty-one (21) years that expands coverage for children and adolescents beyond adult limits to ensure availability of (1) screening and diagnostic services to determine physical or mental defects and (2) health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered. EPSDT ensures access to all Medically Necessary health services within the federal definition of "medical assistance".

2.9 ***Emergency Medical Condition*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or part.

2.10 ***Emergency Services*** means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. §§ 438.114(a) and 1032(b)(2), and needed to screen, evaluate and stabilize an Emergency Medical Condition.

2.11 ***Medically Necessary or Medical Necessity*** means health care services that: (1) are in accordance with generally accepted, evidence-based medical standards or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective professional organizations to be the standard of care; (2) are deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunctions; (3) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease; and (4) must be clinically appropriate, individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not Medically Necessary."

2.12 ***Primary Care Provider or PCP*** means the individual physician or other licensed nurse practitioner responsible for the management of a Covered Person's health care who is licensed and certified in one of the following general specialties: family practitioner, general practitioner, general pediatrician, general internal medicine, general internal medicine and pediatrics, or obstetrician/gynecologist. The PCP is the patient's point of access for preventive care or an illness and may treat the patient directly, refer the patient to a specialist or admit the patient to a hospital.

2.13 ***Provider Preventable Condition*** means preventable hospital and non hospital-acquired conditions and events identified by DHH for nonpayment to ensure high quality of Medicaid services.

2.14 ***RFP*** means the Louisiana Department of Health and Hospitals Request for Proposal #305PUR-DHHRFP-CCN-P-MVA.

2.15 ***State*** means the state of Louisiana.

2.16 ***State Plan*** or ***Louisiana Medicaid State Plan*** means the binding written agreement between the DHH and the federal Centers for Medicare and Medicaid Services, which describes how the Medicaid program is administered.

2.17 ***Urgent Care*** means medical care provided for a condition that without timely treatment could be expected to deteriorate into an emergency, or cause prolonged, temporary impairment in one or more bodily functions, or cause the development of a chronic ill or need for a more complex treatment. Examples include abdominal pain of unknown origin, unremitting new symptoms of dizziness of unknown cause, or suspected fracture. Urgent Care requires timely face-to-face medical attention within twenty-four (24) hours of Covered Person notification of the existence of an urgent condition.

ARTICLE III
COORDINATED CARE NETWORK – PREPAID PROGRAM REQUIREMENTS

3.1 This Agreement contains all the terms and conditions agreed upon by the parties. The parties shall make no alteration, variation, modification, waiver, extension of this Agreement's termination date or early termination of this Agreement unless such change is reduced to writing, duly signed and attached to this Agreement; however, CCN may, with prior notice to DHH, provide amendments to US Script and contracted providers by written notification through CCN bulletins, if mutually agreed to in terms of the Agreement. US Script and contracted providers shall not assign any of its duties or responsibilities under this Agreement, or enter into any subcontracts or otherwise delegate services provided thereunder, without CCN's prior written approval. The parties agree that they shall, pursuant to this Section 3.1, amend this Product Attachment as necessary to comply with the State Plan, RFP and other requirements of DHH.

3.2 Covered Services shall be provided in accordance with the State Plan. US Script and contracted providersshall provide Covered Services to Covered Persons through the last

day that this Agreement is in effect. US Script and contracted providers acknowledges that all final Medicaid benefit determinations are within the sole and exclusive authority of DHH or its designee.

3.3 US Script and contracted providers shall not refuse to provide Medically Necessary or preventative Covered Services to Covered Persons for non-medical reasons (except those services allowable under federal law for religious or moral objections).

3.4 US Script and contracted providers shall be currently licensed and/or certified under applicable State and federal statutes and regulations and shall maintain throughout the term of this Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by CCN.

3.5 If US Script or contracted providers performs Emergency Services, US Script or contracted providers shall (i) render Emergency Services without the requirement of prior authorization from CCN of any kind and (ii) determine when the Covered Person is sufficiently stabilized for transfer or discharge. Emergency Services shall be available on a twenty-four (24) hours a day, seven (7) days a week basis.

3.6 If US Script or contracted providers performs laboratory services, US Script and contracted providers shall meet all applicable State and federal requirements related to the provision of laboratory services, including but not limited to 42 C.F.R. §§ 493.1 and 493.3.

3.7 US Script and contracted providers shall permit DHH, U.S. Department of Health and Human Services ("HHS"), Centers for Medicare and Medicaid Services, Office of Inspector General, State Comptroller, State Auditor's Office, and the Louisiana Attorney General's Office to evaluate through audit, inspection, or other means, whether announced or unannounced, any records pertinent to this Agreement, including quality, appropriateness and timeliness of Covered Services and the timeliness and accuracy of encounter data and practitioner claims submitted to the CCN. CCN shall cooperate with these evaluations and inspections and, upon request, assist with such reviews.

3.8 US Script and contracted providers shall participate and cooperate in any internal and external quality assessment review, utilization management, and grievance procedures established by CCN and/or DHH or its designee, whether announced or unannounced.

3.9 US Script and contracted providers shall monitor and report the quality of Covered Services delivered under this Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which US Script and contracted providers practices and/or the standards established by DHH or its designee.

3.10 US Script and contracted providers shall comply with any plan of corrective action initiated by CCN and/or required by DHH.

3.11 US Script and contracted providers shall submit all reports and clinical information required by the CCN, including but not limited to, HEDIS, AHRQ (the Agency for Healthcare Research & Quality), and EPSDT.

3.12 US Script and contracted providers shall safeguard Covered Person information in accordance with applicable State and federal laws and regulations and the standards set forth below:

3.12.1 Be at least as restrictive as those imposed upon the DHH by 42 CFR Part 431, Subpart F (2005, as amended) and La. R.S. 45:56;

3.12.2 Identify and comply with any stricter State or federal confidentiality standards which apply to specific types of information or information obtained from outside sources;

3.12.3 Require the written authorization of the Covered Person or potential Covered Person before disclosure of information about him or her under circumstances requiring such authorization pursuant to 45 C.F.R. § 164.508;

3.12.4 Not prohibit the release of statistical or aggregate data which cannot be traced back to particular individuals; and

3.12.5 Subject violators to appropriate personnel sanctions.

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

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

3.13 US Script and contracted providers acknowledges and agrees that this Agreement makes full disclosure of the method and amount of compensation or other consideration to be received from CCN.

3.14 US Script and contracted providers shall provide the name and address of the official payee to whom payment shall be made and shall also promptly submit to CCN all information, which shall be complete and accurate, needed for CCN to make payment to US Script and contracted providers for Covered Services provided to Covered Persons hereunder.

3.15 US Script shall pay ninety percent (90%) of all Clean Claims of each provider type within

fifteen (15) days of the date of receipt. US Script shall pay ninety-nine percent (99%) of all Clean Claims of each provider type within thirty (30) days of the date of receipt. The date of receipt shall be considered the date US Script receives the Clean Claim, as indicated by the date stamp on the Clean Claim. The date of payment shall be considered is the date of the check or other form of payment.

3.16 US Script shall ensure contracted provider shall submit all claims for payment no later than twelve (12) months from the date of service.

3.17 US Script and contracted providers shall accept payment made by CCN as payment-in-full for Covered Services provided and shall not solicit or accept any surety or guarantee of payment from the Covered Person, with the exception of any copayments or cost sharing arrangements. For purposes of this section, the term, "Covered Person" shall include the patient, and, if applicable, the patient's parent(s), guardian, spouse or any other legally or potentially legally responsible person of the Covered Person.

3.18 At all times during the term of this Agreement, US Script and contracted providers shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to this Agreement, unless the Provider is a state agency. Specifically, for all Providers that are not state agencies, USS Script and contracted providers shall indemnify, defend, protect, and hold harmless DHH and any of its officers, agents, and employees from:

3.18.1 Any claims for damages or losses arising from services rendered by any subcontractor, person, or firm performing or supplying services, materials, or supplies for US Script and contracted providers in connection with the performance of this Agreement;

3.18.2 Any claims for damages or losses to any person or firm injured or damaged by erroneous or negligent acts, including disregard of State or federal Medicaid regulations or legal statutes, by US Script and contracted providers, its officers, employees, or subcontractors in the performance of this Agreement;

3.18.3 Any claims for damages or losses resulting to any person or firm injured or damaged by US Script and contracted providers, its agents, its officers, employees, or contractors by the publication, translation, reproduction, delivery, performance, use, or disposition of any data processed under this Agreement in a manner not authorized by this Agreement or by federal or State regulations or statutes;

3.18.4 Any failure of US Scriptand contracted providers , its officers, employees, or subcontractors to observe the federal or State laws, including, but not limited to, labor laws and minimum wage laws;

3.18.5 Any claims for damages, losses, or reasonable costs associated with legal expenses, including, but not limited to, those incurred by or on behalf of DHH in connection with the defense of claims for such injuries, losses, claims, or damages specified above; and

3.18.6 Any injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses which may in any manner accrue against DHH or its agents, officers or employees, through the intentional conduct, negligence or omission of US Script and contracted providers, its agents, officers, employees or subcontractors.

3.19 US Script and contracted providers recognizes and shall abide by all State and federal laws, rules and regulations and guidelines applicable to the provision of Covered Services under the Coordinated Care Network – Prepaid Program.

3.20 This Agreement incorporates by reference all applicable federal and State laws, rules and regulations, and any revisions of such laws, rules or regulations as they become effective. In the event that changes in this Agreement as a result of revisions to applicable federal or State law or regulations materially affect the position of either party, the parties agree to negotiate in good faith such further amendments as may be necessary to correct any inequities.

3.21 The parties recognize that in the event of termination of the Medicaid CCN Contract, CCN shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the parties' activities undertaken pursuant to this Agreement. The provision of such records shall be at no expense to DHH.

3.22 The parties acknowledge that they are responsible for resolving any disputes in accordance with the provisions of this Agreement, and the parties agree that no dispute shall disrupt or interfere with the provisions of Covered Services to Covered Persons including but not limited to continuity of care.

3.23 US Script and contracted providers shall give CCN immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on US Script and contracted providers ability to perform under this Agreement.

3.24 CCN shall not prohibit or otherwise restrict US Script and contracted providers from advising or advocating on behalf of a Covered Person who is US Script and contracted provider's patient (i) for the health status, medical care or treatment options for the Covered Person, including any alternative treatment that may be self-administered; (ii) for any information that the Covered Person needs in order to decide among all relevant treatment option; (iii) for the risks, benefits and consequences of treatment or non-treatment; and (iv) for the Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions, provided US Script and contracted provider is acting within the lawful scope of practice.

3.25 In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), US Script and contracted providers shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance

necessary to afford them meaningful and equal access to the Covered Services provided under this Agreement.

3.26 If US Script and contracted providers is a hospital, US Script and contracted providers shall notify CCN and DHH of births when the mother is a Covered Person and shall complete and electronically submit the DHH Request for Medicaid ID Number to the local DHH/State DHH office.

3.27 If US Script and contracted providers is an FQHC or RHC, the following shall apply:

3.27.1 CCN shall reimburse the FQHC/RHC the PPS rate in effect on the date of service for each encounter.

3.28 US Script and contracted providers acknowledges that no provision contained in this Agreement provides incentives, monetary or otherwise, for the withholding of Medically Necessary services.

3.29 In accordance with 43 C.F.R. §438.210(e), compensation to CCN or individuals that conduct utilization management activities shall not be structured as to provide incentives for the individual or CCN to deny, limit, or discontinue Medically Necessary services to any Covered Person.

3.30 CCN is prohibited from making payments to US Script and contracted providers for the provision of medical assistance for healthcare-acquired conditions and other Provider-preventable conditions as may be identified by DHH.

3.31 US Script and contracted providers may only contract with a CCN if such conflict of interest safeguards at least equal to federal safeguards (41 USC 423, section 27) are in place per State Medicaid Director letter dated December 30, 1997 and 1932 (d)(3) of the Social Security Act addressing 1932 State Plan Amendment and the default enrollment process under the State Plan Amendment option.

3.32 US Script and contracted providers represents and covenants that it presently has no interest and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of its services hereunder. US Script and contracted providers further covenants that, in the performance of this Agreement, no person having any such known interests shall be employed.

3.33 CCN shall comply with requirements for physician incentive plans, as required by 42 C.F.R 438.6(h) and set forth (for Medicare) in 42 C.F.R. 422.208 and 422.210. CCN will provide assurance satisfactory to the Secretary that the requirements of § 422.208 are met. CCN, as applicable will provide the following information to any Medicare beneficiary who requests it: whether the CCN uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement, and whether the stop-loss protection is provided.

3.34 In addition to any requirements contained in this Agreement relating to record maintenance and retention, US Script and contracted providers shall maintain and retain records as follows:

3.34.1 US Script and contracted providers shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly accepted information elements for Covered Services rendered to Covered Persons pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement). US Script and contracted providers shall give Covered Persons and their representatives access to and copies of the Covered Persons' medical records, to the extent and in the manner provided by La. R. S. § 40:1299.96 and 45 C.F.R. § 164.524, as amended, and subject to reasonable charges.

3.35 US Script and contracted providers shall retain any and all Covered Person records, including but not limited to financial and medical records, for at least six (6) years following the date of final payment for Covered Services provided by US Script and contracted providers to a Covered Person, and for a longer period of time if the records are under review, audit or related to any matter in litigation until the review, audit or litigation is complete. Exception to this requirement shall include once-in-a-lifetime events such as (but not limited to) an appendectomy, etc. Records retained pursuant to this subsection shall be made available for fiscal audit, medical audit, medical review, utilization review and other periodic monitoring upon request of any authorized representative of DHH.

3.36 US Script and contracted providers shall retain all records originated or prepared in connection with US Script and contracted providers's performance of its obligations under this Agreement, including but not limited to working papers related to the preparation of fiscal reports, medical records, progress notes, charges, journals, ledgers and electronic media, in the State and shall safeguard such records in accordance with the terms and conditions of the Medicaid CCN Contract. US Script and contracted providers further agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Covered Persons relating to the delivery of care or service under this Agreement, and as further required by DHH, for a period of six (6) years from the expiration date of this Agreement, including any extensions. If any litigation, claim, or other actions involving the records have been initiated prior to the expiration of such period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of such period, whichever is later. If US Script and contracted providers stores records on microfilm or microfiche, US Script and contracted providers must agree to produce, at its expense, legible hard copy records upon the request of State or federal authorities, within twenty-one (21) calendar days of the request.

3.37 US Script and contracted providers acknowledges and agrees that this Agreement specifies the amount, duration and scope of services to be provided by US Script and

contracted providers and informs US Script and contracted providers of Covered Services under the State Plan, including all specific provider requirements outlined in the Medicaid CCN Contract.

3.38 US Script and contracted providers shall adhere to all requirements for CCN's Participating Health Care Providers set forth in the RFP, the Medicaid CCN Contract, which terms are incorporated herein by this reference. CCN shall furnish these documents to US Script and contracted providers upon request.

3.39 CCN may not make payment to US Script and contracted providers for US Script and contracted providers Preventable Conditions.

3.40 At the direction of DHH, CCN shall impose financial penalties on US Script and contracted providers in the event US Script and contracted providers fails or refuses to respond to CCN's request for medical record and/or credentialing information.

3.41 In the event CCN and US Script and contracted providershave entered into an alternative reimbursement arrangement, subject to prior approval by DHH, US Script and contracted providers shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by the CCN.

3.42 In accordance with 42 C.F.R. §438.106(c) and 1932(b)(6) of the Social Security Act, US Script and contracted providers shall not bill Covered Persons for Covered Services payments any amount greater than would be owed if the CCN provided the services directly.

3.43 US Script will ensure contracted providers shall submit all claims for payment no later than no later than twelve (12) months from the date of service. EPSDT screening claims should be submitted within sixty (60) days from date of service to accommodate for frequency of screening services and for EPSDT reporting requirements. EPSDT screening claims must also include information related to immunizations, referrals and health status as published in the EPSDT Services Rule (contained in the Louisiana Register, Vol. 30, No.8).

3.44 US Script and contracted providers, as applicable, shall register through LEERS (Louisiana Electronic Event Registration System) which is administered by DHH/Vital Records Registry.

3.45 If US Script or contracted providers is a PCP, PCP shall specify the maximum number of linkages the CCN may link to the PCP. PCP shall also stipulate that by signing the Agreement, PCP confirms that the PCP's total number of Medicaid members for the CCN Program will not exceed 2,500 lives.

3.46 US Script and contracted providers is not permitted to encourage or suggest, in any way, that covered person be placed in state custody in order to receive medical or specialized behavioral health services covered by DHH.

3.47 US Script and contracted providers will comply and submit to the CCN disclosure of information in accordance with the requirement specified in 42 CFR §455, Subpart B.

3.48 US Script and contracted providers is not restricted from contracting with another CCN.

3.49 US Script and contracted providers shall not have contract arrangement with any service provider in which the service provider represents or agrees that it will not contract with another CCN or CCN subcontractor or in which the CNN or CNN subcontractor represents or agrees that it will not contract with another service provider.

3.50 This Agreement shall not, nor shall it be construed to, limit or restrict CCN in any manner from entering into any other agreements of any nature whatsoever with other persons or entities for the provision of the same or similar services contemplated herein.

3.51 Nothing in this contract shall allow, or shall be interpreted to allow, **US Script, contracted pharmacies** or **CCN** to charge **Covered Person** fees of any kind or any copay or cost-sharing amount above what exists in the Medicaid State Plan.

3.52 Nothing in this contract shall allow, or shall be interpreted to allow, **US Script** or **CCN** to charge **Pharmacy** fees of any kind.

ARTICLE IV
STATE MANDATED REQUIREMENTS

4.1 In the event CCN fails to pay for Covered Services as set forth in the evidence of coverage, the Covered Person will not be liable to US Script and contracted providers for any sums owed by CCN.

4.2 US Script and contracted providers acknowledges and agrees to the procedure for processing and resolving grievances and the location and telephone number where grievances may be submitted is set forth in the Provider Manual in accordance with La. R. S. § 22:263.

EXHIBIT 1
Compensation

Retail Pharmacy Fees

Brand:	AWP less 15%, plus $2.50 dispensing fee	
Generic:	Lesser of:	i) AWP less 15% plus $2.50 dispensing fee; ii) MAC, plus $2.50 dispensing fee; or iii) Pharmacy Usual & Customary.

An administration fee of $0.50 per transaction will be charged.

Mail Order Pharmacy Fees

Brand:	AWP less 21% plus $0.00 dispensing fee
Generic:	AWP less 68% plus $0.00 dispensing fee

An administration fee of $0.50 per transaction will be charged.

Specialty Pharmacy Fees

Separate Drug Specific Fee Schedule

An administration fee of $0.50 per transaction will be charged.

Other Fees

Plastic ID Cards	Not Applicable
Rebates	75% to HMO / 25% to US Script, net of payment to Formulary Manager
Universal Claim Forms (Manual Claims)	No Charge
Point-of-Sale Coordination of Benefits	No Charge
All other Coordination of Benefits	5% of amounts recovered (plus an additional 20% of amounts recovered for outside vendor)
Eligibility Updates	No Charge
Prior Authorizations	No Charge
Standard Reporting	No Charge
Direct Member Reimbursement	No Charge
On-Site and Off-Site Network Pharmacy Audits	10% of Amounts Recovered (plus an additional 30% of amounts recovered for outside vendor)
Production of Additional State Reports (i.e., Required By State Agency)	No Charge
Production of All Other Additional Non-Standard Reports	Reasonable fee
Influenza Vaccine	Direct pharmacy cost plus 10%
Medication Therapy Management	Direct pharmacy consulting fees plus 10%
340B Pharmacy Fees	Pharmacy Submitted Ingredient Cost + 340B Pharmacy Dispensing Fee.

Exhibit 2
PBM Services

The services listed below will be performed and/or delegated by US Script for HMO. HMO may request the discontinuation of any service listed below and/or may perform any service listed below internally.

1. **Claims Processing**
   - Electronic processing in-network
   - Paper claims processing in-network and out-of-network
   - Coordination of benefits administration
   - Twelve month on-line claims history retention
   - Monitor Participating Pharmacy compliance
   - On-line viewing access to claims history

2. **Eligibility Management**
   - Administration of eligibility submitted by multiple sources per tape or electronically with variable HMO formats with reasonable notice of changes to such formats
   - Load eligibility tapes within one (1) business day and inform HMO upon completion via report
   - Toll-free access to US Script's help desk for eligibility/claims processing assistance
   - Administration of paper adds/deletes/changes
   - 24 hour eligibility/claims processing support

3. **Benefits Management/Utilization Management**
   - Establishing, applying and maintaining pharmaceutical management procedures.
   - Configuration of claims adjudication system to administer Covered Benefits
   - Administration of appeal rights to providers, Covered Persons, as applicable
   - Monitoring the quality and timeliness of Utilization Management decisions
   - Administration of Prior Authorization process

4. **Pharmacy Network Management**
   - Establish, license-verification (as referenced in Exhibit 3), contract, and maintain Participating Pharmacy networks for HMO
   - Develop and distribute communications to Participating Pharmacies following review by HMO

5. **Call Center Services**
   - Network Pharmacy Service as follows: 8 a.m. – 8 .p.m. CST Monday through Friday; 10 a.m. – 4:00 p.m. CST on Saturday. (24x7 after hours coverage by contracted third party)
   - Toll-free telephone access to Network Pharmacy Service for use by benefits personnel, pharmacists and physicians

EXHIBIT 3
Performance Standards and Requirements for PBM Services

1. Network Pharmacy License Verification

Activities include, but are not limited to, the following:

(a) Verification of active pharmacy licenses for all Network Pharmacies;

(b) Verification of current State Medicaid, or if applicable, Medicare certification;

(c) Provision of policies and procedures for reducing, suspending, or terminating pharmacy privileges; and

(d) Verification of National Provider Identifiers (NPIs).

INDICATOR	DUE DATE
Verify active pharmacy licenses and State Medicaid and/or Medicare certification for all Network Pharmacies.	Upon initial contracting, then every third year by credentialing date anniversary.
Provide policies and procedures for reducing, suspending, or terminating pharmacy privileges.	Initial and forward any revisions made within 30 days of revision, or, if no policy revision, send electronic notice (no written follow-up required) by January 31st of each year verifying no revisions have been made in the previous year.
Submission of an annual schedule of network verification.	Annually on by February 28th.
Pharmacies and Pharmacists terminated or disciplined	For termination of pharmacies: As per Section 3.3 of this agreement. For termination of pharmacists: 10 business days after the close of each quarter.
Complete pharmacy network.	5th of each month (per State requirements).

2. Quality Improvement

Quality Improvement ("QI") activities may include, but are not limited to, the following:

(a) Planned monitoring of previously identified issues, including tracking and trending of issues over time;
(b) Customer service indicators such as call monitoring (for both provider calls and, if applicable, Covered Person calls) shall be reported and include, but are not limited to: number of calls, calls answered, calls abandoned, abandonment rate, and average time on hold;
(c) A process by which findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QI activity are documented and reported to the appropriate individuals of US Script and HMO;
(d) Coordination of QI activities are coordinated with other performance monitoring activities;

(e) Identify important areas for improvement and set meaningful priorities through annual physician and pharmacy surveys;
(f) A process for monitoring pharmacy access and availability; and
(g) A process that uses measurements, QI data collection, and analysis to track quality improvement, takes action to improve quality and assesses the effectiveness of these actions through systematic follow-up.

INDICATOR	DUE DATE
Submission of policies and procedures.	Initial and forward any revisions made within 30 days of revision, or send electronic notice (no written follow-up required) by February 28th of each year verifying no revisions have been made in the previous year.
Submission of US Script QI work plan and US Script QI program description.	Annually by February 28th.
Submission of the QI program evaluation of the prior year.	Annually by February 28th.
Copies of all QI meeting minutes included in the quarterly report.	60 days after close of the quarter.

3. Utilization Management/Appeals

Utilization management activities include approval and denial of services based upon the Payor Contract and Medical Necessity in the following circumstances:

(a) Prior authorization;
(b) Concurrent review; and
(c) Retrospective review.

INDICATOR	DUE DATE
Submission of annual utilization written plan.	Annually by February 28th.
Submission of annual utilization management program evaluation.	Annually by February 28th.
Monthly reports.	15th day following the end of the previous month.
Quarterly Executive Summary Reports.	60th day following the end of the previous quarter.

4. Complaints/Appeals/Grievances

Cooperate with HMO's complaint, appeal, and grievance activities, including cooperation with the following:

(a) Registering, investigating and responding to complaints, appeals, and grievances;
(b) Documentation of substance of complaints, appeals, grievances, and actions taken; and
(c) Aggregation and analysis of complaint, appeal and grievance data.

INDICATOR	DUE DATE
Electronic submission of policies and procedures.	Initial and forward any revisions made within 30 days of the revision, or send electronic notice (no written follow-up required) by February 28th of each year verifying no revisions have been made in the previous year.
Submission of complaint, appeal and grievance activity by the 15th day following the end of the month.	15th day following the end of the previous month.

5. Claims Administration

Claims administration activities include the following:

(a) Development and submission to HMO of US Script's documented claims processing program that, at a minimum, satisfies the standards and procedures required by HMO's claims processing policies and procedures and the requirements under the HMO Contract. The documentation shall be provided by US Script to HMO for review and approval, on or before the Commencement Date, at any time thereafter upon HMO's request, and whenever a material modification to such documented claims processing program is made by US Script. All claims processing related delegated duties shall be performed by US Script in strict compliance with US Script's written clean claims processing program, and subsequently paid as approved by HMO.

(b) US Script represents and warrants that US Script's claims processing program will be administered in accordance with HMO's claims processing program standards and procedures established in accordance with state and federal laws and shall include, but is not limited to, the following:

(1) Verification of eligibility;
(2) Verification of authorization (if applicable);
(3) Verification of payee;
(4) Application of benefits in accordance with Benefit Contracts;
(5) Payment in accordance with provider contract terms;
(6) Appropriate level of medical review;
(7) Timely payment for "clean" claims in accordance with pharmacy contract terms, or within 30 days for non-contracted providers.

INDICATOR	DUE DATE
Electronic submission of all HMO pharmacy claims.	15th day following the end of the previous month.

INDICATOR	DUE DATE
Submission of Encounter Data according to State specifications	As determined pursuant to the State-mandated schedule, or more frequently if otherwise agreed to by the parties. In the event that no State-mandated schedule is provided to US Script, US Script shall submit encounter data no later than the 5th day of each month, and all critical and high volume non-critical errors shall be corrected within 90 days of the date of encounter data submission.

6. Subcontracting

To the extent US Script subcontracts any functions required under the applicable Payor Contract, such subcontracting arrangements shall require prior written approval of HMO. If US Script, with HMO's prior written approval, partners with another entity to perform any portion of the PBM Services, US Script shall provide documentation and demonstrate oversight of such entity by US Script to include:

(a) An executed agreement, including what is to be delegated and made available to HMO;
(b) The responsibilities of US Script and subcontractor;
(c) The process by which US Script evaluates the subcontract;
(d) The remedies, including revocation of the delegation available to US Script if the subcontractor does not fulfill its obligation;
(e) Evaluation of the subcontractor's capacity to perform the delegated activities prior to the execution of the contract;
(f) Annual evaluation of performance in accordance with HMO's accreditation and regulatory and statutory standards (URAC);
(g) The role of US Script and any subcontractor under this Agreement limited to performing certain delegated functions of HMO, using standards approved by HMO and which are in compliance with applicable statutes and rules.

HMO retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by HMO. Further, HMO retains the right to modify, rescind, or terminate at any time any one or all delegated activities under this amendment, regardless of any sub-delegation that may be approved.

7. Reporting Requirements

US Script shall prepare and deliver to HMO all reports required under the State Contracts held by HMO according to the Report Matrix developed by the State or as otherwise required by HMO, including but not limited to the following:

	Report / Spec Name	File Name	Due Date to Centene	Location / Method	Design Document
Encounters	Encounter Data		Monthly, by 5rd business day or as required by State	To be pulled from USS Server to STLSFTP1 (uhp\inbound\nonedi) at specific HP file location\Reports	837 unless otherwise required by State contract
Provider Directory	Provider Demographics File Format_TEMPLATE.xls	State Abbreviation_USSCRIPT_YYYYMMDD	Weekly, Tuesday by 10:00 a.m. CST	To be pulled from USS Server to STLSFTP1 (uhp\inbound\nonedi) at specific HP file location\Reports)	Companion Guide
State Reporting	As required by HMO contract with the State	State Abbreviation_US_report name_YYYYMMDD	As required	ST To be pulled from USS Server to STLSFTP1 (uhp\inbound\nonedi) at specific HP file location\Reports	As required. If no requirement, as mutually agreed upon.
Internal Reporting	Provider Supplemental File	US_Provider_YYYYMMDD.csv	Weekly, Tuesday by 10:00 a.m. CST	To be pulled from USS Server to STLSFTP1 (uhp\inbound\nonedi) at specific HP file location\Reports)	Per Companion Guide
	RX Claim Report	State Abbreviation_US_ClaimsRX_YYYYMMDD.csv	Weekly, Tuesday by 10:00 a.m. CST	To be pulled from USS Server to STLSFTP1 (uhp\inbound\nonedi) at specific HP file location\Reports)	Per Companion Guide

	Standard Reporting Suite	State Abbreviation_US_Report Name_YYYYMMDD	Monthly	To be pulled from USS Server to STLSFTP1 (uhp\inbound\no nedi) at specific HP file location\Reports)	Standard Templates

Additionally, US Script shall provide reporting as applicable for HMO oversight of delegated services.

