

louisiana healthcare connections™

For the health of all.

Response to the Request for Proposals

BUSINESS AND TECHNICAL PROPOSAL

RFP #: 3000017417
FOR LOUISIANA MEDICAID MANAGED CARE ORGANIZATIONS
PROPOSAL DUE DATE/TIME:
September **10**, 2021, 3 PM CT

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

TO:
Ali Bagbey
Louisiana Department of Health
628 N. Fourth Street
Baton Rouge, LA 70802
(225) 219-0206

REDACTED COPY

CONFIDENTIAL INFORMATION, TRADE SECRETS, AND PROPRIETARY INFORMATION

The data contained in the following pages of the proposal have been submitted in confidence and contain 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.

Section #	Proposal Page(s)	Redacted Information
Section 2.4.1	PDF Pages 5-9	Innovative Model, Map, Partnerships, Staffing, Company Information, Litigation
Section 2.5	PDF Pages 12-13	Staffing, Material Subcontractors, Company Information
Section 2.6.2.1	PDF Page 36	Partnerships, Value Based Payment Information
Section 2.6.2.2	PDF Pages 39-44	Minimum Wage, Average Salary, Senior Leadership and Key Personnel, Current and Proposed Staffing Numbers
Section 2.6.3	PDF Pages 46, 48-49, 52-57	Innovative Model, Partnerships, Grants, Value-added benefits model design, Additional Value-Adds
Section 2.6.4	PDF Pages 60, 65-67, 69-70	Partnerships, Provider Investments, Technology
Section 2.6.5	PDF Pages 73-77, 80-82	Innovative Model, Map, Partnerships, Action Plans
Section 2.6.6	PDF Pages 86-87, 90-92, 94, 96-97	Partnerships, Data, Grants, Caseload Ratios, Payment Methodologies
Section 2.6.7	PDF Pages 84-85, 86 107, 117, 126, 131, 138	Partnerships , Value-added Benefits Model Design
Section 2.6.8	PDF Pages 147-150, 153-154	Provider Partnerships, Provider Incentives, Reimbursement Strategies, Provider Grant
Section 2.6.9	PDF Pages 159, 162-163, 165	Provider Partnerships, Provider Grant, VBP Strategies, Incentives, Provider Performance
Section 2.6.10	PDF Pages 170, 176, 179-181	Provider Partnerships, Innovative Model, Community Partnerships, Staffing
Section 2.6.11	PDF Pages 185-188, 190, 192, 194	Innovative Model, Provider Partnerships, VBP Strategies and Incentives, Enrollee Incentives, Value-Added Benefits Design Model, Community Partnerships, Organizational Chart
Section 2.6.12	PDF Pages 200-207	Payment Models and Strategies
Section 2.6.14	PDF Pages 221, 223, 227-228	Provider Payment Recoveries, Technology
Section 2.6.15	PDF Pages 232, 233-235, 237, 239	Provider Value Based Payments, Grants, Technology, Innovative Program, Partners
ATTACHMENTS		
Attachment 2.6.2.1.3	PDF Pages: 242-264	Non Compliance Events
Attachment 2.6.2.2.2.a-h	PDF Pages: 266-285	Key Personnel Resumes
Attachment 2.6.2.2.3.a-m	PDF Pages: 287-299	LHCC Organization Charts
Attachment 2.6.3.4	PDF Pages: 301-302	LHCC Certification of Actuarial Values
Attachment 2.6.13.2	PDF Pages: 364	IT Systems Landscape
Attachment 2.6.13.2.3.a-g	PDF Pages: 366-373	Data and Process Flows
Attachment 2.6.13.3	PDF Pages: 375	Contingency Plan
ELECTRONIC ONLY		
Attachment 2.5.4.3.a	Electronic document all pages	Exhibit B Material Subcontractor Envolve Vision, Inc.
Attachment 2.5.4.3.b	Electronic document all pages	Exhibit B Material Subcontractor Veyo, LLC
Attachment 2.5.5.1.1.a-c	Electronic document all pages	LHCC Financial Information
Attachment 2.5.6.3	Electronic document all pages	Exhibit D Medicaid Ownership and Disclosure Form
Attachment 4.4	Electronic document all pages	Hudson and Veteran Initiative Response Template

SECTION 2.4

Table of Contents

"When I received the crib from Louisiana Healthcare Connections… it lit up my day. The cribette was a blessing… You have people out there who care about you and your kid and they're actually reaching out. That was a really big deal for me.

With everything Louisiana Healthcare Connections has done for me and my baby, they just make me feel like family."

- **Moneisha**
Enrollee, Monroe

Hear more from Moneisha on YouTube: https://lahealth.cc/moneisha

2.4 TABLE OF CONTENTS

RFP Section	Requirement	Proposal Section	Proposal Page(s)
2.4	Table of Contents	2.4	Exempt
2.4.1	Cover Letter	2.4.1	Exempt
2.5 Business Proposal			
2.5.1*	Mandatory Qualifications	2.5.1	1
2.5.2*	Conflict of Interest	2.5.2	1-2
2.5.3*	Moral or Religious Objections	2.5.3	2
2.5.4*	Material Subcontractors	2.5.4	3-4
2.5.5*	Financial Condition	2.5.4	4
2.5.6*	Required Forms and Certifications	2.5.5	4
2.5 Business Proposal Attachments			
Attachment	2.2.1 Board Resolution Granting Signature Authority Signed	2.2.1	Exempt
Attachment	2.5.4.3.a Exhibit B Material Subcontractor Envolve Vision, Inc.	Electronic Only	Exempt
Attachment	2.5.4.3.b Exhibit B Material Subcontractor Veyo, LLC	Electronic Only	Exempt
Attachment	2.5.5.1.1.a LHCC 2020 Audited Financial Statements	Electronic Only	Exempt
Attachment	2.5.5.1.1.b LHCC 2019 Audited Financial Statements	Electronic Only	Exempt
Attachment	2.5.5.1.1.c LHCC 2018 Audited Financial Statements	Electronic Only	Exempt
Attachment	2.5.5.1.1.d Centene 2020 10K Audited Financials	Electronic Only	Exempt
Attachment	2.5.5.1.1.e Centene 2019 10K Audited Financials	Electronic Only	Exempt
Attachment	2.5.5.1.1.f Centene 2018 10K Audited Financials	Electronic Only	Exempt
Attachment	2.5.5.1.2.a LHCC Certificate of Good Standing DOR	Attachment	Exempt
Attachment	2.5.5.1.2.b LHCC Certificate of Good Standing SOS	Attachment	Exempt
Attachment	2.5.6.1 Exhibit C Proposal Compliance Matrix	Attachment	Exempt
Attachment	2.5.6.2 Exhibit A Certification Statement	Attachment	Exempt
Attachment	2.5.6.3 Exhibit D Medicaid Ownership and Disclosure Form	Electronic Only	Exempt
2.6 Technical Proposal			
2.6.2	Proposer Organization and Experience:		
2.6.2.1	Proposer Organization	2.6.2.1	5-6
2.6.2.2	Proposed Staff Qualifications and Organizational Structure	2.6.2.2	7-12
2.6.3	Enrollee Value-Added Benefits	2.6.3	13-24
2.6.4	Population Health	2.6.4	25-36
2.6.5	Health Equity	2.6.5	37-48
2.6.6	Care Management	2.6.6	49-62
2.6.7	Case Scenarios	2.6.7	63-107
2.6.8	Network Management	2.6.8	108-117
2.6.9	Provider Support	2.6.9	118-128
2.6.10	Utilization Management	2.6.10	129-142
2.6.11	Quality	2.6.11	143-155
2.6.11.6	Quality Response Template	Electronic Only	Exempt
2.6.12	Value-Based Payment	2.6.12	156-165
2.6.13	Claims Management and Systems and Technical Requirements	2.6.13	166-174
2.6.14	Program Integrity	2.6.14	175-183
2.6.15	Physical & Specialized Behavioral Health Integration Requirements	2.6.15	184-192

2.6 Technical Proposal Attachments			
Attachment	2.6.2.1.3 Non Compliance Events	2.6.2	193-215
Attachment	2.6.2.2.2-.a-h Key Personnel Resumes	2.6.2	216-235
Attachment	2.6.2.2.3.a-m LHCC Organizational Charts	2.6.2	236-248
Attachment	2.6.3.4 LHCC Certification of Actuarial Values	2.6.3	249-250
Attachment	2.6.11.5 LHCC Adopted CPGs and Sample CPG	2.6.11	Exempt
Attachment	2.6.11.7 Certificates of Accreditation	2.6.11	Exempt
Attachment	2.6.13.2 IT Systems Landscape	2.6.13	Exempt
Attachment	2.6.13.2.3.a-g Data and Process Flows	2.6.13	Exempt
Attachment	2.6.13.3 Contingency Plan	2.6.13	Exempt
Veteran and Hudson Initiative Programs Participation			
Attachment	4.4 Hudson and Veteran Initiative Response Template	Electronic Only	Exempt

**** Section 2.5 has been provided as one section per Q&A Document, #43 revision:*** *"Proposers may include more than one subsection (i.e., 2.5.1, 2.5.2, etc.) of the business proposal on the same page, rather than include only one on each page, to meet the recommended 5-page limit. Each subsection should be clearly marked."*

SECTION 2.4.1

Cover Letter



"On behalf of the City of Lake Charles, I am writing to express my appreciation to Louisiana Healthcare Connections for their support... as part of our commitment to educate the community on chronic disease and prevention. Additionally, members of the poor and underserved in our community benefited greatly from LHCC's financial and volunteer role in our free, mobile medical events, 'Operation Healing and Restoration.'

Louisiana Healthcare Connections provides resources central to the vitality of our community and we have seen the impact of your commitment to better health."

- Nicholas E. Hunter
Mayor, City of Lake Charles

September 10, 2021

Ali Bagbey
Louisiana Department of Health
628 N. Fourth Street
Baton Rouge, LA 70802
(225) 219-0206

Dear Ms. Bagbey:

Louisiana Healthcare Connections, Inc. (LHCC) is pleased to submit our response to the Louisiana Department of Health – Request for Proposals for Louisiana Medicaid Managed Care Organizations RFP #: 3000017417. LHCC acknowledges receipt of all addenda.

2.4.1.1 Location of Proposer's administrative office with full-time personnel;

Main Headquarters:
Baton Rouge
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

Lafayette:
825 Kaliste Saloom Rd
Brandywine 1, Ste. 200
Lafayette, LA 70508

Covington:
144 New Camellia Blvd.
Covington, LA 70433

New Orleans
880 W. Commerce Road
New Orleans, LA 70123

[redacted]

As we approach our tenth year serving Louisiana's Medicaid enrollees, we are excited by LDH's vision for the future of Medicaid and the opportunity for dramatic advancements in health equity; expanded approaches to foster health beyond healthcare settings; deeper, value-based collaboration among providers and MCOs; and transformative improvement in the health of our state's population.

The recent impact of Hurricane Ida brings into focus the fragility of our livelihoods, homes and communities. In the coming weeks, LHCC will begin to care for new enrollees who are unexpectedly finding themselves relying on SNAP, FEMA and Medicaid, perhaps for the first time in their lives. Some of them will be our family members and friends. Recovering from disaster also brings into focus the importance of our safety nets, our partners, our local resources, and the strength of our communities.

Based on our hurricane response plan that has been refined by previous storms, LHCC has quickly deployed emergency support for our enrollees, providers and communities, including delivering food, water, emergency medical supplies; COVID-19 prevention face masks and hand sanitizer; and care coordination for enrollees evacuated out of state - especially pregnant enrollees approaching their due date and those with special health care needs. We will continue to address enrollees' SDOH needs and support their recovery in the coming months, in close coordination with our network of CBOs and providers. We have been here before. We will rebuild and recover, together.

As an example of our investment in sustainable solutions within our communities to support health, wellness, and recovery, LHCC is opening nine Community Wellness Centers strategically located throughout Louisiana. In addition to improving population health, we are locating four of our Centers in areas where our enrollees experience disproportionate impacts of health disparities and barriers to health. Through our strong partnerships with community-based organizations, our Centers will connect enrollees with fundamental necessities such as food pantries, housing assistance, after-school and summer educational programs, tuition scholarships and grants, broadband internet access, and workforce development training.

[redacted]

[redacted]

[redacted]

2.4.1.2 Name and address of Proposer's 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

2.4.1.3 Name and address of the Proposer's corporate principal office to issue checks and/or drafts;
James Schlottman, Plan President and CEO
8585 Archives Avenue, Suite 310
Baton Rouge, LA 70809

2.4.1.4 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.

2.4.1.5 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.

2.4.1.6 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.

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

2.4.1.8 If any of Proposer's 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
[redacted]	[redacted]	[redacted]

2.4.1.9 Proposer's State and federal tax identification numbers, LaGov vendor number, and Louisiana Department of Revenue number, if available;

[redacted]

2.4.1.10 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:

CONFIDENTIAL

Date	Court	Parties	Complaint	Status
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Closed Litigation:

Date	Court	Parties	Complaint	Status
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

louisiana healthcare connections

Date	Court	Parties	Complaint	Status
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Date	Court	Parties	Complaint	Status
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

The signed Exhibit A Certification Form along with the certified copy of a board resolution granting such authority is provided as part of the attachments following the Business Proposal. Additionally, we are confirming that our proposal is compliant and within the page limits set forth, per RFP instructions in Section 2.4.3 on page 22, "Proposals should not exceed two hundred fifty (250) pages in total, inclusive of attachments, appendices, and exhibits, unless explicitly exempted in this RFP."

The vision for the Medicaid managed care that LDH laid out in this RFP is transformational for the future of Louisianan's health. We are excited by the opportunity to make dramatic improvements in health equity and whole-person health for all Louisianans. Aligned with LDH's objectives, the changes in our organization and expansions of our benefits and programs described in our proposal are inspired by and tailor to LDH's goals for the Medicaid program.
We are grateful for the opportunity to respond to this RFP, humbled by the progress of the past ten years, and energized to continue our partnership with LDH during this pivotal moment in healthcare transformation for all Louisianans.

Sincerely,

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

SECTION 2.5

Business Proposal

"You don't know how much it means to have someone that's there to say 'Okay, what else can I do for you today?' I was able to pick up the phone and tell them that Angelica had a doctor's appointment... and they would send a car to pick us up. With all of the day-to-day challenges I have just to get through one day, my healthcare makes everything just a little bit easier.

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
Enrollee, Shreveport

Hear more from Sherrika on YouTube: https://lahealth.cc/sherrika

2.5 BUSINESS PROPOSAL [5 PAGE LIMIT]

Louisiana Healthcare Connections (LHCC) asserts that it meets the mandatory requirements to respond to RFP #: 3000017417 as indicated in the following responses.

2.5.1 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 for receipt of proposals:

2.5.1.1 Meets 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.

2.5.1.2 Has 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 2.6 Technical Proposal Requirements.

2.5.1.3 Is not 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).

2.5.1.4 Has 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 9 years of experience serving Medicaid enrollees in the state of Louisiana, exceeding the minimum requirement of five years.

2.5.1.5 Has, 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 managed care population equal to or greater than 1.5 million Enrollees*; 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 1.5 million enrollees. Additional information may be found in ***Technical Response Section 2.6.2 Proposer Organization and Experience***.

2.5.1.6 Has its principal place of business located inside the continental United States.

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

2.5.2 Conflict of Interests

Neither the Proposer nor any of its subcontractors 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:

2.5.2.1 A signed Exhibit A, Certification Statement, attesting that the Proposer does not have any financial, legal, contractual, and other business interest that 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 Model Contract. A signed Exhibit A Certification Statement is provided within the attachments section at the end of the response as ***Attachment 2.5.6.2***.

2.5.2.2 A signed Exhibit A, Certification Statement, 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 vendors' 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 in such vendors' subcontractors. A signed Exhibit A Certification Statement is provided within the attachments section at the end of the response as ***Attachment 2.5.6.2.***

2.5.2.3 A signed Exhibit A, Certification Statement, 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 our financial, legal, contractual, or other business interests as they relate to the RFP and contract. A signed Exhibit A Certification Statement is provided within the attachments section at the end of the response as ***Attachment 2.5.6.2.***

2.5.2.4 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; and

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

2.5.2.5 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.

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.

2.5.3 Moral or Religious Objections

The Proposer shall provide:2.5.3.1 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, and Services.

2.5.3.2 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.

2.5.4 Material Subcontractors

Proposers may enter into subcontractor arrangements or agreements, however, shall acknowledge in their proposals total responsibility for the entire contract.
2.5.4.1 If the Proposer intends to subcontract for portions of the work, the Proposer shall identify any subcontractor relationships and include specific designations of the tasks to be performed by the subcontractor. Information required of the Proposer under the terms of this RFP shall also be required for each subcontractor, if requested by the State. The prime Contractor shall be the single point of contact for all subcontract work.

LHCC will continue to be compliant with 2.5.4.1. In ***Table 2.5.4.2*** below, we detail our material subcontractor relationships and specific designations of tasks to be performed by each material subcontractor.

2.5.4.2 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, and if so, shall identify each such subcontractor by corporate or other legal entity name, address, and telephone number. Additional information is requested in the technical proposal requirements.

[redacted]

Table 2.5.4.2 LHCC Material Subcontractors

Material Subcontractor	Principal Address and Telephone Number	Tasks to be Performed by Material Subcontractor
Affiliated		
[redacted]	[redacted]	[redacted]
[redacted]	[redacted]	[redacted]

[redacted]

2.5.4.3 Where the Proposer utilizes a material subcontractor to provide behavioral health, or vision services, or a value-added benefit such as dental service, the Proposer should provide a completed Exhibit B, Material Subcontractor Response Template, including the executed or draft agreement, for each material subcontractor. This response may be submitted in electronic format in lieu of hard copy and is exempt from the business proposal and total page limits.

[redacted]

2.5.4.4 The Proposer must submit a signed Exhibit A, Certification Statement, attesting that the Proposer:
2.5.4.4.1 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'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; and

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. Please see Exhibit A, Certification Statement in ***Attachment 2.5.6.2*** located within the Attachments and Exhibits section of the RFP response.

2.5.4.4.2 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.

2.5.4.4.3 Unless provided for in the contract, the Proposer shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department.

LHCC will not contract with any other party for services without the express prior written approval of LDH.

2.5.5 Financial Condition [exempt from business proposal and total page limits]

2.5.5.1 The Proposer shall submit documentation to demonstrate to the satisfaction of LDH that the Proposer's organization (and the Proposer's parent organization) has adequate financial resources for performance, or has the ability to obtain such resources as required during performance. The documents submitted should include the following:
2.5.5.1.1 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. The Proposer should also submit such information with respect to the Proposer's parent organization. The Proposer may submit this information in electronic format in lieu of hard copy;

LHCC has provided copies of audited financial statements for the last three years for our organization and our parent organization as ***Attachments 2.5.5.1.1.a-f.*** 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 2.5.5.1.1.a LHCC 2020 Audited Financial Statements CONFIDENTIAL Attachment 2.5.5.1.1.b LHCC 2019 Audited Financial Statements CONFIDENTIAL Attachment 2.5.5.1.1.c LHCC 2018 Audited Financial Statements CONFIDENTIAL
Parent Organization	
Centene Corporation	Attachment 2.5.5.1.1.d Centene 2020 10K Audited Financials Attachment 2.5.5.1.1.e Centene 2019 10K Audited Financials Attachment 2.5.5.1.1.f Centene 2018 10K Audited Financials

2.5.6 Required Forms and Certifications [exempt from the business proposal and total page limits]

The Proposer shall complete and submit the forms detailed below. Electronic versions of the forms are available in the procurement library.
2.5.6.1 Exhibit C, Proposal Compliance Matrix.
2.5.6.2 Exhibit A, Certification Statement. 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 Proposer's Certification Statement. Information on registration may be found at https://wwwcfprd.doa.louisiana.gov/osp/lapac/Vendor/VndPubMain.cfm?tab=2.
2.5.6.3 Exhibit D, Medicaid Ownership and Disclosure Form, as Federal laws require full disclosure of ownership, management, and control of MCOs. The Proposer may submit this information in electronic format in lieu of hard copy.

Exhibit C, Proposal Compliance Matrix is provided within the attachments section at the end of the response as ***Attachment 2.5.6.1.*** A signed Exhibit A Certification Statement is provided within the attachments section at the end of the response as ***Attachment 2.5.6.2.*** Per the RFP, Exhibit D, Medicaid Ownership and Disclosure Form is provided in electronic format in lieu of hard copy as ***Attachment 2.5.6.3.*** This information is exempt from business proposal and total page limits per Q&A line 45.

2.5 BUSINESS PROPOSAL



ATTACHMENTS

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.2.1

LHCC Board Resolution

RECORD OF ACTION
BY UNANIMOUS CONSENT
IN LIEU OF SPECIAL MEETING
OF THE BOARD OF DIRECTORS OF
LOUISIANA HEALTHCARE CONNECTIONS, INC.

The undersigned, being all the directors of Louisiana Healthcare Connections, Inc. (the "Company"), a Louisiana corporation, do hereby consent to the adoption of the following resolution by unanimous written consent, all in accordance with Section 1-821 of the Louisiana Business Corporation Act:

It was moved and seconded that the following resolution be adopted:

BE IT RESOLVED, that the Board of Directors of the Company do hereby authorize James Elliot Schlottman, Chief Executive Officer and Plan President, or any other named officer of the Company to negotiate at any time within 2 years from this date and on terms and conditions that he may deem advisable, a contract or contracts with the Louisiana Department of Health, and to execute said documents on behalf of the Company, and further we do hereby give him the power and authority to do all things necessary to implement, maintain, amend or renew said documents.

Dated August 23, 2021

James Elliot Schlottman

Thomas Wise

William Brent, III

Michael Fleming, M.D.

Christopher Leumas, M.D.

Terrie Thomas, M.D.

Dawn Vick, M.D.



CERTIFICATE OF AUTHORITY

I Joel B. Samson, hereby certify that I am Secretary of Louisiana Healthcare Connections, Inc., a Louisiana corporation organized and existing under the laws of the State of Louisiana (the "Corporation").

I further certify that James Elliot Schlottman, Chief Executive Officer and President of the Corporation is authorized to sign on behalf of the Corporation any and all agreements and execute any and all contracts, documents and instruments necessary to bind 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 23rd

Joel B. Samson, Secretary

State of Missouri

County of St. Louis

On this 23rd day of August, 2021, before me, Laura L. Greeno, the undersigned Notary Public, personally appeared Joel B. Samson, 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.

Signature of Notary

LAURA L GREENO
Notary Public - Notary Seal
St Louis County - State of Missouri
Commission Number 12426339
My Commission Expires Dec 18, 2024

ATTACHMENT 2.5.4.3.a

Exhibit B Material Subcontractor Envolve Vision, Inc.

Per the RFP, the Proposer may submit this information as an attachment in electronic format in lieu of hard copy.

CONFIDENTIAL

ATTACHMENT 2.5.4.3.B

Exhibit B Material Subcontractor Veyo, LLC

Per the RFP, the Proposer may submit this information as an attachment in electronic format in lieu of hard copy.

CONFIDENTIAL

ATTACHMENT 2.5.5.1.1.a-f

Audited Financial Reports



Per the RFP, the Proposer may submit this information as an attachment in electronic format in lieu of hard copy.

CONFIDENTIAL

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.5.5.1.2

LHCC Certificate of Good Standing DOR

LOUISIANA DEPARTMENT of REVENUE
Post Office Box 66658
Baton Rouge, LA 70896-6658

LOUISIANA HEALTHCARE CONNECTIONS INC
7700 FORSYTH BLVD STE 800
SAINT LOUIS MO 63105-1837

Date of Notice: 07/20/2021
Letter ID: L1389247504
Account ID: 6152516-001-200
Tax Type: Corporat on Income & Franch se

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,

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

- EXEMPT FROM PAGE LIMITS -

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.5.5.1.2.b

LHCC Certificate of Good Standing SOS

UNITED STATES OF AMERICA

State of Louisiana

R. Kyle Ardoin

SECRETARY OF STATE

As Secretary of State, of the State of Louisiana, I do hereby Certify that

LOUISIANA HEALTHCARE CONNECTIONS, INC.

A corporation domiciled in BATON ROUGE, LOUISIANA,

Filed charter and qualified to do business in this State on November 02, 2009,

I further certify that the records of this Office indicate the corporation has paid all fees due the Secretary of State, and so far as the Office of the Secretary of State is concerned is in good standing and is authorized to do business in this State.

I further certify that this Certificate is not intended to reflect the financial condition of this corporation since this information is not available from the records of this Office.

In testimony whereof, I have hereunto set my hand and caused the Seal of my Office to be affixed at the City of Baton Rouge on,

July 9, 2021

Secretary of State

Web 40041839D

Certificate ID: 11424476#5PK73

To validate this certificate, visit the following web site, go to Business Services, Search for Louisiana Business Filings, Validate a Certificate, then follow the instructions displayed.
www.sos.la.gov

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.5.6.1

Exhibit C Proposal Compliance Matrix

Exhibit C: Proposal Compliance Matrix

RFP #:	**3000017417**
Proposer:	**Louisiana Healthcare Connections, Inc. (LHCC)**

RFP Section	Requirement	Proposal Section	Proposal Page(s)
2.4	Table of Contents	2.4	Exempt
2.4.1	Cover Letter	2.4.1	Exempt
Business Proposal – Section 2.5			
2.5.1	Mandatory Qualifications	2.5.1	1
2.5.2	Conflict of Interest	2.5.2	1-2
2.5.3	Moral or Religious Objections	2.5.3	2
2.5.4	Material Subcontractors	2.5.4 Attachments 2.5.4.3.a-b	3-4
2.5.5	Financial Condition	2.5.5 Attachments 2.5.5.1.1.a-f 2.5.5.1.2.a-b	4
2.5.6	Required Forms and Certifications	2.5.6	4
2.5.6.1	✓ Proposal Compliance Matrix	Attachment 2.5.6.1	Exempt
2.5.6.2	✓ Certification Statement	Attachment 2.5.6.2	Exempt
2.5.6.3	✓ Medicaid Ownership and Disclosure Form	Attachment 2.5.6.3	Exempt
Technical Proposal – Section 2.6			
2.6.2	Proposer Organization and Experience:		
2.6.2.1	✓ Proposer Organization	2.6.2.1 Attachment 2.6.2.1.3	5-6
2.6.2.2	✓ Proposed Staff Qualifications and Organizational Structure	2.6.2.2 Attachments 2.6.2.2.2.a-g 2.6.2.2.3.a-m	7-12
2.6.3	Enrollee Value-Added Benefits	2.6.3 Attachment 2.6.3.4	13-24
2.6.4	Population Health	2.6.4	25-36
2.6.5	Health Equity	2.6.5	37-48
2.6.6	Care Management	2.6.6	49-62
2.6.7	Case Scenarios	2.6.7	63-107
2.6.8	Network Management	2.6.8	108-117
2.6.9	Provider Support	2.6.9	118-128
2.6.10	Utilization Management	2.6.10	129-142

Exhibit C: Proposal Compliance Matrix

2.6.11	Quality	2.6.11 Attachments 2.6.11.5 2.6.11.7	143-155
2.6.11.6	Quality Response Template	Attachment 2.6.11.6	Exempt
2.6.12	Value-Based Payment	2.6.12	156-165
2.6.13	Claims Management and Systems and Technical Requirements	2.6.13 Attachments 2.6.13.2 2.6.13.2.3.a-g 2.6.13.3	166-174
2.6.14	Program Integrity	2.6.14	175-183
2.6.15	Physical & Specialized Behavioral Health Integration Requirements	2.6.15	184-192
Veteran and Hudson Initiative Programs Participation – Sections 1.44 and 4.4			
4.4	Veteran and Hudson Initiatives Response	4.4	Exempt

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.5.6.2

Exhibit A Certification Statement

EXHIBIT A: CERTIFICATION STATEMENT

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

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. The Proposer should identify the Contact name and fill in the information below: (Print Clearly)

Official Contact Name:	James Schlottman, Plan President and CEO
E-mail Address:	jschlottman@centene.com
Facsimile Number with area code:	1-866-768-9374
US Mail Address:	8585 Archives Avenue, Suite 310 Baton Rouge, LA 70809

Proposer shall certify that the above information is true and shall grant permission to the State or Agencies to contact the above named person or otherwise verify the information provided.

By its submission of this proposal and authorized signature below, Proposer shall certify that:

1. The information contained in its response to this RFP is accurate and all copies are correct and complete.
2. Proposer shall comply with each of the mandatory requirements listed in the RFP and will meet or exceed the functional and technical requirements specified therein.
3. Proposer shall accept the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. 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.
5. Proposer does not have any financial, legal, contractual, and other business interest that will conflict in any manner or degree with the performance required under the contract.
6. 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 or in such vendor's subcontractors, if any.
7. Proposer 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'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.
8. Proposer acknowledges that proposals to use subcontractors shall not cause any additional administrative burden on LDH as a result of the use of multiple entities.
9. Unless provided for in the contract, the Proposer shall not contract with any other party for any of the services provided for therein without the express prior written approval of the Department
10. Proposal shall be valid for at least ninety (90) Calendar Days from the date of proposer's signature below.

11. Proposer understands that if selected as the successful Proposer, he/she will have twenty (20) Calendar Days in which to complete contract negotiations and twenty (20) Calendar Days from the date of delivery of final contract in which to execute the final contract document.
12. Proposer shall certify, 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 CFR §200 Subpart F. (A list of parties who have been suspended or debarred can be viewed via the internet at https://www.sam.gov.)
13. 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 La. R.S. 39:1624(A)(10) by providing its seven-digit LDR account number in order for tax payment compliance status to be verified.
14. 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.
15. 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.
16. Proposer certifies that its proposal was independently arrived at without collusion.

Signature of Proposer or Authorized Representative:	
Typed or Printed Name:	James Schlottman
Date:	8/1/2021
Title:	Plan President and CEO
Company Name:	Louisiana Healthcare Connections, Inc.
Address:	8585 Archives Avenue, Suite 310
City:	Baton Rouge
State:	LA
Zip:	70809

ATTACHMENT 2.5.6.3

Exhibit D Medicaid Ownership and Disclosure Form



Per the RFP, the Proposer may submit this information as an attachment in electronic format in lieu of hard copy.

CONFIDENTIAL

SECTION 2.6

Technical Proposal

"As soon as they found out, they stepped in and started helping find what my daughter needed, for her to have the medication she needs and the supplies she needs to be able to remain out of the hospital. They've been there through everything, and they were right there with a helping hand. And wanting *to help. They were brought into our lives and have been very, very much a blessing to all of us."*

- Tesha
Enrollee, Ferriday

Hear more from Tesha on YouTube: https://lahealth.cc/tesha

SECTION 2.6.2

Proposer Organization and Experience



"With nurses comprising 25% of their workforce, LHCC is one of the largest non-hospital employer of nurses in the state. And because they believe you must take care of yourself before you can take care of others, they ensure a healthy culture of empowerment, stability and mutual support for their nurses.

For our nurses in the community, they partnered with LSNA to provide care packages at the hardest-hit hospitals across the state during the COVID-19 pandemic.

They are a partner that nurses strong values and values strong nurses."

- Thea Ducrow
Executive Director, Louisiana State Nurses Association

SECTION 2.6.2.1

Proposer Organization



Compared to other Medicaid MCOs, Louisiana Healthcare Connections' higher number of in-state FTEs per member is responsible for an additional $98.4 million in economic impact for Louisiana.

They created a total economic impact of $904.8 million in the state from 2012 to 2020, with a peak employment of 673 FTE jobs. Including indirect and induced jobs, their peak total jobs impact was 1,283 employees.

- Baton Rouge Area Chamber
Economic Impact Analysis, March 2021

2.6.2 Proposer Organization and Experience

2.6.2.1 Proposer Organization [2-page limit; information related to non-compliance actions are exempt from section-specific page limit]

2.6.2.1.1 Louisiana Healthcare Connections (LHCC) Organizational History and Service

As we approach our tenth year serving Louisiana's Medicaid enrollees, we are excited by LDH's vision for the future of Medicaid and the opportunity for dramatic advancements in health equity; expanded approaches to foster health beyond healthcare settings; deeper, value-based collaboration among providers and MCOs; and transformative improvement in the health of our state's population. We are grateful and humbled by the progress of the past nine years, and excited to continue our partnership with LDH during this pivotal moment in healthcare transformation across Louisiana.

The most gratifying testament to our decade in Louisiana is our ***enrollees' demonstrated improvement in health outcomes***. For example, comparing 2012 Medicaid baseline data to our 2020 HEDIS measure performance, our enrollees benefit from significant increases in key measures in maternal, child health, and preventive screenings. These measures represent tens of thousands of pregnancies, ***a generation of children with a healthier start to life,*** and the promise of lifelong improvement in health and happiness through ensuring access and completion of preventive screenings.

45.63 pp* ↑ Well-child visits (0-15 months)	38.3 pp* ↑ Well-child visits (3-6 years)	17.73 pp* ↑ Prenatal care	19.75 pp* ↑ Postpartum care	55.78 pp* ↑ Childhood immunization status	18.22 pp* ↑ Breast cancer screening

**pp denotes the percentage point improvement observed.*

Central to these health achievements is our core belief in ***locally driven, collaborative relationships with healthcare providers*** to design initiatives specific to the needs, capacity, and culture of each community. Provider partnerships drive improvements in the healthcare system and the health outcomes of our enrollees – their patients. The strength of our collaborations is demonstrated in measures of provider engagement, including:

#1 Ranked first among MCOs for overall satisfaction in LDH's 2020 Provider Satisfaction Survey	42% Ranked first in 42% of measures in LDH's Provider Satisfaction Survey – the most first place rankings of any MCO	[redacted]	39,250 Providers choose to participate in our integrated network, making it the largest with 7,929 more than the next MCO	6 Only 6 Independent Review Requests in 2020, 46 less than the next MCO

We take these results as confirmation from Louisiana's providers of the value they place on our ***collaborative efforts to improve the healthcare system's*** outcomes and reduce administrative burden. We believe that transforming health in a community has to start with the community and strive to be an organization of, in and with the communities we serve. That is why we seek out and hire individuals with lived experience in the Louisiana Medicaid program; locate more of our jobs in-state; invest in more than 300 local community partners; and embed community health workers and Community Wellness Centers in neighborhoods throughout Louisiana.

7 out of 10 LHCC staff have personal experience with Medicaid in Louisiana	41% Of all in-state Medicaid MCO FTEs are employed by LHCC	100% Of LHCC staff trained in Trauma-Informed Care and ACEs	[redacted]	90+ Community-based employees across Louisiana

In our commitment to Louisiana and its vibrant communities, we aim to live up to the wisdom of Valerie Billingham's words, ***"Nothing about me, without me."*** Throughout our history, we listen to our enrollees, providers, communities, LDH, and other Louisiana stakeholders to operationalize innovative programs at the community level. We utilize continuous process improvement methodologies to ensure programs and initiatives available to enrollees are relevant and current. Our population health and quality efforts are data-driven and focused through a health equity lens, identifying health inequities by population characteristics such as race, ethnicity, culture, language, gender, geography; overlaying enrollees' social determinants of health (SDOH); and tailoring programs to eliminate disparities, advance health equity and transform Louisiana's health.

LHCC Organizational Goals. LHCC's single overarching ***goal is to transform Louisiana's health, one person at a time***, in alignment with LDH's goals for the Medicaid program and our state's health more broadly. This is the driving motivation for all that we do and the purpose for which our organization was founded. Our intentional alignment with LDH's goals,

objectives and strategies is reflected across our organization and aligned with our population health strategy, health equity plan and quality improvement strategy that informs our population health interventions; care management; advanced payment models and provider support; integrated BH/PH, whole-person care delivery; community partnerships and investments; technology innovations; organizational structure, and more. We understand and appreciate that the aims of Louisiana's Medicaid program grow and evolve, and have redesigned our organization to advance LDH's goals, achieve health equity, and improve the health of Louisiana's Medicaid enrollees.

Louisiana Healthcare Connections (LHCC) Parent Organization. LHCC is a Louisiana-based organization, with local staff and experience, 100% local leadership, and local decision-making. We have the backing of our parent company, Centene Corporation, the nation's largest Medicaid managed care organization, and nationally recognized as promoting a diverse workforce of multi-cultural employees, those with disabilities, LGBTQ+, military veterans, and women. Centene has over 35 years of experience and provides healthcare coverage to 1 in every 15 Americans across 50 states. The synergies between our local data- and enrollee-driven insights and Centene's advanced analytics expertise inform our strategies to meet the health needs of our enrollees.

Relevance of Medicaid Managed Care to LHCC's Mission. LHCC's sole purpose, in alignment with LDH's objectives, is to transform health and wellness in our communities by providing high quality, accessible care to Medicaid enrollees in Louisiana. Our mission is to provide the best benefits and programs possible to improve the overall health of the Louisiana Medicaid enrollees we serve.

Advancing Health Equity In Action

Infant mortality rates in north Louisiana are among the worst in the U.S., with a significant racial disparity. LHCC's Cribs for Kids program provided cribs and safe-sleep education, and decreased infant mortality among north LA enrollees by 56% over a two-year period.

"When I received the crib from LHCC…it lit up my day. The cribette was a blessing… You have people out there who care about you and your kid and they're actually reaching out. That was a really big deal for me. With everything LHCC has done for me and my baby, they just make me feel like family." - Moneisha, Monroen

YouTube: https://lahealth.cc/moneisha

Volume and Location of Medicaid Managed Care Business. LHCC serves approximately 530,000 Medicaid enrollees. Through our Medicaid affiliate health plans in 29 states, we serve over 14 million Medicaid enrollees.

2.6.2.1.2 Current Medicaid Managed Care Contracts

LHCC has served enrollees since 2012, exceeding LDH's preferred qualification of a minimum of seven years of experience providing healthcare services for a Medicaid managed care program. Within the last 12 months, our Medicaid affiliate health plans in AZ, CA, FL, GA, IL, IN, KY, MI, NC, NJ, NJ, NY, OH, PA, TX, and WA have been engaged in contracts with statewide Medicaid populations equal to or greater than 1.5 million enrollees.

2.6.2.1.3 Instances of Non-Compliance

All non-compliance events within the past seven years are provided in ***Attachment 2.6.2.1.3*** at the end of this response.

2.6.2.1.4 Terminated managed care contracts

LHCC has no qualifying terminations to report.

SECTION 2.6.2.2

Proposed Staff Qualifications and Organizational Structure

"When I saw there was an opening to work for Louisiana Healthcare Connections, I said, 'Gosh, they've treated me so well as a member, I am sure they treat their employees just as well.' So I applied and am so glad I did."

- Allegra

Enrollee to Employee, New Orleans

2.6.2.2 Proposed Staff Qualifications and Organizational Structure [6-page limit]

LHCC believes that transforming health in a community has to start with the community. That is why our organizational model emphasizes ***in-state jobs***, ***hiring from the communities*** we serve and serving directly in our communities. We believe our enrollees and provider partners value our local approach, as demonstrated by our ranking ***#1 in enrollee preference*** during 2020 open enrollment and ***#1 in provider satisfaction,*** in the 2020 LDH Provider Satisfaction Survey. We understand these and similar metrics are expressions of trust by our enrollees and providers. They also are the results of investments LHCC has made over time in the staffing, training, and infrastructure needed to support the evolving needs of our enrollees, the providers who serve them, and the communities in which they live. Informed by our local experience; enrollee, provider, and stakeholder feedback; and the events of the last 18 months (hurricanes, COVID-19, and the ongoing need for racial justice), we have once again re-evaluated and refined our structure and staffing model to re-affirm our organizational commitment to health equity. This includes a ***new Health Equity Department,*** as well as additional staff to ***enhance provider support*** and ***address social barriers*** that impede our ability to ***improve population health***. In service to Louisiana, we commit to compliance with all Model Contract requirements, including Section 2.2 and MCO Manual Section Parts 2 and 6, and to be a responsive, reliable partner to LDH.

Local Staff/Local Impact

*From 2012-2020, LHCC created a **total LA economic impact of $904.8M.** In 2020, we employed more than 41% of all in-state MCO jobs —resulting in an additional **$98.4M in economic impact for Louisiana**.*

2.6.2.2.1.a Process for Identifying Key Personnel

We believe in hiring, professionally developing, and promoting locally — ***all our senior leaders are Louisiana residents***. At least bi-annually, LHCC's Executive Team conducts active succession planning to proactively identify qualified staff with the potential to grow to fill Key Personnel vacancies. Some of the resources LHCC uses to identify candidates include:

- **Extensive Local Relationships.** We are committed to hiring from our Louisiana communities and rely on the strong ties we have with our provider and community partners (e.g., the ***Urban League of Louisiana, LA Chamber of Commerce,*** and ***LA State Nurses Association)*** to identify local, highly qualified candidates. Further, we advance broader diversity workforce development initiatives through relationships with local colleges and universities, such as ***Xavier University of Louisiana,*** and local/national staffing and recruitment agencies.
- **Diversity, Equity and Inclusion (DEI).** At LHCC, ***DEI is in our DNA***. Our enterprise-wide commitment to a diverse workforce has resulted in several national recognitions, such as: ***National Organization for Disability 2020 Leading Disability Employer***, and ***Diversity Inc. 2020 Top Companies for Talent Acquisition for Women of Color***, and ***Top 50 Companies for Diversity.*** Our Health Equity & Diversity Committee and active, employee-led race, gender, LGBTQ+ and veteran status inclusion groups (EIGs) inform our candidate search practices. Our ***certified Diversity Recruiters***; dedicated recruiter for Veteran, National Guard, and Reserve applicants; and EIG participants refer talent. We train interviewers to recognize implicit bias, and ensure diverse candidate slates for leadership roles (Director and above) by including at least one woman/one person of color within each candidate pool evaluated by a diverse interview panel.
- **Leveraging National Expertise, State of the Art Tools/Resources.** If we are unable to identify candidates through the above strategies, LHCC can leverage our national Talent Attraction and Executive Recruitment Teams for best-in-class approaches and tools to identify qualified candidates. This includes a unique approach to advertising jobs for ongoing exposure by targeting 10,000+ sites and job board use based on predictive algorithms and performance. LHCC can also access an extensive pipeline of experienced affiliate staff who may be potential candidates.

2.6.2.2.1.b Organizational Management Structure: A Structure Designed to Drive Health Equity

Our organizational charts are included in ***Attachment 2.6.2.2.3.a-m*** which depicts our overall organization, management, key teams and their roles, and local oversight of material subcontractors. Each chart includes a crosswalk with LDH required positions and the LHCC equivalent titles. In addition to our statewide field-based staff, LHCC has four Louisiana offices and ***nine new Community Centers — one in each region***. We comply with all Model Contract requirements, such as: background checks; expertise, experience, licensure, and certification requirements; dedicated staff to meet all required timeframes and geographic coverage; and staff trained in the culturally sensitive provision of services. We also comply with all requirements identifying staff dedicated to this Medicaid product.

Staffed to Advance LDH Goals

- **68% of LHCC staff have personal Medicaid experience**
- **Diverse Workforce**: 54% Black, 41% White, 5% Other; 87% female

[redacted]

Organization. "We are who we serve." LHCC reflects the communities we serve and we prioritize hiring those with lived experience from our communities. We listen to feedback from our providers and enrollees and continually assess our organization and

staffing accordingly. For example, in 2018, in response to enrollees expressing social anxiety and isolation after a BH hospitalization, we created a BH Coaches Team to engage enrollees face-to-face in their chosen setting. Enrollees who engaged with BH Coaches showed increased participation in CM and a decrease in ED and inpatient utilization.
Organizational Charts e and f depict our new ***Health Equity*** and restructured ***Population Health Management (PHM)*** departments, which focus on embedding the voices of our communities through our ***Community Innovations*** (Community Centers; Regional Community Engagement staff), and ***Community Connections*** (SDOH support staff) functions. Other dedicated staff on these teams reflect our emphasis on integrated BH, specialized maternal/child health, and data analytics to identify and mitigate social inequities. Finally, our governance structure and lines of reporting across LHCC help ensure all teams conduct work through a ***health equity lens***, promoting accountability for health equity and population health across the plan. We infuse health equity cross-functionally throughout LHCC.
To support the VP, Health Equity in achieving plan-wide health equity goals, reduce disparities, and improve cultural sensitivity, we follow LDH's model with our inter-departmental ***HEATs (Health Equity Action Teams)***, co-led by Project Managers from the Health Equity Department and each unit's Health Equity Program Manager. These HEATs ensure all units 1 continually use health equity and population health best practices, including effective data collection, use, and sharing to improve population health and promote health equity; 2 support health equity communication and professional development; and 3 report to leadership, our Health Equity & Diversity Committee, and Quality Committees, which monitor/evaluate outcomes for effectiveness continuous improvement.

2.6.2.2.2 - 2.6.2.2.3 LHCC Leadership; Reporting/Interaction with Governance Structure and Parent

Please see ***Attachment 2.6.2.2.2.a-h*** for all key personnel resumes. Other than our ***interim*** VP, Health Equity, all key personnel are LA-based, full-time, only serve in one key personnel position, and are solely dedicated to this product. ***Table 2.6.2.2.3*** details LHCC leadership's extensive experience and relationship to our BOD/Parent.

Table 2.6.2.2.3 LHCC Key Personnel & Senior Leadership

[redacted]

LHCC Senior Leadership

[redacted]

Leadership Interaction with and Reporting to Governance Structure and Parent Corporation

[redacted]

Table 2.6.2.2.3 LHCC Key Personnel & Senior Leadership

[redacted]

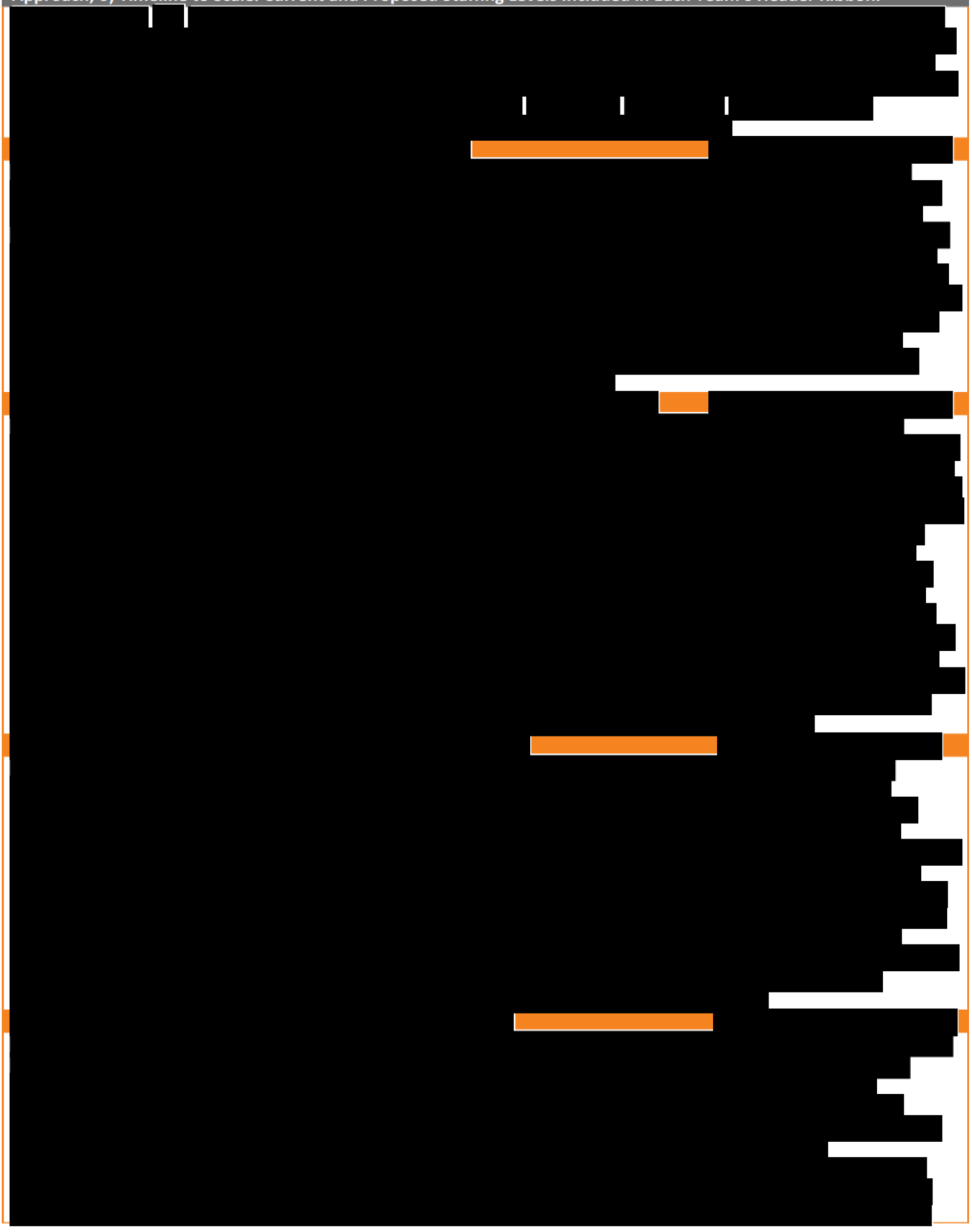
2.6.2.2.3 LHCC Team and Lead Descriptions, Current and Proposed FTEs, and Plan to Scale

Please see below for the required descriptions of each key team and team lead, our total current and proposed FTE counts followed by our plan to scale staffing based on increased or decreased levels.