QI Reports	Frequency	Format	Submission Schedule
Complaints/Grievance/Appeal List	Monthly	Format provided by individual Health Plan. Include all received even if sent to health plan for resolution. Include date and person at health plan to which complaint was forwarded for resolution.	
Geographic Availability Report	Quarterly	Practitioner and Provider distribution in a geographic area. Percentage of members who have a provider within a certain number of miles - as defined per State contract.	
Tracking Quality and Safety of Clinical Care	Quarterly	Summary of Adverse Events tracking and Quality of Care events including investigation outcomes and corrective actions as appropriate.	
Annual Provider Access Evaluation	Annual	May be included in QI Annual Evaluation	Reviewed during Annual Oversight Audit
Annual Provider Availability Evaluation	Annual	May be included in QI Annual Evaluation	Reviewed during Annual Oversight Audit
Evaluation of QI program	Annual		
UM Reports	**Frequency**	**Format**	**Submission Schedule**
Results of inter-rater reliability assessment	Annually	Description of monitoring methods, results for physician and non-physician reviewers, comparison of performance to goal, improvement actions when goal not met	
UM cases handled by service	Monthly	Number and percent of cases by place of service (i.e., inpatient and outpatient)	
UM cases handled by type	Monthly	Number and percent of cases by type of UM request (i.e. pre-service, concurrent, post service)	
Denials by type	Monthly	Number and percent of denials by type of UM request (i.e. pre-service, concurrent, post service)	
Medical Necessity Appeals by type and outcome	Monthly	Number and percent of medical necessity appeals received by type of UM service denied (i.e., . pre-service, concurrent, post	

		service) and outcome (i.e., upheld versus overturned)	
Benefit Appeals by type and outcome	Monthly	Number and percent of benefit appeals received by type of UM service denied (i.e., . pre-service, concurrent, post service) and outcome (i.e. upheld versus overturned)	
Credentialing Reports	**Frequency**	**Format**	**Submission Schedule**
Provider Roster	Monthly Updates; Annual		Concurrent requirements are due to HMO within ten (10) calendar days, including all initially credentialed, de-credentialed and denied re-credentialed providers, with the exception of providers who are suspended or de-credentialed with cause, in which case Network shall notify HMO within three (3) business days of rendering the decision. Annual requirements due to HMO thirty (30) days after the end of the year
Credentialing Activity Summary	Quarterly	Excel	Quarterly requirements are due to HMO fifteen (15) calendar days after the end of the quarter.
Claim Reports	**Frequency**	**Format**	**Submission Schedule**
Claims Process Files	Weekly	Mutually agreed upon	
Provider Service Reports	**Frequency**	**Format**	**Submission Schedule**
Documentation [except for information deemed privileged under State law] of any inquiries and investigation of Network, or any individual subcontracting physician or provider related this Agreement, made by regulatory agencies, and documentation of the final resolution of such an investigation.	Monthly		

8. Performance Standards

Standard Metric	Target	Measurement Tool	Report Frequency
Eligibility	US Script shall load the eligibility file within one (1) business days of receipt from HMO using a term by absence methodology.	US Script to report to HMO in a mutually agreed upon format	Per occurrence
Encounter data	US Script shall deliver the Encounter file to HMO by the close of business on the 5th calendar day of each month or as mutually agreed upon.	HMO will log and track receipt of file	Monthly
Encounter data	US Script shall submit all encounter data to HMO by the 5th calendar day of each month or as mutually agreed upon. Encounter data must meet the State required acceptance rate. If there is not a State acceptance rate, US Script must meet the HMO acceptance rate of 95%.	HMO will log and track receipt of file and errors identified (a) by HMO and (b) by State	Monthly
Claims Processing	Timely payment standards as required by State and federal guidelines	US Script System Report	Monthly
Member and Provider Appeals	If member appeals are not delegated to US Script, US Script may be called upon to provide information on an appeal that HMO is processing. A request for information on a standard appeal shall be responded to within 10 business days. An expedited appeal shall be responded to within 1 business day. HMO must clearly communicate whether the appeal is standard or expedited, and give the appropriate deadline at the time of the request.	HMO Appeal Tracking Log	Per Occurrence
State Requirements	No sanctions or penalties will be assessed by State on HMO as a result of acts or omissions of US	State Reports	Per Occurrence

	Script.		
Contracting and Network Development	US Script must maintain network adequacy requirements required by the State. If no requirements are stated, the standards shall be (1 provider within 30 minutes or 30miles (urban); 1 provider within 45 miles or 45 minutes (rural). US Script will not be penalized in cases where it can demonstrate that a provider is unwilling to contract.	Reports supplied by US Script	Monthly
Telephone answer timeliness	Average speed of answer for US Script's phone unit will be 90% of calls answered in less than 30 seconds, or as otherwise required by the State.	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Call abandonment rate will be less than 5%, or as otherwise required by the State.	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Blocked call rate less than 1%	System report from US Script on all phone units	Monthly
Telephone answer timeliness	First Call Resolution 95%	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Respond to voicemails by next business day	System report from US Script on all phone units	Monthly

1. **Reports must be submitted to the HMO VIA THE SECURE FTP SITE.**
2. **US Script must demonstrate through the appropriate reports and documentation that the performance standards have been met.**

EXHIBIT 4
Oversight Responsibilities of HMO

1. Introduction

HMO may delegate to US Script certain activities that relate to benefit management, claims payment and processing, practitioner/provider network and services, quality assurance, or utilization management, solely or in combination. At all times, HMO shall maintain full responsibility for the provision of Covered Services to Covered Persons. HMO has established, operates, and maintains a health care delivery system, quality assurance system, provider credentialing system and other systems and programs meeting State Department of Insurance standards, if applicable, and is directly accountable for compliance with such standards. HMO may take whatever action it deems necessary to assure that all its systems and functions are in full compliance with the regulatory requirements of the State Department of Insurance. Through the oversight program as described in this Exhibit 4 ("Oversight Program"), HMO shall assure that delegated services meet HMO standards for care and service, as well as the standards of the State Department of Insurance and applicable accrediting agencies such as the Utilization Review Accreditation Committee ("URAC") and National Committee for Quality Assurance ("NCQA").

HMO's Board of Directors has responsibility for the Oversight Program and delegate's implementation of the Oversight Program to HMO's Quality Improvement Committee. The Quality Improvement Committee shall review initial oversight assessments and approve delegated status; review delegation reports, quarterly evaluations and annual assessments; approve and monitor corrective action plans; and recommend changes to the Oversight Program. The Quality Management Director, or designee, shall be responsible for initiating and monitoring the Oversight Program.

The contractual language between HMO and US Script shall specify the delegated activities, US Script's accountability for these activities, the frequency of reporting to HMO and the process by which the delegation shall be evaluated.

The Oversight Program shall be evaluated yearly as part of the annual Quality Management Program appraisal. Modifications shall be presented to HMO's Quality Improvement Committee for approval. In addition, interim modifications, consistent with changes in regulatory requirements or other business requirements, may be required. At all times, the most current revision of this Policy shall direct the oversight activity for US Script.

2. Initial Evaluation

Prior to executing a delegation agreement, HMO shall determine the capacity of US Script's delivery organization to assume responsibility for delegated activity(s) and to maintain HMO standards. This includes both a document review and on-site visit. Documents reviewed may include but are not limited to program descriptions, annual work plans, statements of effectiveness, committee minutes and applicable policies and procedures.

3. Annual Evaluation

Annually, there will be a comprehensive on-site review of US Script's ability to provide care and service according to the standards of HMO, the State's Department of Insurance, and applicable accrediting agencies. The evaluation shall include, but is not limited to, review of US Script's program descriptions, work plans, annual evaluations, committee minutes, policies and procedures

and, as applicable, random sample file reviews to include complaints/grievances/appeals, claims adjudication, medical necessity denials, and credentialing and re-credentialing files. If the audit findings identify noncompliance with the designated standards, a plan of corrective action must be developed. US Script shall provide a copy of its policies and procedures and other documents related to performance of its delegated responsibilities to HMO on an annual basis upon request.

4. Ongoing Monitoring Plan

US Script shall submit monthly/quarterly reports (as defined in the exhibits to this agreement) to HMO's Quality Management Director or Director of Compliance, or such individual's designee.

US Script shall have a quarterly oversight meeting with the HMO. The meeting may be in person or telephonic. Quarterly oversight activities will be comprehensive in nature. In addition to the monthly oversight reports, special focus will be placed upon observed trends, the results of actions initiated by US Script, and the result of corrective actions taken. US Script shall be required to submit a quarterly report summarizing the activities completed during the quarter, identifying barriers to improvement in care and service, and the effectiveness of the improvement plans. More frequent reports may be required from US Script if US Script is placed on a Corrective Action Plan ("CAP") as outlined hereunder.

5. Corrective Action Plan

(a) If HMO receives information through its monitoring plan and/or audit processes that US Script or one of its subcontractors is in material violation of this Agreement or federal or state requirements, or is operating in a condition that renders the continuance of its business hazardous to Covered Persons, HMO will raise the concern to US Script by written or oral notice. If the matter is not resolved within a reasonable time period following such notice, or if the matter is such that resolution may not be procured within a reasonable time period, HMO may request a written and signed Corrective Action Plan (CAP) from US Script. Each CAP shall include, but is not limited to, the following:

(1) Expected, measurable results indicating completion of the CAP;

(2) Detailed action plan to complete activities required by the CAP; and

(3) Due date for completion of CAP.

(b) Submission of the CAP shall be made by US Script to HMO within two (2) weeks of the notification with a written explanation of:

(1) US Script noncompliance with the CAP written agreement; or

(2) The existence of the condition that renders the continuance of US Script's business hazardous to Covered Persons.

(c) Implementation of the CAP shall be completed within thirty (30) days of US Script's receipt of written approval of the proposed CAP by HMO, unless an alternative completion period is approved by HMO in writing. The CAP shall accomplish the written expected results and such results must be validated by a HMO audit within the stated time frame. Failure of US Script or any of its subcontractors to comply with this provision may result, at HMO's discretion, in the suspension or revocation of Services delegation.

(d) HMO will cooperate with US Script or its subcontractors to correct any failure by US Script to comply with the State Department of Insurance's and/or the State Medicaid or other government program's regulatory requirements relating to any matters:

(1) Delegated to US Script by HMO; or

(2) Necessary for HMO to ensure compliance with statutory and regulatory requirements.

EXHIBIT 5
Benefit Contract Design and Preferred Drug List (PDL)

[Available upon request and in a mutually agreed upon format.]

EXHIBIT 6

Business Associate Agreement

This **BUSINESS ASSOCIATE AGREEMENT** ("***Agreement***") is entered into on Nov. 1, 2012 by and between Louisiana Healthcare Connections, Inc. ("***Covered Entity***") and US Script, Inc. ("***Business Associate***").

WHEREAS, pursuant to an agreement dated Nov. 1, 2012 entered into by and between Covered Entity and Business Associate ("***Services Agreement***"), Business Associate provides certain functions, activities, and/or services (collectively, "***Services***") to Covered Entity;

WHEREAS, in Business Associate will create on behalf of Covered Entity, certain Protected Health Information (as such term is defined at 45 C.F.R. § 164.501) ("***PHI***"); and

WHEREAS, pursuant to connection with such Services, Covered Entity will make available and/or transfer to Business Associate, or the authorities set forth above, Business Associate may use or disclose PHI only in accordance with this Agreement.

NOW, THEREFORE, Covered Entity and Business Associate agree as follows:

1. **Definitions.** The Health Insurance Portability and Accountability Act of 1996 (**"HIPAA"**), the Health Information Technology for Economic and Clinical Health Act (**"HITECH"**), and the implementing regulations thereunder, including but not limited to the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Parts 160 and 164 (**the "Privacy Rule"**) and the Security Standards for the Protection of Electronic Health Information at 45 C.F.R. Parts 160 and 164 (**the "Security Rule"**), as may be amended from time to time, shall collectively be referred to herein as the "**HIPAA Authorities**." All other capitalized terms hereunder shall have the meaning ascribed to them elsewhere in this Agreement, or, if no such definition is specified herein, shall have the meaning set forth in the HIPAA Authorities.

2. **Interpretation of Provisions of this Agreement.** In the event of an inconsistency between the provisions of this Agreement and the mandatory terms of the HIPAA Authorities, the terms of the HIPAA Authorities shall prevail. Any ambiguity in this Agreement shall be resolved in favor of a meaning that permits Covered Entity to comply with the HIPAA Authorities. A reference in this Agreement to a section in the HIPAA Authorities means the section in effect or as amended. Titles or headings are used in this Agreement for reference only and shall not have any effect on the interpretation of this Agreement.

3. **Obligations of Business Associate.**

3.1 Limits on Use and Disclosure. Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement or as required by law.

3.2 Safeguards. Business Associate agrees to use reasonable and appropriate administrative, physical and technical safeguards to prevent use or disclosure of PHI other than as provided for by this Agreement.

3.3 Mitigation of Harm. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement or the HIPAA Authorities.

3.4 Report of Improper Use or Disclosure. Business Associate agrees to notify Covered Entity, in writing or orally, without unreasonable delay, but in no case more than five (5) calendar days, of any incident involving the acquisition, access, use or disclosure of the PHI not provided for by this Agreement of which Business Associate becomes aware. As soon as reasonably possible thereafter, in no case more than fourteen (14) calendar days following the incident at issue, Business Associate shall provide Covered Entity with a written report which shall include but not be limited to: i) a description of the circumstances under which the incident occurred; ii) the date of the incident and the date that the incident was discovered; iii) a description of the types of PHI involved in the incident; iv) the identification of each Individual whose PHI is known or is reasonably believed by the Business Associate to have been affected; and v) any recommendations that the Business Associate may have, if any, regarding the steps that Individuals may take to protect themselves from harm.. To the extent that Covered Entity reasonably determines that such incident constitutes a Breach of Unsecured PHI by Business Associate that necessitates the notification of Individuals by Covered Entity under HITECH, Business Associate agrees that it shall immediately reimburse Covered Entity for the reasonable expenses of such notification process. Business Associate shall cooperate with any investigation of such incident conducted by Covered Entity in connection with any report made pursuant to this Section.

3.5 Agents and Subcontractors. Business Associate agrees to ensure that any agent or subcontractor to whom Business Associate provides PHI agrees in writing to the same restrictions and conditions that apply to Business Associate through this Agreement with respect to such PIII prior to the actual disclosure of PHI to such agents or subcontractors.

3.6 Access to Records. At the request of Covered Entity and within five (5) business days of such request and in a reasonable manner designated by Covered Entity, Business Associate shall provide access to PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, in a manner compliance with 45 CFR §164.524 and/or other applicable provisions of the HIPAA Authorities.

3.7 Amendments to PHI. At the request of Covered Entity, or, as directed by Covered Entity, at the request of an Individual, Business Associate shall make, within five (5) business days of such request and in a reasonable manner designated by Covered Entity, any amendment(s) to PHI in a Designated Record Set to which the Covered Entity has agreed pursuant to 45 CFR §164.526, or shall otherwise assist Covered Entity in complying with Covered Entity's obligations under 45 CFR §164.526.

3.8 Availability of Internal Practices, Books and Records. Business Associate shall make its internal practices, books and records, including but not limited to policies and procedures relating to the use and disclosure of PHI, available to Covered Entity or the Secretary for purposes of determining Covered Entity's compliance with the HIPAA Authorities, in a time and manner designated by Covered Entity or the Secretary, as applicable.

3.9 Accounting of Disclosures. Business Associate shall document such disclosures of PHI and information related to such disclosures (i.e., (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528. Such documentation shall be maintained with regard to all disclosures of PHI, except for those disclosures that are expressly exempted from the documentation requirement under the HIPAA Authorities (see, e.g., 45 CFR §§164.502; 164.508; 164. 510; 164.512, etc.).

Documentation required to be collected by the Business Associate under this Section shall be retained for a minimum of six (6) years, unless otherwise provided under the HIPAA Authorities. Business Associate shall further provide the information collected pursuant to this Section to Covered Entity or an Individual, within five (5) business days of the applicable request and in a reasonable manner designated by Covered Entity, as necessary to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or other applicable provision of the HIPAA Authorities.

3.10 Disclosure of Minimum PHI. Business Associate agrees that it shall request, use and/or disclose only the amount and content of PHI that is the Minimum Necessary for Business Associate to fulfill its obligations under the terms and conditions of this Agreement. Business Associate acknowledges that such Minimum Necessary standard shall apply with respect to uses and disclosures by and among members of Business Associate's workforce as well as by or to third parties as permitted hereunder.

3.11 Notification of Claims. Business Associate shall promptly notify Covered Entity upon notification or receipt of any civil or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions ("*Actions*") arising out of or related to this Agreement or PHI, or relating to Business Associate's conduct or status as a business associate for any covered entity, regardless of whether Covered Entity and/or Business Associate are named as parties to such Actions.

3.12 Security Rule Requirements. Business Associate shall implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule. Business ssociate agrees to report to Covered Entity any use or disclosure of PHI not provided for by this Agreement or the HIPAA Authorities of which it becomes aware, including any Security Incident. Accordingly, Business Associate agrees to report any successful Security Incident of which it becomes aware to Covered Entity immediately, but not later than five (5) calendar days after the Security Incident, and agrees to provide a monthly aggregate report of all attempted Security Incidents (e.g., a request-response utility used to determine whether a specific Internet Protocol [IP] address, or host, exists or is accessible) of which it becomes aware to Covered Entity no later than the fifth day of each month following the month in which any such attempted Security Incidents occurred. In addition, Business Associate agrees to provide detailed information regarding any successful and/or attempted Security Incident(s) to Covered Entity upon request, within the capabilities of Business Associate. All reports provided by Business Associate pursuant to this Section 3.3 shall include the actions and the mitigation steps, if any, taken by Business Associate in response to the Security Incident(s).

3.13 HITECH Compliance. Requirements of HITECH or its implementing regulations that are made applicable with respect to business associates, or any other provision required to be included in this Agreement pursuant to HITECH or its implementing regulations, are incorporated into this Agreement by this reference.

4. Permitted Uses and Disclosures by Business Associate.

4.1 Use or Disclosure to Perform Functions, Activities, or Services. Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform those functions, activities, or services that Business Associate performs for, or on behalf of, Covered Entity as specified in the Services Agreement, provided that such use or disclosure would not

violate the Privacy Rule, or the policies and procedures of Covered Entity relating to the "Minimum Necessary Standard," if done by Covered Entity. Any such use or disclosure shall be limited to those reasons and those Individuals as necessary to meet the Business Associate's obligations under the Services Agreement.

4.2 Appropriate Uses of PHI. Except as may be otherwise limited in this Agreement, Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

4.3 Confidentiality Assurances and Notification. Except as may be otherwise limited in this Agreement, Business Associate may disclose PHI for the proper management and administration of the Business Associate, provided that disclosures are Required by Law, or Business Associate obtains reasonable assurances from the person to whom the PHI is disclosed that such PHI will remain confidential and used or further disclosed only as Required by Law or for the purpose for which such PHI was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

4.4 Data Aggregation Services. As applicable, Business Associate may use PHI to provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B), except as may be otherwise provided by this Agreement.

5. **Indemnification**. Business Associate shall indemnify and hold harmless Covered Entity against, and reimburse Covered Entity for, any expense, loss, damages, fees, costs, claims or liabilities of any kind arising out of or related to any Actions, whether asserted or threatened, or whether instigated by a third party or by Business Associate, arising out of or related to Business Associate's acts and omissions associated with Business Associate's obligations under this Agreement or its use or disclosure of PHI or the use and disclosure of PHI by an agent or subcontractor of Business Associate. Such indemnification shall include, but not be limited to, the payment of all reasonable attorney fees associated with any such Action. Business Associate shall obtain and maintain at its sole expense, and in amounts consistent with industry standards, insurance to support its indemnification obligations hereunder. Business Associate shall provide a certificate of insurance evidencing such coverage to Covered Entity upon request.

6. **Obligations of Covered Entity**.

6.1 Notice of Privacy Practices. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices, to the extent that such limitation(s) may affect Business Associate's use or disclosure of PHI.

6.2 Change or Revocation of Permission. Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's permitted or required uses and disclosures of PHI. Business Associate shall comply with any such changes or revocations.

6.3 Restrictions on Use or Disclosure. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI. Business Associate shall comply with any such restrictions. Business Associate shall immediately notify Covered Entity of any request for a restriction on the use or disclosure of an Individual's PHI that Business Associate receives from such Individual.

6.4 No Request to Use or Disclose in Impermissible Manner. Except as necessary for the Data Aggregation Services or management and administrative activities of the Business Associate as allowed herein, Covered Entity shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity.

7. **Term and Termination**

7.1 Term. This Agreement shall be effective as of the earlier of the date first documented above or the effective date of the Services Agreement, and shall terminate upon termination of the Services Agreement for any reason or as otherwise provided in this Agreement.

7.2 Termination with Cause. Upon Covered Entity's knowledge of a material breach by Business Associate, its agents or subcontractors, Covered Entity shall, at its option: i) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this Agreement if Business Associate does not cure the breach or end the violation within the cure period identified in the Services Agreement, or if no cure period is identified in the Services Agreement, as specified by Covered Entity; ii) immediately terminate this Agreement if Business Associate has breached a material term of this Agreement and Covered Entity deems cure by Business Associate not to be possible; or iii) if neither termination nor cure are feasible, report the violation to the Secretary.

7.3 Effect of Termination.

(a) Except as provided in paragraph (b) of this Section, upon termination of this Agreement for any reason, Business Associate shall return or destroy (at Covered Entity's election), and shall retain no copies of, all PHI in the possession of Business Associate.

(b) In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written approval, which shall not be unreasonably withheld, Business Associate may retain the PHI, but shall extend the protections of this Agreement (including, but not limited to, Sections 1 through 5) to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

8. **Standards for Electronic Transactions.** In connection with the Services to be provided to Covered Entity pursuant to this Agreement, Business Associate agrees that if it (or an agent or subcontractor) conducts an electronic transmission for which the Secretary has established a "standard transaction" under 45 C.F.R. Part 164, Subparts A, C, D and E, as applicable (the "Electronic Transactions Standards"), Business Associate (or its agent or subcontractor) shall comply with the requirements of the Electronic Transactions Standards. Business Associate specifically represents that it has obtained such compliance. Business Associate agrees that, in connection with the transmission of standard transactions, it will not (and will not permit any agent or subcontractor with which it might contract to): (i) change the definition, data condition, or use of a data element or segment in a standard; (ii) add any data elements or segments to the maximum defined data set; (iii) use any code or data elements that are either marked "not used" in the standard's implementation specification or are not in the standard's implementation specification; or (iv) change the meaning or intent of the standard's implementation specification(s). Business Associate understands that Covered Entity reserves the right to request an exception from the uses of a standard as permitted by 45 CFR § 162.940, and, if such an exception is sought, Business Associate agrees to participate in a test modification.

9. Confidentiality of Business Information.

9.1 Business Information. In the event the parties have not agreed to alternative confidentiality language with respect to business information in the Services Agreement or elsewhere, the following provisions will apply. Neither party will disclose to any third party any information related to this Agreement or to the business operations of the other party, or any proprietary information belonging to the other party (collectively, "*Confidential Business Information*") without the prior written consent of the other party, except as may be required under law; provided that a party required by law to disclose Confidential Business Information shall inform the other party in order that the other party may contest such requirement. Each party hereby agrees that all Confidential Business Information communicated to it by the other party, whether oral or written, and whether before or after execution of this Agreement, was and will be received in strict confidence and will be used only for purposes set forth in the Services Agreement. Upon termination of this Agreement, each party shall, upon the request of the providing party, promptly return all such Confidential Business Information to the providing party or, at the providing party's option, shall destroy such Confidential Business Information and certify as to its destruction. This obligation of confidentiality shall not apply to information i) which was known by the recipient without the obligation of confidentiality prior to its receipt of such information; ii) is or becomes publicly available without breach of this Agreement; or iii) is received from a third party without an obligation of confidentiality and without breach of this Agreement. This paragraph shall not apply to uses and disclosures of PHI, which shall be governed by the remaining provisions of this Agreement.

9.2 Response to Subpoena. Business Associate shall be permitted to disclose PHI and Confidential Business Information that Business Associate is required to disclose pursuant to court order, subpoena or other compulsory legal process, provided that prior to making any disclosure thereunder, Business Associate shall provide Covered Entity within five (5) calendar days prior written notice (or as much notice as reasonably practicable under the circumstances) of the intended disclosure, specifying the basis and nature of the same.

10. Miscellaneous.

10.1 Assignment; Waiver. This Agreement shall be binding upon and inure to the benefit of the respective legal successors of the parties. Neither this Agreement nor any rights or obligations hereunder may be assigned, in whole or in part, without the prior written consent of the other party. Except as provided herein, this Agreement shall create no independent rights in any third party or make any third party a beneficiary hereof. No failure or delay by either party in exercising its rights under this Agreement shall operate as a waiver of such rights, or of any prior, concurrent, or subsequent breach.

10.2 Property Rights. All PHI shall be and remain the exclusive property of Covered Entity. Business Associate agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this Agreement.

10.3 Right to Cure. Business Associate agrees that in the event Business Associate fails to cure a breach of this Agreement pursuant to this Agreement, Covered Entity has the right, but not the obligation, to cure the same. Expenses, costs or fines reasonably incurred in connection with Covered Entity's cure of Business Associate's breach(es) shall be borne solely by Business Associate.

10.4 Injunctive Relief. Business Associate agrees that breach of the terms and conditions of this Agreement shall cause irreparable harm for which there exists no adequate remedy at law. Covered Entity retains all rights to seek injunctive relief to prevent or stop any breach of the terms of this Agreement, including but not limited to the unauthorized use or disclosure of PHI by Business Associate or any agent, contractor or third party that received PHI from Business Associate.

10.5 Survival; Severability. The respective rights and obligations of Business Associate under this Agreement, including but not limited to Business Associate's indemnification obligations, shall survive the termination of this Agreement. The parties agree that if a court determines that any of the provisions of this Agreement are invalid or unenforceable for any reason, such determination shall not affect the enforceability or validity of the remaining provisions of this Agreement.

10.6 Entire Agreement; Amendment. This document, together with any written Schedules, amendments and addenda, constitutes the entire agreement of the parties and supersedes all prior oral and written agreements or understandings between them with respect to the matters provided for herein. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for Covered Entity to comply with the requirements of the HIPAA Authorities and HIPAA. Any modifications to this Agreement shall be valid only if such modifications are in accordance with the HIPAA Authorities, are made in writing, and are signed by a duly authorized agent of both parties.

10.7 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Kansas to the extent that the HIPAA Authorities do not preempt the same.

10.8 Notice. Any notice required or permitted to be given by either party under this Agreement shall be sufficient if in writing and hand delivered (including delivery by courier) or sent by postage prepaid certified mail return receipt requested, to the following address:

If Covered Entity:	**If Business Associate:**
Louisiana Healthcare Connections, Inc.	US Script, Inc. President 2425 W. Shaw Avenue Fresno, California 93711 Fax:: 559-244-3793

10.9 Independent Contractors. For purposes of this Agreement, Covered Entity and Business Associate are and will act at all times as independent contractors. None of the provisions of this Agreement shall establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the parties.

Each party to this Agreement warrants that it has full power and authority to enter into this Agreement, and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

COVERED ENTITY
By: _____
Title: CEO
Date: 11/30/12

BUSINESS ASSOCIATE
By: _____
Title: PRESIDENT
Date: 11/27/12

AMENDMENT NUMBER ONE

PHARMACEUTICAL BENEFIT MANAGEMENT SERVICES AGREEMENT

This Amendment Number One to the Pharmacy Benefit Management Services Agreement ("***Amendment***") is made and entered into this 20th day of November 2014, by and between US Script, Inc. ("***US Script***") and Louisiana Healthcare Connections, Inc. ("***HMO***").

WHEREAS, US Script and HMO are parties to a Pharmaceutical Service Agreement dated November 1, 2012 (the "***Agreement***"); and

WHEREAS, US Script and HMO desire to amend the Agreement effective as of February 1, 2015, as it relates to Exhibit 3.

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree to amend the Agreement as follows:

1. Section 8 of Exhibit 3, entitled "Performance Standards", shall be deleted in its entirety and replaced with the attached Section 8, Performance Standards.
2. Capitalized terms used in this Amendment and not otherwise defined herein shall have the same meaning as in the Agreement. All other terms and conditions of the Agreement not inconsistent with this Amendment shall remain in effect.

Louisiana Healthcare Connections, Inc.

By: _____

Name: James E. Schlotman

Title: CEO / Plan President

Date: 7/20/15

US Script, Inc.

By: _____

Name: Donald Howard

Title: President and CEO

Date: 07/16/15

EXHIBIT 3
Performance Standards and Requirements for PBM Services

8. Performance Standards

Standard Metric	Target	Measurement Tool	Report Frequency
Eligibility	US Script shall load the eligibility file within one (1) business day of receipt from HMO using a term by absence methodology.	US Script to report to HMO in a mutually agreed upon format	Per occurrence
Encounter data	US Script shall deliver the Encounter file to HMO by the close of business on the 5th calendar day of each month or as mutually agreed upon.	HMO will log and track receipt of file	Monthly
Encounter data	US Script shall submit all encounter data to HMO by the 5th calendar day of each month or as mutually agreed upon. Encounter data must meet the State required acceptance rate. If there is not a State acceptance rate, US Script must meet the HMO acceptance rate of 95%.	HMO will log and track receipt of file and errors identified (a) by HMO and (b) by State	Monthly
Claims Processing	Timely payment standards as required by State and federal guidelines.	US Script System Report	Monthly
Member and Provider Appeals	If member appeals are not delegated to US Script, US Script may be called upon to provide information on an appeal that HMO is processing. A request for information on a standard appeal will be responded to within 10 business days. An expedited appeal will be responded to within 1 business day. HMO must clearly communicate whether the	HMO Appeal Tracking Log	Per Occurrence

	appeal is standard or expedited, and give the appropriate deadline at the time of the request.		
State Requirements	No sanctions or penalties will be assessed by State on HMO as a result of acts or omissions of US Script.	State Reports	Per Occurrence
Contracting and Network Development	US Script must maintain network adequacy requirements required by the State. If no requirements are stated, the standards will be (1 provider within 30 minutes or 30 miles (urban); 1 provider within 45 miles or 45 minutes (rural)). US Script will not be penalized in cases where it can demonstrate that a provider is unwilling to contract.	Reports supplied by US Script	Monthly
Telephone answer timeliness - Provider Call Centers	US Script's phone unit will answer 90% of calls in less than 30 seconds or direct the call to an automatic call pickup system with IVR options, unless otherwise required by the State.	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Call average abandonment rate will be less than 5%, or as otherwise required by the State.	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Blocked call rate less than 1%	System report from US Script on all phone units	Monthly
Telephone answer timeliness	First Call Resolution 95%	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Respond to voicemails by next business day	System report from US Script on all phone units	Monthly

1. Reports must be submitted to the HMO via the Secure FTP Site.
2. US Script must demonstrate through the appropriate reports and documentation that the performance standards have been met.

AMENDMENT NUMBER TWO

PHARMACEUTICAL BENEFIT MANAGEMENT SERVICES AGREEMENT

This Amendment Number Two to the Pharmacy Benefit Management Services Agreement ("***Amendment***") is made and entered into this 23rd day of September 2015, by and between US Script, Inc. ("***US Script***") and Louisiana Healthcare Connections, Inc. ("***HMO***").

WHEREAS, US Script and HMO are parties to a Pharmaceutical Service Agreement dated November 1, 2012 (the "***Agreement***"); and

WHEREAS, US Script and HMO desire to amend the Agreement effective as of September 1, 2015, as it relates to Exhibit 3 and Exhibit 7.

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree to amend the Agreement as follows:

1. Section 8 of Exhibit 3, entitled "Performance Standards", shall be deleted in its entirety and replaced with the attached Section 8, Performance Standards.

2. Exhibit 7, "Louisiana State-Specific Subcontract Requirements" attached hereto, shall be added to the Agreement.

3. Capitalized terms used in this Amendment and not otherwise defined herein shall have the same meaning as in the Agreement. All other terms and conditions of the Agreement not inconsistent with this Amendment shall remain in effect.

Louisiana Healthcare Connections, Inc.

By: Kendra Case

Name: Kendra Case

Title: COO

Date: 05/03/16

US Script, Inc.