1) Team Role/Accountable Operating Activities; 2) Reporting to Leadership; 3) Competencies; 4) Team Lead; 5) Staffing Approach; 6) Timeline to Scale. Current and Proposed Staffing Levels Included in Each Team's Header Ribbon.

[redacted]

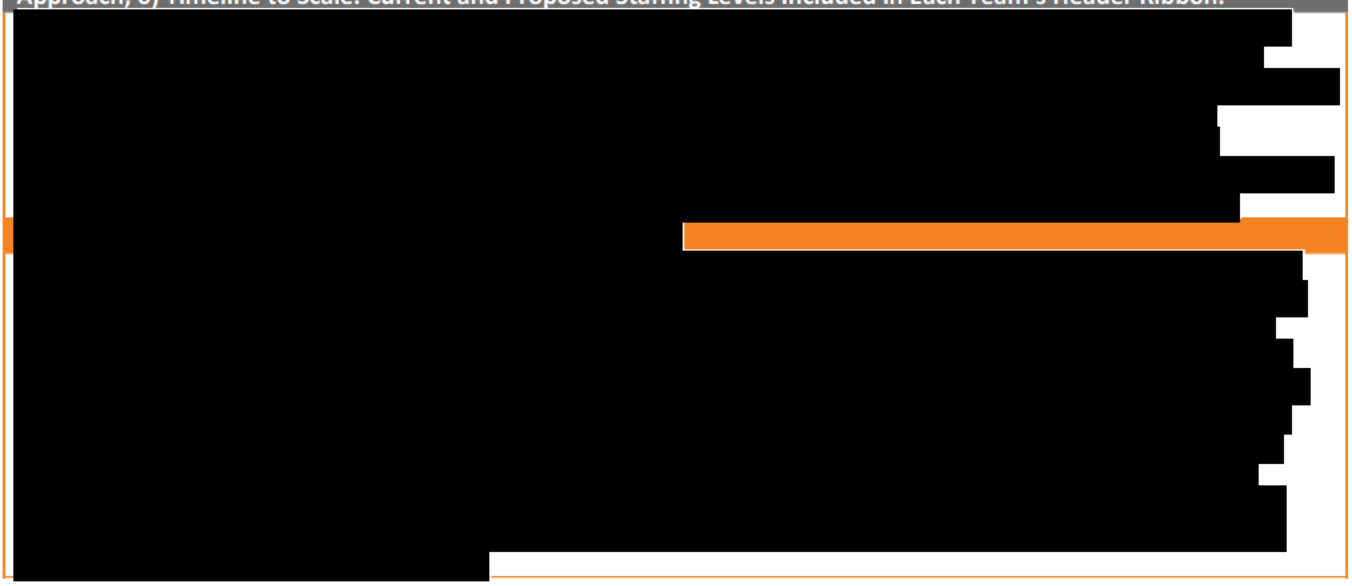
1) Team Role/Accountable Operating Activities; 2) Reporting to Leadership; 3) Competencies; 4) Team Lead; 5) Staffing Approach; 6) Timeline to Scale. Current and Proposed Staffing Levels Included in Each Team's Header Ribbon.



1) Team Role/Accountable Operating Activities; 2) Reporting to Leadership; 3) Competencies; 4) Team Lead; 5) Staffing Approach; 6) Timeline to Scale. Current and Proposed Staffing Levels Included in Each Team's Header Ribbon.



1) Team Role/Accountable Operating Activities; 2) Reporting to Leadership; 3) Competencies; 4) Team Lead; 5) Staffing Approach; 6) Timeline to Scale. Current and Proposed Staffing Levels Included in Each Team's Header Ribbon.



SECTION 2.6.3

Enrollee Value-Added Benefits

From Enrollees about Hurricane SDOH Relief Grants from LHCC:

"I thank God everyday for the relief grant. It help me tremendously, I was able buy supplies for me and my children during the hurricane."
- Lacritia, Sulphur

"I had a baby right after the hurricane and I was able to buy the necessities I needed for her." **- Dominique,** DeQuincy

"It helped me buy my autistic daughter shakes and diapers that she needed, and helped me get her some more clothes to get us through until I could get moved." **- Priscilla**, Lake Charles

Hear more from Priscilla on YouTube: https://lahealth.cc/priscella

2.6.3 Enrollee Value-Added Benefits [15-page limit]

2.6.3.1 LHCC's Commitment to All Eight Optional Value-Added Benefits (VAB) & Enhanced Supports

LHCC is committed to exceeding RFP and Model Contract requirements by implementing ***all eight optional enrollee value-added benefits (VABs).*** Our ***VABs will be multi-faceted, multi-modal, and easily accessible*** for all eligible enrollees to meet their health and wellness needs and help LDH meet its goals for improving population health, addressing social determinants of health (SDOH), and advancing health equity.

Figure 2.6.3.1 LHCC's enrollee-centric VABs are integrated into our population health and health equity strategies.



We ***integrate VABs into our population health management (PHM) strategic plan*** to ensure all eligible enrollees are aware of and can access VABs. Additionally, we stratify our enrollee data by race/ethnicity, geography, age, gender, language, and disability status to determine where health disparities exist and then ***target our outreach to each VAB's priority sub-population to address health equity across Louisiana***. We train our Care Management staff and Customer Service Representatives as well as our provider network and community-based partners on VABs. We educate our enrollees about VABs through our website, welcome packets, and outreach activities to help enrollees use all tools available to improve their health. If an enrollee requests and is determined to be ineligible for a VAB, LHCC will send the enrollee a notification letter regarding our decision.

LHCC will provide oversight and monitoring for all VABs by reporting utilization plus process and outcome measures to our Quality Assessment and Performance Improvement Committee (QAPIC). QAPIC oversees health, wellness, and quality outcomes across our entire population. Reporting to the QAPIC, the Health Equity & Diversity Committee, co-chaired by LHCC's Vice President of Health Equity and Vice President of Population Health and Clinical Operations, will review the impact of VABs on our PHM goals and reducing disparities, and make recommendations for improvements in promotion or future offerings to maintain alignment. When a VAB is provided by a subcontractor or partner, LHCC's Vendor Oversight Committee will provide additional oversight.

[redacted]

2.6.3.1.1 Evidence-based Non-pharmacologic Alternatives to Opioids for Chronic Pain Management

We are committed to fighting the opioid epidemic in Louisiana and helping LDH achieve its goal of better health outcomes for enrollees by ***offering multiple, evidence-based alternatives to opiate therapies for chronic pain management, including: acupuncture, massage therapy, physical therapy, and additional supports***. LHCC currently has more than 20,000 enrollees with a chronic pain diagnosis who will have access to our non-pharmacologic chronic pain management VABs. LHCC will work with an enrollee with chronic pain and their care team, to include, at a minimum, the enrollee's PCP, an LHCC credentialed pain management specialist, and an LHCC Case Manager. This team will work with the enrollee to understand their condition and tailor a treatment plan based on enrollee preference and provider recommendations.

Our VABs for chronic pain management align with the Agency for Healthcare Research and Quality evidence review[1] and the Centers for Disease Control and Prevention recommendations of non-pharmacologic treatments for chronic pain and are shown to improve function and pain for at least 30 days after treatment. Evidence-based treatment options will include ***acupuncture,***[2] ***massage therapy, and physical therapy*** to alleviate pain and restore activity levels. Exercise is also shown to reduce pain severity and improve physical function.[3] LHCC will support enrollees by providing ***memberships to the YMCA or similar exercise facility*** and ***exercise kits*** for home use. In addition to these physiological benefits, LHCC will provide access to a ***comprehensive Digital Health and Wellness Platform (available on both mobile and web portal platforms)*** that provides a suite of highly interactive, individually tailored, and ***evidence-based virtual tools***[4] to help users address depression, anxiety, stress, chronic pain, and sleep challenges, while also supporting the physical and spiritual aspects of ***whole-person health***.

An enrollee may select any or all VABs in coordination with their care team. We will also wrap our VABs into existing Louisiana Medicaid coverage for behavioral health services such as cognitive behavioral therapy, operant behavioral therapy, mindfulness-based stress reduction, and acceptance and commitment therapies.

2.6.3.3.1 The populations who may receive the benefit. VABs for chronic pain management will be available to enrollees with chronic pain diagnoses or those at-risk for developing chronic pain as medically necessary regardless of age. LHCC will prioritize outreach to enrollees identified through weekly grand rounds, case management, provider referrals and enrollee self-referral, and through our Opioid Risk Classification Algorithm (ORCA), a proprietary predictive analytic model used to proactively identify enrollees at risk for the development of an opioid use disorder (OUD) using a series of clinical indicators based on past diagnostic, clinical, pharmaceutical, and social history. This model has a positive predictive accuracy rate of 98% and since its inception in 2017, has increased the identification of enrollees with OUD by over 150%. LHCC will utilize two methods to outreach and engage enrollees:

- **General education.** LHCC is committed to meeting enrollees where they are by ensuring information about this benefit is distributed in a variety of settings. All enrollees will receive education through our welcome packet, enrollee handbook, our website, social media, and via interactions with LHCC Community Health Workers (CHWs) and other staff.
- **Individually targeted.** Our algorithm regularly identifies enrollees likely to be experiencing chronic pain who may benefit from this VAB. We will conduct coordinated, multi-modal, HIPAA-compliant outreach to these enrollees (e.g., via CHW, phone, email, mail, and/or text message) to make them aware of the benefit and encourage their engagement.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. Our VABs increase options for chronic pain management and exceed Louisiana Medicaid coverage. The table below describes the scope of our VABs.

Table 2.6.3.1.1 Non-pharmacologic Treatments for Chronic Pain Management

Service	Procedure Codes	Description	Frequency
Acupuncture	97810, 97811, 97813, 97814	15-minute increments of personal contact, one or more needles, with and without electrical stimulation	1 session per day; 365 days per year
Massage Therapy	97124, 97140	Therapeutic procedure including massage stroking, compression, and percussion; therapeutic procedure including mobilization, manipulation, manual lymphatic drainage, or manual traction, one or more areas, 15-minute increments	1 session per day; 365 days per year
Physical Therapy	97161, 97612, 97163, 97110	Dry needling; low-, moderate-, high-, complexity evaluation; therapeutic exercise	1 session per day; 365 days per year
Exercise Memberships/ Home Exercise Kits	n/a	Monthly memberships to YMCA or similar facility; exercise kits provided to enrollees (yoga, etc.)	12 months per year; one exercise kit per year
Virtual Support	n/a	Targeted mobile support application provides 24/7 emotional support for enrollees online or via their mobile app; services	Unlimited access

[1] https://effectivehealthcare.ahrq.gov/products/nonpharma-treatment-pain/research-2018
[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5927830/
[3] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5461882/
[4] https://effectivehealthcare.ahrq.gov/products/nonpharma-treatment-pain/research-2018

Service	Procedure Codes	Description	Frequency
		include personalized support and recommended content and activities based on enrollee need	

Louisiana Medicaid does not currently cover acupuncture or massage therapy services. The State does cover physical therapy services for adults age 21 and older through hospital outpatient or home health services with prior authorization. Our chronic pain management VAB includes physical therapy services beyond the existing Louisiana Medicaid benefit by allowing physical therapy in freestanding clinics.

2.6.3.3.3 Any proposed co-payments. No co-pays will be required. Free transportation will be provided.

2.6.3.3.4 How the benefit will be provided, including, if provided through a subcontractor, either the selected subcontractor or description of how the subcontractor shall be selected. LHCC will provide VABs for chronic pain management through our contracted provider network. Physical therapy and massage therapy will be provided by LHCC's network of more than 225 licensed physical therapists across the state. LHCC will provide acupuncture services by recruiting a network of physician and non-physician licensed acupuncturists across the state. We will work with the Acupuncture Association of Louisiana, Louisiana Board of Massage Therapy, and American Physical Therapy Association Louisiana to expand our network of acupuncturists, massage therapists, and physical therapists to increase access to care across the Model Contract lifespan.

Memberships to the YMCA or similar facility will be provided through provider or enrollee self-referral to LHCC's Care Management team for review and administration. Home exercise equipment, such as exercise mats, will be mailed directly to enrollees.

Mobile and web platform behavioral health support will be provided through LHCC's Digital Health Management platform through ShareCare.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. In addition to process and outcomes measures reported to LHCC's QAPIC, our Health Equity & Diversity Committee and Population Health and Clinical Operations Committee will review enrollee, provider, and community feedback, and analyze pharmacy data and claims from enrollees utilizing this VAB to evaluate whether the program is supporting a decrease in opioid prescriptions, Emergency Department (ED) visits, and inpatient utilization. Our Vendor Oversight Committee will monitor the contract with ShareCare.

2.6.3.1.2 Respite Care Model for Homeless Persons with Post-Acute Medical Needs

LHCC's goal in offering this VAB is to address post-acute health needs of enrollees experiencing homelessness (EEH) through respite care and intensive care management and to successfully transition as many enrollees as possible to safe and stable housing. We have designed a medical respite model built on the National Health Care for the Homeless Council's Standards for Medical Respite Programs[5] and in

[redacted]

We believe housing is healthcare.

Our medical respite care and housing support VAB will provide an effective care transition from hospital to housing while supporting an enrollee's needs through intensive care management and other services.

[5] https://nimrc.org/wp-content/uploads/2021/04/Standards-for-Medical-Respite-Programs.pdf

2.6.3.3.1 The populations who may receive the benefit. Any enrollee identified as unhoused, including those identified by providers, community organizations, LHCC staff, and self-referral, will be eligible for the medical respite VAB. We will use the Louisiana Balance of State Continuum of Care (LA BOSCOC) Coordinated Entry System (CES) Homeless Management Information System (HMIS) as a tool to identify enrollees for in-person outreach and engagement activities and coordinate services. LHCC's Care Management team works closely with each of our contracted hospital's discharge planning team before enrollee discharge to identify post-discharge needs, including medical respite care and stable housing. Finally, we will use our Centelligence Health Informatics Platform to regularly identify EEH who may benefit from this VAB. We will conduct coordinated, multi-modal, HIPAA-compliant outreach to these enrollees to make them aware of the benefit and encourage their engagement.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. LHCC's current data estimates approximately 1,200 enrollees are homeless or housing insecure, with 24% in the New Orleans area, 10% in the Lake Charles area, 9% in Baton Rouge, and 5% in the Shreveport area. Based on recent trends, we project a need for approximately 65 respite beds at any given time. We have structured our agreements with partners accordingly, and built in capacity for increases in utilization as needed. [redacted]

LHCC will offer this VAB as described above to EEH for up to 90 days, based on medical necessity and SDOH needs, to allow the enrollee a sufficient stay to recover and transition to stable housing. LHCC's medical respite care services are not currently covered by Louisiana Medicaid. Through intensive case management, we also will ensure each enrollee is accessing needed covered benefits to address whole-person health needs.

To support enrollees' transition to stable housing, [redacted]

2.6.3.3.3 Any proposed co-payments. No co-pays will be required for homeless medical respite. LHCC will provide free transportation to and from respite care and for healthcare appointments and SDOH needs while in care.

2.6.3.3.4 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. Our qualified partners will provide intensive case management and a safe place to stay for enrollees while in respite care. LHCC's Care Management team will conduct bi-weekly collaborative meetings with our partners to ensure enrollees' plans of care and goals are being met. Support for stable housing from LHCC's Housing and Health Care Transition Fund will be managed by LHCC's Care Management team as well as continued case management once an enrollee has transitioned out of medical respite care.

2.6.3.3.5 How the Proposer will provide oversight of the value-added benefits. In addition to the oversight provided by LHCC's QAPIC, our Health Equity & Diversity Committee and Population Health and Clinical Operations Committee will review enrollee, provider, and community feedback as well as analyze claims data and outcomes measures for enrollees pre- and post-medical respite care for ED utilization, 30-day all-cause readmissions, primary care utilization, and housing status changes [redacted]

2.6.3.1.3 Newborn Circumcision Benefits

LHCC respects an enrollee's choice regarding male newborn circumcision. We will educate our enrollees regarding the benefits and risks of circumcision while emphasizing the American Academy of Pediatrics policy that the health benefits outweigh the risks, and recognizing cultural perspectives and traditions. LHCC has a proven track record administering this benefit as seen in the 77.4% rate of circumcision for newborns from May 2020 to April 2021.

2.6.3.3.1 The populations who may receive the benefit. LHCC will continue to offer circumcisions for newborn enrollees during initial hospitalization at birth, or in an office setting, up to a child's first birthday.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. Providers will use procedure codes 54150, 54160, or 54161. Louisiana Medicaid does not currently cover newborn circumcision.

2.6.3.3.3 Any proposed co-payments. No co-pays will be required. Free transportation will be provided.

2.6.3.3.4 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. LHCC is committed to meeting enrollees where they are by ensuring information about this benefit is distributed in a variety of settings. Enrollees will receive education through their interaction with LHCC Care Management staff, LHCC's maternal and child health program, LHCC enrollee materials such as our welcome packet, website, and enrollee handbook, and community events for pregnant and parent enrollees. Enrollees may also access this benefit through LHCC's hospital partners and contracted provider network, who will create awareness for this benefit during an enrollee's prenatal, delivery, and postnatal appointments.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. This VAB will be overseen by LHCC's QAPIC. The Population Health and Clinical Operations Committee will review enrollee, provider, and community feedback as well as analyze utilization data at aggregate and enrollee levels to understand utilization and where to target educational activities. We also will review claims data by hospital and provider to ensure effective VAB utilization.

2.6.3.1.4 Tobacco Cessation Benefits, Other Than Medications and Counseling

Research shows using a combination of tobacco cessation methods increases the likelihood of quitting. Therefore, ***LHCC encourages our enrollees to stop using tobacco and nicotine through multiple, integrated opportunities*** including existing Louisiana Medicaid coverage for medications, in-office counseling for pregnant and postpartum women, and other resources such as Louisiana Tobacco Control Initiative services (self-help material, behavioral counseling, Quitline assistance, and social support) and the Teche Action Clinic (intensive cessation counseling, telephonic and web-based support, cessation tools not covered by Medicaid). ***Our complementary VABs will promote evidence-based practices for digital tobacco cessation programs for both adolescents and adults, hypnotherapy, and an enrollee cessation incentive.***

- ***This is Quitting*** **and** ***Craving to Quit*** **(digital/mobile cessation programs**). LHCC understands that prevalence of adult tobacco use is correlated with the intensity of tobacco use during childhood and adolescence, and preventive strategies should be designed to reduce, delay, or eliminate youth access to tobacco. As such, LHCC will partner with the Truth Initiative to license and co-brand ***This is Quitting***, a first-of-its-kind, evidence-based, anonymous text messaging program that has helped more than 300,000 youth and young adults on their journey to quit vaping. This is Quitting reaches 13- to 18-year-olds via text messages from peers to help youth feel motivated, inspired, and supported. This is Quitting is available 24/7 and provides tailored, interactive messages best suited to the user. Research shows quit rates were nearly 40% higher among young adult e-cigarette users who used This is Quitting compared to a control group.[6] To support adult enrollees, LHCC will partner with Sharecare to offer ***Craving to Quit***, an evidence-based digital program that teaches enrollees how habits are formed, and how to break them. This award-winning virtual program teaches awareness of cravings and habits to help participants quit smoking or vaping through weekly coaching calls, self-guided video lessons and exercises, and expert community support. With a higher prevalence of smoking in rural areas of the state, these digital programs provide greater access and flexibility.
- **Hypnotherapy.** Nicotine and tobacco research shows hypnotherapy in conjunction with behavioral therapy is more successful than behavioral therapy alone in encouraging tobacco cessation.[7] Trained therapists or healthcare professionals can conduct hypnotherapy. A therapist uses verbal repetition and mental images to heighten an enrollee's focus and concentration to help address behavior change. To support enrollees' commitment to quitting, LHCC will offer hypnotherapy in conjunction with psychotherapy sessions when appropriate. Enrollees under 18 will need permission from a parent or guardian.
- **Enrollee Quit Incentive**. LHCC will offer enrollees a $25 annual incentive for engaging in tobacco cessation counseling or for filling the first prescription for tobacco cessation medication. Recognizing a higher prevalence of smoking in our Native American population, and the sacred or traditional connotations that may exist, this incentive includes enrollment in the American Indian Commercial Tobacco (AICT) Program, which balances the importance of traditional tobacco use with protecting the community from the harmful effects of commercial tobacco use.

[6] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2779740
[7] https://academic.oup.com/ntr/article-abstract/10/5/811/1074110

2.6.3.3.1 The populations who may receive the benefit. All enrollees who use tobacco or nicotine will be eligible. Free transportation to hypnotherapy will be provided.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. Our VABs enhance existing Louisiana Medicaid coverage for medications and in-office counseling, and supports multiple cessation opportunities for all our enrollees through digital cessation supports, hypnotherapy, and an incentive to engage in counseling (including the AICT Program) and fill cessation medication prescriptions.

Table 2.6.3.1.4 Tobacco Cessation VABs

Service	Procedure Code	Description	Frequency
This is Quitting (Digital Cessation Supports)	n/a	Motivational text message support for tobacco and vaping cessation	Unlimited
Craving to Quit (Digital Cessation Supports)	n/a	Teaches enrollees how habits are formed and how to break them through coaching calls, self-guided lessons, and community support	Unlimited
Hypnotherapy	90880	Hypnotherapy for diagnostic/therapeutic purposes; provided in conjunction with psychotherapy	Aligned with the medical literature, we will provide two, 60-minute sessions per quit attempt and two telephonic follow-up calls with the hypnotherapist per hypnotherapy visit
Enrollee Quit Incentive	n/a	A $25 incentive for engaging in tobacco cessation counseling (including AICT) or filling first cessation medication prescription	Once annually

2.6.3.3.3 Any proposed co-payments. No co-pays will be required. Free transportation will be provided.

2.6.3.3.4 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. LHCC will provide these benefits through our contracted provider network and our partnership with ***This is Quitting*** and ***Craving to Quit***. For general outreach and education, we will promote tobacco cessation VABs in our enrollee newsletter, Enrollee Handbook, new enrollee welcome packet, social media, website, and through provider training and outreach. For virtual counseling and other tobacco cessation resources, such as the American Indian Commercial Tobacco Program, we will promote availability of and how to access these self-service resources and the LHCC incentive for engagement, based on enrollee attestation. ***This is Quitting*** also promotes via social media. We will also build an algorithm to regularly identify enrollees using tobacco who may benefit from this VAB. We will conduct coordinated, multi-modal, HIPAA-compliant outreach to these enrollees (e.g., via CHW, phone, email, mail, and/or text message) to make them aware of the benefit and encourage their engagement, including enrollees who identify as tobacco users in the HNA. Eligible enrollees may select an in-network provider to schedule appointments for services, or LHCC's Customer Service Representatives can assist. Our ***Craving to Quit*** mobile and web platform support will be provided through LHCC's Digital Health Management platform through ShareCare.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. LHCC will oversee this benefit through our QAPIC, with input from our Health Equity & Diversity Committee and Population Health and Clinical Operations Committee, which will review process and outcomes data for the listed procedure codes, usage of digital cessation supports, enrollee, provider, and community feedback, and claims related to medical assistance with tobacco cessation. LHCC's Vendor Oversight Committee will monitor the contract for ***This is Quitting*** and ***Craving to Quit***.

2.6.3.1.5 Adult Vision Benefits, Including Annual Exam and Glasses or Contacts



Healthy vision is part of the whole health approach that LHCC takes when caring for our enrollees. Annual eye exams can detect both vision conditions and other serious health problems, such as diabetes, high blood pressure, high cholesterol, and even cancer. ***LHCC's adult vision benefit will increase coverage for adults by providing routine exams for eye health, vision correction, and refractive error, and eyewear such as eyeglasses or contacts.*** During the current contract period, LHCC provided more than $4.0 million in adult vision care to approximately 20% of adult enrollees.

2.6.3.3.1 The populations who may receive the benefit. All enrollees age 21 years and older will be eligible.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. For adult enrollees, LHCC will provide one annual eye exam and

refraction, one pair of eyeglasses or twelve pairs of contacts per year, and medically necessary specialty eyewear (e.g., contacts, bifocal, or trifocal lenses).

Table 2.6.3.1.5 Adult Vision Procedure Codes

Procedure Code	Description
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, one 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
V2020	Frames, purchases
V2100 – V2399	Single vision, bifocal, trifocal; glass or plastic lens; per lens
99211	Office or other outpatient visits for the evaluation and management of an established patient that may not require the presence of a physician or other qualified healthcare professional

For enrollees ages 21 and older, Louisiana Medicaid's current vision coverage is limited to exams and treatments for eye conditions. LHCC's adult vision VAB increases vision coverage to the same level as Louisiana Medicaid for enrollees ages 0 to 20. Similar to the benefit for enrollees age 0 to 20, a prescription will be required for eyeglasses or contacts.

2.6.3.3.3 Any proposed co-payments. No co-pays are required. Free transportation will be provided.

2.6.3.3.4 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. LHCC will provide vision services to eligible enrollees through the provider network of our affiliate, Envolve Vision. Enrollees may self-refer to one of more than 525 local Envolve Vision providers listed in our Provider Directory and searchable on our website, or by contacting LHCC's Customer Service Department for assistance. Envolve Vision provides adult vision benefits to LHCC's current enrollees and they will continue going forward to assure enrollees experience consistency and access to care.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. As described previously, the QAPIC will oversee the implementation of all VABs, including review of enrollee, provider, and community feedback and input from the Health Equity & Diversity Committee and Population Health and Clinical Operations Committee. LHCC's Vendor Oversight Committee also will meet routinely with Envolve Vision to ensure our enrollees receive services as outlined in the subcontractor agreement, including both State-covered services and LHCC VABs.

2.6.3.1.6 Identification & Remediation of Health-harming Environmental Factors Related to Shelter



LHCC is dedicated to using this VAB to meet enrollee SDOH needs by identifying and remediating health-harming environmental factors in enrollees' shelters. LHCC has a history of helping our enrollees address SDOH issues related to shelter by providing directed grants after Hurricane Laura and during the COVID-19 pandemic. ***LHCC provided $1.2 million in COVID-19 and hurricane recovery grants to 5,784 enrollees to mitigate issues with shelter,*** utilities, and food and water access. As an ongoing VAB, we will provide directed grants to enrollees specific to remediating health-harming issues within their shelter.

LHCC's grants improve enrollee health.

We observed 25% lower ED utilization and 49% lower inpatient utilization for enrollees who received SDOH-related Hurricane Laura and COVID-19 Relief Grants versus those who did not.

2.6.3.3.1 The populations who may receive the benefit. All enrollees will be eligible. Enrollee must agree to receive LHCC Care Management program services and a home assessment.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. [redacted]

[redacted]

MLPs can hold landlords accountable for remediating poor housing conditions that aggravate an individual's health condition. MLP lawyers will educate enrollees on their rights and meet with them to determine the appropriate path to take with their landlord, ranging from legal correspondence through negotiation up to and including civil legal proceedings. They may also participate in care team meetings to fully support enrollees.

LHCC will leverage existing statewide programs to build awareness and drive the adoption of this VAB. For example, one common environmental factor affecting health as identified by LDH is mold.[8] LHCC will leverage content from LDH's Indoor Environmental Quality Education Service to raise awareness about the dangers of mold and to showcase proven remediation services, such as cleaning air ducts, replacing carpeting, and fixing leaks and seepage. LHCC also supports the goals of the Louisiana Healthy Homes and Childhood Lead Poisoning Prevention Program. Referrals to LHCC from the Childhood Lead Poisoning Prevention Program will connect enrollees with our directed grants.

Louisiana Medicaid does not cover the remediation of health-harming environmental factors related to an enrollee's shelter.

2.6.3.3.3 Any proposed co-payments. No co-pays will be required for this VAB. Free transportation will be provided to MLP appointments.

2.6.3.3.4 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. LHCC will establish a Healthy Homes Grant Program to administer this VAB and to ensure enrollees receive both identification and remediation of environmental factors. [redacted] First, we will build an algorithm to regularly identify enrollees who may benefit from this VAB. We will conduct coordinated, multi-modal, HIPAA-compliant outreach to these enrollees (e.g., via CHW, phone, email, mail, and/or text message) to make them aware of the benefit and encourage their engagement. Case Managers will conduct or coordinate the home assessment and work with the enrollee to identify the appropriate remediation service or product and proactively outreach to high risk enrollees and other sub-populations that could benefit. Second, LHCC will develop a provider communication plan to ensure all contracted providers are aware of this VAB, as providers are a trusted resource for enrollees in their health journey. Providers will be encouraged to make referrals to LHCC's Care Management program. Third, LHCC will accept enrollee self-referrals. All enrollees will receive education through our welcome packet, enrollee handbook, our website, social media, and via interactions with LHCC staff.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. In addition to the oversight provided by LHCC's QAPIC, the Healthy Homes Grant distribution will be tracked in LHCC's Care Management Platform and reported to LHCC's Health Equity & Diversity Committee and Population Health Clinical Operations Committee. We will review enrollee, provider, and community feedback as well as analyze pharmacy, claims, and encounter data at aggregate and enrollee levels to understand utilization and where to target additional outreach activities. LHCC's Vendor Oversight Committee will regularly monitor and provide oversight of our MLP.

2.6.3.1.7 Non-clinical Home-based Interventions for Asthma

LHCC is committed to partnering with enrollees to manage their asthma through home-based interventions. Slightly more than 26,900 current LHCC enrollees are diagnosed with asthma, the majority of which are Black enrollees living in urban areas. To support enrollee's with asthma and remove barriers to health, LHCC will develop a continuum of care for enrollees, so enrollees can move towards actively managing their asthma condition through these VABs:

[8] https://ldh.la.gov/index.cfm/faq/category/41

- [redacted]

2.6.3.3.1 The populations who may receive the benefit. All enrollees will be eligible for this VAB. Enrollee must have an asthma diagnosis and agree to receive LHCC Care Management program services.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. [redacted] LHCC's Case Managers will work with the enrollee to determine which benefits will best address their asthma issues over time and apply the VAB flexibly. In special circumstances, based on health harming effects, enrollees may receive additional grants if authorized by the Vice President of Population Health and Clinical Operations or LHCC's Chief Medical Officer.

Home-based asthma education will be provided by LHCC Case Managers (e.g., nurses and CHWs). Education will include education about asthma, a home assessment to identify asthma triggers, and a plan with action steps to remediate triggers, including how to access the Healthy Homes Grant Program and tobacco cessations benefits.

Louisiana Medicaid does not cover non-clinical home-based interventions for asthma.

2.6.3.3.3 Any proposed co-payments. No co-pays will be required for this VAB.

2.6.3.3.4 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. LHCC will use four methods to ensure enrollees learn about and access this VAB. First, to ensure health equity, LHCC will launch a targeted and culturally sensitive campaign for ***urban, Black enrollees with asthma, actively outreaching via coordinated and multi-modal methods (e.g., via CHW, phone, email, mail, and/or text message) for participation*** in this VAB. We will continue to monitor asthma prevalence and utilization of services related to asthma across enrollees, stratifying data by race/ethnicity, geography, language, and disability status to identify and engage sub-populations that are disproportionately impacted. Second, LHCC will train enrollee-facing business units on this VAB and how to do warm hand-offs to LHCC Case Managers. Third, LHCC will develop a provider communication plan to ensure all contracted providers are aware of this VAB, as providers are a trusted resource for enrollees in their health journey. Providers will be encouraged to make referrals to LHCC Case Managers. Finally, LHCC will accept enrollee self-referrals. All enrollees will receive education through our welcome packet, enrollee handbook, our website, social media, and via interactions with LHCC staff.

For directed grants, LHCC will continue our work with the state's BREATHE program to offer assessments to our enrollees, prevent duplication, and extend program reach, and look to leverage other VABs (e.g., tobacco and vaping cessation) so enrollees access the right services to fit their needs. LHCC also will continue offering evidence-based coaching and education support for enrollees with asthma.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. In addition to the oversight provided by LHCC's QAPIC, the Healthy Homes Grant distribution will be tracked in LHCC's Care Management Platform and reported to LHCC's Health Equity & Diversity Committee and Population Health Clinical Operations Committee. We will review enrollee, provider, and community feedback as well as analyze and stratify pharmacy, ED claims, tobacco cessation claims, and other encounter data at aggregate and enrollee levels to understand utilization and where to target additional outreach activities.

2.6.3.1.8 Comprehensive, Evidence-based, Longitudinal Home Visiting Programs

LHCC is committed to improving prenatal and maternal health and birth outcomes, child health and development, families' economic self-sufficiency, and maternal life course development by aligning this VAB with longitudinal home visiting programs such as Nurse-Family Partnership (NFP), Parents as Teachers (PAT), and Healthy Start. Our approach for achieving this goal is two-fold. ***LHCC will support the existing Louisiana NFP program*** to reach more first time pregnant women and their families to help guide them through pregnancy and newborn care. ***LHCC will also work with the Office of Public Health (OPH) to expand their current PAT*** home visiting affiliate model to support families who are expecting a baby or have young children navigate services and keep babies on track for a healthy life. We will align with Louisiana's NFP and PAT programs to ensure enrollees receive comparable services and that the program is consistent for providers, to minimize confusion. ***We seek to invest and expand, not to fragment or duplicate.***

To meet these goals, LHCC will offer a three-pronged approach for increasing access to NFP and the program's long-term sustainability:

- [redacted]

2.6.3.3.1 The populations who may receive the benefit. LHCC will engage pregnant enrollees via our Care Management program, which includes connecting them to NFP, PAT, and other evidence-based programs. NFP will be available for enrollees who are first-time mothers with enrollment taking place as early as 28 weeks gestation and running through the child's second birthday. LHCC will risk stratify expectant mothers and work with them to appropriately offer the NFP program. PAT will be available to enrollees from pregnancy through the child's matriculation to kindergarten.

2.6.3.3.2 The scope of the benefit, including procedure codes, descriptions where applicable, and how the scope compares to existing Louisiana Medicaid coverage. LHCC's NFP program will cover home visit procedure codes, such as 99501, 99502, H1004, and S9123, and will include one-on-one home visits by a registered nurse or other paraprofessionals as approved by NFP's National Service Office. In-home visits may be weekly, bi-weekly, or monthly depending on the stage and needs of the enrollee and may be supplemented with telephonic supports. LHCC's investment in PAT expansion will allow affiliates in current and expansion Regions to provide families with young children personal visits, group connections, child screenings, and resources connections.

Louisiana Medicaid managed care currently does not cover these services.

2.6.3.3.3 Any proposed co-payments. No co-pays will be required for these VABs. Free transportation will be provided.

2.6.3.3.4 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. LHCC proposes a partnership with LDH to expand LDH's existing programs and to maximize federal funding streams (e.g., provide funding directly to LDH to support NFP expansion, stand-up new programs managed by LHCC, migrate NFP to another host agency). LHCC also will work with LDH (or other NFP host agencies) to create policies and procedures for billing LHCC for home visit services.

LHCC will implement a no-wrong door approach to enrollee referral, including notification of pregnancy forms, enrollee self-referral, referrals from providers or community organizations, and identification of eligible enrollees via our Centelligence Health Informatics Platform (which consider clinical, SDOH, and health equity factors). We will promote NFP and PAT through our enrollee welcome packet, handbook, website, and social media. We will inform providers via LHCC's provider manual, website, and training. We also will engage targeted community organizations focused on maternity and early childhood.

2.6.3.3.5 How the proposer will provide oversight of the value-added benefits. LHCC's QAPIC will have primary oversight for these VABs with support from the Health Equity & Diversity Committee, LHCC Maternal Child subcommittee, and Vendor Oversight Committee. Additionally, LDH's NFP and PAT community advisory boards will help provide oversight and guidance for these programs. LDH staff, providers, community-based organizations, and enrollees serve on the community advisory board. We will review enrollee, provider, and community feedback as well as analyze claims data for participating

enrollees regarding prenatal, postpartum, and well-child visits, health screenings, childhood immunizations, and hospital claims for delivery stays to understand the impact of these VABs on maternal and child health.

2.6.3.2 Additional Value-added Benefits during Contract Term

LHCC understands and acknowledges LDH's right to add additional VAB options during the term of the Model Contract. We will work with LDH to implement any additional VABs during the term of the Model Contract. Over 9 years serving the Louisiana Medicaid population, LHCC has worked with LDH to implement new VABs based on the evolving needs of our population.

2.6.3.4 Actuarial Value of Benefits

LHCC's certification of per member, per month (PMPM) actuarial values for the eight selected VABs is provided as ***Attachment 2.6.3.4***. We understand the proposed monetary benefit of our VAB is considered binding, and LDH may require an alternate benefit or reconciliation should the aggregated annual PMPM not be expended.

2.6.3.5 Statement of Commitment to Offer Value-Added Benefits for Full Contract Period

LHCC will provide the eight requested VABs described herein for the entire 36-month term of the Model Contract and any applicable extensions. All encounterable LHCC VABs will be identified as such per the MCO Manual and MCO System Companion Guide. We will offer the VABs as agreed upon with LDH and may offer additional VABs during the term of the Model Contract with approval from LDH per the MCO Manual and MCO System Companion Guide. LHCC will annually seek written pre-approval from LDH at least six months before open enrollment for any proposed additions, deletions, or modifications to components of our VABs. We will commit to providing all VAB components for at least one year. Annually, we will assess usage and outcomes of VABs and provide the PMPM actuarial value of the VABs, individually and in aggregate, based on enrollment projections for LHCC, accompanied by a certification statement from an American Academy of Actuaries actuary.

LHCC's Additional Value-Added Benefits

As described in the introduction, LHCC also proposes four additional VABs to more fully address enrollees' SDOH needs, incentivize healthy behaviors, and improve health and wellbeing. As these benefits were not specifically requested in the RFP, we provide limited descriptions and respectfully request LDH's review of these VABs in concert with the VABs described above. If these VABs are approved by LDH, we will provide actuarial certifications during Readiness Review. None of the VABs below require any co-payment and all are overseen by our QAPIC with input from our Health Equity & Diversity Committee.

[redacted]



[redacted]



[redacted]

[redacted]



[redacted]



[redacted]

SECTION 2.6.4

Population Health



"Louisiana Healthcare Connections double matching my EBT purchases has allowed me to get the foods we need. Without it, I would not be able to get the things I need for my family. A big part of being a mother is providing nutrition for my family."

- Emily
Enrollee, Baton Rouge

2.6.4 Population Health [12-page limit]

2.6.4.1 Population Health Reflection and Overview

Population health is inherent in LHCC's purpose: ***to transform Louisiana's health, one person at a time***. The events of the last 18 months – hurricanes, COVID-19, and the far-reaching racial justice movement – have been a stark reminder that to truly improve the health of the population, we need to address the inequities. Self-reflection has triggered a review, re-organization, and re-framing of our principles and approach to ***raise the voice of the community***. This evolution is supported by our population health management (PHM) framework, aligned staff and committee structure, and local, community-anchored initiatives, all developed through a ***health equity lens***. In this response, we will provide (1) an overview of our local PHM approach and population health principles, (2) our experience improving population health for the ***Louisiana Medicaid population***, including challenges and solutions, and (3) our PHM strategic goal areas and measures.

LHCC's Population Health Principles

- *Health Equity*
- *Enrollee Engagement*
- *Provider Support*
- *Sustainable Community Solutions*
- *Prevention and Wellness*
- *Continuum of Services & Support*
- *Qualitative & Quantitative Data*

1. Louisiana Medicaid PHM Approach and Population Health Principles

Our stated purpose offers a succinct definition of population health, which, when combined with our principles and LDH's Health Equity Plan, Quality Strategy, and goals, is the heart of our approach. This involves showing up for every enrollee to address disparities, remove barriers, and positively impact health, wellness, and quality of life. By approaching everything from the enrollee's perspective and through a health equity lens, we support solutions that are culturally aligned, address historic disparities, and overcome social determinants of health (SDOH). This is facilitated and achieved using our PHM Framework.

Louisiana PHM Framework. Health equity is a guiding principle and way of life at LHCC. ***PHM is the framework to achieve health and wellness for all, free from barriers***. ***Figure 2.6.4.1.A*** summarizes our PHM approach and structure to inform and guide our work to remove health disparities and improve population health through prevention and wellness, care management (CM), utilization management (UM), quality improvement (QI), PH/BH integration, value-based payments (VBP), and community-based initiatives. Each box represents a set of coordinated activities and resources that ***inform and align*** at each stage of 1 goal setting and strategy, 2 assessment and planning, 3 implementation, and 4 evaluation, all performed with enrollees at the center through a health equity lens.

Figure 2.6.4.1.A Population Health Management (PHM) Framework
Person-Centered, Data-Driven Approach to Achieve Health Equity and Optimal Outcomes



LHCC Principles Driving Individual, Community, and Population Health. Our principles drive performance:

Health Equity. Achieving health equity is woven into all we do. We identify and address health disparities through boots-on-the-ground engagement; qualitative and quantitative data collection and analytics; targeted and tailored interventions; ***partnering with trusted messengers*** and entities such as the Louisiana Center for Health Equity, Louisiana Healthy Communities Coalitions, Ochsner-Xavier Institute for Health Equity and Research, United Way, Urban League, the Louisiana Chapter of the American Academy of Pediatrics, and Louisiana Primary Care Association; and soliciting input through our ***Neighborhood Equity Councils*** **and** ***Enrollee, Community, and Provider Councils*** to identify barriers and promote community-driven solutions.

Enrollee Engagement. We focus on the needs of our entire population through PHM initiatives aimed at prevention and wellness, health literacy, and removing health disparities, while at the same time identifying enrollees and subpopulations with special healthcare needs for targeted outreach. Engagement is tailored and flexible. For example, we will offer ***every new enrollee an in-home visit*** in their first 90 days of enrollment. Partners and staff with lived experience in regions across

the state build trust and facilitate open dialogue through health fairs and other community events. We expand our reach through call campaigns, text, email, social media, and self-service education resources, including our Health & Wellness Platform (see below).

Provider Support. Providers are key partners and drivers of population health. We collaborate with providers to remove access barriers, deliver meaningful data, and align PHM goals. For example, our dashboards located on our secure Provider Portal offer PCPs the ability to assess and manage their patients as a population. To expand broadband coverage in rural parts of the state, LHCC is partnering with AT&T to offer providers expedited access to the Federal FirstNet network, a new nationwide wireless broadband service featuring faster, more reliable internet service. If upfront hardware costs are a barrier, we provide grants to cover the expense, promoting equal access across the state.

Quick Response

In 2020, we distributed 400 smartphones for telehealth visits and distributed 320,000 masks to providers and first responders to ensure continued access virtually or in person.

Sustainable Community Solutions. Population health cannot be achieved alone. Our role is to partner with and invest in the people we serve, without displacing or fragmenting what exists [redacted] e refer enrollees to local and state resources, including OPH, OBH, OCDD Waiver, and EarlySteps, and design programs to fill gaps and complement services in the community.

Prevention and Wellness. Prevention and wellness is a core tenant of any population health program. We design and implement PHM programs for the whole population, as well as sub-populations, with targeted outreach based on gaps, disparities, and special healthcare needs. Activities include individual ***care gap alerts systematically shared*** via our secure web portals, Community Health Worker (CHW) engagement and peer-led events, and financial incentives for healthy behaviors. New in 2022 is our ***Digital Health and Wellness Platform*** (mobile and web) that promotes daily health and wellness through tailored educational messaging; reminders regarding medications, appointments, and community/health events; sleep, diet, and exercise tracking; and targeted engagement and reminders regarding LHCC PHM programs, including case and chronic care management.

Continuum of Services and Support. Our PHM approach ensures timely and appropriate services and supports that ***wrap around enrollee needs***. LHCC facilitates access along the continuum -- maternity care, early childhood development, prevention and wellness, social supports, chronic condition management, treatment, recovery, and end-of-life care. This includes removing SDOH, geographic, and cultural or language barriers; maintaining a diverse network of traditional and non-traditional providers, including CBOs; and integrating and coordinating physical health (PH), behavioral health (BH), and social needs at the individual and community level.

Qualitative and Quantitative Data. PHM is a data-driven approach, listening to both the facts and figures, and the voice of our enrollees and communities via surveys (e.g., CAHPS), advisory and neighborhood councils, focus groups, and direct feedback. Leveraging ***multi-source data and analytics***, described in 2.6.4.1.2 below, we identify care gaps and disparities to understand and address the clinical, social, economic, familial, cultural, and other factors that influence outcomes. We share data with staff, providers, and communities to activate change. For example, we are partnering with Louisiana Rural Health Association and Louisiana Tech University to provide data from our chronic care programs to identify and address underlying factors driving rural chronic health disparities. We monitor utilization data to identify trends by diagnosis, provider, time of year, geography, and race, ethnicity, language, and disability data (RELD), and drill down on root causes to inform all work.

2. Experience Improving Population Health for the Louisiana Medicaid Population

LHCC was established in 2012 with the sole purpose of improving the health of Louisiana's Medicaid population. We have since grown to serve over 530,000 Medicaid enrollees and a network of over 39,250 healthcare providers, the largest Medicaid network by nearly 8,000 providers. A local plan with local experience, LHCC is backed by the nation's largest Medicaid managed care organization. LHCC's parent company, Centene, has over 35 years of experience and provides healthcare coverage to 1 in every 15 Americans, focused on government-sponsored healthcare in 50 states, including Medicaid, Medicare, and Marketplace. With this combined experience, we partner locally to bring best practices and proven programs to impact population health and improve lives.

Demonstrating our impact since inception, LHCC achieved the following outcomes through CM programs and public health campaigns targeting prevention and wellness. Outcomes below use LDH 2012 baseline data compared to 2020 HEDIS measurement year (MY) data, unless otherwise referenced.

- Well-child visits ↑ ***45.63 percentage points*** (1st 15 months) and ↑ ***38.3 percentage points*** (3-6 years)
- Prenatal and postpartum care ↑ ***17.73 percentage points*** (prenatal) and ↑ ***19.75 percentage points*** (postpartum)
- Childhood immunizations status ↑ ***55.78 percentage points***
- Chlamydia screenings ↑ ***11.07 percentage points*** and Breast Cancer screenings ↑ ***18.22 percentage points***
- Flu vaccinations ↑ ***14.6 percentage points*** (Reporting Year [RY] 2016-2020)
- Advising smokers and tobacco users to quit ↑ ***6.74 percentage points*** (RY2015-2020)

Examples of specific LHCC PHM programs and their impact in Louisiana are highlighted in ***Figure 2.6.4.1.B*** below.

Figure 2.6.4.1.B LHCC PHM Programs and Outcomes

Cribs for Kids • Maternal and Child

Sleep-related incidents are the leading causes of death in babies up to 12 months in age, with rates among Black infants far exceeding other races. Cribs for Kids provides a Safe Sleep Survival Kit include a Cribette, Halo Sleepsack, and Safe Sleep educational material.

56%↓ lower infant mortality over two years in the 2 pilot regions

"When I received the crib from [LHCC]...it lit up my day. The cribette was a blessing... You have people out there who care about you and your kid and they're actually reaching out. That was a really big deal for me. With everything [LHCC] has done for me and my baby, they just make me feel like family."

Geaux Baby and Me • Maternal and Child

Louisiana performs among the lowest in the country on measures of infant mortality, preterm birth, and low birth weight. Based on our national Start Smart program in place since inception, our local maternal health program brings education and resources to pregnant enrollees through the first year of life.

5.8%↓ reduction in the number of early pre-term births (<32 weeks)

21.3%↑ point improvement in Postpartum Care HEDIS rate, 2015-2020

"You don't know how much it means to have someone that's there to say 'Okay, what else can I do for you today?' With all of the day-to-day challenges I have just to get through one day, my healthcare makes everything just a little bit easier. To the people at [LHCC], 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."

Disease Management (DM) Programs • Chronic Conditions

According to the CDC, heart disease ranks as the leading cause of death in Louisiana, with chronic lower respiratory disease, diabetes, and kidney disease also in the top 10. Our DM programs provide targeted education, health coaching, and self-management skills training for enrollees and caregivers. For example, we have served over 5,500 enrollees in our Sickle Cell Program since 2012.

8%↓ reduction in IP utilization for enrollees in DM (2019)

31%↑ increase in use of Sickle Cell Hydroxyurea (2018-2020)

"As soon as they found out, they stepped in and started helping find what my daughter needed, for her to have the medication she needs and the supplies she needs to be able to remain out of the hospital. They've been there through everything, and they were right there with a helping hand. And wanting to help. They were brought into our lives and have been very, very much a blessing to all of us."

COVID-19 and Hurricane Relief Grants • SDOH

LHCC identified health disparities and SDOH barriers precluding enrollees from accessing needed services. Our grant program provided $200/enrollee grants to 8,129 individuals, totaling $1.62 million.

25%↓ decrease in ED utilization for the grant population post relief grants

49%↓ decrease in IP utilization for the grant population post relief grants

"It helped me buy my autistic daughter some shakes and diapers that she needed, and helped me get her some more clothes to get us through until I could get moved."

SNAP Match Program • SDOH

Based on a 2019-2020 study, the top SDOH category of need for LHCC enrollees was Food Insecurity. Our multi-year, community investment program has increased food resources across the state through $15 dollar for dollar match of SNAP funds.

✓ Sustained support for SNAP match programs, resulting in new acceptance of SNAP and matching programs in 3 cities (Shreveport, Natchitoches, Hammond), expanding access to food for enrollees.