By: _____

Name: Donald Howard

Title: President and CEO

Date: 4/29/2016

EXHIBIT 3
Performance Standards and Requirements for PBM Services

8. Performance Standards

Standard Metric	Target	Measurement Tool	Report Frequency
Eligibility	US Script shall load the eligibility file within one (1) business day of receipt from HMO using a term by absence methodology.	US Script to report to HMO in a mutually agreed upon format	Per occurrence
Encounter data	US Script shall deliver the Encounter file to HMO by the close of business on the 5th calendar day of each month or as mutually agreed upon.	HMO will log and track receipt of file	Monthly
Encounter data	US Script shall submit all encounter data to HMO by the 5th calendar day of each month or as mutually agreed upon. Encounter data must meet the State required acceptance rate. If there is not a State acceptance rate, US Script must meet the HMO acceptance rate of 95%.	HMO will log and track receipt of file and errors identified (a) by HMO and (b) by State	Monthly
Claims Processing	Timely payment standards as required by State and federal guidelines.	US Script System Report	Monthly
Member and Provider Appeals	If member appeals are not delegated to US Script, US Script may be called upon to provide information on an appeal that HMO is processing. A request for information on a standard appeal will be responded to within 10 business days. An expedited appeal will be responded to within 1 business day. HMO must clearly communicate whether the appeal is standard or expedited,	HMO Appeal Tracking Log	Per Occurrence

	and give the appropriate deadline at the time of the request.		
State Requirements	No sanctions or penalties will be assessed by State on HMO as a result of acts or omissions of US Script.	State Reports	Per Occurrence
Contracting and Network Development	US Script must maintain network adequacy requirements required by the State. If no requirements are stated, the standards will be (1 provider within 30 minutes or 30 miles (urban); 1 provider within 45 miles or 45 minutes (rural)). US Script will not be penalized in cases where it can demonstrate that a provider is unwilling to contract.	Reports supplied by US Script	Monthly
Telephone answer timeliness - Provider Call Centers	US Script's phone unit will answer 95% of calls in less than 30 seconds or direct the call to an automatic call pickup system with IVR options, unless otherwise required by the State. The metric is calculated as the total number of calls answered by a live operator or IVR system within 30 seconds divided by total incoming calls.	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Call average abandonment rate will be less than 5%, or as otherwise required by the State.	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Blocked call rate less than 1%	System report from US Script on all phone units	Monthly
Telephone answer timeliness	First Call Resolution 95%	System report from US Script on all phone units	Monthly
Telephone answer timeliness	Respond to voicemails by next business day	System report from US Script on all phone units	Monthly

1. Reports must be submitted to the HMO via the Secure FTP Site.
2. US Script must demonstrate through the appropriate reports and documentation that the performance standards have been met.

EXHIBIT 7

LOUISIANA STATE-SPECIFIC SUBCONTRACT REQUIREMENTS

DEFINITIONS

For the purposes of this instrument, the following definitions shall apply:

a. Addendum shall mean this addendum to the Subcontract.

b. CFR shall mean the Code of Federal Regulations.

c. DHH shall mean the Louisiana Department of Health and Hospitals.

d. MCO shall mean Louisiana Healthcare Connections

e. Medicaid shall mean medical assistance provided under a state plan approved under Title XIX of the Social Security Act.

f. Member shall mean a Medicaid consumer.

g. Provider Agreement shall mean the contract between DHH and MCO.

h. State shall mean the State of Louisiana.

i. Subcontract shall mean that certain written agreement by and between Louisiana Healthcare Connections and Subcontractor.

j. Subcontractor shall mean US Script.

k. USC shall mean the United States Code.

PROVISIONS

1. This Addendum will supplement the Subcontract and will run concurrently with the terms of the Subcontract. This Addendum is limited to the terms and conditions governing the provision of services to or on behalf of MCO in the fulfillment of MCO's contractual responsibilities to DHH regarding the arrangement of health care services to Medicaid members.

2. Conflicts:

   a) The provisions of this Addendum supersede any language to the contrary which may appear elsewhere in the Subcontract; and

b) If any requirement in the Subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect; and
c) If any requirement in the Subcontract or this Addendum conflicts with the contract between DHH and MCO, the contract between DHH and MCO will prevail.

3. Subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the Subcontractor upon request.

4. The subcontract and its appendices contain all the terms and conditions agreed upon by the both parties, the MCO and Subcontractor.

5. No modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties, the MCO and Subcontractor.

6. Alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.

7. The MCO and Subcontractor agree that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and Subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.

8. Subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.

9. If any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.

10. If applicable, services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the Subcontractor provide these services to members through the last day that the subcontract is in effect.

11. If applicable, Subcontractor shall be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.

12. If applicable, emergency services shall be coordinated without the requirement of prior authorization of any kind.

13. If the Subcontractor performs laboratory services, the Subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.

14. Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.

15. If applicable, record retention requirements as specified in the contract between DHH and the MCO shall be included in the Subcontract.

16. Subcontractor shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.

17. Subcontractor shall submit to the MCO a disclosure of ownership in accordance with RFP Section 15.1.10 to be submitted to DHH.

18. Subcontractor shall provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee, whether announced or unannounced.

19. Subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /Subcontractor practices and/or the standards established by DHH or its designee.

20. Subcontractor shall comply with any corrective action plan initiated by the MCO and/or required by DHH.

21. MCO may assess any monetary penalties, sanctions or reductions in payment on Subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a Subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the Subcontractor as appropriate.

22. If applicable, Subcontractor shall provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.

23. Subcontractor shall safeguard information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.

24. Subcontractor shall comply with DHH's claims processing requirements as outlined in the RFP and shall adhere to DHH's timely filing guidelines as outlined in the RFP.

25. If Subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.

26. Subcontractor, if performing a key internal control, shall submit to an independent SSAE 16 SOC type 1 and/or type II audit of its internal controls and other financial and performance audits from outside companies to assure both the financial viability of the (outsourced) program and the operational viability, including the policies and procedures placed into operation. The audit firm will conduct tests and render an independent opinion on the operating effectiveness of the controls and procedures. When required by DHH, the Subcontractor must provide a quality control plan, such as third party Quality Assurance (QA), Independent Verification and Validation (IV&V), and other internal project/program reviews and audits.

27. Subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.

28. At all times during the term of the subcontract, the Subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the Subcontractor is a state agency. For Subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety

in the Subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.

29. Subcontractor shall secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The Subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.

30. Subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.

31. The subcontract incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.

32. MCO and Subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.

33. Subcontractor shall adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the Subcontractor.

34. Subcontractor shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the Subcontractor's ability to perform the services included in its contract with the MCO.

35. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the Subcontractor shall take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.

36. The subcontract is a non-exclusive agreement and nothing herein shall prohibit or restrict Subcontractor from subcontracting with another MCO or other managed care entity.

37. If the MCO has entered into an alternative reimbursement arrangement with Subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.

38. The services to be provided under this subcontract shall be performed entirely within the boundaries of the United States. In addition, the Subcontractor will not hire any individual to perform any services under this subcontract if that individual is required to have a work

visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

39. Subcontractor assigns to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "Pharmacy" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.

AMENDMENT THREE
TO THE
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

This Amendment Three ("Amendment") is entered into as of **March 1, 2016** (the "Effective Date"), by and between **US Script, Inc.** a corporation organized and existing under the laws of the State of Delaware, ("US Script"), and **Louisiana Healthcare Connections, Inc.** ("HMO"), collectively referred to herein as the "Parties".

WHEREAS, US Script and HMO have previously entered into a Pharmacy Benefit Management Services Agreement with an effective date of November 1, 2012 (the "Agreement"); and

WHEREAS, US Script and HMO desire to amend certain terms of the Agreement;

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein contained, the Parties hereby agree to amend the Agreement as follows:

1. The following sections are hereby deleted and amended in their entirety as follows:

2.4 Mail Order Pharmacy Services. The following will apply to the extent mail order pharmacy is included as a Covered Pharmacy Service:

2.4.1 General. US Script will provide mail order pharmacy services to Covered Persons through a contracted mail order pharmacy ("Mail Order Pharmacy"). In the event HMO elects to implement a mail order network by adding or requiring US Script to add mail service providers in addition to US Script's contracted Mail Order Pharmacy, the fees and rates contained in this Agreement shall be negotiated by the Parties. US Script will cause the Mail Order Pharmacy to dispense new or refill prescription orders, consistent with the terms of this Agreement, the Payor Contract, and applicable Laws, upon receipt from a Covered Person of (i) a valid prescription order or a completed refill order form and (ii) the applicable Co-Payment and/or deductible.

8.2 Disclaimers. Except as provided in this section, US Script disclaims all express and all implied warranties of any kind, including the suitability for any particular purpose of the data generated through the US Script Claim System. US Script relies on MediSpan or comparable databases in providing HMO and Covered Persons with DUR services. US Script has utilized due diligence in collecting and reporting the information contained in the databases and has obtained such information from sources believed to be reliable. US Script, however, does not warrant the accuracy of reports, alerts, codes, prices or other data contained in the databases. US Script does not warrant that its services will be uninterrupted or error free. US Script does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services. Network Pharmacies are independent contractors of US Script, and US Script shall have no liability to

HMO any Covered Person, or any other person or entity for any act or omission of any Network Pharmacy or its agents or employees. Neither party will be liable to the other for indirect, incidental, consequential, punitive, special, or exemplary damages, arising out of or related to this Agreement, even if advised of the possibility of such damages.

All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

INTENDING TO BE LEGALLY BOUND, the parties have duly executed the Amendment as of the Effective Date.

US Script	HMO
	Kendra Case
Authorized Signature	Authorized Signature
Donald Howard	Kendra Case
Print Name	Print Name
President and CEO	COO
Office or Title	Office or Title
4/29/2016	05/03/16
Date	Date

AMENDMENT FOUR
TO THE
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

This Amendment Four ("Amendment") is entered into as of **July 1, 2016** (the "Effective Date"), by and between **US Script, Inc.** a corporation organized and existing under the laws of the State of Delaware, ("US Script"), and **Louisiana Healthcare Connections, Inc.** ("HMO"), collectively referred to herein as the "Parties".

WHEREAS, US Script and HMO have previously entered into a Pharmacy Benefit Management Services Agreement with an effective date of January 1, 2013 (the "Agreement"); and

WHEREAS, US Script and HMO desire to amend certain terms of the Agreement;

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein contained, the Parties hereby agree to amend the Agreement as follows:

1. The following sections are hereby added as follows:

   1.17 "Claims Adjudication Subcontractor" means a the third-party vendor contracted by US Script, or a US Script affiliate to perform Claims processing, retail network contracting and other Claims adjudication related services.

   1.18 "Pricing Source" will mean Medi-Span or another nationally available reporting service of pharmaceutical prices as selected by US Script and/or Subcontracted Network.

   3.6 On-Line Data Entry. HMO may have on-line access to inquire, update plan design information, and, if applicable, input Claims, overrides, eligibility, and other information. HMO acknowledges and agrees that US Script, Subcontracted Network, and the Network Pharmacies are entitled to rely on the accuracy and completeness of any information entered by HMO into US Script's systems through this on-line access, and HMO will bear the risk of, and indemnify US Script and/or Subcontracted Network for, any mistakes or inaccuracies. US Script may require HMO to sign a separate agreement or addendum for the use of such on-line service.

2. The following sections are hereby deleted and amended in their entirety as follows:

   Recital number two:

   WHEREAS, US Script has established and/or subcontracted for the provision of retail, mail order and specialty pharmacy networks ("Subcontracted Network(s)") to deliver pharmacy services to individuals; and

   1.2 "Average Wholesale Price" or "AWP" will mean the benchmark price established by the Pricing Source, based on the 11-digit National Drug Code ("NDC") of the Covered Pharmacy Service actually dispensed as reported by the Network

Pharmacy to US Script and/or to a Subcontracted Network. AWP pricing will be updated on a daily basis, excluding weekends and holidays, with data received from the Pricing Source. AWP does not represent a true wholesale price, but rather is a fluctuating benchmark provided by third party sources. If at any time the Pricing Source changes the methodology for calculating AWP, or ceases publishing or replaces AWP, or US Script and/or Subcontracted Network proposes to begin to utilize another pricing benchmark, and such change would materially change the economic benefit to HMO under the Agreement (a "Material Pricing Change"), then US Script will provide HMO with proposed modified pricing terms. If the parties fail to mutually agree upon the modified pricing terms before the effective date of the Material Pricing change, then US Script's proposed modified pricing terms will go into effect until otherwise agreed, and either party will have the right to terminate this Agreement upon sixty (60) days prior written notice to the other party.

1.4 "Claims" will mean those claims for Covered Pharmacy Services processed through US Script's and/or Claims Adjudication Subcontractor's proprietary on-line claims adjudication system, or otherwise transmitted or processed in accordance with the terms of this Agreement and the Benefit Enrollment Form.

1.11 "Network" or "Network Pharmacy(ies)" will mean a retail pharmacy or group of pharmacies that has/have agreed to provide Covered Pharmacy Services to Covered Persons under an agreement with US Script and/or with a Subcontracted Network.

2.2.2. Claims Processing. HMO acknowledges and agrees that US Script may subcontract Claims adjudication services and activities. Subject to applicable Regulatory Requirements, US Script and/or Claims Adjudication Subcontractor will use their claims system(s) to adjudicate all Claims submitted by Network Pharmacies based on the pharmacy benefit parameters set forth in the Benefit Enrollment Form, the requirements contained in the applicable provider manual, the terms of this Agreement, and all applicable Laws, as applicable. US Script and/or Claims Adjudication Subcontractor will accept direct Claims submitted by Covered Persons on properly completed standard claim forms together with proof of payment ("Direct Claims"). US Script and/or Claims Adjudication Subcontractor will adjudicate such properly submitted Direct Claims, based on the pharmacy benefit parameters of the Plan, as set forth in the Description of Coverage, and produce: (i) payments for the agreed upon reimbursement amounts for Covered Persons for allowable Claims; or (ii) requests for information for Claims that are ineligible for payment.

2.3 Network Pharmacies. US Script and/or a Subcontracted Network will maintain a network of Network Pharmacies to dispense Covered Pharmacy Services to Covered Persons as set forth herein ("Network").

2.3.1 Network Participation Agreement. US Script and/or the Subcontracted Network will enter into an agreement with each Network Pharmacy which will require that such Network Pharmacy will: (i) provide Covered Pharmacy Services consistent with the terms of the applicable Benefit Enrollment Form and all applicable Laws; (ii) ensure appropriate industry standard credentialing requirements are performed with respect to each Network Pharmacy; (iii) provide all Covered Pharmacy Services hereunder in accordance with the standard of pharmaceutical care, skill and diligence

applicable in the Network Provider's community and (iv) shall not contract with or maintain any Network Pharmacy whom US Script and/or the Subcontracted Network knows (or should have known, including based upon the publication of any notice by any governmental agency, has been debarred, suspended or excluded from participation in federal contracting or in any state or federal health care program, including Medicare and Medicaid. US Script and/or the Subcontracted Network will direct the Network Pharmacy to charge and collect the applicable Co-Payment from Covered Persons for each Covered Pharmacy Service provided.

2.3.2 Credentialing. US Script and/or Subcontracted Network will credential Network Pharmacies in a manner consistent with industry standards.

2.3.3 Accessibility of Network Providers. US Script and/or Subcontracted Network will select Network Pharmacies at such locations and in such numbers as will ensure reasonable access to Covered Pharmacy Services by Covered Persons. US Script and/or Subcontracted Network will ensure that retail Network Pharmacies will be open during normal retail hours at least five (5) days per week and a minimum of eight (8) hours per day. Legal Federal and State holidays will not be counted against the availability of retail hours.

2.3.4 Network Participation. US Script will provide HMO with a complete list of the names, addresses, license numbers, and normal hours of operation of the Network Pharmacies, together with the provider-specific information required by HMO, upon execution of this Agreement and on a monthly basis thereafter. HMO hereby acknowledges and agrees that additions or deletions to the Network will be in US Script's and/or Subcontracted Network's sole discretion, except that US Script and/or Subcontracted Network may request removal of a Network Pharmacy from the Network upon the request of HMO based on reasonable cause. Prior to the effective date of any such termination, or as soon as possible following the effective date of such termination if prior notice is not practicable, US Script will send letters (the text of which has been approved in writing by HMO) to affected Covered Persons (as agreed upon by the parties) notifying them of significant changes to the Network. HMO will be responsible for postage costs for any mailings to Covered Persons pursuant to this Section. For the purposes of this Section, "significant changes to the Network" will be defined as the termination of five percent (5%) or more of Network Pharmacies from the Network, or other change in the Network as requested by HMO.

2.3.5 Network Pharmacy Audits. US Script will maintain criteria, which may be amended from time to time, to establish when and how a Network Pharmacy may be audited to verify compliance with its agreement with US Script and/or Subcontracted Network. HMO acknowledges and agrees that US Script and/or Subcontracted Network may contract with a third-party auditor to conduct such periodic on-site and off-site audits. US Script will retain twenty-five percent (25%) of any overpayments recovered from Network Pharmacies as compensation for audit and administrative costs. US Script's and/or Subcontracted Network's efforts under this paragraph will be deemed to be made on HMO's behalf and the balance of any collected overpayments will be paid to HMO. US Script and/or Subcontracted Network will not be required to institute any litigation to collect any overpayments. US Script's obligations to attempt collection of such overpayments will be US Script's only

obligation with respect to remedying such overpayments, and US Script will not be obligated to repay such overpayments.

2.5.2 Drug Utilization Review (DUR). US Script and/or Subcontracted Network will provide its automated concurrent drug utilization review (DUR) services for point-of-sale Claims. Certain DUR edits will result in non-payment of a Claim unless the dispensing pharmacist requests an override, while other DUR edits may result in the transmission of an alert message to the dispensing pharmacist, but will not affect Claim payment. Network Pharmacies are directed to review such alerts and use their professional judgment as to whether action is required. HMO acknowledges that the DUR system: (i) is a highly automated system, without individual review in most circumstances, and (ii) is necessarily limited by the amount, accuracy, and completeness of data concerning Covered Persons inputted into the system or obtained from Claims and from information provided by HMO. The DUR program is intended as a supplement to, and not a substitute for, the knowledge, expertise, skill, and judgment of physicians, pharmacists, or other health care providers in providing patient care. US Script and/or Subcontracted Network will have no obligation to acquire information concerning any Covered Person beyond the information that is included in US Script's and/or Subcontracted Network eligibility or claims databases. Pharmacists are individually responsible for acting or not acting upon information generated and transmitted through the DUR services, and for performing services consistent with the scope of their licenses. In performing DUR services, US Script and/or Subcontracted Network will not, and are not required by this Agreement, to deny Claims, or require prescriber, pharmacist, or patient compliance with any norm or suggested drug regimen, or in any way substitute US Script's and/or Subcontracted Network judgment for the professional judgment or responsibility of the prescriber or pharmacist. The absence of an alert for a given drug or drug combination will not be construed to indicate that the drug or drug combination is safe, appropriate, or effective for any Covered Person. Accordingly, US Script and/or Subcontracted Network assume no liability to HMO, Plan, any Covered Person, or any other person in connection with the DUR services, including, without limitation, the failure of the DUR services to identify a prescription that results in injury to a Covered Person. US Script and/or Subcontracted Network will update its DUR databases on a reasonable basis to reflect changes in available standards for pharmaceutical prescribing; however, no database will contain all available information or accepted medical practices or prescribing practices.

2.6 Compliance with Grievance System. US Script and/or Subcontracted Network will maintain a provider grievance system which complies with HMO and State requirements. US Script and/or Subcontracted Network will, and will require Network Pharmacies to, cooperate with HMO's Covered Person and Provider grievance and appeals procedures, and will require Network Pharmacies to agree that all communications and documents relating to benefit determinations, complaints, and grievances and records relating to such problems will be referred to HMO in accordance with the grievance procedures.

2.7 Call Center Services. US Script, through its own and subcontracted call centers, will provide a toll-free telephone line 24 hours a day, seven days a week for

inquiries from HMO, pharmacies and prescribers regarding the services provided by US Script under this Agreement. Services to be provided via the toll-free number include answering questions regarding Claims, Covered Person eligibility, covered benefits, deductible status and required Co-Payments, if any, Claims submission, Claims payment, instructions for completing a claim form, and location of Network Pharmacies. Call center services provided hereunder will meet the requirements set forth at Exhibit 2 to this Agreement.

2.8.3 Formulary Compliance and Promotion Programs. HMO may have in effect a Formulary compliance program designed to promote the prescribing of Formulary drugs by Participating Providers, the dispensing of Formulary drugs by Network Pharmacies, and the awareness of the advantages of the Formulary by Covered Persons. HMO will notify US Script, in advance, of any proposed material Formulary compliance program modifications. Additionally, HMO may, at its option, participate in US Script's and/or Subcontracted Vendor's formulary compliance programs, which may include communications with Covered Persons, Network Pharmacies and/or Participating Providers, as well as financial incentives to Network Pharmacies for their participation in the Formulary. HMO will approve and may make reasonable changes to the content of Formulary communications before distribution.

3.2 Benefit Design and Eligibility File. Within 90 days prior to the Service Commencement Date, or another mutually agreeable timeframe, HMO will furnish US Script the details of the benefit design on the Benefit Enrollment Form and the initial Eligibility File. This information must be complete and accurate and in a format and media approved by US Script. US Script will not be obligated to perform any Services unless the Benefit Enrollment Form and initial Eligibility File are so furnished. US Script, Subcontracted Network, and the Network Pharmacies are entitled to rely on the accuracy and completeness of this information.

3.5 Covered Person/Network Pharmacy Communication. All communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons in Plan will be made by HMO, unless otherwise expressly delegated to US Script hereunder. US Script and Subcontracted Network agrees that all written communications sent to Covered Persons that relate specifically to the provision of Covered Pharmacy Services hereunder must be reviewed and approved in advance by HMO, which review and approval will be completed within a reasonable time period following submission by US Script.

4.5 Effect of Termination. Any termination of this Agreement will have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Termination of this Agreement will not release US Script and/or Subcontracted Network, or the Network Pharmacies from their obligations to continue to provide Services and Covered Pharmacy Services hereunder for which compensation has been received prior to the effective date of termination.

5. COMPENSATION, BILLING, AND PAYMENT. HMO will pay US Script for all Covered Pharmacy Services based upon the rates set forth in Exhibit 1 of this Agreement. US Script and/or Subcontracted Network will be responsible for payment to the Network Pharmacies for Covered Pharmacy Services solely to the extent it has received funds provided by HMO for payment of such services. US Script and/or Subcontracted Network will not be required to render payments to Network Pharmacies or Covered Persons unless and until US Script has received payment for the Claims from HMO. US Script will invoice HMO for Covered Pharmacy Services twice a month. All invoices are due and payable by electronic funds transfer by HMO within five (5) business days of receipt. In the event HMO objects to any cost in an invoice, HMO is still obligated to remit payment of the full payment amount to US Script within the agreed upon payment terms. Within 30 days of HMO's receipt of the invoice, HMO will identify and fully explain the basis for such objections in writing to US Script. HMO and US Script will then work together to determine the validity of the amounts to which HMO has objected. Any overpayments or underpayments will be reconciled through a charge or credit in a subsequent invoice.

5.1 US Script agrees that in no event, including, but not limited to nonpayment by HMO, HMO's insolvency, or breach of this Agreement, will US Script, Subcontracted Network or the Network Pharmacies, charge, collect, seek compensation, remuneration, or reimbursement from, or have any recourse against Covered Persons or persons acting on the Covered Person's behalf for Covered Pharmacy Services provided pursuant to this Agreement. US Script and/or Subcontracted Network will cause a Network Pharmacy to be bound under its agreement with US Script and/or Subcontracted Network to terms regarding compensation substantially similar to this Section. US Script further agrees that (i) the provisions of this Section will survive the termination of this Agreement regardless of the cause leading to termination and will be construed in favor of Covered Persons, and (ii) this Section will supersede any oral or written contrary agreement now existing or hereafter entered between US Script and a Covered Person or person acting on the behalf of a Covered Person. The terms hereunder will not apply to any deductibles, Co-Payments, or non-covered pharmacy services that are Covered Person's responsibilities as described in Benefit Enrollment Form.

7.1 Use of Name. Each party will have the right to use the name of the other party to inform existing or potential HMOs that US Script supplies Covered Pharmacy Services to HMO. Neither US Script nor HMO will otherwise use the other party's name, symbols, trademark, or service marks without the prior written consent of the other party, and both parties will cease any such use upon termination of this Agreement. Notwithstanding the above, US Script and/or Subcontracted Network agrees HMO may use the name, address, and phone numbers and descriptions of the Network Pharmacies in HMO's directories.

7.2 US Script Intellectual Property. HMO acknowledges that all US Script's and Claims Adjudication Subcontractor's databases, as well as the software, hard-coding, and logic used to generate the compilations of information contained in US Script's and/or Claims Adjudication Subcontractor's adjudication system(s) and in all other databases developed by US Script or Claims Adjudication Subcontractor or its

designees in connection with performing services, and the format of all reports, printouts, and copies thereof developed by US Script and/or Claims Adjudication Subcontractor, and any prior and future versions thereof by any name, are the property of US Script or Claims Adjudication Subcontractor and are protected by copyright which will be owned by US Script or Claims Adjudication Subcontractor.

8.2 Disclaimers. Except as provided in this section, US Script disclaims all express and all implied warranties of any kind, including the suitability for any particular purpose of the data generated through the US Script and/or Claims Adjudication Subcontractor's systems. US Script and/or Claims Adjudication Subcontractor relies on Medispan or comparable databases in collecting and reporting the information contained in the databases and has obtained such information from sources believed to be reliable. US Script and/or Claims Adjudication Subcontractor, however, does not warrant the accuracy of reports, alerts, codes, prices or other data contained in the databases. US Script and/or Claims Adjudication Subcontractor does not warrant that its services well be uninterrupted or error free. MCE acknowledges and agrees that: (i) US Script does not direct or exercise any control over the professional judgment exercised by any pharmacist in dispensing prescriptions or otherwise providing pharmaceutical related services; (ii) Network Pharmacies are independent contractors of US Script and/or Subcontracted Network; and (iii) in no event will US Script and/or Subcontracted Network have any responsibility for, or liability to, MCE, any Plan, any Covered Person, or any other person or entity in connection with any act or omission of any Network Pharmacy or its pharmacists, employees, or agents in providing services in connection with this Agreement.

12.2 Notices. All notices, requests, demands and other communications provided for hereunder will be in writing and will be deemed duly given: (i) on the date of receipt if delivered in person; (ii) on the date of receipt if sent by facsimile transmittal; (iii) on the date of receipt if sent by commercial overnight delivery service, charges paid by the sender, (iv) on the date of receipt of electronic mail if sent by electronic mail, provided such transmission is followed by written notice of the same, or (v) on the date of deposit in the United States mail, first class, registered or certified, return receipt requested, with proper postage prepaid as follows:

Notices to HMO:

Louisiana Healthcare Connections, Inc.
Attn: President & CEO
8585 Archives Avenue
Baton Rouge, LA 70809

Notices to US Script:

US Script, Inc.
Attn: President & CEO
8427 Southpark Circle, Suite 400
Orlando, FL 32819-9057

With a copy to:

US Script, Inc.
Attn: Snr. VP, Finance
5 River Park Place East, Suite 210
Fresno, CA 93720-1560

12.14 Covered Person Hold Harmless. US Script and/or Subcontracted Network agrees that it will look only to HMO and agrees to hold Covered Persons harmless for compensation for all Covered Pharmacy Services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to nonpayment by HMO, HMO's insolvency, or HMO's breach of this Agreement, will US Script, Subcontracted Network, or any Network Pharmacy bill, charge, collect a deposit or surcharge from or seek compensation, remuneration, or reimbursement from, or have any recourse against, Covered Person or persons acting on the Covered Person's behalf for Covered Pharmacy Services provided pursuant to this Agreement. This provision will not prohibit collection of Copayments or Deductibles. US Script further agrees that this provision will: (i) survive the termination of this Agreement, regardless of the reason for termination, and will be for the benefit of the Covered Person; (ii) supersede any oral or written agreement now existing or hereafter entered into between US Script and a Covered Person or persons acting on the Covered Person's behalf; and (iii) be construed to inure to the benefit of Covered Persons and persons acting on the Covered Person's behalf.

Exhibit 2, PBM Services

US Script and/or Claims Adjudication Subcontractor will provide:

1. Claims Processing

- Electronic processing in-network
- Paper claims processing in-network and out-of-network
- Coordination of benefits administration
- Twelve month on-line claims history retention
- Monitor Participating Pharmacy compliance
- On-line viewing access to claims history

2. Eligibility Management

- Administration of eligibility submitted by multiple sources per tape or electronically with variable Plan formats with reasonable notice of changes to such formats
- Load eligibility tapes within an average of 24 hours and inform HMO upon completion via report
- 24/7/365 Toll-free access to US Script's and/or Claims Adjudication Subcontractor's help desk for eligibility/claims processing assistance
- Administration of paper adds/deletes/changes

3. Benefits Management/Utilization Management

- Establishing, applying and maintaining pharmaceutical management procedures.
- Configuration of claims adjudication system to administer Covered Benefits
- Administration of appeal rights to providers, Covered Persons, as applicable
- Monitoring the quality and timeliness of Utilization Management decisions
- Administration of Prior Authorization process

4. Pharmacy Network Management

- Establish, license-verification (as referenced in Exhibit 3), contract, and maintain Participating Pharmacy networks for Plan
- Develop and distribute communications to Participating Pharmacies following review by HMO

5. Call Center Services

- Network Pharmacy Service as follows: 7 a.m. – 7 p.m. CST Monday through Friday; 10 a.m. – 4:00 p.m. CST on Saturday. (24x7 after hours coverage by contracted third party)
- Toll-free telephone access to Network Pharmacy Service for use by benefits personnel, pharmacists and physicians

Exhibit 3, Performance Standards and Requirements for PBM Services

1. Network Pharmacy License Verification

Activities include, but are not limited to, the following:

(a) Verification of active pharmacy licenses for all Network Pharmacies;

(b) Verification of current State Medicaid, or if applicable, Medicare certification;

(c) Provision of policies and procedures for reducing, suspending, or terminating pharmacy privileges; and

(d) Verification of National Provider Identifiers (NPIs).

INDICATOR	DUE DATE
Verify active pharmacy licenses and State Medicaid and/or Medicare certification for all Network Pharmacies.	Upon initial contracting, then every third year by credentialing date anniversary.
Provide policies and procedures for reducing, suspending, or terminating pharmacy privileges.	Initial and forward any revisions made within 30 days of revision, or, if no policy revision, send electronic notice (no written follow-up required) by January 31st of each year verifying no revisions have been made in the previous year.
Submission of an annual schedule of network verification.	Annually on by February 28th.

Pharmacies and Pharmacists terminated or disciplined	For termination of pharmacies: As per Section 2.3 of this agreement. For termination of pharmacists: 10 business days after the close of each quarter.
Complete pharmacy network.	5th of each month (per State requirements).

US Script and/or Claims Adjudication Subcontractor will provide:

5. Claims Administration

Claims administration activities include the following:

(a)Development and submission to HMO of US Script's and/or Claims Adjudication Subcontractor's documented claims processing program that, at a minimum, satisfies the standards and procedures required by HMO's claims processing policies and procedures and the requirements under the HMO Contract. The documentation will be provided by US Script to HMO for review, on or before the Commencement Date, and at any time thereafter upon HMO's request. All claims processing related delegated duties will be performed by US Script and/or Claims Adjudication Subcontractor in strict compliance with US Script's written clean claims processing program, and subsequently paid as approved by HMO.

(b) US Script and/or Claims Adjudication Subcontractor's claims processing program will be administered in accordance with HMO's claims processing program standards and procedures established in accordance with state and federal laws and will include, but is not limited to, the following:

(1) Verification of eligibility;

(2) Verification of authorization (if applicable);

(3) Verification of payee;

(4) Application of benefits in accordance with Benefit Contracts;

(5) Payment in accordance with provider contract terms;

(6) Appropriate level of medical review;

(7) Timely payment for "clean" claims in accordance with pharmacy contract terms, or within 30 days for non-contracted providers.

INDICATOR	DUE DATE
Electronic submission of all Plan pharmacy claims.	15th day following the end of the previous month.

Submission of Encounter Data according to State specifications	As determined pursuant to the State-mandated schedule, or more frequently if otherwise agreed to by the parties.

6. Subcontracting

To the extent US Script subcontracts any functions required under the applicable Payor Contract, such subcontracting arrangements will require prior written approval of HMO. If US Script, with HMO's prior written approval, partners with another entity to perform any portion of the PBM Services, US Script will provide documentation and demonstrate oversight of such entity by US Script to include:

(a) The responsibilities of US Script and subcontractor;

(b) The process by which US Script evaluates the subcontract;

(c) The remedies, if the subcontractor does not fulfill its obligation;

(d) Evaluation of the subcontractor's capacity to perform the delegated activities prior to the execution of the contract;

(e) Annual evaluation of performance in accordance with HMO's accreditation and regulatory and statutory standards (URAC);

HMO retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by HMO.

7. Reporting Requirements

US Script will prepare and deliver to HMO all reports required under the Payor Contracts held by HMO according to the Report Matrix developed by the State or as otherwise required by HMO, including but not limited to the following:

	Report / Spec Name	File Name	Due Date to HMO	Location / Method	Design Document

Encounters	Encounter Data		As required by State		NCPDP post adjudication standard or as required by Payor Contract
Provider Directory	Provider Demographics File(s)		Monthly		Companion Guide
State Reporting	As required by HMO contract with the State		As required		As required. If no requirement, as mutually agreed upon.
Internal Reporting	RX Claim Extract		As frequently as daily		Per Companion Guide
	Standard Reporting Suite		Monthly		Standard Templates

Additionally, US Script will provide reporting as applicable for HMO oversight of delegated services.

QI Reports	Frequency	Format	Submission Schedule
Complaints/Grievance/Appeal List	Monthly	Format provided by individual Health Plan. Include all received even if sent to health Plan for resolution. Include date and person at health Plan to	

		which complaint was forwarded for resolution.	
Geographic Availability Report	Quarterly	Practitioner and Provider distribution in a geographic area. Percentage of members who have a provider within a certain number of miles - as defined per Payor Contract.	
Tracking Quality and Safety of Clinical Care	Quarterly	Summary of Adverse Events tracking and Quality of Care events including investigation outcomes and corrective actions as appropriate.	
Annual Provider Access Evaluation	Annual	May be included in QI Annual Evaluation	Reviewed during Annual Oversight Audit
Annual Provider Availability Evaluation	Annual	May be included in QI Annual Evaluation	Reviewed during Annual Oversight Audit
Evaluation of QI program	Annual		
UM Reports	**Frequency**	**Format**	**Submission Schedule**
Results of inter-rater reliability assessment	Annually	Description of monitoring methods, results for physician and non-physician reviewers, comparison of performance to goal, improvement actions when goal not met	
UM cases handled by service	Monthly	Number and percent of cases by place of service (i.e., inpatient and outpatient)	
UM cases handled by type	Monthly	Number and percent of cases by type of UM request (i.e. pre-service, concurrent, post service)	
Denials by type	Monthly	Number and percent of denials by type of UM request (i.e. pre-	

		service, concurrent, post service)	
Medical Necessity Appeals by type and outcome	Monthly	Number and percent of medical necessity appeals received by type of UM service denied (i.e., . pre-service, concurrent, post service) and outcome (i.e., upheld versus overturned)	
Benefit Appeals by type and outcome	Monthly	Number and percent of benefit appeals received by type of UM service denied (i.e., . pre-service, concurrent, post service) and outcome (i.e. upheld versus overturned)	
Credentialing Reports	**Frequency**	**Format**	**Submission Schedule**
Provider Roster	Monthly Updates; Annual		Concurrent requirements are due to HMO within ten (10) calendar days, including all initially credentialed, de-credentialed and denied re-credentialed providers, with the exception of providers who are suspended or de-credentialed with cause, in which case Network will notify HMO within three (3) business days of rendering the decision. Annual requirements due to HMO thirty (30) days after the end of the year
Credentialing Activity Summary	Quarterly	Excel	Quarterly requirements are due to HMO fifteen (15) calendar days after the end of the quarter.

Provider Service Reports	Frequency	Format	Submission Schedule
Documentation [except for information deemed privileged under State law] of any inquiries and investigation of Network, or any individual subcontracting physician or provider related this Agreement, made by regulatory agencies, and documentation of the final resolution of such an investigation.	Monthly		

8. Performance Standards

Standard Metric	Target	Measurement Tool	Report Frequency	Penalty
Eligibility	US Script will load the eligibility file within an average of 24 hours of receipt from HMO using a term by absence methodology.	US Script to report to HMO in a mutually agreed upon format	Per occurrence	$0.02 PMPM each month eligibility is not loaded as specified
Encounter data	US Script shall ensure the complete, accurate, and timely submission of encounter data for all services for which US Script has incurred any financial liability whether directly or through subcontractors or other arrangements. Encounters shall be formatted and submitted in accordance with DHCS' most recent Encounter Data Dictionary related to Encounter data reporting. Encounter files should be delivered to the HMO as required by the State Errors shall be corrected within sixty (60) calendar days upon notification.	HMO will log and track receipt of file and errors identified (a) by HMO» and (b) by State.	Monthly	$0.02 PMPM each month encounter data is not submitted timely as specified.

Claims Processing	90% of all clean claims must be paid within 30 days of receipt and 99% within 90 days of receipt.	US Script System Report	Monthly	$0.01 PMPM for each month the target is not met.
Member Appeals	If member appeals are not delegated to US Script, US Script may be called upon to provide information on an appeal that HMO is processing. A request for information on a standard appeal will be responded to within 10 business days. An expedited appeal will be responded to within 3 business days. HMO must clearly communicate whether the appeal is standard or expedited, and give the appropriate deadline at the time of the request.	Plan Appeal Tracking Log	Per Occurrence	$500 for each appeal not responded to as specified.
State Requirements	No sanctions or penalties will be assessed by State on HMO as a result of acts or omissions of US Script.	State Reports	Per Occurrence	100% remuneration to HMO for any penalty or sanction assessed by State resulting from acts or omissions of Network.
Provider Appeals	100% of written provider appeals must be resolved within 30 calendar days. 1st level shall be the responsibility of US Script; all 2nd level appeals will be routed same day to HMO for resolution. US Script will adhere to findings of 2nd level appeals and 3rd level arbitration. US Script shall provide copies to HMO immediately upon request.	Audit of Provider Appeals	Quarterly	$0.01 PMPM for each quarter the target is not met.

	US Script shall enter into its dispute resolution mechanism system(s) each provider dispute submission (whether or not complete) and shall identify and acknowledge the receipt of each provider dispute within two (2) business days of the date of receipt for electronic provider submissions and within fifteen (15) business days of receipt for paper filings.			
Contracting and Network Development	US Script and/or Claims Adjudication Subcontractor must maintain network adequacy requirements required by the State.	Reports supplied by US Script	Monthly	$2,500 per month for each county that is non-compliant. Network will not be subject to penalties upon production of documentation to support all reasonable efforts to contract with providers have been unsuccessful.
Telephone answer timeliness 1	Average speed of answer for US Script's and/or Claims Adjudication Subcontractor's phone unit will be 80% of calls answered in less than 30 seconds, or as otherwise required by the State.	System report from US Script on all phone units	Monthly	$1,000 per month for each percent below 80%
Telephone answer timeliness 2	Call average abandonment rate will be less than 5%, or as otherwise required by the State.	System report from US Script on all phone units	Monthly	$1,000 per month for each percent above 5%

Telephone answer timeliness 3	Blocked call rate less than 1%	System report from US Script on all phone units	Monthly	$1,000 per month for each percent above 1%.
Telephone hold times	Average hold time will be 2 minutes or less.	System report from US Script on all phone units.	Monthly	$1,000 per month for each minute above 2 when average exceeds 2 minutes.

1. Reports must be submitted to the **HMO VIA THE SECURE FTP SITE.**
2. US Script must demonstrate through the appropriate reports and documentation that the performance standards have been met.
3. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

Signature page follows.

INTENDING TO BE LEGALLY BOUND, the parties have duly executed the Amendment as of the Effective Date.

US Script, Inc.

Authorized Signature

DON HOWARD
Print Name

PRESIDENT/CEO
Office or Title

4/29/2016
Date

Louisiana Healthcare Connections, Inc.

Kendra Case
Authorized Signature

Kendra Case
Print Name

COO
Office or Title

05/03/16
Date

AMENDMENT FIVE
TO THE
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

This Amendment five ("Amendment") is entered into as of **July 1, 2016** (the "Effective Date"), by and between **US Script, Inc.** a corporation organized and existing under the laws of the State of Delaware, ("US Script"), and **Louisiana Healthcare Connections, Inc.** ("HMO"), collectively referred to herein as the "Parties".

WHEREAS, US Script and HMO have previously entered into a Pharmacy Benefit Management Services Agreement with an effective date of January 1, 2013 (the "Agreement"); and

WHEREAS, US Script and HMO desire to amend certain terms of the Agreement;

NOW, THEREFORE, in consideration of the promises and the mutual covenants herein contained, the Parties hereby agree to amend the Agreement as follows:

1. The following sections are hereby deleted and amended in their entirety as follows:

Exhibit 3, Performance Standards and Requirements for PBM Services, Section 6

6. Subcontracting

To the extent US Script subcontracts any functions required under the applicable Payor Contract, such subcontracting arrangements will require prior written approval of HMO. If US Script, with HMO's prior written approval, partners with another entity to perform any portion of the PBM Services, US Script will provide documentation and demonstrate oversight of such entity by US Script to include:

(a) The responsibilities of US Script and subcontractor;

(b) The process by which US Script evaluates the subcontract;

(c) The remedies, if the subcontractor does not fulfill its obligation;

(d) Evaluation of the subcontractor's capacity to perform the delegated activities prior to the execution of the contract;

(e) Annual evaluation of performance in accordance with HMO's accreditation and regulatory and statutory standards (URAC);

HMO retains the right to perform additional evaluation of the subcontractor, if deemed necessary by HMO.

2. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Agreement, the terms of this Amendment shall prevail.

Signature page follows.

INTENDING TO BE LEGALLY BOUND, the parties have duly executed the Amendment as of the Effective Date.

US Script, Inc.	Louisiana Healthcare Connections, Inc.
Authorized Signature	Authorized Signature
Donald Howard Print Name	James E. Schlottman Print Name
CEO Office or Title	CEO Office or Title
07/01/2016 Date	07/06/2016 Date

AMENDMENT SIX
TO THE
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

This **Amendment Six ("Amendment")** is entered into **October 17, 2016** , (the **"Effective Date")**, and amends that certain Pharmacy Benefit Management Services Agreement (the **"Agreement")** dated November 1, 2012, by and between **US Script, Inc. ("US Script")** and **Louisiana Healthcare Connections, Inc. ("HMO")**.

WHEREAS, the parties entered into the Agreement for the provision of pharmacy benefit management services by US Script to HMO; and

WHEREAS, US Script, Inc., by an amendment to its certificate of incorporation, dated April 12, 2016, has properly effected a legal name change under applicable law; and

WHEREAS, All documentary evidence of this change of corporate name has been filed with the appropriate government entities; and

WHEREAS, The Amendment accomplishes a change of corporate name only, and all rights and obligations of Envolve Pharmacy Solutions, Inc. and HMO are unaffected by this name change.

NOW, THEREFORE, in consideration of the premises and terms and conditions herein contained, the parties hereby agree to amend the Agreement as follows:

The Agreement and any and all Amendments and/or Addendums to the Agreement and/or ancillary contractual documents to the Agreement, which are currently in effect, are amended by substituting the name "Envolve Pharmacy Solutions, Inc.", ("Envolve") for the name "US Script, Inc.", ("US Script") wherever it appears in the Agreement, Amendment, Addendum, and/or ancillary contractual document.

INTENDING TO BE LEGALLY BOUND, the parties have duly executed the Amendment as of the Effective Date.

US Script, Inc., now
Envolve Pharmacy Solutions, Inc.

Signature
~~Donald Howard~~ Stephen Jensen
Print Name
~~Chief Executive Officer~~ CFO
Office or Title
02/13/2017
Date

Louisiana Healthcare Connections, Inc.

Signature
Jamie Schlottman
Print Name
Plan President & CEO
Office or Title
February 9, 2017
Date

SEVENTH AMENDMENT TO
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

THIS SEVENTH AMENDMENT TO THE PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT ("***Amendment***") is made and entered into this 1st day of January, 2018, by and between Envolve Pharmacy Solutions, Inc., a Delaware corporation (hereinafter referred to as "***Envolve***") and Louisiana Healthcare Connections, Inc. (hereinafter referred to as "***HMO***"), collectively referred to herein as the "Parties".

WHEREAS, the parties hereto, are parties to a Pharmacy Benefit Management Services Agreement effective November 1, 2012 (the "***Agreement***");

WHEREAS, HMO desires to amend the Pharmacy Benefit Management Services Agreement to add Medicare products;

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree to the following: effective as of January, 1, 2018 ("***Effective Date***"):

1. ATTACHMENT B, Medicare Product Attachment, attached hereto, shall be incorporated to the Agreement.

2. Capitalized terms used in this Amendment and not otherwise defined herein shall have the same meaning as in the Agreement. All other terms and conditions of the Agreement not inconsistent with this Amendment shall remain in effect.

3. The parties further agree that any entity defined in the Agreement as an "Plan" shall be authorized to submit copies of the Agreement and any amendments thereto to any regulatory agency for the purpose of obtaining necessary regulatory approvals or conducting other business of a regulatory nature.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first above written.

Louisiana Healthcare Connections, Inc.

Authorized Signature

Jamie Schlottman
Printed Name

Plan President & CEO
Title

Signature Date: 1/26/2017
Effective Date of Amendment: 1/1/2018

Envolve Pharmacy Solutions, Inc.

Authorized Signature

Dan Howard
Printed Name

CEO
Title

Signature Date: 2/8/2017

Attachment B: Medicare

MEDICARE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS)

THIS PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between Louisiana Healthcare Connections, Inc. ("***Health Plan***") and Envolve Pharmacy Solutions, Inc. ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain Pharmacy Benefit Management Services Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Medicare Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: Medicare Product (which is sometimes referred to in this Attachment as this "***Product***"). The term "***Medicare Product***" refers to those programs and health benefit arrangements offered by Health Plan or another Company in connection with one or more of the following Medicare product types that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof) on its own or jointly with a State that administers or regulates such program or plan (each a "***Medicare Product Type***"): a non-Dual Eligible Special Needs Plan Medicare Advantage plan ("***MA Plan***"); a Medicare Advantage prescription drug plan ("***MA-PD Plan***"); a Dual Eligible Special Needs Plan ("***DSNP Plan***"); a Capitated Financial Alignment Demonstration ("***MMP Plan***") plan or program (e.g., a plan or program adopted or established under the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments); or other Medicare Product Types. The Medicare Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a Medicare Product. The Medicare Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Product. Provider acknowledges that it will participate in each Medicare Product Type for which a Compensation Schedule(s) is attached to the Agreement.

2.2 Participation. Except as otherwise specified in this Attachment, all Contracted Providers under the Agreement will participate in the Medicare Product as "Participating Providers," and will provide to Covered Persons enrolled in the Medicare Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Attachment and the Agreement (including the Provider Manual). Provider acknowledges that all or certain of Health Plan's duties with respect to the Medicare Product may be delegated to a Company, a Payor or their delegates. Neither Health Plan, Company nor any Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels and/or Medicare Product Types, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Medicare Product Type.

2.3 Attachment. This Attachment constitutes the Product Attachment for the Medicare Product.

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicare Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party or a Contracted Provider terminates the participation of the Contracted Provider in the Medicare Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. CMS Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicare Product under a Governmental Contract.

5. State-Mandated Regulatory Requirements. Schedule B to this Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by State law to be included in the Agreement with respect to the Medicare Product.

SCHEDULE A
CMS REGULATORY REQUIREMENTS

This Schedule sets forth required provisions that are applicable to all Medicare Product Types under this Medicare Product Attachment.

1. **DEFINITIONS.** The following terms shall be defined as set forth below as used in this Medicare Product Attachment. Capitalized terms not otherwise defined in this Schedule shall be defined as set forth in the Agreement or elsewhere in the Medicare Product Attachment.

1.1 ***Capitated Financial Alignment Demonstration Program*** means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 ***Clean Claim*** means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 ***CMS*** means Centers for Medicare and Medicaid Services.

1.4 ***CMS Contract*** means the contract between Health Plan or a Payor and CMS, or among Health Plan or a Payor, CMS and the State, that governs the terms of Health Plan's or Payor's participation in a Medicare Plan.

1.5 ***Covered Persons*** means those individuals who are enrolled in a Medicare Plan.

1.6 ***Covered Services*** means those services which are covered under a Medicare Plan.

1.7 ***Downstream Entity*** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.8 ***First Tier Entity*** means any party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.9 ***HHS*** means the United States Department of Health and Human Services.

1.10 ***Medicare Advantage Program*** means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.11 ***Related Entity*** means any entity that is related to Health Plan by common ownership or control and (1) performs some of Health Plan's management functions under contract or delegation; (2) furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Health Plan at a cost of more than $2,500 during a contract period.

1.12 ***State*** means one or more applicable state governmental agencies of the State of Louisiana.

2. **COVERED SERVICES.** Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Medicare Product Attachment.

3. **SUBCONTRACTOR OBLIGATIONS.** To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Medicare Product Attachment.

4. **GOVERNMENT RIGHT TO INSPECT.**

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Medicare Product Attachment or from the date of completion of any audit, whichever is later. *42 C.F.R. § 422.504 (i)(2)(i) and (ii)*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Medicare Product Attachment directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii)*

4.3 Provider further agrees that HHS, the Comptroller General or their designees have the right to audit, evaluate and inspect any books, contracts, medical records, documents, papers, patient care documentation and other records of the Provider, that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under this Medicare Product Attachment, or as the Secretary of HHS may deem necessary to enforce the CMS Contract. Provider shall cooperate with and shall assist and provide such information and documentation to such entities as requested. Provider shall retain, and agrees that this right to inspect, evaluate and audit shall extend for a period of ten (10) years following the termination

date of this Medicare Product Attachment or completion of audit, whichever is later, unless (i) CMS determines that there is a special need to retain a particular record or group of records for a longer period and notifies Payor at least 30 days before the normal disposition date; (ii) there has been a termination, dispute, or allegation of fraud or similar fault by Payor, in which case the retention may be extended to six (6) years from the date of any resulting final resolution of the termination, dispute, fraud, or similar fault; or (iii) CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit at any time. This provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. § 422.504 (e)(2).*

5. **CONFIDENTIALITY AND ENROLLEE RECORD REQUIREMENTS.** Provider shall comply with all confidentiality and enrollee record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (3) maintaining the records and information in an accurate and timely manner; and (4) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §422.504(a)(13) and 422.118*

6. **HOLD HARMLESS.**

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of Payor. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(i)*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Health Plan or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. **COMPLIANCE WITH CMS CONTRACT.** Provider shall perform its obligations under this Medicare Product Attachment in a manner consistent with and in compliance with Health Plan's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §422.504(i)(3)(iii)*

8. **PROMPT PAYMENT.** Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Exhibit 1 to this Medicare Product Attachment. Any Clean Claim, as defined in 42 C.F.R. § 422.500, shall be paid within thirty (30) days of receipt by Health Plan, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, at such address as may be designated by Health Plan. *42 C.F.R. §422.520(b)(1) and (2)*

9. **COMPLIANCE WITH FEDERAL AND STATE LAWS.** Health Plan, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §422.504(i)(4)(v)*

10. **DELEGATION OF DUTIES.** In the event that Health Plan delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Medicare Product Attachment shall be subject to the prior written approval of Health Plan or Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

    10.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement, Statement or Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

    10.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or Payor determine that such parties have not performed satisfactorily.

    10.3 Health Plan or Payor will monitor the performance of the parties on an ongoing basis.

    10.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Health Plan, or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

    10.5 If Health Plan or Payor delegates the selection of providers, contractors, or subcontractors, Health Plan or Payor retains the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. §§ 422.504(i)(4) and (5)*

11. **NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS.** Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

12. **SERVICE AVAILABILITY.** Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

13. **CULTURAL COMPETENCE.** Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

14. **FOLLOW-UP CARE.** Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

15. **ADVANCE DIRECTIVES.** Provider shall comply with Health Plan's and Payor's policies and procedures concerning advance directives. *42 C.F.R. §422.128(b)(1)(ii)(E).*

16. **PROFESSIONALLY RECOGNIZED STANDARDS OF CARE.** Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

17. **CONTINUATION OF BENEFITS.** Provider shall provide Covered Services as provided in the Agreement and this Medicare Product Attachment: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

18. **PHYSICIAN INCENTIVE ARRANGEMENTS.** If Provider is a physician or physician group, neither Payor nor Health Plan shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider agrees that, if Health Plan or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish

itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). Health Plan*42 C.F.R. §422.208.*

19. **INFORMATION DISCLOSURES TO CMS.** Provider shall cooperate with Health Plan and Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

20. **NOTICE OF PROVIDER TERMINATIONS.** Health Plan shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

21. **RISK ADJUSTMENT DATA.** Provider shall provide to Health Plan risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4).* Upon Health Plan's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

22. **COMPLIANCE WITH HEALTH PLAN POLICIES AND PROCEDURES.** Provider shall comply with Health Plan's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Health Plan's request, consult with Health Plan regarding Health Plan's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b).* Provider shall comply with Health Plan's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

23. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION.** In the event Health Plan suspends or terminates this Medicare Product Attachment with respect to Provider or any physicians employed or contracted with Provider, Health Plan shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Health Plan, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

24. **NOTICE OF WITHOUT CAUSE TERMINATION.** Health Plan and Provider must provide at least sixty (60) days written notice to each other before terminating this Medicare Product Attachment without cause. *42 C.F.R. §422.202(d)(4).*

25. **COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS.** Health Plan and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

26. **FEDERAL FUNDS.** Provider acknowledges that payments Provider receives from Health Plan or Payor to pursuant to this Medicare Product Attachment are, in whole or part, from Federal funds. Therefore, Provider and any of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

27. **EXCLUDED PERSONS/PROGRAM INTEGRITY.** Provider warrants to Health Plan and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Health Plan and Payor any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8).* Provider shall promptly notify Health Plan and Payor in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

28. **COMPLIANCE: TRAINING, EDUCATION AND COMMUNICATION.** Provider agrees it, its employees, and Downstream and Related Entities who provide services under this Medicare Product Attachment shall receive general compliance training as well as fraud, waste, and abuse ("FWA") training, and that such training shall occur within ninety (90) days of initial hiring and annually thereafter. Unless otherwise agreed to by Health Plan or Payor in writing, such training shall be the general compliance and FWA training modules located on the CMS Medicare Learning Network ("MLN") at: https://learner.mlnlms.com/Default.aspx.

Health Plan and Payor shall accept the system-generated certificate of completion as evidence of compliance with the training requirement. The FWA training requirement is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment in Parts A or B of the Medicare program or through accreditation as a supplier of DMEPOS. However, compliance with the general training requirement is still required. Provider shall maintain records of Provider's and its employees' training. *42 C.F.R. § 422.503(b)(4)(vi)(C)(3).*

29. **COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS.** Provider shall cooperate and comply with all applicable State, federal Health Plan and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Health Plan and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. **OFFSHORE SUBCONTRACTORS.** In addition to the applicable requirements of Section 10 of this Medicare Product Attachment, Provider shall disclose to Health Plan in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *Health Plan Management System memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. **SCOPE AND CONFLICTS.** Nothing in this Medicare Product Attachment shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Medicare Product Attachment. In the event of any conflict between this Medicare Product Attachment and any provision of the Agreement, the provisions of this Medicare Product Attachment shall govern. In the event that any provision of this Medicare Product Attachment conflicts with the provisions of any statute or regulation applicable to Health Plan, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. **TERMINATION.** This Medicare Product Attachment shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. This Medicare Product Attachment may be further terminated by Health Plan immediately upon written notice to Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid.

SCHEDULE B
STATE-MANDATED REGULATORY REQUIREMENTS

This Schedule sets forth the provisions that are required by State or federal law to be included in the Agreement with respect to all Medicare Product Types under this Medicare Product Attachment. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on this Schedule A, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

LA-1 In the event the Payor fails to pay for Covered Services as set forth in the Coverage Agreement, the Participating Provider agrees that the Covered Person shall not be liable to the Participating Provider for any sums owed by the Payor. (LA. REV. STAT. § 22:263(A)(1))

LA-2 Each Participating Provider acknowledges that the Agreement (including the Provider Manual) sets forth the methodology by which payment will be made and the procedure for processing and resolving grievances as required under LA. REV. STAT. § 22:267, as may be amended including the location and telephone number where grievances may be submitted. (LA. REV. STAT. §§ 22:263(A)(2); 22:263(A)(3))

EIGHTH AMENDMENT TO
PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

THIS EIGHTH AMENDMENT TO THE PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT ("*Amendment*") is made and entered into this 1st day of January, 2018, by and between Envolve Pharmacy Solutions, Inc., a Delaware corporation (hereinafter referred to as "*Envolve*") and Louisiana Healthcare Connections, Inc. (hereinafter referred to as "*HMO*"), collectively referred to herein as the "Parties".

WHEREAS, the parties hereto, are parties to a Pharmacy Benefit Management Services Agreement effective November 1, 2012 (the "*Agreement*");

WHEREAS, Manager and HMO desire to amend certain terms of the Agreement;

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree to the following: effective as of January 1, 2018 ("*Effective Date*"):

1. The following sections are hereby added to Attachment B, Schedule A, CMS Regulatory Requirements, as follows:

33. Part D. If Manager provides pharmacy benefit services, the following provisions shall apply.

33.1 Prompt Payment by Part D Sponsors. Subcontractor shall issue, mail, or otherwise transmit payment with respect to all clean claims, as defined in paragraph (b) of this section, submitted by network pharmacies (other than mail-order and long-term care pharmacies) within

a. 14 days after the date on which the claim is received, as defined in paragraph (a)(2)(i) of this section, for an electronic claim; or

b. 30 days after the date on which the claim is received, as defined in paragraph (a)(2)(ii) of this section, for any other claim.

33.2 Access to Covered Part D Drugs. Subcontractor shall comply with the following requirements:

a. Use of standardized technology. Subcontractor shall issue and reissue, as necessary, a card or other type of technology that its Covered Persons may use to access negotiated prices for covered Part D drugs as provided under § 423.104(g). The card or other technology must comply with standards CMS establishes.

b. Subcontractor shall require its network pharmacies to submit claims unless the Covered Person expressly requests that a particular claim not be submitted to the Part D sponsor or its intermediary.

33.3 Disclosing Drug Pricing. Subcontractor shall (i) update any prescription drug pricing standard (as defined in §423.501) based on the cost of the drug used for reimbursement of network pharmacies by January 1 of each contract year and not less frequently than once every 7 days thereafter;(ii) Indicate the source used

for making any such updates; and (iii) Disclose all individual drug prices to be updated to the applicable pharmacies in advance of their use for reimbursement of claims, if the source for any prescription drug pricing standard is not publicly available.

33.4 Validation of Part D Reporting Requirements. Subcontractor shall comply with the following reporting requirements:

a. Required information. Subcontractor shall have an effective procedure to develop, compile, evaluate, and report to Health Plan, to Covered Persons, and to the general public, at the times and in the manner that CMS requires, statistics indicating the following:

i. The cost of its operations.

ii. The patterns of utilization of its services.

iii. The availability, accessibility, and acceptability of its services.

iv. Information demonstrating that the Part D plan sponsor has a fiscally sound operation.

v. Other matters that CMS may require.

b. Reporting requirements. Subcontractor must provide to Health Plan and Health Plan must provide to CMS, in a manner specified by CMS, the following:

i. The total number of prescriptions that were dispensed.

ii. The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies.

iii. The percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by Health Plan.

iv. The aggregate amount and type of rebates, discounts, or price concessions (excluding bona fide service fees as defined in §423.501) that the Subcontractor negotiates that are attributable to patient utilization under the plan.

v. The aggregate amount of the rebates, discounts, or price concessions that are passed through to the Health Plan, and the total number of prescriptions that were dispensed.

vi. The aggregate amount of the difference between the amount the Health Plan pays Subcontractor and the amount that the Subcontractor pays retail pharmacies, and mail order pharmacies.

c. Confidentiality of Subcontractor Data. Information disclosed by Subcontractor is confidential and must not be disclosed by Health Plan, except that the Secretary may disclose the information in a form which

does not disclose the identity of Subcontractor or Health Plan, or prices charged for drugs, for the following purposes:

i. As the Secretary determines necessary to carry out section 1150A of the Act or Part D of Title XVIII.
ii. To permit the Comptroller General to review the information provided.
iii. To permit the Director of the Congressional Budget Office to review the information provided.

2. Capitalized terms used in this Amendment and not otherwise defined herein shall have the same meaning as in the Agreement. All other terms and conditions of the Agreement not inconsistent with this Amendment shall remain in effect.

3. The parties further agree that any entity defined in the Agreement as an "Plan" shall be authorized to submit copies of the Agreement and any amendments thereto to any regulatory agency for the purpose of obtaining necessary regulatory approvals or conducting other business of a regulatory nature.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment as of the date first above written.

Envolve Pharmacy Solutions, Inc.

Authorized Signature

Stephen Jensen
Printed Name

CFO
Title

Signature Date: 2/14/17
Effective Date of Amendment: 1/1/2018

Louisiana Healthcare Connections, Inc.