"Louisiana Healthcare Connections double matching my EBT purchases has allowed me to get the foods we need. Without it, I would not be able to get the things I need for my family. A big part of being a mother is providing nutrition for my family."

3. Three-Year LHCC Population Health Strategy Goal Areas

Each year LHCC will identify specific goal areas to be articulated in our PHM strategy and used to prioritize and align initiatives and efforts and drive permanent change in key measures relevant to our population and supportive of LDH's quality strategy and population health goals. For Years 1 to 3, our PHM goal areas will tie directly to LDH targets outlined in the Model Contract, Section 2.5.1.2, categorized as: ***Communicable Diseases (2.5.1.2.1), Maternal & Early, Childhood Health (2.5.1.2.2 & 2.5.1.2.9), Behavioral Health (2.5.1.2.3 & 2.5.1.2.4), Chronic Conditions (2.5.1.2.5 to 2.5.1.2.7), Tobacco Cessation (2.5.1.2.8), and Prevention and Wellness (2.6.1.1.11),*** with specific measures in each. For example, under Communicable Disease we will look at HIV Viral Load Suppression; Chronic Hepatitis C Virus (HCV) Screening and

Pharmaceutical Treatment Initiation; and Syphillis and Chlamydia screening. We will also identify and target disparities within each category, such as improving Prenatal & Postpartum Care (PPC) and Controlling High Blood Pressure (CBP) for Black enrollees and reducing tobacco use among American Indian enrollees.

2.6.4.1.1 Identifying Baseline Measures and Targets for Health Improvement

As an NCQA-accredited health plan, currently pursuing NCQA Multicultural Health Care Distinction, we develop an annual PHM Strategy Description and Impact Report. As part of this process, we identify baseline health outcome measures and targets for improvement based on annual population health needs assessments. The assessment includes an evaluation of subpopulations and disparities and prior year progress. While PHM itself is structured and process-oriented, the mission and intent is never lost, which is to improve individual and community health. We identify baseline measures and targets to align our efforts and ensure we have a positive impact on the health of our enrollees.

Data and Infrastructure to Identify Baseline Data. With almost a decade of Louisiana experience, we have accumulated a rich resource of population health data. We leverage our Centelligence health informatics platform to identify baseline health outcomes data. We report on all datasets, including HEDIS, EPSDT services, claims and referrals, Performance Improvement Project informatics, and CM planning and assessment data, including SDOH. We assess over time and drill down and stratify on demographics such as geography, age, gender, and RELD. To evaluate program impact, we create control groups of like individuals or compare pre-and post-implementation and measure statistical significance. Baseline data that will be used in our Contract Year 1 Population Health Strategy are included below in ***Table 2.6.4.2***.

Specific Targets for Improvement. LHCC manages our entire membership on an ongoing basis using systematic reporting to identify individual opportunities for health improvement. This is an ongoing and agile approach to health improvement, one enrollee at a time. Further aligning resources and efforts are overarching population goals defined annually as part of our PHM Strategy. For the new contract, we have aligned PHM targets with LDH (Model Contract Section 2.5.1.2), as described in 2.6.4.1 above. Using a drill-down approach, overlaying demographic, SDOH, geography, and other relevant data, including RELD, we identify specific measures, subpopulations, and goals under each category to systematically evaluate annual population health impact.

2.6.4.1.2 Measuring Population Health Status and Identifying Sub-Populations

We continuously monitor and evaluate population health status using internal and external data sources, as summarized in ***Table 2.6.4.1.2*** below. Data is reviewed and analyzed at individual and population levels by Population Health, Quality, CM, and UM functions via daily, weekly, monthly, and quarterly reporting and LHCC proprietary tools (see 2.6.4.1.3). Methods of evaluation and analysis include ongoing risk stratification; daily and weekly integrated clinical rounds; monthly and quarterly cross-functional workgroups; and annual evaluations, including our Annual Quality Review and PHM Impact Report. Findings are analyzed and reported up through our QI Committee structure for ongoing monitoring and action and Board of Directors for oversight.

Table 2.6.4.1.2 Sources and Types of Data and Information used to Measure & Monitor Health

Data Type	Data and Information Sources	Frequency
Community Assessment and Reports	- Louisiana State Health Assessment, Health Improvement Plan, and Health Data Portal - Bureau of Minority Health Access Annual Report - Hospital community needs assessments, Parish Health Rankings, and city dashboards - Barrier Analysis Reports and Neighborhood Action Plans - United Way ALICE Report and Louisiana 211 utilization data - Healthy People 2030 and American Community Survey census data - USDA Food Access Research Atlas - Public health registries and public safety and school performance reports - CDC data (e.g. CDC Social Vulnerability Index, Chronic Disease Indicators, National Environment Public Health Tracking, Behavioral Risk Factor Surveillance System)	Annually
Individual Enrollee Screenings & Assessments	- Health Needs Assessment (HNA) (upon enrollment and then annually) - Comprehensive Assessment and available provider screenings and assessments - Ongoing assessment for socio-cultural needs (at each encounter) - Patient Health Questionnaire (PHQ)-9 and General Anxiety Disorder (GAD)-7 - Edinburgh Postnatal Depression Scale (EPDS) and Start Smart for Your Baby OB Screen	As clinically indicated or upon change in condition
Transactional Data	- Claims and authorization data (Medical, BH, Dental, Pharmacy) - Laboratory data, including lab results if available - CM program data (e.g. plans of care, assessments, etc.) and notice of pregnancy forms - External data sources (e.g. LINKS immunization registry, EHR, HIE, and ADT feeds) - UM program data (e.g. service utilization, length of stay, etc.) - Enrollee information (e.g. demographics, eligibility, PCP assignment, RELD, etc.)	Daily, weekly, monthly, quarterly

Data Type	Data and Information Sources	Frequency
	- Provider information (e.g. specialty, participation status, RELD, etc.) - SDOH data (via Z-codes, SDOH screens, and Census) and Health surveillance data (Kinsa®)	
Stakeholder Input	- Direct input from enrollees, providers, and community stakeholders including focus groups, advisory councils, and through HE Neighborhood Equity Councils	Ongoing
Quality Data	- HEDIS results, CAHPS enrollee satisfaction survey results (child and adult), grievances and appeals, and other quality metrics	Quarterly

Identification of Sub-Populations. Beyond measuring health status, data is used to identify health disparities and inform sub-populations. By honing in on sub-groups, we perform more effective root cause analysis, solicit specific enrollee and community input, and structure outreach and programming to target enrollees who may be under-represented, difficult to engage, or clinically or socially complex. For example, we partnered with the ***National Minority Quality Forum, Teche Action Clinic, and Louisiana Department of Health in a COVID-19 testing and research study*** to understand the impact of COVID-19 on minority and underserved communities. A total of 1,176 participants were tested, 1,018 enrolled in the study. Participants will receive once-per-week follow-up calls for one month and check-ins over the course of the five-year study. Supporting all of our investigational and discovery efforts are our PHM analytic tools highlighted in 2.6.4.1.3 below and fully described in our response to Section 2.6.5 Health Equity. Based on a current review of our population, the following are sample sub-populations for targeted interventions and focus in the current year: ***enrollees with complex SDOH needs, experiencing moderate to severe BH/SUD conditions, in Foster Care, who are Non-English speaking, or with identified racial disparities.*** For example, we participated in multi-tier community effort in Caddo Parish to address health disparities in Black communities ***implausibly reporting zero*** cases of COVID-19 in April 2020. LHCC partnered with David Raines FQHC and other community and local government entities to deploy mobile COVID-19 testing to the Allendale-Lakeside Census tract. The series of screening events tested over 200 individuals a day.

LHCC in Action. The following HEDIS measures show our impact reducing racial disparities from 2019 to 2020:

- ***40.4% reduction in disparity in Timeliness of Prenatal Care*** for Black enrollees; ***Disparity eliminated in Postpartum Care*** measure (63.8% of Black and 62.3% of White enrollees attended postpartum visits in 2020)
- ***7.5% reduction in disparity*** in Antidepressant Medication Management (AMM) Acute Phase for Black enrollees; ***17.8% reduction in disparity*** AMM Continuation Phase for Black enrollees
- ***Disparity eliminated for Follow-Up After Hospitalization for Mental Illness*** (39.8% of Black enrollees and 39.2% of White enrollees attended follow-up visits in 2020)

2.6.4.1.3 Identifying Key Determinants and Strategies

Leveraging multi-source data and drill-down capabilities, we identify key determinants creating disparities and barriers to inform strategies and interventions. Determinants can include SDOH, such as housing, food insecurity, and personal safety; behavioral, such as substance use disorder (SUD) or mental health; cultural, race/ethnicity, geographic, or access barriers; physical disability or cognitive challenges; and health literacy.

Identification Tools. We apply PHM analytic processes and inputs from more than 200 data elements to identify disparity reduction opportunities and track related performance leveraging proprietary tools. For example, our ***Neighborhood, Economic, and Social Traits (NEST) Tool*** supports root-cause analysis by providing both an individual and community risk score indicative of adverse health outcomes based on social, economic, and environmental conditions. Our ***SDOH Dashboard*** aggregates SDOH data from claims and assessments to identify SDOH needs and the impact on health and utilization. Our ***Health Equity Dashboard*** displays LHCC performance across priority HEDIS measures by race, ethnicity, and geography, using heat maps, tables, and bar charts to easily recognize disparities by sub-population, as well as change over time. Using these tools in combination, we identify disparities, create targeted interventions across a specific zip code or sub-population, and measure the impact of initiatives to ensure they are improving health equity.

Community Voice. We use our HE Neighborhoods' Councils and Advocates; Enrollee, Provider, and Community Advisory Councils; and trusted messengers such as CHWs to validate quantitative data based on qualitative inputs. For example, our NEST tool may show access to a grocery store in a given zip code while direct enrollee input clarifies that the grocery story is a corner market with no fresh food options.

Targeted Programs and Interventions. Guided by the above inputs, we use our quality committee structure to internally and externally vet ideas and collaboratively design, implement, evaluate, and scale interventions. Our overarching programs, such as CM, chronic care management, health education, and VBP, are augmented with local partnerships and technology solutions to promote engagement. For example, we offer convenient access to ***on-demand Video Remote Interpreters***. Flexible mobile options bring live interpreters when and where they are needed most. Expanding our community touchpoints, LHCC will open ***nine***



community wellness centers over the next eighteen months. Neighborhood locations are selected based on membership density, health disparities, and quality care gaps within Baton Rouge, Lake Charles, Monroe, Alexandria, Gretna, Hammond, Lafayette, New Orleans, and Shreveport. Centers will provide on-site enrollee services; monthly orientations, baby showers, and peer groups; immunization events; health education events; and direct SDOH support, including computer access, SafeLink Wireless sign-up, WIC referral, financial management, back-to-school supplies, job/education fairs, parenting classes, and nutrition services.

Below are examples of targeted interventions by PHM focus area.

Communicable Diseases. Baton Rouge and New Orleans have two of the top three highest rates of HIV diagnosis in the country and are identified hotspots in our Health Equity Dashboard. Key determinants impacting spread tend to include homelessness, injection drug use, low education, low health literacy, cultural norms, poverty, and lack of access to care. LHCC is partnering with ***AbsoluteCare*** to open clinics in New Orleans to serve enrollees with these complex medical conditions in coordination with enrollees' PCPs and other providers. Their evidence-based model of care is a national best practice in communicable disease management and includes primary care, integrated BH services, care coordination, health coaching, social support services, and onsite diagnostics. To promote access to screenings (e.g., HIV, Hep-C) in under-resourced areas, such as the Northeast Delta region, we will sponsor mobile events and Wellness Caravans using mobile clinics to offer Wellness Days in locations across the state.

Maternal and Early Childood Health. To help identify and address key determinants in maternal and child health, LHCC will



offer a nurse home visit to every pregnant enrollee, using Nurse-Family Partnership (NFP), Parents as Teachers, and other CBOs, in combination with our nurse staff, to ensure ***every mother has access to in-home support*** as needed. We are also building a ***comprehensive doula program*** based on outcomes from affiliates who saw a 26.8% higher postpartum visit rate in enrollees with a doula versus without, coupled with national research showing lower rates of unnecessary C-sections, lower preterm birth rates, and shorter NICU length of stays for women with doula support. These services are especially important for Black enrollees with known adverse outcomes due to systemic racism, socioeconomic stressors, and cultural barriers to care. In addition, all enrollees will have access to ***24/7 on-demand maternal and pediatric experts*** for lactation support, enrollee education, and nurse triage. LHCC affiliates implementing a similar platform saw a 1.9-day reduction in NICU length of stay, 2.75% increase in well-child visits, an average of 1.4 more prenatal visits, and a 10.7% increase in postpartum care visits.

Research has shown that experiencing one or more Adverse Childhood Experiences (ACEs) is linked to many lifelong health and social problems. ***Addressing ACEs as a common risk factor*** can reduce costs, promote health equity, and improve quality of life, including the lives of our 7,300 children enrolled in Foster Care. Since 2019, LHCC has provided continuing education units (CEUs) to 363 providers on ACES. We are selecting LHCC CHWs to apply to become certified ACE educators through Partners for Family Health Louisiana. Once certified, our CHWs will be able to educate communities on the importance of acknowledging and addressing ACEs. As of August 2021, ***100% of LHCC staff have completed Trauma-Informed Care and ACEs Training***.

Behavioral Health. Underlying mental health and SUD are key determinants in both PH and BH. In 2020, 7 of the top 15 chronic conditions for LHCC enrollees were BH/SUD related. LHCC provided grants of $100,000 each to three pediatric



practices (Red Stick Pediatrics, Children's Clinic of Southwest Louisiana, and Pediatric Center of Southwest Louisiana) to ***hire and co-locate BH specialists*** (LCSWs) to expand integrated primary and BH care for children, as well as paying an enhanced rate for BH services. The physicians and LCSWs are reporting that connecting patients to the resources and services they need at the point of care is helping to improve outcomes.

"In a patient population with so many challenges accessing care and achieving good health due to social and environmental obstacles, providing mental health resources that are convenient, easy to access and well-coordinated with medical providers is probably the most critical thing we can offer these children and their families."

- Dawn Vick, MD | Red Stick Pediatrics

OpiEnd, LHCC's multidisciplinary, ***evidence-based approach to opioid misuse***, leverages machine learning to identify and intervene for enrollees at risk of opioid use disorder. Our goal is to effectively manage pain and prevent opioid misuse through four strategic pillars: Pharmacy Protocols, Provider Engagement, Enrollee Education, and Community Awareness. To address neonatal abstinence syndrome (NAS) and neonatal opioid withdrawal syndrome (NOWS), LHCC is implementing ***Strongwell SUD/OUD Exposed Pregnancy Program, a peer support care community*** to help pregnant women who use

opioids or other substances safely stabilize their medications and SDOH before birth. This program provides intensive case management services that include certified peer specialists with diverse backgrounds and similar lived experiences as the enrollees we serve. These high-touch support services have shown success in ***decreasing ED utilization*** (12% reduction), ***increasing adherence with Medication-Assisted Treatment*** (greater than 80% adherence), and increasing rates of prenatal and postpartum visits (30% and 15% respectively).

Chronic Care. COVID-19 shed light on many disparities and barriers to health access. To help alleviate transportation barriers and COVID concerns, we are sending enrollees with diabetes ***in-home A1c testing kits***. [redacted] Based on success in affiliate health plans, we are bringing similar programs to Louisiana for diabetes, hypertension, and CHF.

Tobacco Cessation. Health problems caused by tobacco include tooth decay, damaged metabolism, breathing problems, cancers, and death. With 90% of daily tobacco users starting by age 18, LHCC is focusing on youth populations to reduce or prevent tobacco use. This is Quitting is a teen and young adult-focused ***vaping cessation text messaging*** program that builds upon scientific evidence and formative research with young adult e-cigarette users. National results reported: 13% of teens and 17% of young adults reported quitting, and 46.6% of teens and 46.3% of young adults reported using less often. For adult enrollees, LHCC will offer ***Craving to Quit***, an evidence-based digital program that teaches enrollees how habits are formed, and how to break them. This award-winning virtual program teaches awareness of cravings and habits to help participants quit smoking or vaping through weekly coaching calls, self-guided video lessons and exercises, and expert community support. With a higher prevalence of smoking in rural areas of the state, these digital programs provide greater access and flexibility. Noting the highest prevalence of smoking among our American Indian enrollees, we tailor our outreach and materials to address ***cultural considerations*** about tobacco use, such as the sacred or traditional connotations that may exist for certain tribal enrollees. LHCC will offer enrollees an incentive for engaging in tobacco cessation counseling, for filling the first prescription for tobacco cessation medication, or enrollment in the American Indian Commercial Tobacco Program.

Prevention and Wellness. LHCC offers My Health Pays, our rewards program that promotes personal healthcare responsibility and ownership by offering enrollees financial incentives for healthy behaviors. Enrollees can earn rewards by making healthy choices and completing healthy activities like annual doctor visits, annual cancer screenings, flu vaccination, annual comprehensive diabetes care, and infant well visits. These rewards can be spent on almost any item at Walmart (except alcohol, tobacco, firearms, and withdrawl to cash), as well as to pay utilities, phone service, rent, childcare, education, and transportation, directly addressing SDOH while promoting preventive care. [redacted]

2.6.4.1.4 Aligning and Integrating For a Comprehensive, Consistent, and Purposeful Approach

Aligning the efforts and resources of our CM, UM, Quality, Enrollee and Provider Services, and VBP programs are critical to achieving PHM goals. As part of the assessment and identification process described above, data analytics and information are shared through cross-functional workgroups, committees, and rounds. For example, while our PHM framework looks at the entire population, it recognizes specialized enrollee needs for individual engagement in CM programs, including case management/care coordination, DM, ED diversion, care transitions, and transition-age youth programs. Our health promotion, education, and quality initiatives are working in parallel to promote wellness, prevention, and identify and address health disparities across the entire population, with our provider VBP arrangements aligned to ensure we are all working toward the same health, equity, and quality goals. Enrollee and Provider Services are the front-line staff who identify needs and connect enrollees to appropriate internal and external resources. Ensuring all of this cross-functional communication and alignment take place is our deliberate Population Health and Health Equity Infrastructure (see below).

Integrated Infrastructure. Our internal governance structure is used to operationalize the PHM framework and facilitate integration across functional departments, with direct input from external stakeholders. We use our quality committee

structure, including our Health Equity and Diversity Committee (HEDC), to ensure cross-functional coordination and input. The HEDC is co-led by our Vice President of Population Health and Vice President of Health Equity, with participation from across the organization -- Quality, CM, Network/Provider Engagement, Operations, Human Resources, Community Engagement, Enrollee Engagement, Pharmacy, Compliance, and Analytics -- to ensure alignment with all other Model Contract requirements and LHCC initiatives. Based on issues identified and initiatives recommended, the HEDC will activate cross-functional Health Equity Action Teams to identify disparities, key determinants, and carry out activities with a health equity lens. Feeding the HEDC, which reports up to the QI Committee, are internal subcommittees, external advisory councils, and qualitative and quantitative data (see ***Table 2.6.4.1.2***), representing all functional areas and key stakeholders. Through this structure, LHCC departments and stakeholders coordinate, collaborate, develop, implement, and evaluate recommendations that support PHM, health equity, LDH, and community goals.

LHCC in Action. The following provides an example of a health equity action plan to improve maternal health.

CM	Quality	Enrollee Services	Provider Engagement	Community Relations	VBP/Incentives	Human Resources
Maternal case management, nurse home visits, SUD/depression screenings, health education, SDOH supports, bias testing	Identification of disparities, hotspotting, monitoring & oversight, PIPs, CLAS Standards	SDOH screenings, information on available services, CM referrals, language services, appointment scheduling assistance & reminders	Education on available programs and how to refer, training on BH & developmental screenings, process-mapping	Community partnerships, HE Neighborhoods, community education and events, doula workforce development	Provider and enrollee incentives for timely prenatal & postpartum care, targeted VBP to address disparities	Targeted training and hiring, Employee Inclusion Group alignment, Unconscious bias and CLAS training

2.6.4.1.5 Other Considerations in Improving Population Health

Working to improve the health of the entire population and moving the needle on quality and health outcomes is a complex yet inspiring effort. Critical to our approach is ongoing evaluation, monitoring, and innovative programming, which includes essential community engagement and partnership.

Evaluation and Monitoring. Our framework includes a continuous loop to measure impact and course-correct as indicated. Rigorous scientific methods (e.g. Plan, Do, Study, Act) help evaluate impact, improve outcomes, and drive innovation at the individual and population level. Vital to this step is engaging with enrollees, providers, state partners, and key stakeholders to ensure a continuous feedback loop for those most impacted. Methods to get direct feedback include our advisory and focus groups; surveys; use of CHWs and peers to connect with enrollees one- on-one and at community events; field-based provider staff meeting with providers daily; and direct community engagement, as described below. Evidence of our impact in Louisiana is included above in ***Figure 2.6.4.1.A***. By applying our PHM framework, partnerships, and processes, we will achieve our goals and continue to transform the health of the community, one person at a time.



- [redacted]

Social Health Bridge (SHB). In 2019, LHCC launched SHB in New Orleans. Through SHB, LHCC identified a low-income housing community with LHCC enrollees experiencing health disparities. We partnered with a resident director in the community, trained and equipped her with tools and information, and engaged her as a trusted messenger to her neighbors. With SHB support, she was able to assess individual and family needs, and connect enrollees to health and social services to address SDOH, ensure care gap closure, and reduce reliance on the emergency department. SHB is a first-in-the-nation effort to move from grant funding for community-based organizations to sustainable, value-based funding from the health sector. Despite the pandemic, ***in 2020, SHB completed assessments for 63% of resident enrollees, resulting in care plans for 38% of enrollee households***.

Young Women Choosing Action (YWCA). Implemented in 2019, LHCC partnered with YWCA of Northwest Louisiana to implement a two-year pilot for teen girls ages 13-19. YWCA is a culturally and gender-responsive, trauma-informed education and leadership program, empowering young women to effectively employ choice and leadership strategies in a wide variety of life situations. The participants learn real-world leadership skills by working together to identify and address an authentic community need. The curriculum was developed to integrate the best of what is known about adolescent development, positive youth development, gender and leadership, mindfulness practices, adverse childhood experiences, and trauma's impact on the brain and body. The pilot yielded positive results and is being replicated nationwide.

2.6.4.2 Year One Population Health Milestones and Timeframes

LHCC continues to update our PHM programming to support LDH goals. With staff, processes, infrastructure, goals, and baseline measures in place today to meet all of the requirements in Section 2.5 of the Model Contract, our year one milestones are tied directly to improvements in health and healthy behaviors. While we are making year-over-year improvements and changing lives daily, achieving population health and health equity is a process that takes years. To move the needle, it is important to focus our resources strategically. Based on Year 1 to 3 PHM goal areas (aligned to Model Contract Section 2.5.1.2), we selected specific Year 1 focus measures. These target measures will serve as Year 1 milestones for addressing population health, in concert with PHM initiatives to be implemented. This does not preclude us from working diligently on all 58 measures in Attachment H Quality Performance Measures or identifying and acting on other opportunities throughout the year. Our overall QI, CM, outreach and education, VBP, and other key drivers of health and wellness work to meet and exceed all quality goals through their daily activities, programs and initiatives, and common objectives to improve population health and health equity for all.