Authorized Signature

James E. Schlotthman
Printed Name

CEO + Plan President
Title

Signature Date: 2/10/17

AMENDMENT NINE

PHARMACY BENEFIT MANAGEMENT SERVICES AGREEMENT

THIS AMENDMENT NINE (the "Amendment"), to the Pharmacy Benefit Management Services Agreement is made and entered into on April 1, 2018, (the "Effective Date"), by and between Envolve Pharmacy Solutions, Inc., a corporation organized and existing under the laws of the State of Delaware, ("Envolve") and Louisiana Healthcare Connections, Inc. ("HMO"), collectively referred to herein as the "Parties".

WHEREAS, Envolve and HMO have previously entered into the Agreement with an effective date of November 1, 2012; and

WHEREAS, the Parties wish to amend the Agreement as set forth herein.

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree to amend the Agreement as follows:

1. **Section 1., Definitions**, shall be amended with the addition of the following:

   1.16 **"CMS Rebates"** will mean those manufacturer rebates collected as part of the Medicaid Drug Rebate Program pursuant to Section 1927 of the Social Security Act.

   1.17 **"Compound Drug"** will mean a mixture of two or more ingredients when at least one of the ingredients in the preparation is a FDA approved federal legend drug or state restricted drug in a therapeutic amount, and which is not otherwise generally available in its compound form. It excludes the addition of only water or flavoring to any preparation. Further, "Compound Drug" shall not include a compound preparation administered by infusion.

   1.18 **"Rebate Processor"** will mean the third-party Rebate Processor contracted with Envolve to manage Envolve's prescription drug formulary and collect Rebates from pharmaceutical manufacturers for claims submitted by Envolve and/or the Claims Adjudication Subcontractor.

   1.19 **"Specialty Drugs"** will mean medications as defined by Benefit Plan that are generally high cost and designed to treat rare or complex conditions that require special dispensing, handling, patient education/counseling and/or restricted distribution channels and cost in excess of $600 for a thirty (30) day supply. Envolve's current Specialty Drug list is attached hereto as Exhibit A-1.

   1.20 **"Specialty Pharmacy (ies)"** will mean a pharmacy or group of pharmacies that has/have agreed to provide Covered Pharmacy Services to Covered Persons for Specialty Drugs under an agreement with Envolve or HMO.

   1.21 **"Supplemental Rebates"** will mean all manufacturer rebates that are not CMS Rebates and that are collected by Envolve or by the Rebate Processor in its capacity as a group purchasing organization for Envolve's plan sponsor clients, on behalf

of HMO, from various pharmaceutical manufacturers that are directly attributable to the utilization of certain pharmaceuticals by Covered Persons.

1.22 **"Usual and Customary Charge" or "U&C"** will mean the amount a regular cash paying customer without insurance pays a Network Pharmacy (including any applicable discounts) for a pharmaceutical good or service at the Network Pharmacy location on that date, which shall be submitted by the Network Pharmacy to Envolve and/or Claims Adjudication Subcontractor with the Claim. Envolve and/or Claims Adjudication Subcontractor shall require Network Pharmacies to submit their Usual and Customary Charge with all Claim submissions.

1.23 **"U&C Claim"** will mean a Claim where the Ingredient Cost Charge plus the Dispensing Fee is greater than or equal to: (i) the Usual and Customary Charge; and/or (ii) the Ingredient Cost Submitted plus the Dispensing Fee Submitted.

2. **Section 2.8, Rebates and Formulary Management**, shall be deleted and replaced in its entirety, as follows:

2.8 Rebates and Formulary Management

2.8.1 CMS Rebates. Envolve and HMO acknowledge and agree that, under HMO's State Contracts, the Louisiana Department of Health or its designee will negotiate agreements for CMS Rebates with drug companies and collect CMS Rebates for the State for the Louisiana Medicaid Program. Neither Envolve nor HMO is authorized to negotiate CMS Rebates with drug companies for Benefit Plan Claims.

Envolve and HMO shall implement processes to timely support the Louisiana Department of Health's Medicaid CMS Rebate dispute resolution process, including the following:

A. Envolve shall allow the Louisiana Department of Health or its designee to contact Network Pharmacies to verify information submitted on claims, and will, upon the Louisiana Department of Health's request, assist with this process;

B. Envolve and HMO shall establish a single point of contact where the Louisiana Department of Health's designee can send information on claims needing correction; and

C. When the Louisiana Department of Health notifies HMO of claims submitted with incorrect information, HMO, in collaboration with Envolve, will correct this information on the next scheduled pharmacy encounter data transmission.

2.8.2 Supplemental Rebates. Envolve will provide Supplemental Rebate services directly or through a third-party formulary manager and rebate processor (the **"Rebate Processor"**) contracted by Envolve to collect rebates from pharmaceutical manufacturers for claims submitted by Envolve and provide other formulary management services (the **"Rebate Services Agreement"**). HMO authorizes Envolve to: (i) act as, or engage the Rebate Processor as, the exclusive agent for negotiating and arranging for Supplemental Rebates on the purchase of prescription drugs from pharmaceutical manufacturers and related services; and (ii) authorizes Envolve and/or the Rebate Processor to contract with pharmaceutical companies for Supplemental Rebates as a group purchasing organization for Envolve's HMOs, including HMO. Nothing in this Agreement or otherwise shall be deemed to confer upon either Envolve or the Rebate Processor: (a) the status of fiduciary as defined in ERISA or any applicable state law with respect to HMO or any Benefit Plan; (b) any responsibility for the terms or validity of the Benefit Plan; or (c) discretionary authority or responsibility with respect to any Benefit Plan or its administration. Envolve and/or the Rebate Processor shall have no liability to HMO or any Benefit Plan or Covered Person as a result of any plan design issue.

A. The Supplemental Rebates formulary identifies those preferred products that are covered by HMO for dispensing to Covered Persons as identified in the Benefit Enrollment Form.

B. HMO shall make its current Supplemental Rebates formulary accessible to Benefit Plans, Covered Persons, pharmacies and physicians, on HMO's website, and print and distribute copies of the Supplemental Rebates formulary as requested by Envolve.

C. HMO acknowledges and agrees that Envolve and/or the Rebate Processor shall be the exclusive agent for negotiating and arranging for Supplemental Rebates from pharmaceutical manufacturers under this Agreement. During the term of this Agreement, and any renewals hereof, HMO will not directly or indirectly contract or agree with any pharmaceutical manufacturer for the purpose of obtaining Supplemental Rebates related to the drug utilization of Covered Persons, including the use of over-the-counter drugs. HMO shall, without claim against Envolve or the Rebate Processor, cancel any existing agreements, arrangements, and/or contracts with any pharmaceutical manufacturer related to such Supplemental Rebates as of the Effective Date. HMO acknowledges that any failure to comply with this Section may result in a partial or complete loss of Supplemental Rebates under this Agreement, and that any such loss shall be in addition to any other rights or remedies available to Envolve for such breach.

D. Subject to the terms and conditions of this Agreement, Envolve shall remit Supplemental Rebates to HMO as set forth in **Exhibit A** of this Agreement.

Envolve's payment of such Supplemental Rebate amounts to HMO in accordance with the terms of this Agreement will constitute payment in full of Envolve's obligation to HMO for Supplemental Rebates. HMO acknowledges and agrees that it shall have no right to interest on, or the time value of, any rebates received by the Rebate Processor or by Envolve or monies payable under this Agreement. Envolve and/or the Rebate Processor may have financial relationships with pharmaceutical companies and may receive and retain administrative fees from pharmaceutical companies for services rendered and property provided to pharmaceutical companies, limited to, administrative fees that range between one percent (1%) and four percent (4%) of the Wholesale Acquisition Cost ("WAC") of the products dispensed across the Rebate Processor's book of business. The Rebate Processor and Envolve also own and operate dispensing pharmacies that may receive concurrent or retrospective discounts from pharmaceutical manufacturers attributable to or based on products purchased by such affiliated dispensing pharmacies. The term rebates as used in this Agreement does not include these fees or discounts, which belong exclusively to the Rebate Processor or to Envolve, as applicable. Nothing in this Agreement shall preclude Envolve and/or the Rebate Processor from pursuing other, independent sources of revenue from pharmaceutical manufacturers, and engaging in other revenue-producing relationships with pharmaceutical manufacturers provided such revenue is unrelated to drug utilization of a Covered Person. In the event that Envolve enters into a new or amended Rebate Services Agreement, or begins to provide similar services directly through its own contracts with pharmaceutical manufacturers, the compensation to be paid to the Rebate Processor for its services, or to Envolve for similar services, may change. Envolve shall provide prior written notice to HMO of any such changes.

E. HMO waives, releases and forever discharges Envolve and the Rebate Processor from any claims, liabilities, demands, losses, damages, costs or expenses of any kind, including without limitation, reasonable attorneys' fees and disbursements, arising directly from a pharmaceutical company's: (i) failure to pay Supplemental Rebates; (ii) breach of an agreement related to Supplemental Rebates; or (iii) negligence. Envolve and the Rebate Processor waives, releases and forever discharges HMO from any claims, liabilities, demands, losses, damages, costs or expenses of any kind, including without limitation, reasonable attorneys' fees and disbursements, arising directly from Envolve's: (i) breach of this Agreement related to Supplemental Rebates; or (iii) negligence. HMO acknowledges and agrees that whether and to what extent pharmaceutical companies are willing to provide Supplemental Rebates may depend upon a variety of factors, including the content of the Formulary, plan design features, meeting specified criteria for rebates, and

the extent of participation in formulary management programs, as well as Envolve and/or the Rebate Processor receiving sufficient information regarding each claim that is submitted to pharmaceutical companies for rebates. HMO acknowledges and agrees that Envolve and/or the Rebate Processor may, but shall not be required to, initiate collection action to collect Supplemental Rebates from a pharmaceutical company. In the event that Envolve and/or the Rebate Processor does initiate action against a pharmaceutical company to collect Supplemental Rebates, Envolve and/or the Rebate Processor may allocate any reasonable and actual costs, including reasonable attorneys' fees and expenses, arising from any such action amongst all of the Rebate Processor's business subject to such collection action on a pro rata basis and offset the amounts allocated to the eligible plans, including HMO, against the Supplemental Rebates actually collected by the Rebate Processor as a result of such collection action and otherwise payable to the eligible plans, including HMO.

F. Envolve hereby notifies HMO that to the extent HMO contracts with Medicare, Medicaid, or any other Federal healthcare program as defined in Section 1128B (f) of the Social Security Act, 42 U.S.C. § 1320a-7b (f) (or any successor thereto), HMO may be obligated to fully and accurately report the rebates and discounts in costs claimed or charges made to such government programs. Envolve shall cooperate with HMO to determine and provide all information concerning the Supplemental Rebates that is necessary for HMO to comply with any applicable government program reporting requirements, including, with respect to Medicare Subsidized Benefit Plans, 42 C.F.R. 423, Subpart R.

G. If HMO has been paid Supplemental Rebates with respect to claims that pertain to pharmaceuticals of a particular manufacturer, and if for any reason (including without limitation, manufacturer takebacks, manufacturer shortpays, duplicate claims, audit, reconciliation or otherwise) Envolve is required to repay all or a part of any Supplemental Rebate it has received with respect to such claims, HMO, upon demand of Envolve, will promptly repay to Envolve (i) the Supplemental Rebate amount HMO was paid with respect to such claims or (ii) in the case of a partial repayment by Envolve, a pro rata portion of such Supplemental Rebate, as determined by Envolve in its reasonable discretion, based on the portion of the billed Supplemental Rebates that Envolve is required to repay, whichever is applicable. Envolve may offset any amount owed to it under this paragraph against amounts owed to HMO under this Agreement.

H. HMO shall: (i) obtain from Covered Persons all consents and/or authorizations required, if any, for Envolve and/or the Rebate Processor to perform its services or activities including the use and disclosure of Protected

Health Information; and (ii) disclose to Covered Persons any and all matters relating to the plan design that are required by law to be disclosed, including information relating to the calculations of co-payments, coinsurance amounts, deductibles or any other amounts that are payable by a Covered Person in connection with the plan design, and any other disclosures required by applicable law or reasonably requested by Envolve or the Rebate Processor. HMO authorizes Envolve to provide the Rebate Processor with all information about Covered Persons as may be reasonably necessary for the Rebate Processor to perform its Supplemental Rebate processing services under the Rebate Services Agreement. In compliance with applicable law, including HIPAA, the Rebate Processor may share Covered Person information as appropriate for the treatment, payment, and health care operations of other health care providers (which may or may not be affiliated with the Rebate Processor) or Benefit Plans. Claims data, as well as eligibility information that is de-identified in accordance with HIPAA and other applicable law, and which is not identifiable on a Plan, Benefit Plan, or Covered Person basis, may be used, disclosed, reproduced, or adapted by Envolve and/or the Rebate Processor. Envolve and/or the Rebate Processor may also provide such de-identified data to nationally recognized data integration firms to support appropriate administration of the drug management programs. This benchmarking data enables Envolve and/or the Rebate Processor to compare against other drug population sets and improve programs and services.

I. Under the terms of their agreements with the Rebate Processor and/or Envolve, pharmaceutical manufacturers may from time to time modify the definition of what constitutes an "eligible plan" for the purpose of receiving Supplemental Rebates. In the event that Benefit Plan ceases to satisfy a pharmaceutical manufacturer's definition of an eligible plan for whatever reason, Benefit Plan will cease to be eligible for Supplemental Rebates from that manufacturer as of the date Benefit Plan ceased to satisfy such definition, and Envolve shall have the right to equitably adjust the pricing terms of this Agreement.

J. Under the Rebate Services Agreement, the following events may trigger a good faith renegotiation of the Supplemental Rebates to be paid under the Rebate Services Agreement: (i) the enactment or amendment of state or federal laws or regulations resulting in an adverse impact on the Supplemental Rebate benefits, rights or obligations under the Rebate Services agreement; (ii) a decrease in participation in the Supplemental Rebate program by pharmaceutical manufacturers; (iii) the unexpected introduction of a generic version of a branded product; (iv) the recall or withdrawal of a branded product from the market prior to patent expiration; (v) the occurrence of any

government imposed or industry wide change that impedes the ability to provide its services (including any prohibition or restriction on Envolve and/or the Rebate Processor to collect Supplemental Rebates under its contracts with pharmaceutical companies); (v) a change in plan design parameters that results in a material reduction in Supplemental Rebates; (vi) a decrease in the current level of alignment with the Envolve Formulary; (vii) the average days' supply being something other than 30 days for retail and 90 days for mail order; (viii) a failure to participate in formulary management programs; and (ix) a material change in the performance of HMO's Benefit Plan(s) that results in a material reduction in Supplemental Rebates. HMO acknowledges and agrees that in the event of such a renegotiation of Supplemental Rebates between Envolve and the Rebate Processor, Envolve may equitably adjust the Supplemental Rebate amounts to be paid to HMO under this Agreement. In any renegotiation, Envolve will make best efforts to maintain the Supplemental Rebate amounts that are economically equivalent to current levels.

K. HMO acknowledges and agrees that the termination of the Rebate Services Agreement could eliminate Envolve's ability to provide Supplemental Rebates services under this Agreement. In the event of the termination of the Rebate Services Agreement, Envolve will use good faith efforts to enter into a similar agreement with another Rebate Processor; provided, however, that if Envolve is unable to do so, then all obligations of Envolve for Supplemental Rebate services under this Agreement will cease or be suspended until Envolve is able to enter into a new agreement for such services.

L. In the case of the expiration or termination of this Agreement, according to its terms, or the expiration or termination of the Rebate Services Agreement, any Supplemental Rebate amounts owed by Envolve to HMO for the period ending on the date of such expiration or termination will remain due and payable to HMO and will be paid to HMO according to the terms of this Agreement to the extent received by Envolve from the Rebate Processor and/or Pharmaceutical Manufacturers. During the quarter prior to the expiration or termination of the Agreement, Envolve may delay the remittance of Supplemental Rebates already received by Envolve to HMO to allow for final adjustments under this Agreement. Upon termination of the Rebate Services Agreement, the Rebate Processor may delay the remittance of: (i) up to twenty percent (20%) of Supplemental Rebates for a period of up to six (6) months to allow for final adjustments; and (ii) additional rebates to the extent such Supplemental Rebates are subject to an ongoing audit or negotiations relating to an audit by a pharmaceutical manufacturer.

M. If the Rebate Services Agreement is terminated or otherwise suspended through action outside the control of Envolve and the Rebate Processor, such

as governmental action, all obligations of Envolve for Supplemental Rebate services under this Agreement will cease, or be suspended, as of the date of the outside action, and thereafter such obligations will either terminate or continue in accordance with the terms of the Rebate Services Agreement. Any Supplemental Rebate amounts owed by Envolve to HMO for the period ending on the date of the outside action will remain due and payable to HMO and will be paid to HMO according to the terms of this Agreement unless otherwise prohibited by Law.

3. **Section 2.12, Specialty Pharmacy Services**, shall be added in its entirety, as follows.

2.12 Specialty Pharmacy Services

2.12.1 Envolve will provide Covered Pharmacy Services for Specialty Drugs to Covered Persons through Envolve's contracted Specialty Pharmacies. Envolve will dispense through the Specialty Pharmacies new or refill prescription orders for Specialty Drugs, consistent with the terms of this Agreement, the Description of Coverage, and applicable Law, upon receipt from a Covered Person of (i) a valid prescription order or a completed refill order form and (ii) the applicable Co-Payment and/or deductible.

2.12.2 Envolve will replace Specialty Drugs lost in shipment, but will have no other liability to HMO, Benefit Plan, or Covered Person for any delay in delivery resulting from circumstances beyond Envolve's control. Shipments shown as having been delivered by the delivery service tracking system will not be deemed a lost shipment and such shipments will not require reshipment. Shipment of Specialty Drugs will be to the Covered Person at the address set forth in the eligibility file or as appearing on the face of the prescription so long as such address is in the continental United States, and will be by first class mail or, in the case of controlled substances as defined by the Drug Enforcement Administration, registered mail or express shipper such as UPS. The Specialty Pharmacies will dispense temperature-sensitive Specialty Drugs in appropriate materials and use an appropriate delivery service to ensure the Specialty Drugs maintain the manufacturer-required temperature range until received by the Covered Person. All shipping, freight and other costs associated with the delivery of Specialty Drugs by the Specialty Pharmacy are included in the Specialty Drug Pricing set forth on Exhibit A-1. In the event that a shipment is delayed due to circumstances beyond Envolve's control, Envolve will notify the Covered Person promptly upon discovery of the delay.

2.12.3 The Specialty Pharmacy may dispense Specialty Drugs even if the prescription is not accompanied by the correct Co-Payment and/or deductible. In the event that the Specialty Pharmacy elects to dispense Specialty Drugs without the correct Co-Payment, HMO will be liable to Envolve for such amounts.

2.12.4 The Specialty Pharmacy will dispense only those Specialty Drugs that, in its sole and reasonable discretion, fulfill the requirements of the prescription writer and comply with applicable law. The Specialty Pharmacy will have the right to refuse to

fill or renew a prescription for any Covered Person when the Covered Person has not satisfied his or her payment obligations or, in the pharmacist's professional judgment, the filing or renewing of such prescription is not in the best interest of the Covered Person or the pharmacist has reason to doubt the authenticity of the prescription.

2.12.5 Envolve will use reasonable efforts such that all Covered Pharmacy Services ordered through the Specialty Pharmacy will be shipped to the Covered Person within forty-eight (48) hours after the prescription has been received by the Specialty Pharmacy, provided that the prescription is properly written and that the medication required by the physician's prescription is available. If the Specialty Drug is not available from the Specialty Pharmacy's standard suppliers, it will make every reasonable effort to obtain the Specialty Drug as quickly as possible. The Specialty Pharmacy will contact the Covered Person directly to notify them of such delay.

4. **Exhibit A - Compensation**, shall be deleted and replaced in its entirety, attached hereto.

5. **Exhibit A-1 - Specialty Drug Network Price List** shall be added in its entirety, attached hereto.

6. **Exhibit A-2 - Vaccination Price Schedule** shall be added in its entirety, attached hereto.

Capitalized terms used in this Amendment and not otherwise defined herein shall have the same meaning as in the Agreement. All other terms and conditions of the Agreement not inconsistent with this Amendment shall remain in effect.

Notwithstanding anything to the contrary contained herein, in the event this Amendment is required to be filed with and approved (or alternatively, if applicable, not disapproved) by the Louisiana Department of Insurance and the Louisiana Department of Insurance does not approve (or alternatively, if applicable, does disapprove) this Amendment after such filing, then the provisions of this Amendment will be void and of no force and effect unless and until such time as this Amendment and any modifications hereto are approved (or not disapproved) by the Louisiana Department of Insurance.

Signature page follows.

INTENDING TO BE LEGALLY BOUND, the parties have duly executed this agreement as of the Effective Date. Each party to the Amendment warrants that it has full power and authority to enter into this Amendment, and the person signing this Amendment on behalf of either party warrants that he/she has been duly authorized and empowered to enter into the Amendment.

Envolve Pharmacy Solutions, Inc.

Signature

Stephen Jensen
Print Name

CFO
Office or Title

4/30/18
Date

Louisiana Healthcare Connections, Inc.

Signature

James E. Schlottmann
Print Name

CEO
Office or Title

4/9/18
Date

EXHIBIT A

COMPENSATION

PASS-THROUGH DRUG PRICING

NETWORK	DRUG TYPE	DISCOUNT OFF AWP	DISPENSING FEE	NOTES
RETAIL NETWORK All Days' Supply	Brand Name Drug	17.5%	State Mandated Dispensing fees will be Pass-Through	1,2,3,4,5
	Generic Drug	82.0%	State Mandated Dispensing fees will be Pass-Through	1,2,3,4,5
SPECIALTY NETWORK	Brand Name Drug	See Exhibit A-1, Specialty Drug Network Price List	0.00 per paid Rx	1,2,5,6
	Generic Drug	21.0%	0.00 per paid Rx	1,2,5,6
MAIL ORDER	Brand Name Drug	NA		
	Generic Drug			

PERFORMANCE BONUSES

PERFORMANCE MEASURE	RATE
GENERIC FILL RATE (GFR) EXCEEDS 90%	$0.75 PER CLAIM

REBATES AND SUPPLEMENTAL REBATES

	RATE	NOTES
Rebates and Supplemental Rebates paid to HMO	75.0%	7
Rebates and Supplemental Rebates retained by	25.0%	7

FEES

FEE TYPE	FEE RATE
Administration Fee, PMPM	$2.50
Plastic ID cards – PVC card stock, per ID card	N/A
Manual Claim (UCF), per Manual Claim	0.00
Paper Claim (DMR), per Claim	Included
Coordination of Benefits – Point of Sale	Included
Coordination of Benefits – all other	5% of recovery plus up to 22% of recovery for outside vendor
Prior authorization – administrative, per PA	Included
Prior authorization – clinical review, per PA	Included

Prior authorization – specialty, per PA	Included
Standard reporting	Included
FEE TYPE	**FEE RATE**
Additional State Reports – required by State Agency	Included
Ad hoc reporting	$150/hr.; $500 minimum
Influenza Vaccine	See Exhibit A-2, Vaccination Price Schedule
Medication Therapy Management (MTM)	Direct Pharmacy Consulting Fee, plus 10%
340B Pharmacy Fees	Pharmacy Submitted Ingredient Cost; plus 340B Pharmacy Dispense Fee
Compound Drugs	Processed as multi-ingredient, and will apply the Brand or Generic pricing discounts as applicable; plus Pharmacy Dispense Fee; plus contracted dispense fee of $1.25

PASS-THROUGH PRICING MODEL

1 Discount rates off AWP are based on post-settlement pricing.

2 Claims adjudicate at the lesser of the Brand AWP discount, MAC or U&C. The stated discount rates in this Exhibit are estimates of aggregated rates and are not guaranteed.

3 If the Benefit Plan(s) qualify for the Caremark retail network credit, the credit will be passed through to HMO for all retail claims.

4 Excludes Specialty Drugs.

5 Excludes vaccination pricing. See **Exhibit A-2, Vaccination Price Schedule**.

6 Standard billing rate for specialty claims is at an AWP discount 0.50% less than the contracted specialty drug reimbursement amount with no dispense fee.

REBATES

Envolve will pay HMO 75.0% of Rebate and Supplemental Rebate amounts collected by Envolve or by the Rebate Processor on behalf of HMO during a quarter, within 90 days of the close of such quarter. Envolve's payment of Rebates and Supplemental Rebates to HMO as described in **Section 2.8.2 (D.)** of the Agreement and this **Exhibit A** will constitute payment in full of Envolve's obligation to HMO for Rebates and Supplemental Rebates under this Agreement. Only the Rebate administration fee will be retained by Envolve.

EXHIBIT A-1

SPECIALTY DRUG LIST AND NETWORK PRICE LIST

The price list is as follows:

EXHIBIT A-2

VACCINATION PRICE SCHEDULE

Vaccination	Envolve Pricing
Injectable Seasonal Influenza Vaccine (Trivalent and Quadrivalent)	$ 36.00
Intranasal Seasonal Influenza Vaccine (FluMist) Intradermal Influenza Vaccine (Short Needle)	$ 39.00
Injectable Seasonal Influenza - Vaccine High-Dose (Fluzone)	$ 64.00
Anthrax	AWP - 13.5% + $15.00
Diphtheria, Tetanus	AWP - 13.5% + $15.00
Diphtheria, Tetanus, Pertussis	AWP - 13.5% + $15.00
Diphtheria, Tetanus, Pertussis, Haemophilus B	AWP - 13.5% + $15.00
Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus	AWP - 13.5% + $15.00
Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Haemophilus B	AWP - 13.5% + $15.00
Diphtheria, Tetanus, Pertussis, Inactivated Poliovirus, Hepatitis B	AWP - 13.5% + $15.00
Haemophilus B	AWP - 13.5% + $15.00
Haemophilus B, Hepatitis B	AWP - 13.5% + $15.00
Hepatitis A	AWP - 13.5% + $15.00
Hepatitis A & B	AWP - 13.5% + $15.00
Hepatitis B	AWP - 13.5% + $15.00
Human Papillomavirus	AWP - 13.5% + $15.00
Inactivated Poliovirus	AWP - 13.5% + $15.00
Japanese Encephalitis	AWP - 13.5% + $15.00
Measles, Mumps, Rubella	AWP - 13.5% + $15.00
Measles, Mumps, Rubella, Varicella	AWP - 13.5% + $15.00
Meningococcal	AWP - 13.5% + $15.00
Meningococcal, Haemophilus B, Tetanus	AWP - 13.5% + $15.00
Pneumonia	AWP - 13.5% + $15.00
Rabies	AWP - 13.5% + $15.00
Rotavirus	AWP - 13.5% + $15.00
Tetanus	AWP - 13.5% + $15.00
Tetanus, Diphtheria Toxoids	AWP - 13.5% + $15.00
Tetanus, Diphtheria, Pertussis	AWP - 13.5% + $15.00
Typhoid (Injection only)	AWP - 13.5% + $15.00
Varicella	AWP - 13.5% + $15.00
Yellow Fever	AWP - 13.5% + $15.00
Zoster (Zostavax)	AWP - 13.5% + $20.50

- The program is effective from August through April for influenza vaccinations and is open ended for non-seasonal component pricing vaccines. Seasonal vaccines can only be administered once the vaccine has been released to the marketplace by the manufacturer.
- A current list of retail pharmacies participating in the Broad Vaccination Network is available from your account team upon request.
- This Broad Vaccination Network applies to all of client's covered members unless otherwise instructed by client.
- Participating retail pharmacies may decline to provide vaccinations to minors based on state law or clinical considerations.
- Provision of vaccinations is subject to the participating retail pharmacies' receipt of an adequate supply of vaccine. **Not all participating retail pharmacies will stock all available vaccines. Plan members should call the pharmacy to confirm availability.**
- Vaccines intended for the treatment of avian flu are not covered items under this network.
- HMO will be invoiced for vaccinations on its standard PBM services invoice.
- Except for payment obligations, this Enrollment Form shall terminate annually as of April 30th with respect to seasonal vaccines.

ATTACHMENT 2.10.2.3
Appendix F
Envolve Vision, Inc.

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health, one person at a time.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Louisiana Healthcare Connections, Inc. (LHCC)
Material subcontractor name:
Envolve Vision, Inc.
Description of the Proposer's role and material subcontractor's role:
Proposer's role: LHCC is responsible for evaluating the material subcontractor's ability to perform all activities to be subcontracted, and will request prior approval from LDH for all amendments and substitutions. Any additional information requested by LDH will be provided by LHCC. LHCC will monitor the material subcontractor's performance on an ongoing basis and perform a formal review annually. LHCC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. **Subcontractor's Role:** Envolve Vision will provide vision benefit management on behalf of LHCC including provider recruitment, credentialing, contracting; provider services and training; vision claims processing; first level review of claims disputes, and provider complaints.
Explanation of why the Proposer plans to subcontract this service and/or function:
Our goal is to avoid interfering with the provider-patient interaction while simultaneously lowering eye care spending and improving outcomes. Envolve Vision supports full-scope-of-licensure practice patterns, collects and advances vision HEDIS measures, encourages eye care providers to act as effective primary care stewards into the overall health care system, develops software solutions to increase efficiency of eye care administration, eliminates waste and fraud via data mining, employs evidence based medicine claim edits and peer-to-peer interventions, and promotes business methods to eliminate unnecessary eyewear markups for our clients and covered enrollees.
A description of the material subcontractor's organizational experience:
Envolve Vision has been providing capitated vision administration services for more than 30 years and currently administers vision benefits for contracting parties in 22 states and Puerto Rico. Envolve Vision has a nationally contracted provider panel with over 23,000 providers at 20,000 locations and administers routine and medical eye care benefits for approximately 10.2 million lives across the country. In North Carolina, Envolve Vision currently has a panel of over 700 providers at 600 locations. Envolve Vision serves a variety of clients, including Medicaid, Medicare and Commercial Health Plans; however, Envolve Vision's business is primarily governmental. Envolve Vision is NCQA Certified in Utilization Management and Credentialing, SSAE 16 certified, and fully HIPAA compliant.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
LHCC monitors subcontractors through compliance and financial reporting, review of financial data, communications from our member and provider communities, and through Vendor Oversight Committee monthly and quarterly meetings. A review of activities and information from data sources may trigger the need for additional financial monitoring. LHCC's Compliance Management System supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities. Any Contract compliance issue identified with a subcontractor is tracked within the Compliance Management System along with progress on any identified issues.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Amendment 6, Attachment B-1, Page 3, Section 3
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).	Envolve Vision Agreement, Page 21
3	Specify the effective dates of the subcontract agreement.	Envolve Vision Agreement, Page 1
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Amendment 6, Attachment B-1, Page 3, Section 4
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	Amendment 6, Attachment B-1, Page 3, Section 5
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Amendment 6, Attachment B-1, Page 3, Section 6
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	Amendment 6, Attachment B-1, Page 3, Section 7
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Amendment 6, Attachment B-1, Page 3, Section 8
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Amendment 6, Attachment B-1, Page 3, Section 9
10	Identify the population covered by the subcontract.	Envolve Vision Agreement, Exhibit 1, Page 33
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.	Amendment 6, Attachment B-1, Page 3, Section 10
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Amendment 6, Attachment B-1, Page 3, Section 11

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.	Envolve Vision Agreement, Exhibit 1, Page 33
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Amendment 6, Attachment B-1, Page 3, Section 12
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.	Amendment 6, Attachment B-1, Page 3, Section 13
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.	Amendment 6, Attachment B-1, Page 4, Section 14
17	Include record retention requirements as specified in the contract between DHH and the MCO.	Amendment 6, Attachment B-1, Page 4, Section 15
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Amendment 6, Attachment B-1, Page 4, Section 16
19	INTENTIONALLY LEFT BLANK	
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.	Amendment 6, Attachment B-1, Page 4, Section 18
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.	Amendment 6, Attachment B-1, Page 4, Section 19
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.	Amendment 6, Attachment B-1, Page 4, Section 20

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Amendment 6, Attachment B-1, Page 4-5, Section 21
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.	Amendment 6, Attachment B-1, Page 5, Section 22
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.	Amendment 6, Attachment B-1, Page 5, Section 23
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Amendment 7, Exhibit 2, Page 5
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.	Amendment 6, Attachment B-1, Page 5, Section 24
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.	Amendment 6, Attachment B-1, Page 5, Section 24
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.	Amendment 6, Attachment B-1, Page 5, Section 25
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Amendment 7, Attachment B-1, Page 10, Section 26
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	Amendment 7, Attachment B-1, Page 10, Section 27
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Amendment 7, Attachment B-1, Page 10, Section 28

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.	Amendment 7, Attachment B-1, Page 10, Section 29
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Amendment 7, Attachment B-1, Page 10, Section 30
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Amendment 7, Attachment B-1, Page 10, Section 31
36	Include a conflict of interest clause as stated in the contract between DHH and the MCO.	Amendment 7, Attachment B-1, Page 7, Section 2
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Amendment 7, Attachment B-1, Page 10, Section 32
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Amendment 7, Attachment B-1, Page 11, Section 33
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Amendment 7, Attachment B-1, Page 11, Section 34
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Amendment 7, Attachment B-1, Page 11, Section 35
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Amendment 7, Attachment B-1, Page 11, Section 36
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Amendment 7, Attachment B-1, Page 11, Section 37

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Amendment 7, Attachment B-1, Page 11, Section 38
44	Contains the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Amendment 10, Pages 1-2, Section 39

ATTACHMENT 2.10.2.3
Appendix F
LogistiCare Solutions, LLC

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health, one person at a time.

Appendix F: Material Subcontractor Response Template

Proposer (MCO) name:
Louisiana Healthcare Connections, Inc. (LHCC)
Material subcontractor name:
LogistiCare, Inc.
Description of the Proposer's role and material subcontractor's role:
Proposer's Role: LHCC is responsible for evaluating the material subcontractor's ability to perform all activities to be subcontracted, and will request prior approval from LDH for all amendments and substitutions. Any additional information requested by LDH will be provided by LHCC. LHCC will monitor the material subcontractor's performance on an ongoing basis and perform a formal review annually. LHCC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Contract. **Subcontractor's Role:** LogistiCare provides LHCC members with non-emergency medical transportation (NEMT) services and related administrative functions (such as call center operations, provider network access and management, and claims management).
Explanation of why the Proposer plans to subcontract this service and/or function:
Through partnerships with different types of local transportation providers, LogistiCare offers a robust transportation network capable of serving members 24/7/365, regardless of their location or level of service needs. LogistiCare's network includes commercial transportation providers (wheelchair, stretcher, and BLS-basic life support/ALS-advanced life support equipped vehicles), Independent Volunteer Drivers (used often in rural areas), public transit, ride-share (Lyft), and mileage reimbursement. Partnering with LogistiCare enables LHCC to ensure members with physical, medical, and cognitive conditions have access to NEMT services.
A description of the material subcontractor's organizational experience:
LogistiCare was founded in 1986 as a logistics software solution developer offering data technology to the ambulance industry. Seeing the challenges their clients faced in managing transportation operations, they entered into the transportation consulting business. In the mid-1990s, LogistiCare switched focus to non-emergency medical transportation (NEMT) as the sole line of business. Their first clients included HMOs in Connecticut where they implemented the first statewide Medicaid NEMT network management system and the State of Georgia where they created a statewide NEMT brokerage system that cut the expense for Medicaid transportation services by 35 percent while increasing participant access by 300 percent. Today, LogistiCare manages over 230 NEMT programs in 43 states and the District of Columbia. They manage more than 65 million trips annually for approximately 24 million members and efficiently respond to more than 26 million calls a year through their URAC-accredited operations centers.

The processes the Proposer will implement to monitor and evaluate the performance of the material subcontractor to ensure that all contract requirements are met and to determine the return on investment:
LHCC monitors subcontractors through compliance and financial reporting, review of financial data, communications from our member and provider communities, and through Vendor Oversight Committee monthly and quarterly meetings. A review of activities and information from data sources may trigger the need for additional financial monitoring. LHCC's Compliance Management System supports our contractual and regulatory oversight capabilities, manages our compliance with Contract requirements, and tracks all compliance activities. Any Contract compliance issue identified with a subcontractor is tracked within the Compliance Management System along with progress on any identified issues.

Instructions: The Proposer should attach the executed or draft contract and indicate compliance with each of the following checklist items by completing the "Location" column.

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
1	Contain language that the subcontractor shall adhere to all requirements set forth for MCO subcontractors in the contract between DHH and the MCO and the department issued guides and either physically incorporating these documents as appendices to the subcontract or include language in the subcontract that the MCO shall furnish these documents to the subcontractor upon request.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.39, page 115
2	Include a signature page that contains a MCO and subcontractor name with titles that are typed or legibly written, subcontractor company name, and dated signature of all appropriate parties (applicable for renewals as well).	LogistiCare Agreement, Page 2
3	Specify the effective dates of the subcontract agreement.	LogistiCare Agreement, Page 1, 1st paragraph
4	Specify that the subcontract and its appendices contain all the terms and conditions agreed upon by the both parties.	Logisticare Agreement, Page 1, 4th paragraph; Page 12, Section 10.9; Page 1 of Amendment 4, 4th paragraph
5	Require that no modification or change of any provision of the subcontract shall be made unless such modification is incorporated and attached as a written amendment to the subcontract and signed by the parties.	LogistiCare Agreement, Section 10.8, Page 12
6	Specify procedures and criteria for any alterations, variations, modifications, waivers, extensions of the subcontract termination date, or early termination of the subcontract and that such change shall only be valid when reduced to writing, duly signed and attached to the original of the subcontract.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.1, page 109
7	Specify that the MCO and subcontractor recognize that in the event of termination of the contract between the MCO and DHH for any of the reasons described in the contract, the MCO shall immediately make available to DHH or its designated representative, in a usable form, any and all records, whether medical or financial, related to the MCO's and subcontractor's activities undertaken pursuant to the subcontract agreement. The provision of such records shall be at no expense to DHH.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.21, page 112

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
8	Ensure the subcontractor shall not, without prior approval of the MCO, enter into any subcontract or other agreement for any of the work contemplated under the subcontract without approval of the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 5.1, page 116
9	Require that if any requirement in the subcontract is determined by DHH to conflict with the contract between DHH and the MCO, such requirement shall be null and void and all other provisions shall remain in full force and effect.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 5.6, page 117
10	Identify the population covered by the subcontract.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 1.1, page 106
11	Specify that the services provided under the subcontract must be in accordance with the Louisiana Medicaid State Plan and require that the subcontractor provide these services to members through the last day that the subcontract is in effect.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.2, page 109
12	Require that the subcontractor be currently licensed and/or certified under applicable state and federal statutes and regulations and shall maintain throughout the term of the subcontract all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated by the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.4, page 109
13	Specify the amount, duration and scope of benefits and services that are provided by the subcontractor.	Exhibit 2 to Transportation Vendor Agreement Compensation Schedule, Page 27; Amendment 2 to Transportation Vendor Agreement replaces Exhibit 2

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
14	Provide that emergency services be coordinated without the requirement of prior authorization of any kind.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.5, page 109
15	Require that if the subcontractor performs laboratory services, the subcontractor must meet all applicable state requirements and 42 CFR §§ 493.1 and 493.3, and any other federal requirements.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.6, page 109
16	Require that an adequate record system be maintained for recording services, charges, dates and all other commonly required information elements for services rendered to MCO members pursuant to the subcontract (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under the contract between DHH and the MCO). MCO members and their representatives shall be given access to and can request copies of the members' medical records, to the extent and in the manner provided by LRS 40:1299.96 and 45 CFR 164.524 as amended and subject to reasonable charges.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.35.1, page 114
17	Include record retention requirements as specified in the contract between DHH and the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.37, page 115
18	Shall make all program and financial records and service delivery sites open to the representative or any designees of the above. HHS, DHH, GAO, the State Auditor's Office, the Office of the Attorney General, and/or the designees of any of the above shall have timely and reasonable access and the right to examine and make copies, excerpts or transcripts from all books, documents, papers, and records which are directly pertinent to a specific program for the purpose of making audits, examinations, excerpts and transcriptions, contact and conduct private interviews with MCO clients, employees, and contractors, and do on-site reviews of all matters relating to service delivery as specified by the Contract. The rights of access in this subsection are not limited to the required retention period, but shall last as long as records are retained. The MCO shall provide originals and/or copies (at no charge) of all records and information requested. Requests for information shall be compiled in the form and the language requested.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.36, page 115
19	INTENTIONALLY LEFT BLANK	

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
20	Whether announced or unannounced, provide for the participation and cooperation in any internal and external quality assessment review, utilization management, and grievance procedures established by the MCO and/or DHH or its designee.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.8, page 110
21	Specify that the subcontractor shall monitor and report the quality of services delivered under the subcontract and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the MCO /subcontractor practices and/or the standards established by DHH or its designee.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.9, page 110
22	Require that the subcontractor comply with any corrective action plan initiated by the MCO and/or required by DHH.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.10, page 110
23	Specify any monetary penalties, sanctions or reductions in payment that the MCO may assess on the subcontractor for specific failures to comply with subcontractual and/or credentialing requirements. This shall include, but may not be limited to a subcontractor's failure or refusal to respond to the MCO's request for information, the request to provide medical records, credentialing information, etc.; at the MCO's discretion or a directive by DHH, the MCO shall impose at a minimum, financial consequences against the subcontractor as appropriate.	Amendment #4 Transportation Vendor Agreement, Page 1, updated section 4.3
24	Provide for submission of all reports and clinical information to the MCO for reporting purposes required by DHH.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.11, page 110
25	Require safeguarding of information about MCO members according to applicable state and federal laws and regulations and as described in contract between DHH and the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.12, page 110

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
26	Make full disclosure of the method and amount of compensation or other consideration to be received from the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.13, page 111; Amendment 2, Exhibit 2
27	Provide that the subcontractor comply with DHH's claims processing requirements as outlined in the RFP.	Amendment 4 to Vendor Transportation Agreement page 1, updated Section 4.4
28	Provide that the subcontractor adhere to DHH's timely filing guidelines as outlined in the RFP.	Amendment 4 to Vendor Transportation Agreement page 1, updated Section 4.4
29	Provide that, if a subcontractor discovers an error or a conflict with a previously adjudicated encounter claim, MCO shall be required to adjust or void the encounter claim within fourteen (14) calendar days of notification by DHH or if circumstances exist that prevent contractor from meeting this time frame a specified date shall be approved by DHH.	Amendment 3 to Vendor Transportation Agreement page 1, Section 4.5
30	Specify that the subcontractor shall accept the final payment made by the MCO as payment-in-full for core benefits and services provided and shall not solicit or accept any surety or guarantee of payment from DHH or the member(s). Member shall include the patient, parent(s), guardian, spouse or any other legally or potentially legally, responsible person of the member being served.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.17, page 111
31	Specify that at all times during the term of the subcontract, the subcontractor shall indemnify and hold DHH harmless from all claims, losses, or suits relating to activities undertaken pursuant to the contract between DHH and the MCO, unless the subcontractor is a state agency. For subcontractors that are not state agencies, the indemnification may be accomplished by incorporating such language from the contract between DHH and the MCO in its entirety in the subcontractor's agreement or by use of other language developed by the MCO and approved by DHH. For state agencies, the liability protection may be accomplished by incorporating language developed by the state agency and approved by DHH.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.18, pages 111-112
32	Require the subcontractor to secure all necessary liability, malpractice, and workers' compensation insurance coverage as is necessary to adequately protect the MCO's members and the MCO under the subcontract. The subcontractor shall provide such insurance coverage upon execution and at all times during the subcontract and shall furnish the MCO with written verification of the existence of such coverage.	Transportation Vendor Agreement, Page 8, Section 8.1

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
33	Specify that the subcontractor agrees to recognize and abide by all state and federal laws, rules and regulations and guidelines applicable to the provision of services.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.19, page 112
34	Provide that the agreement incorporates by reference all applicable federal and state laws, rules or regulations, and revisions of such laws, rules, or regulations shall automatically be incorporated into the subcontract as they become effective.	Amendment 3 Transportation Vendor Agreement, Page 1 Section 4.6
35	Provide that the MCO and subcontractor shall be responsible for resolving any disputes that may arise between the two (2) parties, and that no dispute shall disrupt or interfere with the provisions of services to the MCO member.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.22, page 113
36	Include a conflict of interest clause as stated in the contract between DHH and the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.33, page 114
37	Specify that the subcontractor must adhere to the Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM) requirements as outlined the contract between DHH and the MCO. The QAPI and UM requirements shall be included as part of the subcontract between the MCO and the subcontractor.	Amendment 4 Transportation Vendor Agreement, Page 1 updated Section 4.7
38	Provide that all subcontractors shall give MCO immediate notification in writing by certified mail of any litigation, investigation, complaint, claim or transaction that may reasonably be considered to have a material impact on the subcontractor's ability to perform the services included in its contract with the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.24, page 113
39	Provide that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) and its implementing regulation at 45 CFR Part 80 (2001, as amended), the subcontractor must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under the subcontract.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.26, page 113

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
40	Contain no provision which restricts a subcontractor from subcontracting with another MCO or other managed care entity.	Amendment 3 Transportation Vendor Agreement, Page 2, Section 4.9
41	Require that, when the MCO has entered into an alternative reimbursement arrangement with subcontractor, all encounter data must comply with the same standards of completeness and accuracy as required for proper adjudication of claims by the MCO.	Louisiana Coordinated Care Network – Prepaid Program Product Attachment, Section 3.42, page 115
42	Require that the services to be provided under this subcontract shall be performed entirely within the boundaries of the United States, which includes the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa. In addition, the subcontractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.	Amendment 3 Transportation Vendor Agreement, Page 2, Section 4.8
43	Contain the following language: The subcontractor and the subcontractor's providers assign to the State of Louisiana any and all rights or claims it currently has or may acquire under any state or federal antitrust laws and that are attributable to any product units purchased or reimbursed through any state program or payment mechanism, including but not limited to product units purchased or reimbursed under the state's managed Medicaid program, currently known as Bayou Health. For purposes of this assignment clause, the "subcontractor" shall include any direct or indirect owner to whom the right or claim to be assigned actually belongs, including any and all parents, branches, departments or subsidiaries.	Amendment 6 to Transportation Vendor Agreement, Page 1, Section 4.12

	Checklist Item	**Location** (Include Name of Document, Page Number, and Section Number/Letter)
44	Contains the following language: The subcontractor and the subcontractor's providers shall comply, within a reasonable time, with any information, records or data request from any healthcare oversight agency, including the Louisiana Office of the Attorney General, Medicaid Fraud Control Unit (MFCU), related to any services provided under Louisiana's Medical Assistance Programs. This requirement shall be inclusive of contracts or subcontracts with entities who manage or coordinate certain benefits for Medicaid beneficiaries on behalf of the MCO's but does not directly provide the service to Medicaid beneficiaries. When requested by the MFCU the production of the information, records or data requested by the MFCU shall be done at no cost to the MFCU, and the contractor, subcontractor or provider shall not require the MFCU to enter into any contract, agreement or memorandum of understanding to obtain the requested information, records or data. The MCO contractor, subcontractor and/or provider agrees that this contract creates for the healthcare oversight agency an enforceable right for which the healthcare oversight agency can petition the court in the event of non-compliance with an information, records or data request.	Amendment 6 to Transportation Vendor Agreement, Page 1, Section 4.13

ATTACHMENT 2.10.2.5.1
Accreditation Certificates

Per the RFP, This information is exempt from section-specific and total page limits

Transforming Louisiana's health, one person at a time.

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Louisiana Healthcare Connections, Inc.

Medicaid HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed

NCQA's rigorous requirements for consumer

protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

August 31, 2017	*June 1, 2020*
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Sunshine Health Plan, Inc.

Medicaid HMO

an accreditation status of

Commendable

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

02/08/2019	02/08/2022
DATE GRANTED	EXPIRATION DATE

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Peach State Health Plan

Medicaid HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. O'K
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

June 5, 2017
DATE GRANTED

June 5, 2020
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

IlliniCare Health

Medicaid HMO

an accreditation status of

ACCREDITED

ACCREDITED NCQA HEALTH PLAN ACCREDITED

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. O'K
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

July 6, 2017	*July 6, 2020*
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Coordinated Care Corporation Indiana, Inc. (d/b/a Managed Health Services)

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous

requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

11/16/2016	11/16/2019
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Home State Health Plan, Inc.

Medicaid HMO

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. O'K
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

August 7, 2017	*August 7, 2020*
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Magnolia Health Plan

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

01/30/2017	01/30/2020
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Nebraska Total Care

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oh
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

03/12/2019
DATE GRANTED

03/12/2022
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Granite State Health Plan d/b/a NH Healthy Families

Medicaid HMO

an accreditation status of

Commendable

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

09/12/2018
DATE GRANTED

09/12/2021
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

SilverSummit Health Plan

Medicaid HMO

ACCREDITED NCQA HEALTH PLAN INTERIM

Interim

for basic structure and processes in place to meet expectations for consumer protection and quality improvement.

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

06/06/2018
DATE GRANTED

12/06/2019
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Buckeye Health Plan

Medicaid HMO

an accreditation status of

Accredited

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

03/18/2019
DATE GRANTED

03/18/2022
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Absolute Total Care, Inc.

Medicaid HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

September 13, 2016	*September 13, 2019*
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Sunflower State Health Plan

Medicaid HMO

an accreditation status of

Commendable

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

08/31/2017	05/10/2020
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Superior HealthPlan, Inc

Medicaid HMO

an accreditation status of

Commendable

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

02/05/2018
DATE GRANTED

02/05/2021
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Coordinated Care Health Plan

Medicaid HMO

an accreditation status of

ACCREDITED

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

ACCREDITED NCQA HEALTH PLAN ACCREDITED

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. O'Kane
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

May 16, 2017
DATE GRANTED

May 28, 2020
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Managed Health Services Insurance Corp.

Medicaid HMO

an accreditation status of

COMMENDABLE

for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

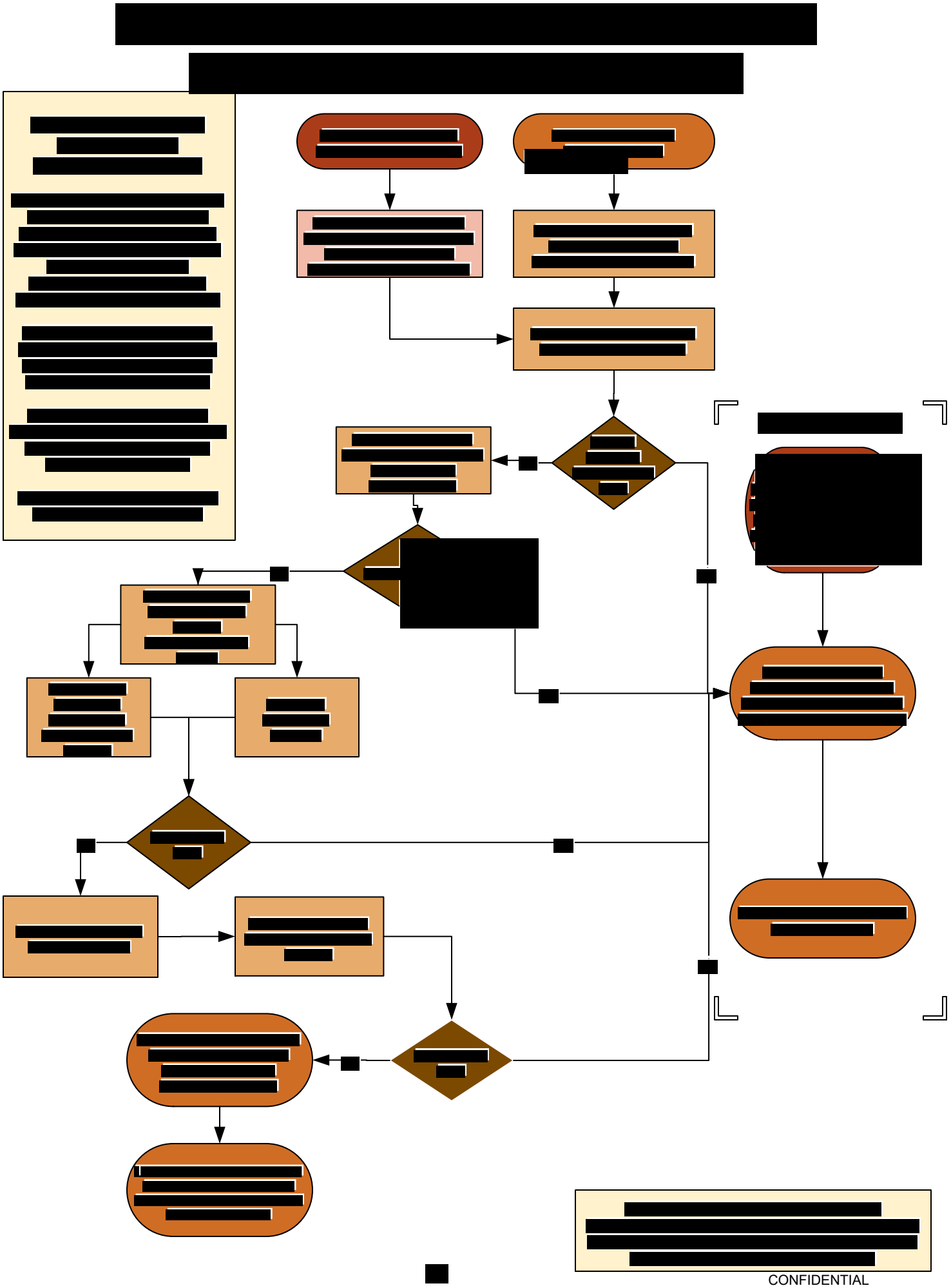
September 20, 2016
DATE GRANTED

September 20, 2019
EXPIRATION DATE

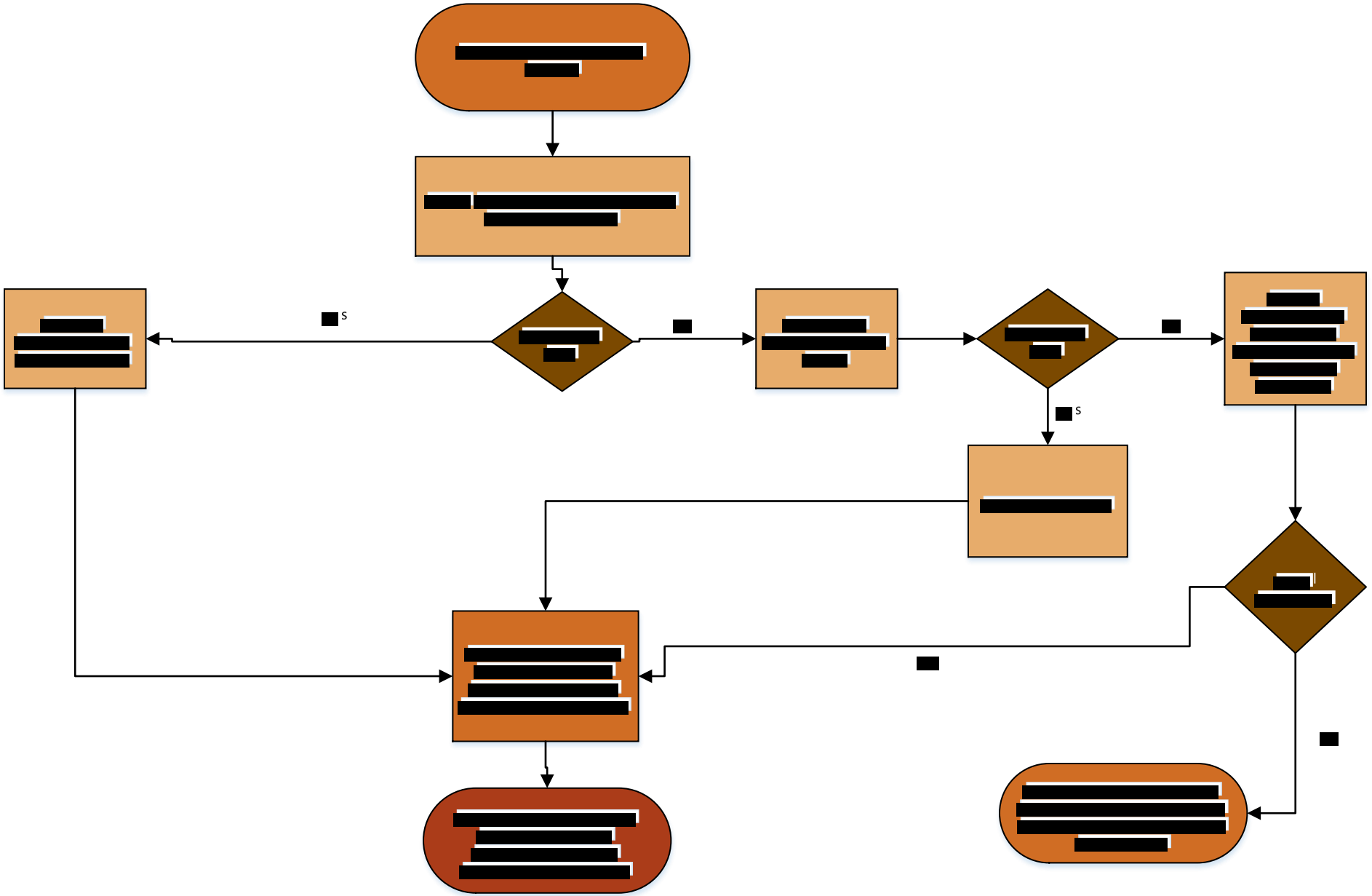
- EXEMPT FROM PAGE LIMITS -

ATTACHMENT 2.10.10.1.A
Authorizations and Informal Reconsideration Workflows

Transforming Louisiana's health,
one person at a time.



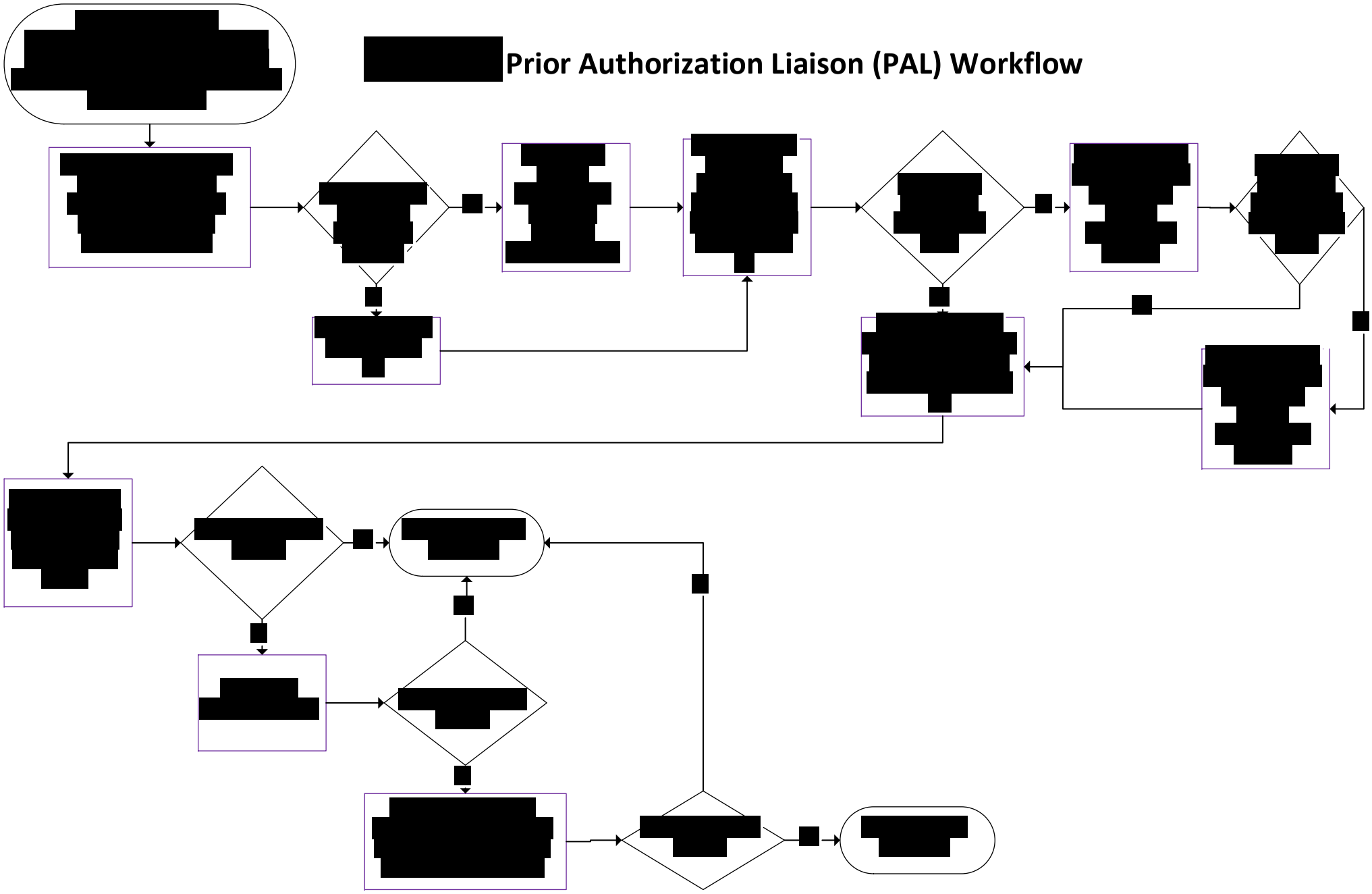
Louisiana Healthcare Connections (LHCC)
Informal Reconsideration Process



ATTACHMENT 2.10.10.1.B
Chisholm Workflows

Transforming Louisiana's health,
one person at a time.

[redacted] Prior Authorization Liaison (PAL) Workflow



- Documentation of EACH action and/or [redacted]

ATTACHMENT 2.10.11.5
LHCC Adopted
CPGs and Sample

Per Addendum 2, This information is exempt from section-specific and total page limits

Transforming Louisiana's health,
one person at a time.