[redacted]



2.6.4.3 Identifying and Addressing SDOH Needs and Barriers

We intentionally gather input from multiple sources to inform PHM activities and generate a full picture of the individual and population-level needs of our membership. LHCC goes beyond traditional means to understand enrollee and community demographics, psychographics, and other characteristics, incorporating 140+ external data elements from public and private sources such as the CDC Social Vulnerability Index, Public Safety and School Performance Reports, and USDA Food Atlas. We garner this information to fill in any gaps after internal data sets have been exhausted (e.g. assessments; notification of pregnancy; claims, including Z-codes; 834 enrollment file), using industry-leading, data-driven technologies to reliably attribute meaningful assets. For example, we can attribute enrollee race and ethnicity based on local data, which has over an 80% validation rate. This reliable attribution model uniquely positions us to accurately identify disparities experienced by different subpopulations using high validity ***data for 100% of our membership***. Our heat maps overlay data points to understand variances across sub-populations. External data sets pulled into our informatics are listed in ***Figure 2.6.4.3.***

Figure 2.6.4.3 SDOH Data Sets

Economic Status	Education	Health & Healthcare	Neighborhood & Built Environment	Social & Community Context
• Income • Economic Stability • Net Worth • Discretionary Spending • Housing Expense • Auto Loan	• Education Attainment • Education Completion Detail • Household Education	• Product Purchase or Interest • Access to Healthcare (vehicle ownership, public transport) • Diet Lifestyle • Sleep Quality • Exercise Frequency • Health Interest Indicators	• Housing Type • Home Ownership Status • Population Density • Presence of Children • Home Square Footage • Home Market Value	• Charitable Contributions • Support of Local Causes • Green Living • Community Group Affiliations

Through our Health Equity Improvement Model and data analytics tools, we have successfully identified, addressed, and mitigated several issues impacted by SDOH. For example:

Food Insecurity. Food insecurity has consistently emerged as a theme in ***individual SDOH screenings, our direct enrollee SDOH survey, advisory meetings, and community assessments***. To inform our interventions, we conducted a listening/learning tour with all regional food banks in Louisiana and consulted with our Enrollee Advisory Council (EAC) to understand their experiences and challenges. With this input, we:

- Established community grants program and funded over 20 locally driven interventions to provide stable food and nutrition. Grants of up to $90,000 have connected enrollees to nutritious food sources by, for example, building food pantries integrated into FQHCs, expanding maternity nutrition services, and deploying mobile produce markets to food deserts across the state.
- Established SNAP matching programs with farmer's markets, worked systematically in Shreveport to establish such a program, and provided over $75,000 in direct nutritious food via SNAP-matched purchases.
- Conducted region-specific outreach campaigns to enrollees with identified food insecurity to make them aware of local food bank programs and educated providers in these regions on resources and how to refer. Targeted outreach to 226,960 enrollee households and distributed toolkits to over 4,125 providers.
- Partnered with LSU Ag Center Expanded Food and Nutrition Education Program to create series of "Build a Healthy Meal" videos designed for Medicaid enrollees, such as "Farmer's Market Meals" and culturally relevant foods like, "Healthy Smothered Greens".
- [redacted]

Method: We continuously evaluate the impact of these interventions through pre-and post-trends in individual SDOH screenings and direct feedback from our EAC and Community Advisory Council. Outcomes: In the months following the region-specific food bank campaigns, the ***rate of food insecurity reported in SDOH assessments dropped 5.2 percentage points***. On the first day of the Shreveport SNAP match, SNAP utilization was more than double their previous highest day, without accounting for the match.

Relief Grants. As we know too well in Louisiana, natural disasters can disrupt or destroy safe environment, basic necessities, and housing for thousands of individuals in just a few hours, as Hurricane Laura demonstrated dramatically last fall. In response to this emergent SDOH crisis, LHCC distributed $1.2M in relief funds paid directly to individual enrollees through our My Health Pays program. Enrollees' SDOH needs were identified by their case managers and ***self-identified via a purpose-built web interface***. Method: To measure impact, LHCC analyzed the post-disaster emergency and hospitalization metrics for the grant population (5,784) and a randomly selected control group in the affected region (30,000). Outcomes: In the three months following Hurricane Laura, ED utilization was 25% lower and IP utilization was 49% lower for the population that received relief grants.

In response to the recent devastation caused by Hurricane Ida, we have quickly deployed emergency support for our enrollees, providers and communities. Our immediate response actions, based on experience gained in previous storms, include delivering food, water, emergency medical supplies, COVID-19 prevention face masks and sanitizer, and care coordination for enrollees evacuated out of state - especially pregnant enrollees approaching their due date and those with special health care needs. We will distribute supplies and relief funds to address enrollees' SDOH needs and support their recovery in the coming weeks and months, in close coordination with our network of CBOs and providers.

2.6.4.4 Engagement, Contracting, and Coordination to Increase Health Equity

Stakeholder engagement is pivotal to our PHM approach. We employ deliberate strategies, learning from what has historically worked and not worked over the past decade in Louisiana. For example, engaging providers in VBP required a staged approach with time for trust, buy-in, capacity building, and risk tolerance. As a result, LHCC increased VBP payments by 137% since 2015, which has directly improved health outcomes. Our approach to engagement is built on our local structure, with field-based enrollee and provider staff meeting with and building trust with individuals in our communities daily. The diversity of our staff directly contributes to our success. We leverage staff with lived experience and use recruiting and hiring practices that ensure we reflect our communities. Cementing these activities are aligned incentives and an inclusive committee structure. For example, enrollees, providers, and CBOs participate on our Board, QI committees, and local advisory councils, helping to direct and meet our PHM goals. Detailed across 2.6.4, other methods of coordinating to improve health and health equity include:

Table 2.6.4.4 Engaging Providers, Enrollees, Families, and Communities to Coordinate Strategies & Improve Outcomes

	Methods	Example
Provider	Care planning and interdisciplinary care teams, Provider Portal, data sharing and analytics, CEUs and other educational opportunities, collaborative investments, one-to-one outreach, HE Neighborhood process mapping, and VBP.	We have multi-year partnerships with three providers to increase HIV screenings, PrEP utilization, and education. A single mobile testing event in New Orleans resulted in more than 100 screenings.
Enrollee & Family	Person and family-centered care planning, Enrollee Portal, digital engagement, enrollee incentives, CHWs/peers/doulas, community activities and events, and ongoing Enrollee Services and CM contact and dialogue.	LHCC CHWs conduct monthly community baby showers where they hear directly from enrollees on their goals and barriers to a healthy pregnancy and birth and receive input on our maternal programs.
Community	Shared community assessments, community education, local collaboration and investments, joint community events, Community Portal, data sharing and MOUs with CBOs, enrollee referrals to social services, workforce development programs and initiatives, and VBP.	[redacted]
Public Health	Direct service contracting, funding initiatives (e.g., NFP), joint public health responses (e.g., COVID-19, developmental screenings), Community Portal, data sharing, and enrollee referrals to OPH services such as WIC, newborn screening, and lead prevention.	

SECTION 2.6.5

Health Equity

"As a university that seeks a more just and humane society, Xavier understands the importance of addressing health equity issues on a systemic level. Our collaboration with Louisiana Healthcare Connections has the potential to profoundly improve the health of our communities and to nurture a more representative, inclusive healthcare workforce."

- Dr. Reynold Verret
President, Xavier University

2.6.5 Health Equity [12-page limit]

2.6.5.1 Health Equity Overview and Approach

Figure 2.6.5.1.a Health Equity Model



Health equity is central to our purpose ***to transform Louisiana's health, one person at a time.*** As a focus of who we are and what we do, LHCC has been deliberate in learning, aligning, and reimagining what it means to transform health through the ***lens of health equity***, adopting best practices, such as ***LDH's health equity framework.*** This fixed focus starts with listening and embedding the perspectives and voices of the community. It involves a restructuring of our governance; realignment of policies and procedures; a purposefully trained and diverse staff and provider network; integrated data systems that stratify quality performance, utilization metrics, and disease prevalence by race, ethnicity, language, and disability (RELD) data to identify social inequities; and culminating this work into meaningful partnerships and investments. It means leading by example and ensuring health equity starts with LHCC.

Management Techniques. Effective management begins with hiring the right people (see 2.6.5.2 below), holding them accountable, and providing them the tools and forums to be successful. Promoting accountability for health equity across LHCC is Erika McConduit, our Regional Vice President, Diversity, Equity and Inclusion (DEI) and interim LHCC ***VP Health Equity***, reporting to our CEO and connecting with communities daily. The VP of Health Equity co-leads our ***Health Equity and Diversity Committee*** with Dr. Dana Lawson, VP of Population Health & Clinical Operations, with Health Equity Action Teams deployed from key functional areas across the organization. Informing all internal activities are external advisory councils, including our Neighborhood Councils and Community Centers (see 2.6.5.5 below), and qualitative and quantitative data, using our Population Health Framework as the lever to promote change. Our ***accountability model*** (***Figure 2.6.5.1.b)*** aligns with National CLAS Standards and embeds health equity into all we do, using the LDH Phase I Health Equity Plan as a guide, and honoring the voice of enrollees, providers, staff, and communities.

Figure 2.6.5.1.b Accountability Model for Health Equity



Policies and Procedures (P&Ps). Our pursuit of ***NCQA Multicultural Health Care Distinction*** (on track to achieve certification in Q1 2022) offers recognition and accountability, helping to magnify our health equity lens, ensure culturally and linguistically sensitive services, and reduce healthcare disparities. To this end, we have reviewed every P&P for impact on health equity, underscoring those specific to health equity. For example:

Table 2.6.5.1 Examples of P&Ps That Promote Health Equity

P&P Number	P&P Description
LA.QI.CLAS.29	Assures compliance with all CLAS standards through a lens of continual process improvement
CC.PRVR.47, LA.CONT.02 & LA.PRVR.41	Process for collecting provider level demographics including RELD and guidelines for provider network participation to meet diverse needs, including enrollee and provider RELD overlays and directory flags to help connect enrollees to providers that meet cultural needs
LA.MBRS.16	Provides for the provision of written, verbal, and in-person language services and prompt use of interpreter services and supports enrollees with language or hearing needs
NON-DISCRIMINATION POLICY: Infused into all contracts and activities, assures & audits equal access regardless of race, ethnicity, cultural background, English proficiency, ability or disability, gender, sexual orientation, or gender identity	

Initiatives. ***Since 2015, we have invested over $3.3 million in more than 340 health equity initiatives across Louisiana.*** Initiatives are identified and realized through our community-rooted, data-driven ***Health Equity Improvement Model*** (***Figure 2.6.5.1***) and range from internal Diversity and Inclusion initiatives to investing in the community where we live, play, pray and have worked since 2012. For example, we developed Unconscious Bias and Unnatural Causes training for staff and providers. To address food insecurity LHCC developed our community grants program and funded over 20 locally driven interventions to provide stable food and nutrition. Grants of up to $90,000 have connected enrollees to nutritious food sources by, for example, building food pantries integrated into FQHCs, expanding maternity nutrition services, and

deploying mobile produce markets to food deserts across the state. More details and initiatives are described across this



2.6.5.2 Diversity in LHCC Leadership and Workforce

Since 2012, LHCC has been an inclusive employer in Louisiana, with a diverse workforce of over 580 employees across the state, reflective of the demographic characteristics of the Medicaid enrollees we serve. LHCC has long fostered hiring initiatives that contribute to our diverse workforce of ***54% Black, 41% White, 5% Other, and 87% female employees.*** We understand that part of continuing to build upon a culture of equity is intentionally recruiting, retaining, and promoting employees at all levels, including individuals from different racial and ethnic backgrounds, individuals with disabilities, LGBTQ+, and veterans. Our commitment to this work shows through our Employee Inclusion Groups (EIGs) and initiatives that empower all employees to be a strong voice informing our policies and approaches for the communities they know best.

Recruiting for Diversity. Our Talent Attraction team maintains a robust pipeline of candidates to promote a diverse workforce. We will certify Talent Advisors as Certified Diversity Recruiters, providing tools, resources, and strategies to locate talent from diverse and underrepresented groups. We rely heavily on our strong ties with provider and community partners such as the Urban League of Louisiana, Louisiana Economic Development, Delgado Community College, and Xavier University to identify qualified and diverse candidates. We supplement local efforts with our national diversity and inclusion partnerships (e.g., National Urban League, Consortium, Reaching Out MBA). Our job posting resources and tools such as Direct Employers, Disability Solutions, and Programmatic ensure job vacancies are widely shared and accessible to a diverse population. Our EIGs are also a source for recruiting diverse candidates as well as providing professional and leadership development opportunities for every employee.

We are who we serve

7 out of 10 LHCC staff have personal experience with Medicaid in Louisiana

Retaining a Diverse Workforce. LHCC prides itself on being an equal opportunity employer that is committed to diversity and values the ways in which we are different. Our vision of success requires a diverse workforce that reflects the communities we serve. Our ***Inclusive and Responsible Workplace training***, developed by our DEI & EIGs, is a required annual training centered on diversity of thought and an inclusive working environment. We train our management staff on ***How to Become an Inclusive Leader*** and recognize implicit bias and support employees as individuals with diverse personal and professional ambitions. Through Centene University, our virtual and personalized learning experience, additional learning playlists have been developed and promoted to deepen knowledge of diversity and inclusion for all staff. Finally, our virtual social community, called "Diversity, Inclusion, and YOU" allows employees to engage in dialogue regarding current issues, share videos and articles, and promote information sharing and learning among colleagues. ***We will continue annual third-party validation activities (e.g., Disability Equality Index, Human Rights Campaign Corporate Equality Index) and use insights to advance inclusive workplace policies.***

Training Beyond CLAS

Our current cultural humility training goes beyond compliance and delves into the root causes of disparities including educating staff on the contribution of racism, slavery, and colonialism on health outcomes and cycles of oppression

As an ongoing process, we use workforce monitoring for potential underrepresentation to inform retention and recruitment initiatives. We ensure equitable compensation based on qualifications and performance by reviewing market data and analyzing pay gaps among our workforce.

Promoting at All Levels. LHCC is dedicated to diverse leadership. Each of LHCC's EIGs offers mentorship programs that focus on employees' individual development needs to

deliver the best outcomes for their professional growth. LHCC reviews high potential employees quarterly with a focus on diversity. Once the employee is identified, we create a detailed career development plan to help gain the needed skills to grow, with quarterly check-ins to gauge progress toward promotion. To ensure diverse candidate slates for leadership roles (Director and above), we include at least one woman and one person of color within each candidate pool evaluated by a diverse interview panel.

Diversity in Promotions

Out of 204 total promotions over the past three years, 109 were people of color and 175 were women.

2.6.5.3 Ensuring Culturally and Linguistically Appropriate Services ("CLAS")

Our organizational practices ensure that LHCC and our provider network are providing culturally competent services with humility through building awareness of culture, using the following practices:

Training. Specific training includes National CLAS Standards and other topics described in 2.6.5.4 below. LHCC has also implemented a Clear Communication program which includes toolkits and clear communication training and resources for staff and providers. Providers have access to resources to reinforce multi-cultural communication strategies such as Teach-back and Ask Me 3.

Hiring and Contracting. As described in 2.6.5.2 above, our hiring practices support a diverse workforce. We also promote a diverse provider network by overlaying our network and enrollee population to identify and then address gaps. Providers are contractually required to comply with ADA and National CLAS Standards.

Language, Cultures and Community. We collect and analyze enrollee language data to stay up on local needs. We include provider languages spoken and language services provided in our provider directory. We offer written, verbal, in-person, and on-demand interpretation and translation services for non-English languages and American Sign Language for staff interactions and provider appointments.

Quality Assurance. As part of our quality improvement plan, we measure HEDIS outcomes and conduct an annual CAHPS Survey and stratify results according to race, ethnicity, and language (REL) preference to identify disparities in performance across specific groups of enrollees. We also monitor grievances and appeals (G&A) related to CLAS, cultural sensitivity, and ADA compliance and trend G&A by REL.

2.6.5.4 Promoting Cultural Humility through Staff, Contractor, and Provider Training

Through a culture of awareness and accountability, ***LHCC provides training to staff, contractors, and providers to ensure that cultural humility and a drive toward health equity are central in all we do.*** All trainings are developed and conducted through a health equity lens and designed to support participants to (1) value diversity, (2) conduct self-assessment, (3) manage the dynamics of difference, (4) acquire and institutionalize cultural knowledge, and (5) adapt to diversity and the cultural contexts of communities. Trainings are in-person, via webinars, and through our e-learning management system, Centene University. Examples of training topics: Cultural Sensitivity, Unconscious Bias, Unnatural Causes, Trauma-Informed Care and Adverse Childhood Experiences (ACEs), SDOH, and Allyship. ***LHCC monitors staff, contractor, and provider training completion through HR, Vendor Oversight, Provider Engagement systems and database tracking; Quality CLAS evaluations, and e-learning platforms***.

Trauma-Informed Staff

As of August 2021, 100% of LHCC staff have completed training in ACEs and Trauma-Informed Care.

In 2022, LHCC will further expand training and education opportunities beyond CLAS through the following:

- Offering CEUs for providers to complete implicit bias and health equity training. ***LHCC will require all network providers to complete health equity training*** using a "no wrong door" approach, allowing providers to fulfill requirements through any entity, including another MCO, their own organization, or another provider group or CBO. ***We will track completion through an attestation linked to our re-credentialing process.***
- Selecting CHWs with lived experiences in all nine regions to apply to receive training to become certified ACE educators in Louisiana.
- [redacted]
- Partnering with provider associations (e.g., Louisiana Primary Care Association, Louisiana American Academy of Pediatrics, etc.) to offer Cost of Poverty Experience (COPE) cultural sensitivity training virtually and as a free session at educational conferences.

2.6.5.5 Experience and Capacity for Engaging Community Members and Providers

Those that live in the communities we serve most deeply understand existing inequities and the solutions needed to address them. Aligned with LDH's Community Engagement Framework and designed with insight from Valerie Billingham's words, "Nothing about me, without me," our approach focuses on ***listening to and empowering local voices***. With LHCC as the convener, integrator, and catalyst, we:

- **Inform**: Providing balanced and objective information to support local assessment and solutioning
- **Consult**: Listening to community and individual feedback and analysis to guide policies, programs, and actions
- **Involve**: Working in communities to understand and incorporate local concerns and aspirations
- **Collaborate**: Partnering with CBOs and advocates in pertinent aspects of decision-making and solutioning
- **Empower**: Place appropriate decision-making in the hands of the community, providers, and individuals

[redacted]

[redacted]

Demonstrated Experience and Success. An individual's SDOH directly contributes to health disparities and inequity. We assess SDOH gaps using data and analytics, including our ***Neighborhood, Economic, and Social Traits (NEST) predictive modeling tool*** (see 2.6.5.9), and ***we listen***. For example, LHCC led an enrollee focus group which met 3 times over 4 weeks to brainstorm barriers to health and solutions. As a result, we developed targeted training for staff to help enrollees with SDOH and partnered with Shreveport Famer's market for the double-up SNAP match program, including a $20 LHCC match to purchase fresh fruits/veggies. In 2019, LHCC launched a provider campaign to promote the use of Z codes to indicate SDOH factors on a claim. LHCC continues to use this data to provide targeted outreach and identify and address trends. From 2019 to 2020, LHCC observed a 65% increase in claims with Z codes, sharing the information with our providers and community partners to collaboratively address disparities caused by SDOH. Other engagement success includes:

Hurricane Laura. Natural disasters amplify issues related to health disparities. LHCC demonstrated the ability to partner quickly in the wake of natural disaster with the devastating impact of Hurricane Laura. For example, we:

- Partnered with Blue Runner Food to deliver 360,000 meals in southwest Louisiana
- Delivered 65,000 bottles of water to Lake Charles, DeQuincy, Leesville, and Natchitoches
- Opened a licensed mental health professional hotline for people in the community experiencing crisis
- Provided $200/enrollee emergency SDOH grants to over 5,000 enrollees, totaling $1.2 million in aid
- Ensured uninterrupted care for enrollees with high-risk pregnancies when displaced out of state by proactively engaging out of state practitioners

Intensive Outpatient Treatment (IOP). Through our provider community we identified a gap in care for enrollees needing a level of care between psychiatric inpatient and outpatient services. We partnered with LDH and concerned providers, including Oceans and Compass Healthcare, to offer psychiatric IOP as an in lieu of service. Through this collaboration and related initiatives (see 2.6.5.9 below), we eliminated the racial disparity related to FUH for Black enrollees between 2019 and 2020 and observed a 7.5% reduction in the disparity for Antidepressant Medication Management (AMM) Acute Phase and 17.9% reduction in AMM Continuation Phase.

2.6.5.6 Current Use of Community Health Workers (CHWs), Peer Support Specialists, and Doulas

LHCC and its Medicaid affiliates utilize CHWs, peer support specialists, and doulas to engage enrollees in a culturally adept manner and further develop a culturally sensitive workforce, as shown in the examples below:

CHWs. Since 2012, LHCC's CHWs have been our enrollees' trusted liaisons, recruited and hired from local communities to reflect enrollee demographics. Our CHWs engage inpatient enrollees in post-discharge follow-up, including assessing the reason for hospitalization, discussing medication changes, assisting with appointment scheduling, and connecting with SDOH services. CHWs perform in-person outreach to enrollees lacking phones, assist in finding enrollees to complete assessments, co-locate within communities, and plan and participate in baby showers, health fairs, and other community events.

Peer Support Specialists. LHCC's peer support specialists are regionally based and can meet with enrollees in their homes, provider offices, or in the community. LHCC identifies, educates, and connects individuals to be certified through the Office of Behavioral Health's Peer Support Specialist training program and sponsors our own staff through certification to further build capacity. Our Medicaid affiliate in Ohio uses peer coaches for individuals with substance use disorder. Coaches meet with enrollees in their home to provide education, help develop goals, and identify steps towards recovery. Those referred to this program ***initiated alcohol and other drug treatment at a rate of 84% compared to 51% for all adult enrollees.*** Based on this success, we are replicating this approach in Louisiana using peers from our CM team or within BH provider practices. To this end, we are supporting 10 Local Governing Entities (LGEs) across 49 locations to increase provider capacity via additional Peer Support Specialists that will support adults in treatment for mental health and/or substance use.

Doulas. LHCC's ***Geaux Baby and Me*** maternal and child health program provides pregnant enrollees access to on-demand 24/7 video visits with certified doulas who support mothers and birth partners throughout the birth journey. Based on successful affiliate experience addressing significant disparities in their Black enrollees' rates of postpartum care and C-sections through a doula project, use of community doulas is a key strategy in our maternal and child health program. Overall, our affiliate found that enrollees paired with a doula had ***27% higher postpartum care visit rates compared to enrollees without doulas.***

How Performance is Measured and Evaluated. LHCC and its affiliates maintain a rigorous approach to continuous quality improvement to ensure we are advancing health equity and enrollee outcomes through the use of CHWs, peer support specialists, and doulas. To measure the effectiveness of CHWs and peer support specialists, we evaluate data such as ED

visits, hospitalizations, utilization of substance use disorder services, and select care gaps. We measure the effectiveness of doula care by evaluating C-section rates, preterm birth rates, breastfeeding rates, and postpartum depression. We also assess enrollee satisfaction, feedback, and suggestions through surveys, focus groups, and enrollee advisory groups.

2.6.5.7 Engaging Medicaid Consumers and Trusted Messengers

As they are the experts in health equity, engaging peers and trusted messengers is key to reducing health disparities, allowing us to have honest and transparent conversations about what is needed and how we can contribute. LHCC recruits trusted sources (e.g., CBOs, local advocates, religious leaders, community confidants, and enrollees) to partner and expand the "peer workforce" (e.g., CHWs, peer supports, or Promotoras) to help realize health equity and population health goals. Focused on workforce development and community activation, our action plan to engage Medicaid consumers and trusted messengers is 3-fold:

[redacted]

Leading the Action Plan. The work of engaging and empowering trusted messengers is charged to all community-facing staff. This work is formalized through our Community Engagement, Network, Population Health, and Health Equity staff, and HE Neighborhoods. Leading peer workforce development, we will designate a liaison, reporting to the VP of Health Equity, as a central contact with capacity to coordinate the workforce, payment models, utilization, supervision, service delivery, and enrollee accessibility. To understand existing resources, the liaison will work with partners, such as the Louisiana Community Health Outreach Network, in alignment with Population Health, HE Neighborhoods, VBP, and other related initiatives. The liaison will help expand use of peers in primary care, specialty care, and oral health offices. Building these workforce opportunities will be important to sustainability, as many roles are entry-level and retention is a challenge.

[redacted]nalysis for the number, type, and location of the peer workforce over the next three years, including the development of a baseline analysis on 2021 utilization, will include: (1) assessment of enrollee satisfaction with peer-led services, (2) ratio of peers to the total number of enrollees, (3) demographics of peers and LHCC membership, (4) # of clinic and community-based peers, and (5), # of interactions

[redacted]

between peers and enrollees in the clinic setting, non-clinic setting, and community-based setting. Through our QI department, we will use data analytics to connect usage of peer resources with improvements in access and outcomes by comparing enrollees engaged with peers with control groups and assessing utilization before and after engagement.

2.6.5.8 Data Collection to Inform Culturally and Linguistically Appropriate Services (CLAS)

Data Collection Procedures. We initially capture enrollee's RELD and geographic data from the 834 file into our management information system. We routinely assess for and document demographic characteristics using multiple methods, such as new enrollee welcome calls, assessments, and claims data. ***For enrollees where we do not have this data, we use an industry-leading model to reliably attribute race/ethnicity based on local demographics,*** allowing us to accurately identify disparities experienced by subpopulations using high validity race/ethnicity data for 100% of our membership. Our Data Governance P&P requires a rigorous and ongoing review process to ensure the results are useful, accurate, fair, and avoid reproducing disparities and biases.

Ongoing Updates. We use culturally appropriate communication methods such as newsletters, mailings, our public website, and enrollee-facing staff to regularly inform enrollees of the need to collect updated demographic information to improve the healthcare services they receive. When an enrollee contacts Enrollee Services, our customer service representatives (trained on health equity and SDOH, beyond CLAS requirements), ask callers for their language and race/ethnicity. If an enrollee speaks a language other than English, we use a trained bilingual staff member or telephone interpreter service. When an enrollee with a disability contacts Enrollee Services to request an accommodation, we offer assistance and document all disability access needs, requests, and actions taken in our systems at the time of the interaction.