Adopted Clinical Practice and Preventive Health Guidelines

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
		Medical		
Adult Preventive Care	American Cancer Society Guidelines for the Early Detection of Cancer (Revised May 2018)	American Cancer Society (ACS)	http://www.cancer.org/Healthy/FindCancerEarly/CancerScreeningGuidelines/american-cancer-society-guidelines-for-the-early-detection-of-cancer	Jun-18
	Morbidity and Mortality Weekly Report (MMWR)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/mmwr/	Jun-18
	U.S. Preventive Services Task Force Recommendations. (Publication dates vary)	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/uspstopics.htm	Jun-18
Asthma	Asthma Care Quick Reference Diagnosing and managing asthma. Guidelines from the National Asthma Education and Prevention Program. Expert Panel Report 3. (Revised 2012.)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	https://www.nhlbi.nih.gov/health-topics/all-publications-and-resources/asthma-care-quick-reference-diagnosing-and-managing	Jun-18
	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (Full Report July 2007) and Changes to the Guidelines (August 2008)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/guidelines/asthma/index.htm	Jun-18
	2018 GINA Report, Global Strategy For Asthma Management and Prevention. Updated 2018	Global Initiative for Asthma (GINA)	http://ginasthma.org/2018-gina-report-global-strategy-for-asthma-management-and-prevention/	Jun-18
Back Pain	Low Back Pain, Adult Acute and Subacute (Updated March 2018)	Institute for Clinical Systems Improvement (ICSI)	https://www.icsi.org/guideline/low-back-pain/	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
	Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society (October 2, 2007)	American College of Physicians; American Pain Society	http://annals.org/article.aspx?articleid=736814 and http://annals.org/aim/fullarticle/739339/correction-diagnosis-treatment-low-back-pain	Jun-18
	Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians (April 2017)	American College of Physicians	http://annals.org/aim/fullarticle/2603228/noninvasive-treatments-acute-subacute-chronic-low-back-pain-clinical-practice	Jun-18
	Low back pain: clinical practice guidelines linked to the International Classification of Functioning, Disability, and Health from the Orthopedic Section of the American Physical Therapy Association (April 2012)	American Physical Therapy Association	https://www.guidelinecentral.com/summaries/low-back-pain-clinical-practice-guidelines-linked-to-the-international-classification-of-functioning-disability-and-health-from-the-orthopaedic-section-of-the-american-physical-therapy-association/#section-society	Jun-18
Chlamydia Screening	Final Recommendation Statement Gonorrhea and Chlamydia: Screening, September 2014	U.S. Preventive Services Task Force (USPSTF)	http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/chlamydia-and-gonorrhea-screening	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
COPD	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2018 Report)	The Global Initiative for Chronic Obstructive Lung Disease	http://goldcopd.org/wp-content/uploads/2017/11/GOLD-2018-v6.0-FINAL-revised-20-Nov_WMS.pdf	Jun-18
Coronary Artery Disease	Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. The Report of the Expert Panel (October 2012)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)	http://www.nhlbi.nih.gov/guidelines/cvd_ped/index.htm	Jun-18
	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk. (Circulation. 2014; 129:S49-S73) (Published online November 12, 2013)	American College of Cardiology (ACC) and American Heart Association (AHA) Task Force	http://circ.ahajournals.org/lookup/doi/10.1161/01.cir.0000437741.48606.98	Jun-18
	The National Physical Activity Plan: A Call to Action from the American Heart Association (Circulation. 2015; 131:1932-1940)	American Heart Association (AHA)	http://circ.ahajournals.org/content/131/21/1932	Jun-18
	AHA Scientific Statement: Secondary Prevention of Atherosclerotic Cardiovascular Disease in Older Adults. (Circulation. 2013; 128:2422-2446)	American Heart Association (AHA)	http://circ.ahajournals.org/content/128/22/2422.full	Jun-18
	AHA/ACC/ASH Scientific Statement Treatment of Hypertension in Patients with Coronary Artery Disease. (Circulation 2015;131:e435-e470)	American Heart Association (AHA), American College of Cardiology (ACC), and American Society of Hypertension	http://circ.ahajournals.org/content/131/19/e435.full	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
	AHA/ACCF Guideline: AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease, 2011 Update (Circulation. 2011; 124: 2458-2473) and	American Heart Association (AHA) and American College of Cardiology Foundation (ACC)	http://circ.ahajournals.org/content/124/22/2458.full.pdf	Jun-18
	The Primary and Secondary Prevention of Coronary Artery Disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (8th Edition)(June 2008)	American College of Chest Phsyicians	http://journal.chestnet.org/article/S0012-3692(08)60130-0/fulltext	Jun-18
Critical Care	Surviving Sepsis Campaign: International Guidelines for Management of Severe Sepsis and Septic Shock: 2016	Society of Critical Care Medicine and European Society of Intensive Care Medicine.	http://www.survivingsepsis.org/Guidelines/Pages/default.aspx	Jun-18
Diabetes	AACE/ACE Consensus Statement: Consensus Statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the Comprehensive Type 2 Diabetes Management Algorithm-2018 Executive Summary (Endocrine Practice 2018; Volume 24, (No.1)	American Association of Clinical Endocrinologists and American College of Endocrinology	https://www.aace.com/sites/all/files/diabetes-algorithm-executive-summary.pdf	Jun-18
	Clinical Practice Recommendations – 2018. Standards of Medical Care in Diabetes (Diabetes Care 2018, Volume 41, Supplement 1)	American Diabetes Association (ADA)	https://professional.diabetes.org/content-page/standards-medical-care-diabetes	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
Heart Failure	2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the ACC, AHA and HFSA (Circulation. 2017; CIR.0000000000000509, originally published April 28, 2017)	American College of Cardiology (ACC) Foundation, American Heart Association (AHA) Task Force on Practice Guidelines and the Heart Failure Society of America (HFSA)	http://circ.ahajournals.org/content/early/2017/04/26/CIR.0000000000000509	Jun-18
	AHA Scientific Statement: Exercise and Heart Failure (Circulation. 2003; 107:1210-1225)	American Heart Association (AHA) Committee on Exercise, Rehabilitation, and Prevention	http://circ.ahajournals.org/content/107/8/1210	Jun-18
	Updated Clinical Practice Guidelines on Heart Failure: An International Alignment (April 2017)	American Heart Association (AHA), American College of Cardiology (ACC) Foundation, Heart Failure Society of American (HFSA), and the Heart Failure Association and the European Society of Cardiology	http://circ.ahajournals.org/content/136/6/e137	Jun-18
	Lipid Management in Adults (February 2017)	Institute for Clinical Systems Improvement (ICSI)	https://www.icsi.org/guideline/lipid-management/	Jun-18
Hyperlipidemia	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. (Circulation 2014; 129:S1-S45)	American College of Cardiology (ACC), American Heart Association (AHA) Task Force on Practice Guidelines	http://circ.ahajournals.org/content/129/25_suppl_2/S1	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
	Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) Final Report September 2002	National Institute of Health and National Heart, Lung, and Blood Institute	http://circ.ahajournals.org/content/106/25/3143.short?rss=1&ssource=mfc	Jun-18
Hypertension	2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults; A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines	Journal of the American College of Cardiology	http://www.onlinejacc.org/content/71/19/e127?_ga=2.107380098.103453671.1529691830-904453439.1529691830 and http://www.onlinejacc.org/content/71/19/2275	Jun-18
Immunizations	Adult Immunization Schedule , United States 2018	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/schedules/hcp/adult.html	Jun-18
	Birth-18 Years & "Catch-up" Immunization Schedules, United States, 2018	Advisory Committee on Immunization Practices (ACIP)	http://www.cdc.gov/vaccines/schedules/hcp/child-adolescent.html	Jun-18
	Prevention and Control of Influenza with Vaccines: Recommendations of the ACIP — United States, 2017–18 Influenza Season	Advisory Committee on Immunization Practices (ACIP)	https://www.cdc.gov/mmwr/volumes/66/rr/rr6602a1.htm	Jun-18
Lead Poisoning	CDC's Childhood Lead Poisoning Prevention Program	Advisory Committee On Childhood Lead Poisoning Prevention (ACCLPP)	https://www.cdc.gov/nceh/lead/default.htm	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
	Recommendations for Blood Lead Screening of Medicaid-Eligible Children Aged 1-5 Years: an Updated Approach to Targeting a Group at High Risk (Last Reviewed 07/28/2009)	Advisory Committee on Childhood Lead Poisoning, Division of Environmental and Emergency Health Services, and National Center for Environmental Health	http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5809a1.htm	Jun-18
Pediatric Preventive Care	Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents (Revised 2013)	American Academy of Pediatric Dentistry	http://www.aapd.org/policies	Jun-18
	Periodicity Schedule: Recommendations for Preventive Pediatric Health Care (2017)	American Academy of Pediatrics	http://www.aap.org/en-us/professional-resources/practice-support/Pages/PeriodicitySchedule.aspx	Jun-18
Perinatal Care	AFP by Topic: Prenatal (2017)	American Academy of Family Physicians (AAFP)	http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=25	Jun-18
	Guidelines for Perinatal Care, Eighth Edition (2017)	The American College of Obstetricians and Gynecologists (ACOG)	Available online for ACOG members only. http://www.acog.org/About-ACOG/ACOG-Departments/Deliveries-Before-39-Weeks/ACOG-Clinical-Guidelines	Jun-18

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
Respiratory Illness	Adult and Pediatric treatment recommendations. (Last updated April 17, 2015)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/getsmart/community/for-hcp/outpatient-hcp/index.html	Jun-18
	Clinical Practice Guideline for the Diagnosis and Management of Group A Streptococcal Pharyngitis: 2012 Update by the Infectious Diseases Society of America. (Clin Infect Dis 2012; 55: e86-e102.) First published online Sept. 9, 2012.	Infectious Disease Society of America	http://cid.oxfordjournals.org/content/55/10/e86.full.pdf+html	Jun-18
	Upper Respiratory Tract Infections (Publication dates vary)	American Academy of Family Physicians (AAFP)	http://www.aafp.org/afp/topicModules/viewTopicModule.htm?topicModuleId=29	Jun-18
	Diagnosis and Treatment of Respiratory Illness in Children and Adults. (Updated September 2017)	Institute for Clinical Systems Improvement (ICSI)	https://www.icsi.org/guideline/respiratory-illness/	Jun-18
Sickle Cell	Sickle Cell Disease, Recommendations (Last updated September 14, 2015)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/ncbddd/sicklecell/recommendations.html	Jun-18
Weight Management	Childhood Obesity Prevention (2018)	Centers for Disease Control and Prevention (CDC)	http://www.cdc.gov/ncbddd/sicklecell/recommendations.html	Jun-18
	Adult Weight Management (AWM) Guideline (2014)	Academy of Nutrition and Diatetics	http://www.andeal.org/topic.cfm?menu=5276&cat=4688	Jun-18
	Active Healthy Living: Prevention of Childhood Obesity Through Increased Physical Activity. (Pediatrics Vol. No.5 May 1, 2006 pp.1834-1842)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/117/5/1834.full	Jul-15 Jun-16 Jun-17

Conditions/ Diseases	Guideline Title	Recognized Source	URL	Review/ Update
	Managing Overweight and Obesity in Adults: Systematic Evidence Review from the Obesity Expert Panel (2013)	U.S. Department of Health and Human Services, National Institute of Health, National Heart, Lung, and Blood Institute	http://www.nhlbi.nih.gov/health-pro/guidelines/in-develop/obesity-evidence-review	Jun-18
	Expert Committee Recommendations Regarding the Prevention, Assessment, and Treatment of Child and Adolescent Overweight and Obesity: Summary Report (December 2007)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/suppl/2007/12/03/120.Supplement_4.S163.DC1/Obesity_Supplement_120-6.pdf	Jun-18
	Final Recommendation Statement Obesity in Children and Adolescents: Screening, June 2017	U.S. Preventive Services Task Force (USPSTF)	https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/obesity-in-children-and-adolescents-screening1	Jun-18

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Behavorial Health				
ADHD	ADHD: Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-deficit/Hyperactivity Disorder in Children and Adolescents. (Published online October 16, 2011; DOI: 10.1542/peds.2011-2654)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/early/2011/10/14/peds.2011-2654.full.pdf+html	Jun-18

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
	Practice Parameter for the assessment and treatment of children and adolescents with attention-deficit/hyperactivity disorder (AACAP Revised: 7/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)62182-1/pdf	Jun-18
	Clinical Practice Guideline: Treatment of the School-Aged Child with Attention-Deficit/Hyperactivity Disorder (Pediatrics Vol. 108 No. 4 October 1, 2001 pp. 1033 -1044)	American Academy of Pediatrics (AAP)	http://pediatrics.aappublications.org/content/108/4/1033.full?sid=6dac3588-095c-49c7-adc5-62643dc1641a	Jun-18
Anxiety Disorder	Practice parameter for the assessment and treatment of children and adolescents with anxiety disorders (Revised: 2/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61838-4/pdf	Jun-18
Bipolar Disorder	Practice Guideline for the Treatment of Patients with Bipolar Disorder. Second Edition. (April 2002) and Guideline Watch (November 2005)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bipolar-watch.pdf	Jun-18
	Practice parameter for the assessment and treatment of children and adolescents with bipolar disorder.(Revised: 1/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61968-7/pdf	Jun-18

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Major Depressive Disorder	Practice Guideline for the Treatment of Patients With Major Depressive Disorder. Third Edition. (2010)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/mdd.pdf	Jun-18
	Practice parameter for the assessment and treatment of children and adolescents with depressive disorders (Revised 11/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)62053-0/pdf	Jun-18
Oppositional Defiant Disorder	Practice parameter for the assessment and treatment of children and adolescents with oppositional defiant disorder. (1/2007)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)61969-9/pdf	Jun-18
Panic Disorder	Practice Guideline for the Treatment of Patients with Panic Disorder. Second Edition. (January 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/panicdisorder.pdf	Jun-18
Schizophrenia	The Practice Guideline for the Treatment of Patients With Schizophrenia. Second Edition.(April 2004) and Guideline Watch(September 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/schizophrenia-watch.pdf	Jun-18
	The Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (September 2013)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(13)00112-3/pdf	Jun-18

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Stress Disorder	The Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder. (November 2004) and Guideline Watch (March 2009)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/acutestressdisorderptsd-watch.pdf	Jun-18
Substance Use Disorders	Practice Guideline for the Treatment of Patients With Substance Use Disorders(May 2006) and Guideline Watch (April 2007)	American Psychiatric Association (APA)	http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse.pdf and http://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-watch.pdf	Jun-18

Condition/Disease	Guideline Title	Recognized Source	URL	Review/ Update
Tobacco Cessation	Smoking Cessation During Pregnancy (Obstet Gynecol 2010; 116: 1241-4)	American College of Obstetricians and Gynecologists (ACOG)	https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Smoking-Cessation-During-Pregnancy	Jun-18
	Smoking and Tobacco Use Cessation	Centers for Disease Control and Prevention (CDC)	https://www.cdc.gov/tobacco/quit_smoking/cessation/index.htm	Jun-18
Use of Psychotropic Medication	Practice parameter for the use of psychotropic medication in children and adolescents (2009)	American Academy of Child and Adolescent Psychiatry (AACAP)	http://www.jaacap.com/article/S0890-8567(09)60156-8/pdf	Jun-18
General Evidence Based Medicine	Choosing Wisely (2018)	Choosing Wisely; American Board of Internal Medicine Foundation	http://www.choosingwisely.org/	Jun-18

Revision log	Date
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines (Added Practice Guidelines for ADHD, Adult Preventive Care, Asthma, Back Pain, Bipolar Disorder, Coronary Artery Disease, Diabetes, Hyperlipidemia, Hypertension, Lead Screening, Major Depressive Disorder, Oppositional Defiant Disorder, Panic Disorder, Pediatric Preventive Care, Perinatal Care, Respiratory Illness, Schizophrenia, Sickle Cell, Stress Disorder, Substance Use Disorders, Tobacco Cessation, Use of Psychotropic Medication. Removed Practice Guidelines for Back Pain, Coronary Artery Disease, Heart Failure, and Hyperlipidemia.)	07/15

Revision log	Date
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current versions of guidelines (Added Practice Guidelines for Heart Failure, Respiratory Illness, and Pediatric Medical and Psychiatric Management).	06/16
Updated Adopted Clinical Practice and Preventive Health Guidelines attachment to most current version of guidelines. Added footer to notate Clinical Policy Committee approval dates. Revised column header to read, "Review/Update Date". Deleted the following as they are out of date: The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults; Lead Toxicity How should patients exposed to lead be evaluated?; Practice parameter for the psychiatric assessment and management of physically ill children and adolescents. Updated heart failure guidelines to include, "2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure: A Report of the ACC, AHA and HFSA (Circulation. 2017; CIR.0000000000000509, originally published April 28, 2017)". Updated schizophrenia guidelines to include, "The Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (September 2013)".	07/17
Updated link to, "The Primary and Secondary Prevention of Coronary Artery Disease: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines".	09/17
Added Sepsis Guidelines; Updated "Prevention and Control of Influenza with Vaccines" and "Smoking Cessation During Pregnancy".	01/18

Revision log	Date
Updated CPG references and links. Added: Noninvasive Treatments for Acute, Subacute, and Chronic Low Back Pain: A Clinical Practice Guideline From the American College of Physicians. Added: The National Physical Activity Plan: A Call to Action from the American Heart Association (Circulation. 2015; 131:1932-1940). Removed: AHA Scientific Statement: Exercise and Physical Activity in the Prevention and Treatment of Atherosclerotic Cardiovascular Disease (Circulation. 2003; 107:3109-3116) Removed: Standards of Medical Care in Diabetes (Diabetes Care July 2017, 40: 811-987) Removed: HFSA 2010 Comprehensive Heart Failure Practice Guideline. (June 2010; 16: e1-e194) Added: Lipid Management in Adults (February 2017) Added: 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults; A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Removed: ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults. (Circulation 2014; 129:S1-S45). Removed: Evidence-Based Management of Sickle Cell Disease. Expert Panel Report, 2014. Removed: The Management of Sickle Cell Disease, Fourth Edition (2004). Added: Childhood Obesity Prevention (2018) Added section: General Evidence-Based Guidelines. Added: Choosing Wisely (2018)	06/18
Updated ICSI links for lipid management, low back pain, and respiratory illness. Updated ACOG perinatal care guidelines to reflect the 2017 eighth edition.	02/2019

Asthma Care Quick Reference

DIAGNOSING AND MANAGING ASTHMA

Guidelines from the National Asthma Education and Prevention Program

EXPERT PANEL REPORT 3

The goal of this asthma care quick reference guide is to help clinicians provide quality care to people who have asthma.

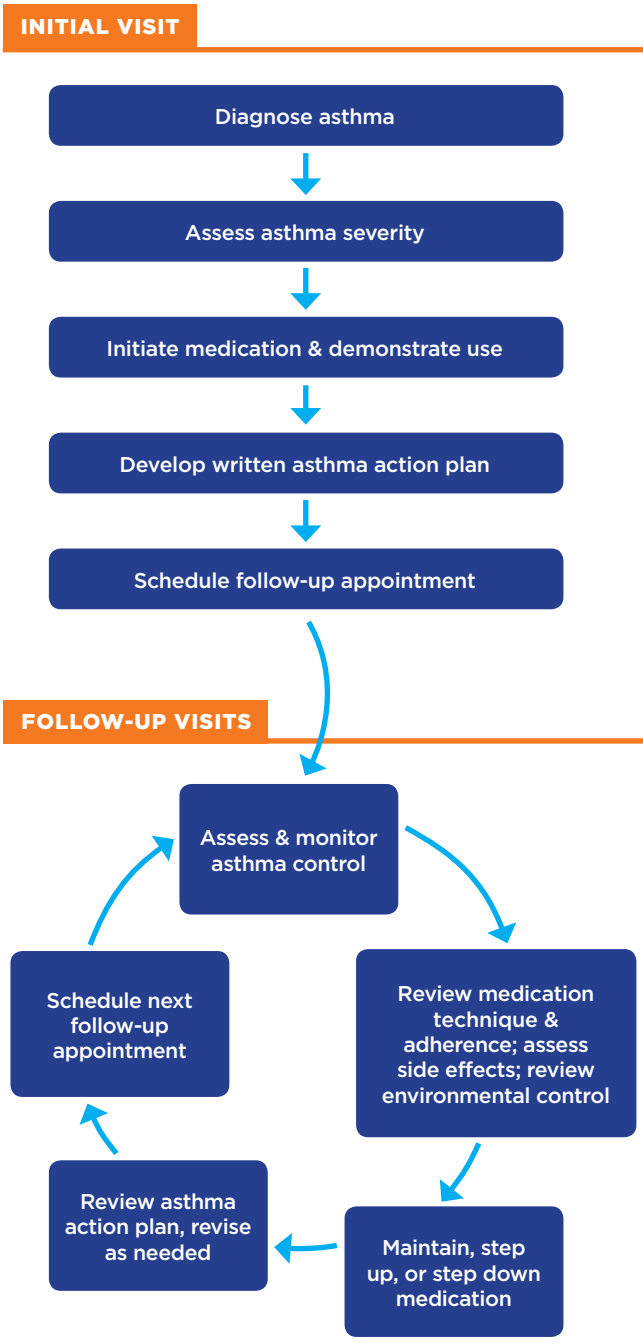
Quality asthma care involves not only initial diagnosis and treatment to achieve asthma control, but also long-term, regular follow-up care to maintain control.

Asthma control focuses on two domains: (1) **reducing impairment**—the frequency and intensity of symptoms and functional limitations currently or recently experienced by a patient; and (2) **reducing risk**—the likelihood of future asthma attacks, progressive decline in lung function (or, for children, reduced lung growth), or medication side effects.

Achieving and maintaining asthma control requires providing appropriate medication, addressing environmental factors that cause worsening symptoms, helping patients learn self-management skills, and monitoring over the long term to assess control and adjust therapy accordingly.

The diagram (right) illustrates the steps involved in providing quality asthma care.

This guide summarizes recommendations developed by the National Asthma Education and Prevention Program's expert panel after conducting a systematic review of the scientific literature on asthma care. See **www.nhlbi.nih.gov/guidelines/asthma** for the full report and references. Medications and dosages were updated in September 2011 for the purposes of this quick reference guide to reflect currently available asthma medications.



U.S. Department of Health and Human Services
National Institutes of Health
National Heart, Lung, and Blood Institute

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KEY CLINICAL ACTIVITIES FOR QUALITY ASTHMA CARE

(See complete table in *Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma* [EPR-3])

Clinical Issue	Key Clinical Activities and Action Steps
➡ ASTHMA DIAGNOSIS	

	Establish asthma diagnosis.
	▪ Determine that symptoms of recurrent airway obstruction are present, based on history and exam.
	  • History of cough, recurrent wheezing, recurrent difficulty breathing, recurrent chest tightness
	  • Symptoms occur or worsen at night or with exercise, viral infection, exposure to allergens and irritants, changes in weather, hard laughing or crying, stress, or other factors
	▪ In all patients ≥5 years of age, use spirometry to determine that airway obstruction is at least partially reversible.
	▪ Consider other causes of obstruction.

➡ LONG-TERM ASTHMA MANAGEMENT	
GOAL: Asthma Control	**Reduce Impairment** ▪ Prevent chronic symptoms. ▪ Require infrequent use of short-acting beta$_2$-agonist (SABA). ▪ Maintain (near) normal lung function and normal activity levels. **Reduce Risk** ▪ Prevent exacerbations. ▪ Minimize need for emergency care, hospitalization. ▪ Prevent loss of lung function (or, for children, prevent reduced lung growth). ▪ Minimize adverse effects of therapy.

Assessment and Monitoring	**INITIAL VISIT: Assess asthma severity to initiate treatment** (see page 5)**.**
	FOLLOW-UP VISITS: Assess asthma control to determine if therapy should be adjusted (see page 6)**.**
	▪ Assess at each visit: asthma control, proper medication technique, written asthma action plan, patient adherence, patient concerns.
	▪ Obtain lung function measures by spirometry at least every 1–2 years; more frequently for asthma that is not well controlled.
	▪ Determine if therapy should be adjusted: Maintain treatment; step up, if needed; step down, if possible.
	
	Schedule follow-up care.
	▪ Asthma is highly variable over time. See patients:
	  • Every 2–6 weeks while gaining control
	  • Every 1–6 months to monitor control
	  • Every 3 months if step down in therapy is anticipated

Use of Medications	**Select medication and delivery devices that meet patient's needs and circumstances.** ▪ Use stepwise approach to identify appropriate treatment options (see page 7). ▪ Inhaled corticosteroids (ICSs) are the most effective long-term control therapy. ▪ When choosing treatment, consider domain of relevance to the patient (risk, impairment, or both), patient's history of response to the medication, and willingness and ability to use the medication. **Review medications, technique, and adherence at each follow-up visit.**

KEY CLINICAL ACTIVITIES FOR QUALITY ASTHMA CARE *(continued)*

Clinical Issue	Key Clinical Activities and Action Steps
Patient Education for Self-Management	**Teach patients how to manage their asthma.** ▪ Teach and reinforce at each visit: • Self-monitoring to assess level of asthma control and recognize signs of worsening asthma (either symptom or peak flow monitoring) • Taking medication correctly (inhaler technique, use of devices, understanding difference between long-term control and quick-relief medications) - ***Long-term control medications*** (such as inhaled corticosteroids, which reduce inflammation) prevent symptoms. Should be taken daily; will not give quick relief. - ***Quick-relief medications*** (short-acting beta$_2$-agonists or SABAs) relax airway muscles to provide fast relief of symptoms. Will not provide long-term asthma control. If used >2 days/week (except as needed for exercise-induced asthma), the patient may need to start or increase long-term control medications. • Avoiding environmental factors that worsen asthma **Develop a written asthma action plan** in partnership with patient/family (sample plan available at *www.nhlbi.nih.gov/health/public/lung/asthma/asthma_actplan.pdf*). ▪ Agree on treatment goals. ▪ Teach patients how to use the asthma action plan to: • Take daily actions to control asthma • Adjust medications in response to worsening asthma • Seek medical care as appropriate ▪ Encourage adherence to the asthma action plan. • Choose treatment that achieves outcomes and addresses preferences important to the patient/family. • Review at each visit any success in achieving control, any concerns about treatment, any difficulties following the plan, and any possible actions to improve adherence. • Provide encouragement and praise, which builds patient confidence. Encourage family involvement to provide support. **Integrate education into all points of care involving interactions with patients.** ▪ Include members of all health care disciplines (e.g., physicians, pharmacists, nurses, respiratory therapists, and asthma educators) in providing and reinforcing education at all points of care.
Control of Environmental Factors and Comorbid Conditions	**Recommend ways to control exposures to allergens, irritants, and pollutants that make asthma worse.** ▪ Determine exposures, history of symptoms after exposures, and sensitivities. (In patients with persistent asthma, use skin or in vitro testing to assess sensitivity to perennial indoor allergens to which the patient is exposed.) • Recommend multifaceted approaches to control exposures to which the patient is sensitive; single steps alone are generally ineffective. • Advise all asthma patients and all pregnant women to avoid exposure to tobacco smoke. • Consider allergen immunotherapy by trained personnel for patients with persistent asthma when there is a clear connection between symptoms and exposure to an allergen to which the patient is sensitive. **Treat comorbid conditions.** ▪ Consider allergic bronchopulmonary aspergillosis, gastroesophageal reflux, obesity, obstructive sleep apnea, rhinitis and sinusitis, and stress or depression. Treatment of these conditions may improve asthma control. ▪ Consider inactivated flu vaccine for all patients >6 months of age.

ASTHMA CARE FOR SPECIAL CIRCUMSTANCES

Clinical Issue	Key Clinical Activities and Action Steps
Exercise-Induced Bronchospasm	**Prevent EIB.*** ▪ Physical activity should be encouraged. For most patients, EIB should not limit participation in any activity they choose. ▪ Teach patients to take treatment before exercise. SABAs* will prevent EIB in most patients; LTRAs,* cromolyn, or LABAs* also are protective. Frequent or chronic use of LABA to prevent EIB is discouraged, as it may disguise poorly controlled persistent asthma. ▪ Consider long-term control medication. EIB often is a marker of inadequate asthma control and responds well to regular anti-inflammatory therapy. ▪ Encourage a warm-up period or mask or scarf over the mouth for cold-induced EIB.
Pregnancy	**Maintain asthma control through pregnancy.** ▪ Check asthma control at all prenatal visits. Asthma can worsen or improve during pregnancy; adjust medications as needed. ▪ Treating asthma with medications is safer for the mother and fetus than having poorly controlled asthma. Maintaining lung function is important to ensure oxygen supply to the fetus. ▪ ICSs* are the preferred long-term control medication. ▪ Remind patients to avoid exposure to tobacco smoke.

MANAGING EXACERBATIONS

Clinical Issue	Key Clinical Activities and Action Steps
Home Care	**Develop a written asthma action plan** (see Patient Education for Self-Management, page 3)**.** **Teach patients how to:** ▪ Recognize early signs, symptoms, and PEF* measures that indicate worsening asthma. ▪ Adjust medications (increase SABA* and, in some cases, add oral systemic corticosteroids) and remove or withdraw from environmental factors contributing to the exacerbation. ▪ Monitor response. ▪ Seek medical care if there is serious deterioration or lack of response to treatment. Give specific instructions on who and when to call.
Urgent or Emergency Care	**Assess severity by lung function measures (for ages ≥5 years), physical examination, and signs and symptoms.** **Treat to relieve hypoxemia and airflow obstruction; reduce airway inflammation.** ▪ Use supplemental oxygen as appropriate to correct hypoxemia. ▪ Treat with repetitive or continuous SABA,* with the addition of inhaled ipratropium bromide in severe exacerbations. ▪ Give oral systemic corticosteroids in moderate or severe exacerbations or for patients who fail to respond promptly and completely to SABA. ▪ Consider adjunctive treatments, such as intravenous magnesium sulfate or heliox, in severe exacerbations unresponsive to treatment. **Monitor response with repeat assessment of lung function measures, physical examination, and signs and symptoms, and, in emergency department, pulse oximetry.** **Discharge with medication and patient education:** ▪ Medications: SABA, oral systemic corticosteroids; consider starting ICS* ▪ Referral to follow-up care ▪ Asthma discharge plan ▪ Review of inhaler technique and, whenever possible, environmental control measures

***Abbreviations:** EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, long-acting beta$_2$-agonist; LTRA, leukotriene receptor antagonist; PEF, peak expiratory flow; SABA, short-acting beta$_2$-agonist.

INITIAL VISIT: CLASSIFYING ASTHMA SEVERITY AND INITIATING THERAPY

(in patients who are not currently taking long-term control medications)

Level of severity (Columns 2–5) is determined by events listed in Column 1 for both impairment (frequency and intensity of symptoms and functional limitations) and risk (of exacerbations). Assess impairment by patient's or caregiver's recall of events during the previous 2–4 weeks; assess risk over the last year. Recommendations for initiating therapy based on level of severity are presented in the last row.