How RELD and Geography Data Informs the Provision of CLAS. Informed by quantitative and qualitative data, our CLAS Program (described in 2.6.5.3) is designed to advance health equity, improve quality, and eliminate healthcare disparities. During our annual CLAS Program evaluation, an analysis of enrollee RELD and geography data is conducted and used to inform the delivery of CLAS. For example, in 2019 we identified a disparity in Well Visits for Arabic and Vietnamese enrollees by stratifying language data. Our CLAS Committee and Quality Team launched a targeted enrollee outreach campaign using outbound messages in native languages, including Arabic and Vietnamese, to educate enrollees on the importance of scheduling Well Visits, available incentives for completing Well Visits, and access to free interpretation and translation services.

"This is so exciting to know that LHCC has this type of service in place…The message was left in Arabic and this is the first company to make contact in Arabic. To know that LHCC has focus on my culture and is assisting with language barriers is an awesome idea. Thank you all for having this available to me."

- Magali, LHCC Enrollee

2.6.5.9 Experience and Proposed Approach to Utilizing RELD and Rural/Urban Data

We use our ***Centelligence*** health informatics platform to conduct analyses and stratify quality performance measures, utilization metrics, disease prevalence, and other health indicators using RELD and geography to identify disparities and inform interventions to promote equity. We also include data such as poverty, gender, SDOH, CM status, and age to observe how these variables impact disparities. Our Health Equity Dashboard displays performance across HEDIS measures by race and ethnicity. The Dashboard's geomaps overlay SDOH census data to help target interventions that are impactful in promoting health equity, and measure outcomes of disparity-reduction initiatives. Contributing to this, our NEST predictive analytics tool provides an indicator of risk of adverse health outcomes based on the social, economic, and environmental conditions that our enrollees experience based on where they live, using a variety of publicly available data from more than 200 sources. ***Our goal is to present data in a context that illuminates the SDOH and structural variables that contribute to disparities in health outcomes, and to highlight the root causes of systemic issues leading to health challenges.***

Reducing Disparities in Behavioral Health (BH). In 2019, we identified BH as a focus area to reduce racial disparities. Our analysis showed that compared to White enrollees, Black enrollees had 33.4% lower odds of receiving a follow-up visit after an ED visit for mental illness (FUM), 53.2% lower odds of receiving a follow-up visit after an ED visit related to alcohol or other drug abuse (FUA), and disparate rates of follow-up after hospitalization for mental illness (FUH). The largest clusters of disparate outcomes were located in New Orleans, Lake Charles, Shreveport, and Baton Rouge. A continuous effort, below, we provide examples of steps to date:

Enrollee Initiative	***Conducted face-to-face post-discharge planning,*** visiting hospitalized enrollees to ensure successful transition from hospital to home setting and appointment scheduling. We matched enrollees with a BH case manager based on geography and enrollee preferences such as gender, race, language and primary need. Due to COVID-19, we currently conduct virtual post-discharge planning activities but will resume in-person visits when it is safe to do so.
Provider Initiative	***Implemented a psychiatric IOP treatment program*** as an in lieu of service for enrollees with psychiatric or co-occurring mental health/SUD conditions. By covering this benefit, we expanded access and ensured an appropriate and safe level of care for enrollees stepping down from inpatient services or referred from an outpatient program. LHCC contracted with eight providers to offer services in 17 locations including those with geographic BH disparities such as New Orleans and Lake Charles, as well as Baton Rouge, Lafayette, Alexandria, Thibodaux and Houma.
Community Initiative	***Launched Social Health Bridge in New Orleans*** to bridge the divide between physical, behavioral, and social health by connecting high-need enrollees living in low-income housing to social services integrated with their care plan, ensure care gap closure, and reduce reliance on the emergency department.

With these initiatives, from 2019 to 2020 we ***eliminated the racial disparity*** related to FUH for Black enrollees, realized a ***7.5% reduction in the racial disparity*** for Antidepressant Medication Management (AMM) Acute Phase; and a ***17.9% reduction in the racial disparity*** in AMM Continuation Phase.

2.6.5.10 Data Stratification, Analysis, and Action to Improve Health Equity

Using methods described in 2.6.5.9 above, below we indicate how we stratify and analyze data, and provide examples of how we have and will act on data regarding inequities in care.

2.6.5.10.1 Pregnancy: Percentage of Low Birthweight Births	
Stratify and Analyze through: ✓ Centelligence ✓ Health Equity Dashboard (2022)	In 2020, 13.4% of Black vs. 8.1% of White enrollees had LBW births. We will implement programs designed to support Black pregnant enrollees deliver healthy newborns, such as: offering in-person and virtual ***doula services*** and offer trainings such as ***"Breaking Through Bias in Maternity Care"*** to providers. Additional initiatives are described further in Sections 2.6.5.11-13.
2.6.5.10.2 Contraceptive Care - Postpartum women Ages 21-44	
Stratify and Analyze through: ✓ Centelligence	To reduce racial disparities, we will engage trusted messengers and LHCC CHWs to host listening and education sessions across the state to better understand historical trauma associated with forced contraception, promote autonomy for enrollee choice on the breadth of contraceptive options available, and encourage enrollees to discuss these options and family planning with their provider.
2.6.5.10.3 Child: Well-Child Visits in the First 15 Months	
Stratify and Analyze through: ✓ Centelligence ✓ Health Equity Dashboard	To address geographic disparities, our ***Community Wellness Centers*** in Baton Rouge, Shreveport, and Lake Charles will focus on maternal, infant, and childhood health and offer a variety of services on site, including but not limited to: immunization events; access to onsite doulas, midwives, and nurse practitioners; parenting classes; and SDOH supports including job training and childcare services.
2.6.5.10.4 Childhood Immunizations (Combo 3)	
Stratify and Analyze through: ✓ Centelligence ✓ Health Equity Dashboard	Compared to White enrollees, Black enrollees had 12.3% lower odds of receiving required childhood immunizations by their second birthday, with the largest concentration of enrollees living in the Lake Charles area. As a result, we selected Lake Charles as one Community Wellness Center site, which will include immunization events, among other initiatives to support childhood health.
2.6.5.10.5 Preventive Dental Services	
Stratify and Analyze through: ✓ Centelligence	Lack of access to preventive dental services disproportionately impacts minority, low-income, and rural populations. In 2020, enrollees under age 21 in urban areas received 2% more preventive dental services than those in rural areas, and White enrollees received 47% more preventive dental services compared to Native American enrollees. In Section 2.6.5.14.2 below we describe actions we have and will take to address these disparities.
2.6.5.10.6 Immunizations for Adolescents	
Stratify and Analyze through: ✓ Centelligence ✓ Health Equity Dashboard	To improve rates of adolescent immunizations in rural areas, we will launch targeted education campaigns in rural areas with the highest disparities, such as Clairborne parish. The campaigns will help enrollees understand the importance of vaccines and reduce stigma around HPV vaccines.
2.6.5.10.7 Adult: Colorectal Cancer Screening	
Stratify and Analyze through: ✓ Centelligence ✓ Health Equity Dashboard	In Louisiana, 6.8% of the population has some form of cancer — in Region 3 this rate is 9.7%. We will work with other MCOs to support Volunteers of America's Determined Health CHW program to increase colorectal cancer screening in Region 3 by providing cancer screening education, connecting enrollees to their provider, and conducting follow-up to ensure a screening was completed.

2.6.5.10.8 HIV Viral Load Suppression	
Stratify and Analyze through: ✓ Centelligence	We recognize that enrollees with HIV frequently face access challenges and geographic barriers to care. LHCC is partnering with AbsoluteCare to open clinics in New Orleans to serve enrollees with multiple chronic and complex medical conditions (e.g. HIV, Hepatitis C, diabetes). AbsoluteCare will provide primary care, care coordination, integrated BH services, social support services, nutrition, radiology, onsite labs, and more.
2.6.5.10.9 Cervical Cancer Screening	
Stratify and Analyze through: ✓ Centelligence ✓ Health Equity Dashboard	Black women have the highest risk and are more likely to die from cervical cancer than any other racial or ethnic group. We will develop an enrollee-centered, culturally tailored toolkit to effectively promote cervical cancer screening for Black, Hispanic, and Asian enrollees to encourage activities that help reduce risk of cervical cancer such as scheduling cervical cancer screenings, receiving the HPV vaccine, and talking to their provider about sexual health including cervical cancer prevention.

2.6.5.11 Data to Identify & Address Inequities Experienced by Prenatal & Postpartum Black Enrollees

Black enrollees and their newborns have far higher mortality rates than their White counterparts and Louisiana's maternal mortality rate exceeds the national average with the fifth-highest infant mortality rate in the country. LHCC is committed to improving the pregnancy, birth, postpartum, infant, and early childhood experiences for Black enrollees and their children. For example, we designed our Cribs for Kids program to specifically address infant mortality. Cribs for Kids provides a Safe Sleep Survival Kit including a Cribette, Halo Sleepsack, and Safe Sleep educational material. We started with a two-year pilot which we have now expanded statewide. Through this and other education and CM interventions, we saw a reduction in infant mortality across the state, with a 56% reduction in North Louisiana (pilot area), twice the statewide reduction.



Data Analysis. Our focus is two-fold: population-level and enrollee-level. This allows us to monitor trends and intervene with targeted programming for specific communities while flagging individuals and responding to their unique needs. Using LHCC membership, at the population level, in 2019 we found when compared to White enrollees, Black enrollees had higher C-section rates and lower rates of prenatal and postpartum visits. When we drilled down to the zip code level to understand what was driving the disparity, the trends continued. The data in ***Table 2.6.5.11*** below serve as an illustrative example of racial disparities for Black enrollees in zip code 70601 and Black enrollees compared to White enrollees across the state.

Table 2.6.5.11 Maternal Racial Disparities by Geography	C-Section	Prenatal Care	Postpartum Care	NICU ALOS (days)
White Enrollees Statewide	34.38%	82.19%	65.91%	2.41
Black Enrollees Statewide	34.18%	80.67%	65.30%	3.16
Black Enrollees in Lake Charles (Zip code 70601)	37.54%	76.56%	64.59%	4.24

As described above in 2.6.5.9, we use our Health Equity Dashboard and Centelligence health informatics platform to investigate and act on maternal and child health disparities. We focus on maternal and child quality performance measures included in Attachment H, looking at year over year trends, stratified by RELD, geography, and SDOH gaps. We share data and collaborate with partners such as the ***Ochsner-Xavier Institute for Health Equity and Research*** to better understand barriers to accessing care for Black enrollees. Examples of data we monitor include HEDIS, CAHPS, screenings and assessments, population health data such as the United Way Alice Report, and Louisiana 211 utilization data. ***Based on preliminary analysis the areas where we have identified significant disparities include areas within Lake Charles, Baton Rouge, and Shreveport.***



[redacted]

2.6.5.12 Using Enrollee & Family Feedback to Identify & Execute Program Improvements



At the foundation of our efforts to improve health equity is the voice of the individuals we are serving and supporting. We engage enrollees, families, and advocates through ad hoc outreach, focus groups, community education activities, surveys, and advisory councils, including our HE Neighborhood Councils. We solicit direct feedback to identify and execute program improvements. For example, two days after the COVID-19 vaccine was eligible to people under age 65, LHCC convened a virtual EAC and sought input about enrollees' understanding and perceptions. Many enrollees were either unaware eligibility had expanded or didn't understand the eligibility criteria. We

revised our education materials, and began sending personalized eligibility announcements, clearly informing enrollees of their individual eligibility and how to access the vaccine.

Examples of Experience and Making it Work for Louisiana Enrollees. Through our local approach, we have eyes and ears in the community. For example, during health fairs, our CHWs observed a lack of basic baby supplies as a common theme. LHCC now gives away diapers, bottles, and diaper bags at Baby Showers and new enrollee welcome events. During home visits, CHWs and CM staff take note of individual needs but often see trends, including access to a safe sleep space for their infants, which became part of the impetus for our Cribs for Kids program. As we expand enrollee reach through community partners, including doulas, nurse home visiting programs, and HE Neighborhoods, we will equip these trusted messengers with tools to solicit and report honest, constructive feedback. This includes training on cultural humility, unconscious bias, person-centered thinking, and trauma informed care and ACEs, and formal channels for reporting back on direct interaction with our enrollees and their family members and caregivers, leveraging our secure Community Portal.

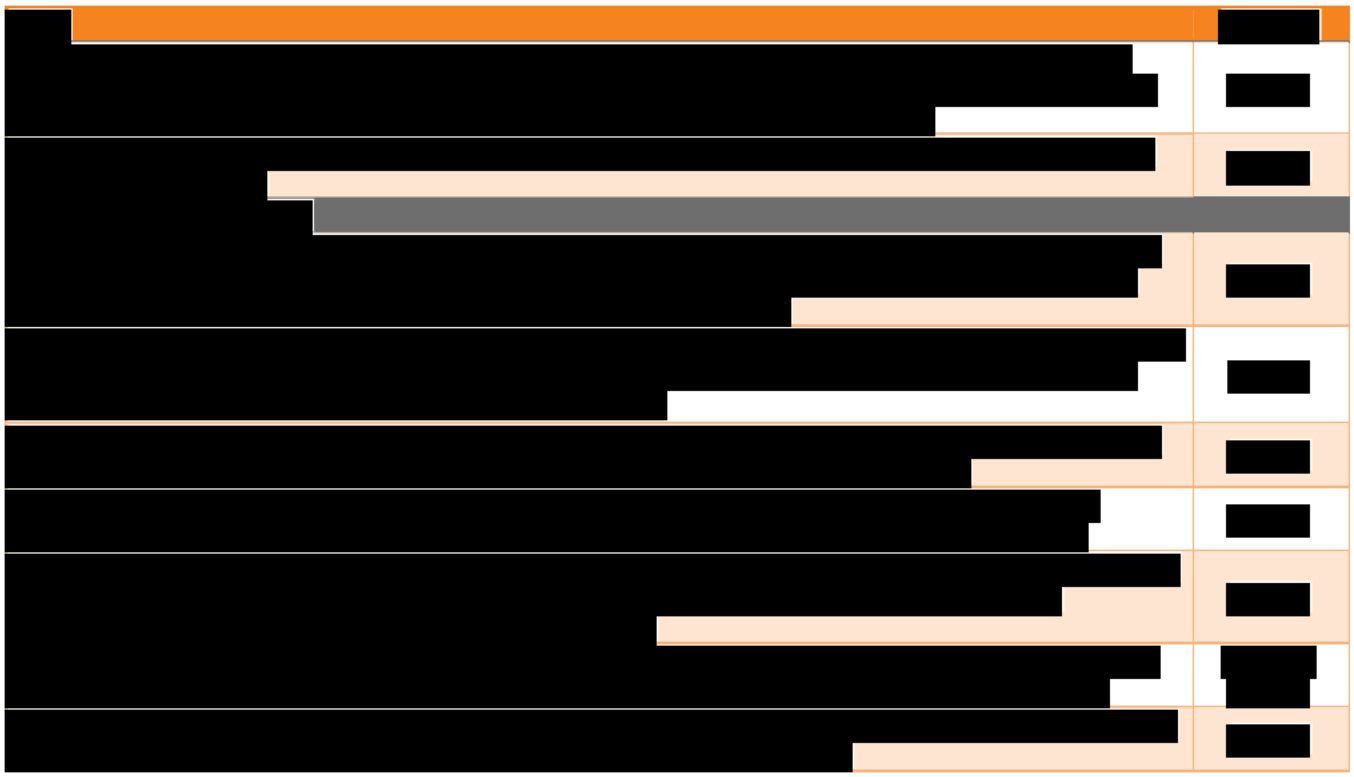
2.6.5.13 Outcome Measures to Improve Pregnancy and Birth Outcomes for Black Populations



Our proposed outcome measures include: 1) percentage of low birthweight babies 2) timeliness of prenatal care, 3) C-section rates for low-risk first birth women, 4) postpartum care, and 5) elective delivery for all mothers. Employing our Health Equity Improvement Model discussed above, we have seen a 40.4% disparity reduction in Timeliness of Prenatal Care and a 47.5% disparity reduction in Postpartum Care from 2019 to 2020 for Black enrollees compared to non-Hispanic White enrollees.

Action Plan. Leveraging the data and recommendations from LDH's SR 240-HR 294 Response: Racial Disparities in Maternal and Child Health Outcomes, national best practices including Robert Wood Johnson Foundation and public health model approaches, and our race and ethnicity data analysis, we have developed a continuum of current and new activities to improve on our proposed focus measures. Activities are designed to address SDOH and other identified root causes, engage enrollees in the community, and increase access. For example, we have recently contracted with Baby Catcher Birth Center, the ***first Black-owned birth center in Lafayette***. Other activities include the following with specific actions and timelines listed below. Activities are statewide unless otherwise indicated.





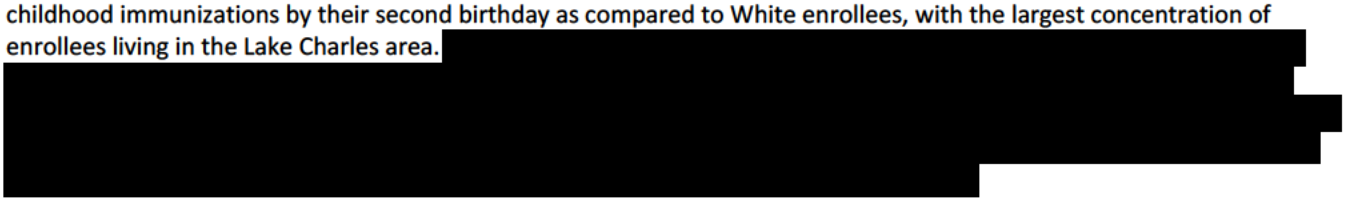
2.6.5.14 Experience and Proposed Approach to Decrease Disparities for Children & Adolescents

LHCC and its State Medicaid affiliates have experience deploying engagement strategies that have successfully improved utilization of preventive services among populations experiencing disparities. Our Health Equity Improvement Model, described in 2.6.5.1, is key to our success. Through this model, we engage subject matter experts in the community and jointly design and implement initiatives with enrollees, their family members, and providers. In Louisiana, we have identified outreach partners that have established relationships with our enrollees and will help us reach enrollees and their parents in a culturally sensitive manner. These include schools (e.g., Lake Charles-Oak Park Elementary, NOLA-Einstein Charter), summer programs (e.g., YMCA, Boys and Girls Club-Lafayette), Head Start programs (e.g., Prime Time Head Start), farmers markets (e.g., Breada-Baton Rouge, Shreveport farmers market), and pediatricians and dentists.

2.6.5.14.1 Experience and Engagement Activities to Improve Well-Child Visits and Vaccination Rates

To reduce disparities in well-child visits and vaccination rates, LHCC will adapt proven interventions and community collaborations used by Medicaid affiliates to the unique environment for LHCC enrollees. For example, our Medicaid affiliate identified low immunization rates for Russian-speaking children by analyzing quality and claims data. Further analysis revealed factors such as traditions, beliefs that immunizations could harm children, and lack of Russian educational materials. In response, they collaborated with the Russian school to educate families on the importance of immunizations, worked with Russian-speaking providers and community leaders to educate parents, and developed materials and public service announcements in Russian. As a result, ***childhood immunization rates for Russian-speaking children increased by 10% the following year***.

Our analysis of childhood immunizations in Louisiana found Black enrollees had 12.3% lower odds of receiving the required childhood immunizations by their second birthday as compared to White enrollees, with the largest concentration of enrollees living in the Lake Charles area.



2.6.5.14.2 Experience and Engagement Activities to Improve Preventive Dental Services

Within our membership we have identified disparities in preventive dental services among rural and Native American enrollees. For example, in 2020, LHCC enrollees under age 21 in urban areas received 2% more services than those in rural areas, and White enrollees received 47% more services compared to Native American enrollees. In 2022 and beyond, LHCC

will deploy Flossy, our mobile dental van, to bring oral health screenings and education to Louisiana schools in targeted rural communities of greatest need. To increase preventive dental services among Native American enrollees, we are launching a targeted campaign to promote services such as fluoride varnish applications and regular teeth cleanings and exams. We will engage enrollees' parents and target Terrebonne Parish, which has the largest concentration of Native American children/adolescent enrollees and high childhood poverty rates.

SECTION 2.6.6

Care Management

"Before I got evicted from my house where I had stayed 11 years, I had two jobs. I had to have surgery on my arm. After my six weeks was up and I tried to go back to both of them, they just never called me back... Then I met Jasmine [her LHCC Case Manager] and she told me things were going to get better, and they did. Then all of it started to come together, finally… Jasmine, for me, made my life like a rose that bloomed again."

- Teresa
Enrollee, New Orleans

Hear more from Teresa on YouTube: https://lahealth.cc/teresa

2.6.6 Care Management [15-page limit]

2.6.6 Care Management Overview

Central to LHCC's purpose to transform Louisiana's health, one person at a time, our Care Management (CM) program integrates and coordinates care for our enrollees across the continuum of services to promote access, health equity, and improved health outcomes. Our Population Health Management Framework, supported by our Health Equity Improvement Model, ensures our CM program and interventions are relevant and customized. Our CM program operates under a local and integrated team-based structure designed to enhance access to all covered and non-covered services, meet holistic enrollee needs, and improve population health through:

- **Person-centered, whole-person care** that is recovery-oriented, culturally responsive, and encourages personal responsibility and enrollee engagement.
- **Identification of each enrollee's needs and strengths**, using a common Health Needs Assessment (HNA) tool, our comprehensive assessment tool, and supplemental assessments that include our Social Determinant of Health (SDOH) mini-screening tool.
- **Population-based predictive modeling and risk stratification** that incorporates assessment, claims, authorization, SDOH, and demographic data, to stratify enrollees into the appropriate case management tier, and match with CM interventions and programs to achieve individual and population health.
- **Individualized, person-centered plan of care (POC)** for all enrollees eligible for case management that documents enrollee-determined strengths, goals, and clear activities and interventions, designed to meet individual goals and address physical health (PH), behavioral health (BH), functional needs, and SDOH.
- **Interdisciplinary Care Teams (ICT)** consisting of LHCC staff and external partners working collaboratively with enrollees and families to support personal health and wellness goals and provide input to the development of the person-centered POC. The enrollee determines ICT participants, which, at minimum, should include the enrollee, the enrollee's primary Case Manager, PCP, and other treating providers.
- **Care Team meetings** that take place regularly in-person, virtually, or telephonically, and are driven by enrollee needs and preferences. Meetings are collaborative and used to recommend interventions to help the enrollee meet their identified health goals, address barriers that hinder progress toward goals, collaborate on innovative solutions to help meet enrollee needs, and communicate critical updates.
- **LHCC Collaborative Care Team** comprised of LHCC PH and BH medical directors, pharmacists, Licensed Mental Health Professionals (LMHPs), registered nurses (RNs), community health workers (CHWs), Permanent Supportive Housing (PSH), BH, Department of Children and Family Services (DCFS), Peer Support and Department of Justice (DOJ) Liaisons, SDOH Community Connections Team (Food Access Specialist, Transportation Specialist, Housing Specialist, Violence Prevention/Safety Specialist, Job Readiness/Employment Specialist) and other LHCC internal resources that provide multidisciplinary support and consultation to the primary Case Manager for enrollees with co-occurring, complex needs.
- **Technology solutions** that support coordination and sharing of health information with the enrollee and among the ICT, providers, and others involved in the care of the enrollee. Our integrated Care Management and Utilization Management Platform ***(LHCC CM Platform)*** incorporates features of our secure Provider and Community Partner Portals and supports our case management workflow processes and collaboration.

2.6.6.1 Timely Completion of the Health Needs Assessment (HNA) through No Wrong Door

The key to optimizing health and wellness is early identification of each individual enrollee's needs, paired with timely access to services and supports. This includes screening and assessing each individual for chronic and complex conditions, pregnancy, BH, and/or substance use issues, and concerns related to SDOH and providing closed loop referrals to address identified social risk factors.

Our approach to engagement is person-centered and community anchored. Our CM staff are locally based across regions of the state and are accountable for outreach and engagement activities such as case finding, education, case management/ care coordination, health and wellness activities, and health coaching. We make multiple attempts to engage enrollees, using a ***variety of high-touch and high-tech methods such as in-person, virtual, and telephonic outreach***. We ask all enrollees their preferred language and outreach method via our assessment process and capture this information in our CM Platform. Our CM Platform also includes data on the enrollee's ***channel engagement preferences, socio-economic, demographic, and geographic indicators,*** allowing us to have a ***360º view*** of each enrollee and personalize outreach.