Components of Severity		Intermittent			Persistent								
					Mild			Moderate			Severe		
		Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years
Impairment	Symptoms	≤2 days/week			>2 days/week but not daily			Daily			Throughout the day		
	Nighttime awakenings	0	≤2x/month		1–2x/month	3–4x/month		3–4x/month	>1x/week but not nightly		>1x/week	Often 7x/week	
	SABA* use for symptom control (not to prevent EIB*)	≤2 days/week			>2 days/week but not daily	>2 days/week but not daily and not more than once on any day		Daily			Several times per day		
	Interference with normal activity	None			Minor limitation			Some limitation			Extremely limited		
	Lung function												
	➔ FEV_1* (% predicted)	Not applicable	Normal FEV_1 between exacerbations >80%	Normal FEV_1 between exacerbations >80%	Not applicable	>80%	>80%	Not applicable	60–80%	60–80%	Not applicable	<60%	<60%
	➔ FEV_1/FVC*		>85%	Normal†		>80%	Normal†		75–80%	Reduced 5%†		<75%	Reduced >5%†
Risk	Asthma exacerbations requiring oral systemic corticosteroids‡	0–1/year			≥2 exacerb. in 6 months, or wheezing ≥4x per year lasting >1 day AND risk factors for persistent asthma	≥2/year		*Generally, more frequent and intense events indicate greater severity.*					
		*Consider severity and interval since last asthma exacerbation. Frequency and severity may fluctuate over time for patients in any severity category. Relative annual risk of exacerbations may be related to FEV_1.**											
Recommended Step for Initiating Therapy *(See "Stepwise Approach for Managing Asthma Long Term," page 7)* *The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.*		Step 1			Step 2			Step 3	Step 3 medium-dose ICS* option	Step 3	Step 3	Step 3 medium-dose ICS* option or Step 4	Step 4 or 5
								Consider short course of oral systemic corticosteroids.					
		In 2–6 weeks, depending on severity, assess level of asthma control achieved and adjust therapy as needed. For children 0–4 years old, if no clear benefit is observed in 4–6 weeks, consider adjusting therapy or alternate diagnoses.											

* **Abbreviations:** EIB, exercise-induced bronchospam; FEV_1, forced expiratory volume in 1 second; FVC, forced vital capacity; ICS, inhaled corticosteroid; SABA, short-acting $beta_2$-agonist.

† Normal FEV_1/FVC by age: 8–19 years, 85%; 20–39 years, 80%; 40–59 years, 75%; 60–80 years, 70%.

‡ Data are insufficient to link frequencies of exacerbations with different levels of asthma severity. Generally, more frequent and intense exacerbations (e.g., requiring urgent care, hospital or intensive care admission, and/or oral corticosteroids) indicate greater underlying disease severity. For treatment purposes, patients with ≥2 exacerbations may be considered to have persistent asthma, even in the absence of impairment levels consistent with persistent asthma.

FOLLOW-UP VISITS: ASSESSING ASTHMA CONTROL AND ADJUSTING THERAPY

Level of control (Columns 2–4) is based on the most severe component of impairment (symptoms and functional limitations) or risk (exacerbations). Assess impairment by patient's or caregiver's recall of events listed in Column 1 during the previous 2–4 weeks and by spirometry and/or peak flow measures. Symptom assessment for longer periods should reflect a global assessment, such as inquiring whether the patient's asthma is better or worse since the last visit. Assess risk by recall of exacerbations during the previous year and since the last visit. Recommendations for adjusting therapy based on level of control are presented in the last row.

Components of Control		Well Controlled			Not Well Controlled			Very Poorly Controlled		
		Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years	Ages 0–4 years	Ages 5–11 years	Ages ≥12 years
Impairment	Symptoms	≤2 days/week	≤2 days/week but not more than once on each day	≤2 days/week	>2 days/week	>2 days/week or multiple times on ≤2 days/week	>2 days/week	Throughout the day		
	Nighttime awakenings	≤1x/month		≤2x/month	>1x/month	≥2x/month	1–3x/week	>1x/week	≥2x/week	≥4x/week
	Interference with normal activity	None			Some limitation			Extremely limited		
	SABA* use for symptom control (not to prevent EIB*)	≤2 days/week			>2 days/week			Several times per day		
	Lung function ➡ FEV_1* (% *predicted*) or peak flow (% *personal best*) ➡ FEV_1/FVC*	Not applicable Not applicable	>80% >80%	>80% Not applicable	Not applicable Not applicable	60–80% 75–80%	60–80% Not applicable	Not applicable Not applicable	<60% <75%	<60% Not applicable
	Validated questionnaires† ➡ ATAQ* ➡ ACQ* ➡ ACT*	Not applicable Not applicable	Not applicable Not applicable	0 ≤0.75‡ ≥20	Not applicable Not applicable	Not applicable Not applicable	1–2 ≥1.5 16–19	Not applicable Not applicable	Not applicable Not applicable	3–4 Not applicable ≤15
Risk	Asthma exacerbations requiring oral systemic corticosteroids§	0–1/year			2–3/year	≥2/year		>3/year	≥2/year	
		Consider severity and interval since last asthma exacerbation.								
	Reduction in lung growth/Progressive loss of lung function	Not applicable	Evaluation requires long-term follow-up care.		Not applicable	Evaluation requires long-term follow-up care.		Not applicable	Evaluation requires long-term follow-up care.	
	Treatment-related adverse effects	*Medication side effects can vary in intensity from none to very troublesome and worrisome. The level of intensity does not correlate to specific levels of control but should be considered in the overall assessment of risk.*								
Recommended Action for Treatment *(See "Stepwise Approach for Managing Asthma Long Term," page 7)* *The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.*		*Maintain current step.* *Regular follow-up every 1–6 months.* *Consider step down if well controlled for at least 3 months.*			Step up 1 step	Step up at least 1 step	Step up 1 step	*Consider short course of oral systemic corticosteroids.* *Step up 1–2 steps.* *Reevaluate in 2 weeks to achieve control.*		
					Reevaluate in 2–6 weeks to achieve control. *For children 0–4 years, if no clear benefit observed in 4–6 weeks, consider adjusting therapy or alternative diagnoses.*					
					Before step up in treatment: *Review adherence to medication, inhaler technique, and environmental control. If alternative treatment was used, discontinue and use preferred treatment for that step. For side effects, consider alternative treatment options.*					

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* **Abbreviations:** ACQ, Asthma Control Questionnaire®; ACT, Asthma Control Test™; ATAQ, Asthma Therapy Assessment Questionnaire®; EIB, exercise-induced bronchospasm; FVC, forced vital capacity; FEV_1, forced expiratory volume in 1 second; SABA, short-acting $beta_2$-agonist.

† Minimal important difference: 1.0 for the ATAQ; 0.5 for the ACQ; not determined for the ACT.

‡ ACQ values of 0.76–1.4 are indeterminate regarding well-controlled asthma.

§ Data are insufficient to link frequencies of exacerbations with different levels of asthma control. Generally, more frequent and intense exacerbations (e.g., requiring urgent care, hospital or intensive care admission, and/or oral corticosteroids) indicate poorer asthma control.

STEPWISE APPROACH FOR MANAGING ASTHMA LONG TERM

The stepwise approach tailors the selection of medication to the level of asthma severity (see page 5) or asthma control (see page 6). The stepwise approach is meant to help, not replace, the clinical decisionmaking needed to meet individual patient needs.

ASSESS CONTROL:

STEP UP IF NEEDED (first, check medication adherence, inhaler technique, environmental control, and comorbidities)

STEP DOWN IF POSSIBLE (and asthma is well controlled for at least 3 months)

At each step: Patient education, environmental control, and management of comorbidities

0–4 years of age

	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
	Intermittent Asthma	**Persistent Asthma: Daily Medication** Consult with asthma specialist if step 3 care or higher is required. Consider consultation at step 2.				
Preferred Treatment†	SABA* as needed	low-dose ICS*	medium-dose ICS*	medium-dose ICS* + either LABA* or montelukast	high-dose ICS* + either LABA* or montelukast	high-dose ICS* + either LABA* or montelukast + oral corticosteroids
Alternative Treatment†,‡		cromolyn or montelukast				
	If clear benefit is not observed in 4–6 weeks, and medication technique and adherence are satisfactory, consider adjusting therapy or alternate diagnoses.					
Quick-Relief Medication	▪ SABA* as needed for symptoms; intensity of treatment depends on severity of symptoms. ▪ With viral respiratory symptoms: SABA every 4–6 hours up to 24 hours (longer with physician consult). Consider short course of oral systemic corticosteroids if asthma exacerbation is severe or patient has history of severe exacerbations. ▪ Caution: Frequent use of SABA may indicate the need to step up treatment.					

5–11 years of age

	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
	Intermittent Asthma	**Persistent Asthma: Daily Medication** Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + either LABA,* LTRA,* or theophylline(b) **OR** medium-dose ICS	medium-dose ICS* + LABA*	high-dose ICS* + LABA*	high-dose ICS* + LABA* + oral corticosteroids
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§		medium-dose ICS* + either LTRA* or theophylline§	high-dose ICS* + either LTRA* or theophylline§	high-dose ICS* + either LTRA* or theophylline§ + oral corticosteroids
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Increasing use of SABA or use >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

≥12 years of age

	STEP 1	STEP 2	STEP 3	STEP 4	STEP 5	STEP 6
	Intermittent Asthma	**Persistent Asthma: Daily Medication** Consult with asthma specialist if step 4 care or higher is required. Consider consultation at step 3.				
Preferred Treatment†	SABA* as needed	low-dose ICS*	low-dose ICS* + LABA* **OR** medium-dose ICS*	medium-dose ICS* + LABA*	high-dose ICS* + LABA* **AND** consider omalizumab for patients who have allergies††	high-dose ICS* + LABA* + oral corticosteroid§§ **AND** consider omalizumab for patients who have allergies††
Alternative Treatment†,‡		cromolyn, LTRA,* or theophylline§	low-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡	medium-dose ICS* + either LTRA,* theophylline,§ or zileuton‡‡		
		Consider subcutaneous allergen immunotherapy for patients who have persistent, allergic asthma.**				
Quick-Relief Medication	▪ SABA* as needed for symptoms. The intensity of treatment depends on severity of symptoms: up to 3 treatments every 20 minutes as needed. Short course of oral systemic corticosteroids may be needed. ▪ Caution: Use of SABA >2 days/week for symptom relief (not to prevent EIB*) generally indicates inadequate control and the need to step up treatment.					

* **Abbreviations:** EIB, exercise-induced bronchospasm; ICS, inhaled corticosteroid; LABA, inhaled long-acting beta$_2$-agonist; LTRA, leukotriene receptor antagonist; SABA, inhaled short-acting beta$_2$-agonist.

† Treatment options are listed in alphabetical order, if more than one.

‡ If alternative treatment is used and response is inadequate, discontinue and use preferred treatment before stepping up.

§ Theophylline is a less desirable alternative because of the need to monitor serum concentration levels.

** Based on evidence for dust mites, animal dander, and pollen; evidence is weak or lacking for molds and cockroaches. Evidence is strongest for immunotherapy with single allergens. The role of allergy in asthma is greater in children than in adults.

†† Clinicians who administer immunotherapy or omalizumab should be prepared to treat anaphylaxis that may occur.

‡‡ Zileuton is less desirable because of limited studies as adjunctive therapy and the need to monitor liver function.

§§ Before oral corticosteroids are introduced, a trial of high-dose ICS + LABA + either LTRA, theophylline, or zileuton, may be considered, although this approach has not been studied in clinical trials.

ESTIMATED COMPARATIVE DAILY DOSAGES: INHALED CORTICOSTEROIDS FOR LONG-TERM ASTHMA CONTROL

	0–4 years of age			5–11 years of age			≥12 years of age		
Daily Dose	**Low**	**Medium***	**High***	**Low**	**Medium***	**High***	**Low**	**Medium***	**High***
MEDICATION									
Beclomethasone MDI†	N/A	N/A	N/A	80–160 mcg	>160–320 mcg	>320 mcg	80–240 mcg	>240–480 mcg	>480 mcg
40 mcg/puff				1–2 puffs 2x/day	3–4 puffs 2x/day		1–3 puffs 2x/day	4–6 puffs 2x/day	
80 mcg/puff				1 puff 2x/day	2 puffs 2x/day	≥3 puffs 2x/day	1 puff am, 2 puffs pm	2–3 puffs 2x/day	≥4 puffs 2x/day
Budesonide DPI†	N/A	N/A	N/A	180–360 mcg	>360–720 mcg	>720 mcg	180–540 mcg	>540–1,080 mcg	>1,080 mcg
90 mcg/inhalation				1–2 inhs† 2x/day	3–4 inhs† 2x/day		1–3 inhs† 2x/day		
180 mcg/ inhalation					2 inhs† 2x/day	≥3 inhs† 2x/day	1 inh† am, 2 inhs† pm	2–3 inhs† 2x/day	≥4 inhs† 2x/day
Budesonide Nebules	0.25–0.5 mg	>0.5–1.0 mg	>1.0 mg	0.5 mg	1.0 mg	2.0 mg	N/A	N/A	N/A
0.25 mg	1–2 nebs†/day			1 neb† 2x/day					
0.5 mg	1 neb†/day	2 nebs†/day	3 nebs†/day	1 neb†/day	1 neb† 2x/day				
1.0 mg		1 neb†/day	2 nebs†/day		1 neb†/day	1 neb† 2x/day			
Ciclesonide MDI†	N/A	N/A	N/A	80–160 mcg	>160–320 mcg	>320 mcg	160–320 mcg	>320–640 mcg	>640 mcg
80 mcg/puff				1–2 puffs/day	1 puff am, 2 puffs pm– 2 puffs 2x/day	≥3 puffs 2x/day	1–2 puffs 2x/day	3–4 puffs 2x/day	
160 mcg/puff				1 puff/day	1 puff 2x/day	≥2 puffs 2x/day		2 puffs 2x/day	≥3 puffs 2x/day
Flunisolide MDI†	N/A	N/A	N/A	160 mcg	320–480 mcg	≥480 mcg	320 mcg	>320–640 mcg	>640 mcg
80 mcg/puff				1 puff 2x/day	2–3 puffs 2x/day	≥4 puffs 2x/day	2 puffs 2x/day	3–4 puffs 2x/day	≥5 puffs 2x/day

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* It is preferable to use a higher mcg/puff or mcg/inhalation formulation to achieve as low a number of puffs or inhalations as possible.

† **Abbreviations:** DPI, dry powder inhaler (requires deep, fast inhalation); inh, inhalation; MDI, metered dose inhaler (releases a puff of medication); neb, nebule.

ESTIMATED COMPARATIVE DAILY DOSAGES: INHALED CORTICOSTEROIDS FOR LONG-TERM ASTHMA CONTROL *(continued)*

	0–4 years of age			5–11 years of age			≥12 years of age		
Daily Dose	**Low**	**Medium***	**High***	**Low**	**Medium***	**High***	**Low**	**Medium***	**High***
MEDICATION									
Fluticasone MDI†	176 mcg	>176–352 mcg	>352 mcg	88–176 mcg	>176–352 mcg	>352 mcg	88–264 mcg	>264–440 mcg	>440 mcg
44 mcg/puff	2 puffs 2x/day	3–4 puffs 2x/day		1–2 puffs 2x/day	3–4 puffs 2x/day		1–3 puffs 2x/day		
110 mcg/puff		1 puff 2x/day	≥2 puffs 2x/day		1 puff 2x/day	≥2 puffs 2x/day		2 puffs 2x/day	3 puffs 2x/day
220 mcg/puff								1 puffs 2x/day	≥2 puffs 2x/day
Fluticasone DPI†	N/A	N/A	N/A	100–200 mcg	>200–400 mcg	>400 mcg	100–300 mcg	>300–500 mcg	>500 mcg
50 mcg/inhalation				1–2 inhs† 2x/day	3–4 inhs† 2x/day		1–3 inhs† 2x/day		
100 mcg/inhalation				1 inh† 2x/day	2 inhs† 2x/day	>2 inhs† 2x/day		2 inhs† 2x/day	≥3 inhs† 2x/day
250 mcg/inhalation						1 inh† 2x/day		1 inh† 2x/day	≥2 inhs† 2x/day
Mometasone DPI†	N/A	N/A	N/A	110 mcg	220–440 mcg	>440 mcg	110–220 mcg	>220–440 mcg	>440 mcg
110 mcg/inhalation				1 inh†/day	1–2 inhs† 2x/day	≥3 inhs† 2x/day	1–2 inhs† pm	3–4 inhs† pm or 2 inhs† 2x/day	≥3 inhs† 2x/day
220 mcg/inhalation					1–2 inhs†/day	≥3 inhs† divided in 2 doses	1 inh† pm	1 inh† 2x/day or 2 inhs† pm	≥3 inhs† divided in 2 doses

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* It is preferable to use a higher mcg/puff or mcg/inhalation formulation to achieve as low a number of puffs or inhalations as possible.

† **Abbreviations:** DPI, dry powder inhaler (requires deep, fast inhalation); inh, inhalation; MDI, metered dose inhaler (releases a puff of medication); neb, nebule.

Therapeutic Issues Pertaining to Inhaled Corticosteroids (ICSs) for Long-Term Asthma Control

- **The most important determinant of appropriate dosing is the clinician's judgment of the patient's response to therapy.** The clinician must monitor the patient's response on several clinical parameters (e.g., symptoms; activity level; measures of lung function) and adjust the dose accordingly. Once asthma control is achieved and sustained at least 3 months, the dose should be carefully titrated down to the minimum dose necessary to maintain control.
- Some doses may be outside package labeling, especially in the high-dose range. Budesonide nebulizer suspension is the only inhaled corticosteroid (ICS) with FDA-approved labeling for children <4 years of age.
- Metered-dose inhaler (MDI) dosages are expressed as the actuator dose (amount leaving the actuator and delivered to the patient), which is the labeling required in the United States. This is different from the dosage expressed as the valve dose (amount of drug leaving the valve, not all of which is available to the patient), which is used in many European countries and in some scientific literature. Dry powder inhaler (DPI) doses are expressed as the amount of drug in the inhaler following activation.
- For children <4 years of age: The safety and efficacy of ICSs in children <1 year of age has not been established. Children <4 years of age generally require delivery of ICS (budesonide and fluticasone MDI) through a face mask that fits snugly over nose and mouth to avoid nebulizing in the eyes. Face should be washed after treatment to prevent local corticosteroid side effects. For budesonide, the dose may be given 1–3 times daily. Budesonide suspension is compatible with albuterol, ipratropium, and levalbuterol nebulizer solutions in the same nebulizer. Use only jet nebulizers, as ultrasonic nebulizers are ineffective for suspensions. For fluticasone MDI, the dose should be divided 2 times daily; the low dose for children <4 years of age is higher than for children 5–11 years of age because of lower dose delivered with face mask and data on efficacy in young children.

USUAL DOSAGES FOR OTHER LONG-TERM CONTROL MEDICATIONS*

Medication	0–4 years of age	5–11 years of age	≥12 years of age
Combined Medication (inhaled corticosteroid + long-acting beta$_2$-agonist)			
Fluticasone/Salmeterol — DPI† 100 mcg/50 mcg, 250 mcg/50 mcg, or 500 mcg/50 mcg MDI† 45 mcg/21 mcg, 115 mcg/21 mcg, or 230 mcg/21 mcg	N/A†	1 inhalation 2x/day; dose depends on level of severity or control	1 inhalation 2x/day; dose depends on level of severity or control
Budesonide/Formoterol — MDI† 80 mcg/4.5 mcg or 160 mcg/4.5 mcg	N/A†	2 puffs 2x/day; dose depends on level of severity or control	2 puffs 2x/day; dose depends on level of severity or control
Mometasone/Formoterol — MDI† 100 mcg/5 mcg	N/A†	N/A†	2 inhalations 2x/day; dose depends on severity of asthma
Leukotriene Modifiers			
Leukotriene Receptor Antagonists (LTRAs) Montelukast — 4 mg or 5 mg chewable tablet, 4 mg granule packets, 10 mg tablet	4 mg every night at bedtime (1–5 years of age)	5 mg every night at bedtime (6–14 years of age)	10 mg every night at bedtime
Zafirlukast — 10 mg or 20 mg tablet *Take at least 1 hour before or 2 hours after a meal. Monitor liver function.*	N/A†	10 mg 2x/day (7–11 years of age)	40 mg daily (20 mg tablet 2x/day)
5-Lipoxygenase Inhibitor Zileuton — 600 mg tablet *Monitor liver function.*	N/A†	N/A†	2,400 mg daily (give 1 tablet 4x/day)
Immunomodulators			
Omalizumab (Anti IgE†) — Subcutaneous injection, 150 mg/1.2 mL following reconstitution with 1.4 mL sterile water for injection *Monitor patients after injections; be prepared to treat anaphylaxis that may occur.*	N/A†	N/A†	150–375 mg subcutaneous every 2–4 weeks, depending on body weight and pretreatment serum IgE level
Cromolyn			
Cromolyn — Nebulizer: 20 mg/ampule	1 ampule 4x/day, N/A† <2 years of age	1 ampule 4x/day	1 ampule 4x/day
Methylxanthines			
Theophylline — Liquids, sustained-release tablets, and capsules *Monitor serum concentration levels.*	Starting dose 10 mg/kg/day; usual maximum: ▪ <1 year of age: 0.2 (age in weeks) + 5 = mg/kg/day ▪ ≥1 year of age: 16 mg/kg/day	Starting dose 10 mg/kg/day; usual maximum: 16 mg/kg/day	Starting dose 10 mg/kg/day up to 300 mg maximum; usual maximum: 800 mg/day
Inhaled Long-Acting Beta$_2$-Agonists (LABAs) – used in conjunction with ICS† for long-term control; LABA is NOT to be used as monotherapy			
Salmeterol — DPI† 50 mcg/blister	N/A†	1 blister every 12 hours	1 blister every 12 hours
Formoterol —DPI† 12 mcg/single-use capsule	N/A†	1 capsule every 12 hours	1 capsule every 12 hours
Oral Systemic Corticosteroids			
Methylprednisolone — 2, 4, 8, 16, 32 mg tablets **Prednisolone** — 5 mg tablets; 5 mg/5 cc, 15 mg/5 cc **Prednisone** — 1, 2.5, 5, 10, 20, 50 mg tablets; 5 mg/cc, 5 mg/5 cc	▪ 0.25–2 mg/kg daily in single dose in a.m. or every other day as needed for control ▪ Short course "burst": 1–2 mg/kg/day, max 60 mg/d for 3–10 days	▪ 0.25–2 mg/kg daily in single dose in a.m. or every other day as needed for control ▪ Short course "burst": 1–2 mg/kg/day, max 60 mg/d for 3–10 days	▪ 7.5–60 mg daily in single dose in a.m. or every other day as needed for control ▪ Short course "burst": to achieve control, 40–60 mg/day as single or 2 divided doses for 3–10 days

* Dosages are provided for those products that have been approved by the U.S. Food and Drug Administration or have sufficient clinical trial safety and efficacy data in the appropriate age ranges to support their use.

† **Abbreviations:** DPI, dry powder inhaler; IgE, immunoglobulin E; MDI, metered-dose inhaler; N/A, not available (not approved, no data available, or safety and efficacy not established for this age group).

The most important determinant of appropriate dosing is the clinician's judgment of the patient's response to therapy. The clinician must monitor the patient's response on several clinical parameters (e.g., symptoms; activity level; measures of lung function) and adjust the dose accordingly. Once asthma control is achieved and sustained at least 3 months, the dose should be carefully titrated down to the minimum dose necessary to maintain control.

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RESPONDING TO PATIENT QUESTIONS ABOUT INHALED CORTICOSTEROIDS

Questions and varying beliefs about inhaled corticosteroids (ICSs) are common and may affect adherence to treatment. Following are some key points to share with patients and families.

- ICSs are the most effective medications for long-term control of persistent asthma. Because ICSs are inhaled, they go right to the lungs to reduce chronic airway inflammation. In general, ICSs should be taken every day to prevent asthma symptoms and attacks.
- The potential risks of ICSs are well balanced by their benefits. To reduce the risk of side effects, patients should work with their doctor to use the lowest dose that maintains asthma control, and be sure to take the medication correctly.
  - Mouth irritation and thrush (yeast infection), which may be associated with ICSs at higher doses, can be avoided by rinsing the mouth and spitting after ICS use and, if appropriate for the inhaler device, by using a valved holding chamber or spacer.
  - ICS use may slow a child's growth rate slightly. This effect on linear growth is not predictable and is generally small (about 1 cm), appears to occur in the first several months of treatment, and is not progressive. The clinical significance of this potential effect has yet to be determined. Growth rates are highly variable in children, and poorly controlled asthma can slow a child's growth.
- ICSs are generally safe for pregnant women. Controlling asthma is important for pregnant women to be sure the fetus receives enough oxygen.
- ICSs are not addictive.
- ICSs are not the same as anabolic steroids that some athletes use illegally to increase sports performance.

RESPONDING TO PATIENT QUESTIONS ABOUT LONG-ACTING BETA$_2$-AGONISTS

Keep the following key points in mind when educating patients and families about long-acting beta$_2$-agonists (LABAs).

- The addition of LABA (salmeterol or formoterol) to the treatment of patients who require more than low-dose inhaled corticosteroid (ICS) alone to control asthma improves lung function, decreases symptoms, and reduces exacerbations and use of short-acting beta$_2$-agonists (SABA) for quick relief in most patients to a greater extent than doubling the dose of ICS.
- A large clinical trial found that slightly more deaths occurred in patients taking salmeterol in a single inhaler every day in addition to usual asthma therapy* (13 out of about 13,000) compared with patients taking a placebo in addition to usual asthma therapy (3 out of about 13,000). Trials for formoterol in a single inhaler every day in addition to usual therapy* found more severe asthma exacerbations in patients taking formoterol, especially at higher doses, compared with those taking a placebo added to usual therapy. Therefore, the Food and Drug Administration placed a Black Box warning on all drugs containing a LABA.
- The established benefits of LABAs added to ICS for the great majority of patients who require more than low-dose ICS alone to control asthma should be weighed against the risk of severe exacerbations, although uncommon, associated with daily use of LABAs.
- LABAs should not be used as monotherapy for long-term control. Even though symptoms may improve significantly, it is important to keep taking ICS while taking LABA.
- Daily use should generally not exceed 100 mcg salmeterol or 24 mcg formoterol.
- It is not currently recommended that LABAs be used to treat acute symptoms or exacerbations.

* Usual therapy included a wide range of regimens, from those in which no other daily therapy was taken to those in which varying doses of other daily medications were taken.

EDUCATIONAL RESOURCES

National Heart, Lung, and Blood Institute

- Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (EPR-3) www.nhlbi.nih.gov/guidelines/asthma
- Physician Asthma Care Education (PACE): www.nhlbi.nih.gov/health/prof/lung/asthma/pace/
- National Asthma Control Initiative (NACI): http://naci.nhlbi.nih.gov

Allergy & Asthma Network Mothers of Asthmatics
800-878-4403
www.aanma.org

American Academy of Allergy, Asthma, and Immunology
414-272-6071
www.aaaai.org

American Academy of Pediatrics
847-434-4000
www.aap.org

American Association of Respiratory Care
972-243-2272
www.aarc.org

American College of Chest Physicians
847-498-1400
www.chestnet.org

American College of Allergy, Asthma & Immunology
847-427-1200
www.acaai.org

American Lung Association
800-LUNG-USA (800-586-4872)
www.lungusa.org

American School Health Association
800-445-2742
www.ashaweb.org

Asthma and Allergy Foundation of America
800-7-ASTHMA (800-727-8462)
http://aafa.org

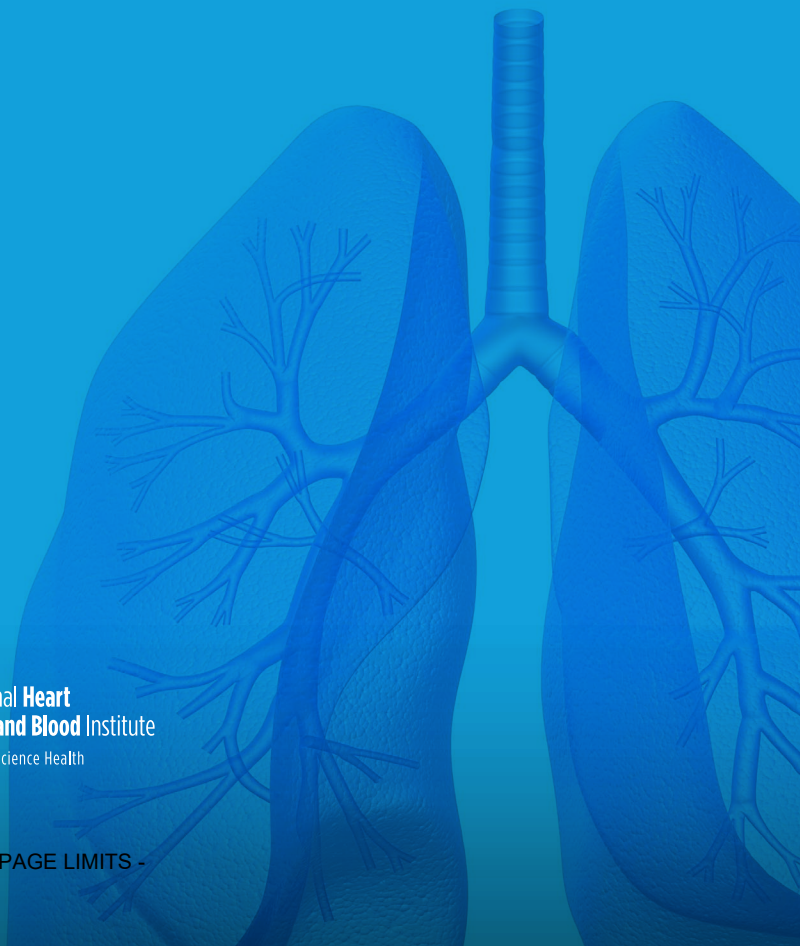
Centers for Disease Control and Prevention
800-CDC-INFO (800-232-4636)
www.cdc.gov/asthma

Environmental Protection Agency/ Asthma Community Network
www.asthmacommunitynetwork.org
800-490-9198 (to order EPA publications)
www.epa.gov/asthma/publications.html

National Association of School Nurses
240-821-1130
www.nasn.org

For more information contact:

NHLBI Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
Phone: 301-592-8573
Fax: 301-592-8563
Web site: www.nhlbi.nih.gov



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ATTACHMENT 2.10.13.1
Claims Processing System

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Transforming Louisiana's health, one person at a time.

ATTACHMENT 2.10.13.2
IT Systems Landscape

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[redacted]

ATTACHMENT 2.10.13.2.1
Contingency Plan

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ATTACHMENT 2.10.13.2.3.A
Enrollment System

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ATTACHMENT 2.10.13.2.3.B
Customer Service Systems

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ATTACHMENT 2.10.13.2.3.C
Care and Utilization Management Systems

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ATTACHMENT 2.10.13.2.3.D
Provider Lifecycle Management System

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ATTACHMENT
2.10.13.3 Centelligence Platform

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