As further described below, we have established systems, procedures, and capabilities in place to assess the health, functional, and social needs of enrollees and identify enrollees who require short-term care coordination or case management for PH, BH, or social needs that comply with Section 2.7.2 of the Model Contract and applicable requirements of the MCO manual. These processes include efforts to continuously refine and improve our enrollee engagement strategy based on additional guidance from LDH, newly discovered best practices, enrollee feedback, provider and community input, and the availability of new technology or digital solutions.

Methods to Complete the HNA. Through experience, we have learned that successfully reaching new enrollees to complete the initial HNA and other health assessments requires repeated attempts using multiple strategies that ***honor an enrollee's preferred mode of engagement and communication***. We employ a "no wrong door" approach and leverage multiple methods to successfully engage the enrollee in completing their HNA.

As part of our new enrollee on-boarding process, we attempt to complete the ***initial HNA within 30 calendar days of enrollment*** into the plan (***exceeding the 90-day requirement***) through multiple modes of outreach and with the consent of each enrollee. For instances where the enrollee is a child, we work with the enrollee's parent or legal guardian to complete the HNA. We utilize a common standardized HNA tool approved by LDH to assess the PH and BH status of our enrollees, including functional limitations, conditions currently under treatment, problems with taking medications (as applicable), recent Emergency Department (ED) or inpatient services, as well as other issues or barriers. Enrollees can complete the HNA telephonically; in-person; virtually using the Virtual Front Door platform, electronically via the Enrollee Portal or mobile app; or self-completion of the tool via mail. To encourage enrollees to complete the HNA, we provide a ***$25 incentive for completing the HNA within 30 days and $15 within 90 days*** through our My Health Pays enrollee incentive program.

HNA Completion

From 2019 to 2020 we had a 17% increase in HNA completion rate.

As part of our new enrollee welcome process, we will make ***at least 5 separate outreach attempts*** by telephone at varying times and days of the week, exceeding the contractual requirement of 3 attempts. If we are not successful, we document all attempts and follow-up with a letter and email with instructions and options for completing the HNA. Our HNA completion efforts are not limited to these formal attempts. We continuously identify opportunities to complete the initial HNA including identifying enrollees that call into our Customer Service Center and haven't yet completed the HNA. We also partner with our providers and community-based organizations (CBOs) as trusted partners for enrollees to assist with the completion of the HNA.

Hard-to-Reach Enrollees. For difficult-to-engage enrollees, such as those without telephones or with unstable housing, our field-based, certified CHWs are available to meet enrollees in their homes, at work, or in the community. [redacted] that assist with enrollee outreach and engagement. We also work with PCPs and pharmacy providers, who may have more up-to-date contact information, or an upcoming appointment or medication fill we can leverage to meet our enrollees in the community.

Enhancing HNA Completion. LHCC is committed to investing in technology and local partnerships to increase HNA completion rates and improve how we engage with our enrollees. In 2022, we will implement:

- **In-Person Home Visits.** As part of our high-touch engagement model, we will offer every new enrollee the option of an in-home health visit by an LHCC care team member within the first 90 days of enrollment. The visit will assess the enrollee's whole health, including home environment and social determinants, ensure the enrollee is assigned a PCP within 15 Calendar Days, and provide education on how to access care and services. Additionally, the home visit will be used to engage the enrollee in care coordination activities, complete screenings, and assessments, and facilitate access to services and appropriate programs and interventions.
- **Email Outreach.** For enrollees where we have an email address, we send an electronic New Enrollee Welcome email upon enrollment. We have valid emails addresses for approximately 40% of our enrollees. The welcome email includes a New Enrollee Checklist that highlights the HNA and includes a link to the secure enrollee portal where the enrollee can complete their HNA. We follow-up with a second email that includes information on the importance of completing an HNA and instructions on ways to complete the HNA. Enrollees receive reminder emails for up to 90 days or until they complete the HNA. Upon completion, the enrollee receives a thank you email that advises them of next steps and details how to spend the My Health Pays rewards they earned by completing the assessment. For all enrollees, we mail the New Enrollee Welcome packet within 10 days of enrollment into the plan and follow-up via phone, as described above.

- **Community Wellness Centers.** LHCC is opening nine Community Wellness Centers in the next 18 months, targeting areas with a high density of LHCC enrollees with identified health disparities, community health needs, and quality care gaps, such as Baton Rouge, Lake Charles, Monroe, Alexandria, Gretna, Hammond, Lafayette, New Orleans, and Shreveport. Centers will allow enrollees to complete the HNA, notification of pregnancy (NOP) forms and assessments, and SDOH screenings, using Enrollee Connect Stations or face-to-face with CHWs. The Centers will also provide convenient on-site enrollee services; monthly new enrollee orientation; SafeLink phone sign-up; SNAP and WIC resources; enrollee education and health resources; and SDOH supports and resources such as computer access, financial management education, job/education fairs, classes, and mobile farmers markets for fresh produce.
- **Technology Driven Enrollee Engagement Tools.** Our multi-faceted digital health management tools empower enrollees to be drivers of their own healthcare. We utilize these platforms to proactively outreach to enrollees and help drive deeper enrollee engagement, self-care, and ease of timely completion of HNAs and assessments. Enrollees can also receive targeted health education and appointment reminders.
- **Use of Coordinated Entry System.** LHCC will make use of the Louisiana Balance of State Continuum of Care (LA BOSCOC) Coordinated Entry System (CES) Homeless Management Information System (HMIS) that provides client-level data. Our CM team will use this as another tool to assist with locating individuals who are experiencing unstable housing to provide in-person outreach and engagement activities to complete the HNA, make referrals to housing and supports and support cross-sector collaboration with other entities serving enrollees who are experiencing unstable housing.

[redacted]

Comprehensive Assessment for Enrollees with Special Health Care Needs (SHCNs). As an integral part of our case management process, we also complete a comprehensive assessment and appropriate supplemental or disease specific assessments for enrollees that we identify may benefit from or be eligible for Tier 1, 2 or 3 Case Management. Our enrollee-centric assessment processes take into account other sources of input for the comprehensive assessment such as feedback from providers and available utilization and SDOH data to gain a comprehensive picture of the enrollee's whole person needs and strengths.

LHCC's CM team attempts to complete a comprehensive assessment within ***30 calendar days*** for all enrollees identified as having SHCN and for enrollees that may benefit from case management services (***exceeding the 90-calendar day requirement***). Comprehensive assessments are tailored to specific populations such as pediatric, adult, and maternal. To facilitate the completion of the comprehensive assessment, our CM staff work with enrollees and their authorized representatives to schedule a convenient time and location for conducting the assessment. To ensure a seamless process, we attempt to schedule the assessment at the same time we are completing the HNA. Our CM Team includes field-based staff, located across the state, that may conduct the comprehensive assessment face-to-face in the enrollee's home, community setting, residential care setting or hospital, while honoring the preference of the enrollee. As part of the assessment process, the CM will contact the enrollee's provider to obtain additional clinical information, as appropriate. Supplemental assessments are incorporated to inform interventions and the development of POCs and transitional care plans, tailored to each individual. These include, but, are not limited to condition specific assessments (e.g., sickle cell, diabetes, asthma); screenings for COVID-19, tobacco/gaming, emergency preparedness, SDOH screenings; Adverse Childhood Experiences (ACEs) as appropriate; and BH screenings (e.g., Edinburgh, PHQ-9, GAD-7).

Sharing of Assessment Information. All screening and assessment information is stored and documented in our CM Platform. This information is used to develop and update the POC and confirm appropriate risk stratification based on additional clinical and social factors identified. Through a secure log-in process, enrollees or their authorized representative/caregivers can access their assessment results and POC and track their own care in our Enrollee Portal. LHCC's CM team will ensure a seamless and coordinated enrollee experience and non-duplication of efforts by sharing assessment (including HNA data) and POC information with the enrollee's PCP, other treating providers, and LDH, as requested, via secure access to our CM Platform. We also share and exchange health information during regular case conferences and ICT meetings.

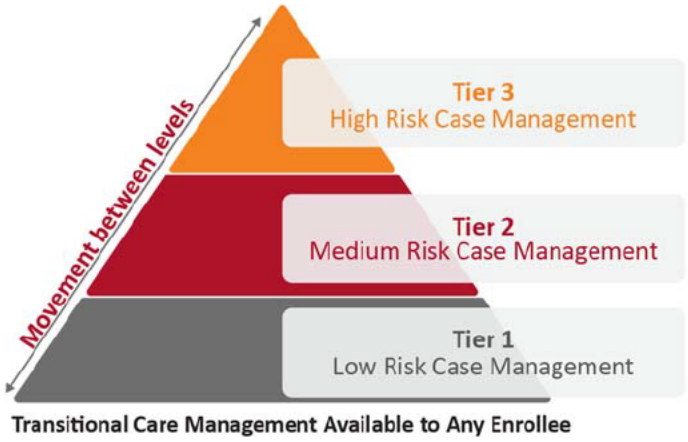
2.6.6.2 Identifying Individuals Who Could Benefit from Case Management

LHCC's Tiered Case Management Program. Our CM Model is built on the tenets of achieving health equity and population health and includes ***three tiers of case management (Figure 2.6.6.2.A),*** supported by ***transitional care management***, and

other clinical and social programs targeted to meet the unique needs of special populations. We assign enrollees who may benefit from case management into one of the three tiers.

- **Tier 3: High Risk Case Management** is focused on addressing the needs of enrollees with complex physical, BH and/or SDOH needs that require a higher level of staff expertise, intensity, and interventions. This intensive case management tier for high risk enrollees aligns with NCQA's Complex Care Management standards and LDH's requirements.
- **Tier 2: Medium Risk Case Management** is focused on enrollees with rising risk that require case management services and supports to meet their clinical/SDOH needs.
- **Tier 1: Low Risk Case Management** is the lowest level of risk within our Case Management program and is focused on providing care coordination supports and addressing the SDOH needs of enrollees.

Figure 2.6.6.2 LHCC's Case Management Tiers



Enrollees who are not enrolled in case management services (Tier 3, 2 or 1) will have access to ***care coordination services and population health programs*** designed to improve the health and wellness of our entire population. As part of our risk stratification and predictive modeling process, we continuously identify and outreach to individuals who would benefit from prevention and wellness and other population health programs and activities (described in the Population Health Section 2.6.4) to ensure optimal health for all enrollees.

Tools to Identify Individuals Who Can Potentially Benefit from Case Management. We use a combination of tools that include eligibility and enrollment data; screenings and assessments; current and historical claims, authorizations, and utilization trends; state, staff, provider, and enrollee self-referrals; and case management reports to identify individuals that may benefit from case management services, including enrollees with SHCNs and enrollees who are part of the Department of Justice (DOJ) Agreement target population. A description of tools and how information is used for the identification of enrollees is detailed in the graphic and table below.

Figure 2.6.6.2 Proactively Identifying and Connecting Enrollees to Services

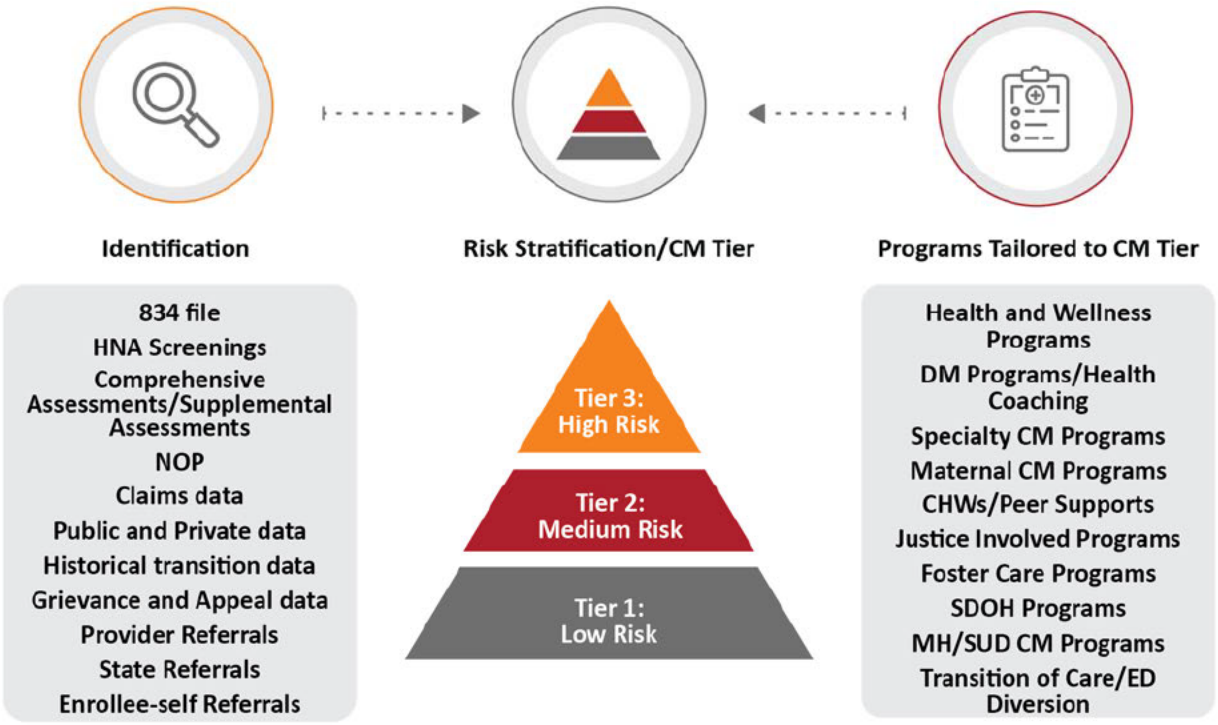


Table 2.6.6.2 Specific Tools for Identification and Engagement in Case Management	
Tools	**Description and How We Use It**
834 File	We use the 834- file to proactively identify SHCN enrollees with specific eligibility code indicators, such as HCBS; DOJ and a special indicator for formerly incarcerated enrollees transitioning to the community.
HNA and Comprehensive Assessment	We use the HNA to identify enrollee's PH, BH, and SDOH needs. It is scored and identifies enrollees that are candidates for CM. We also conduct an age or condition-specific comprehensive assessment.
Centelligence Stratification Tool Supported by our Proprietary Algorithms and Data Analytics	Our ***Centelligence Stratification Tool*** synthesizes and analyzes various data inputs to build a comprehensive risk profile for enrollees. This allows us to identify and prioritize enrollees with SHCNs and other enrollees that may benefit from case management services using our proprietary algorithms and advanced predictive analytics. Data inputs include, but are not limited to, the following: • Enrollee demographics, including eligibility and enrollment information • Claims data (Medical, BH, Vision, Pharmacy) and laboratory data and results if available • Electronic Health Records (EHR) feeds, when available • New Orleans Health Information Exchange (HIE) and Admissions, Discharges, and Transfer (ADT) feeds from Audacious Inquiry • Utilization Management data (e.g., authorization data, concurrent review data) • CM program data, including screenings and assessments, SDOH Mini- Screens, OB Screen, Notice of pregnancy (NOP) forms and POC • SDOH data via Z Codes • Historical FFS data from the state and/or transition data from other MCOs
Public and Private Data	We use public and private data that includes over 140 data elements from sources such as the CDC Social Vulnerability Index, American Community Survey, Public Health Registries, CDC Chronic Disease Indicators, CDC National Environment Public Health Tracking, Public Safety Reports, USDA Food Atlas, and CDC Behavioral Risk Factor Surveillance System. These data sources create a geo-demographic and ***360 risk profile*** for each enrollee indicative of the level and type of care management resources needed.
State, Provider, Enrollee, and Community Referrals	We consider referrals for engagement in case management from enrollees; enrollee's family; providers; trusted messengers; community agencies; the judicial system and State agencies (i.e. BHSF, OBH, OAAS, OCDD, OPH and DCFS). Our Provider Portal also allows users to make a referral to case management.

2.6.6.3 Enrollee Engagement in Case Management

CM staff trained in cultural sensitivity and unconscious bias use evidence-based practices such as Motivational Interviewing (MI), Trauma-Informed Care (TIC), Person-Centered Care Planning, and the Strengths-Based Model to engage with enrollees who may benefit from case management. CM staff meet enrollees and families where they are by embedding staff in the community and targeting information and interventions to the enrollee's willingness to engage, level of health literacy, degree of trauma, disparities endured, and cultural preferences.

We approach each enrollee as a unique individual, guiding self-identified needs and goals; designating action steps that enrollees agree to take responsibility for; and asking enrollees to evaluate their progress toward their goals. Our community-based staff are accountable for outreach and engagement activities such as case finding, education, case management/care coordination, health and wellness activities, and health coaching. As described above, staff make multiple attempts to engage enrollees, using telephonic, virtual, and in-person outreach. We ask all enrollees their preferred language and outreach method during the HNA to drive all LHCC outreach. We utilize external data on ***communication preferences, socio-economic, demographic, and geographic indicators***, providing a ***360º view*** of each enrollee to customize engagement.

Engagement starts with identification of the enrollees' needs, preferences, and goals. We then match interventions and programs based on enrollee feedback and stage of engagement. The ICT will assesses for and addresses SDOH, linking with community-based resources such as housing, employment, and social connections. Below we describe ways in which we engage with specific enrollee populations.

2.6.6.3.1 Children and Youth with SHCN including BH Needs. For children and youth with SHCN and BH needs, LHCC uses the System of Care (SoC) model. This approach is person- and family-centered, strength-based, and recovery-oriented to meet enrollees wherever they are, identify their assets, resources, and needs, and provide individually tailored services. We honor the voice of parents and guardians to make healthcare decisions in their children's best interests. Each enrollee's SoC is grounded in an individualized ICT, which includes both provider and community resources and supports designed to wrap around each enrollee. For example, children with SHCN often access services from various agencies across the larger health system, including Child Welfare and Juvenile Justice, as well as schools. We coordinate across the system to ensure a coordinated approach to care. Children and youth with BH needs are approached with hope for their recovery as they define it. Working in collaboration with the enrollee-identified circle of support (including the family), we deliver ongoing

education on recovery and rehabilitation, health and wellness, and self-help coaching. We connect enrollees to evidence-based, culturally responsive services and support system navigation, addressing SDOH barriers, stigma, literacy, and language and cultural obstacles. The ICT coordinates specialty care and BH access by ensuring enrollee PH and BH needs are appropriately assessed; self-determined goals are developed, documented, and shared across the plan, provider, and community-based care teams; and access is monitored to ensure appropriate services in the least restrictive setting.

2.6.6.3.2 Pregnant and Postpartum Enrollees with Substance Use Disorder (SUD) and their Newborns. Our Perinatal SUD Management program educates and connects pregnant enrollees with SUD ***without the fear of stigma*** to appropriate providers and community resources. We engage enrollees through tailored, personal support, resources, and education to increase positive outcomes for newborns and to help mothers achieve and maintain the best possible quality of life. Our program includes transportation assistance to meet the requirements of Medication-Assisted Treatment (MAT). Our Case Managers with specialized training in addiction and mental healthcare, use MI to engage enrollees in treatment and facilitate behavioral change in partnership with the enrollee's treating providers and ICT. Starting in 2022, we are offering ***Strongwell's Substance Exposed Pregnancy Program***, a peer support care community that helps enrollees develop coping mechanisms, build resiliency, access appropriate medication from the right in-network providers, and address SDOH prior to birth and the critical postpartum stages, without fear of stigma. The program helps opioid and other substance-dependent pregnant women safely stabilize their medications and SDOH prior to birth. Each enrollee has a Clinical Team that includes a Psychotherapist, Certified Peer Recovery Specialist, Resource Advocate, and Nurse Educator, which collaborates with the enrollee's Case Manager and OB/GYN and other providers to ensure effective and coordinated care. We also provide the ***Eat, Sleep, Console (ESC) training,*** which is an evidence-based method of care that helps new parents care for their infants who may be suffering from neonatal abstinence syndrome (NAS).

2.6.6.3.3 Children from Immigrant Families who may have Unique Cultural and Linguistic Needs. LHCC serves enrollees from a diverse variety of cultural backgrounds with different levels of health literacy and needs and has sophisticated approaches for identification. Going beyond the usual enrollee assessment and claims perspective, we create an enhanced enrollee profile by integrating a variety of external data into our Centelligence risk stratification database [redacted] This enhanced profile allows us to segment by geo-demographic characteristics, including children from immigrant families, to ensure we address their cultural and linguistic needs as we engage and interact with them, including tailored materials and pairing them with culturally alike providers and case management resources and translation services, as appropriate. For example, for our Hispanic families, we have learned that educational materials should normalize conversations on illnesses and engage family members and friends to encourage each other to see a PCP when needed. Recognizing trust is a significant issue for immigrant parents, Promotoras can be effective in spreading the word on services and health education. We also employ a family-centered approach to promoting family primary care visits with appropriate interpretor services to accommodate the needs of parent and child as oftentimes a child can become the defacto interpreter for their parents.

2.6.6.3.4 Pregnant Enrollees Prior to Delivery, to Ensure that they will Establish Care with a Pediatrician. Our enrollee engagement model utilizes a multi-faceted approach to engage pregnant enrollees that includes use of trusted messengers, home visiting programs, community-agencies and OB/GYN providers. All pregnant women are enrolled in our maternal and child health program, that includes case management services from notification of pregnancy to 12 months postpartum. Anchored by our national Start Smart for Your Baby (Start Smart), LHCC's Geaux Baby and Me program is tailored for the unique needs of pregnant enrollees, infants, and children residing in diverse communities throughout Louisiana. As part of Geaux Baby and Me, expectant mothers are encouraged to choose a pediatrician 60 calendar days before the expected date of delivery and are provided with a tool kit on how to interview and select a pediatrician for their baby. Case Managers confirm each pregnant enrollee has identified a pediatrician for their infant and assist the enrollee with scheduling newborn screenings and well child visits, including helping the enrollee schedule a visit with the pediatrician prior to delivery. We use results of the NOP form, documented in our CM Platform, to track compliance and ensure appropriate follow-up and outreach to new moms that have not yet received the required well child visits for their infant. Our nurse home visit programs, doulas, community baby showers, and CHWs embedded in OB offices and hospitals, will also assist with identifying a pediatrician for the infant. We also encourage our OB providers to work with their patients to secure a pediatrician, and our Enrollee Services staff are trained to inquire if a pregnant enrollee needs assistance finding a pediatrician.

2.6.6.3.5 Enrollees at Risk for Rapid Repeat Birth, defined as Pregnancy Occurring within 18 Months of a Birth. We manage over 11,000 births annually and offer a suite of services that supports a woman and her baby's health—from

preconception and continuing that support of mom and baby through early childhood. As part of our NOP and assessment process, we identify enrollees who are at risk for repeat pregnancy and births less than 18 months apart. Upon identification, as part of our ***Geaux Baby and Me*** program, using a multi-faceted approach including the use of trusted messengers, we engage the enrollee in preconceptual planning, explain the risks of rapid repeat births, and provide contraceptive education and referrals (including long-acting reversible contraceptive), all incorporated into their POC. We also work with the new mom to ensure she attends her postpartum visit where contraception is also discussed with her OB/GYN.

2.6.6.3.6 Adolescents Transitioning to Adulthood. We engage all transition-age youth starting at age 16 to promote healthy behaviors and accountability for their health. We have policies and procedures in place to ensure a seamless transition for enrollees transitioning from adolescence to adulthood. The Case Manager will collaborate with the enrollee and the enrollee's PCP to ensure a seamless transition, including the identification of an adult medical home/PCP and transfer of medical records to the new PCP, as appropriate.

Additionally, our ***Adolescence to Adulthood, "a to A" Program*** CM program is specifically designed to help Foster Care enrollees acquire skills to self-manage their healthcare and transition to independent living. CM staff assist youth to take ownership of their health through education and coaching in collaboration with DFCS staff. This includes helping them transition their care to an adult provider and identify their health and personal goals, such as education and employment. For enrollees choosing "a to A", an ACE Questionnaire is administered to determine their ACE score which reveals strong predictors of later health risks and disease. Enrollees are linked with a Case Manager to discuss future risk factors and develop a Healthy Living Plan. When engaging enrollees in Foster Care, our CM staff explain at the beginning of the initial outreach contact that they are not Child Protective Services staff. Enrollees are often ready to cut ties to the Foster Care system and may not be familiar with LHCC. Staff are sensitive to this and the importance of gaining enrollee trust to support engagement. We tailor our approach to reflect each enrollee's willingness and ability to engage and their goals and priorities. We educate enrollees about the assistance we can provide with accessing PH and BH services and connect them to resources such as for housing and employment. Our approach also includes "boots on the ground" engagement, outreaching, and engaging youth on the street and in shelters as needed.

2.6.6.3.7 Children with Type 1 Diabetes Mellitus. We engage children with type 1 diabetes mellitus who can benefit from case management services through a multi-faceted approach that includes outreach and education to families; referrals from schools and providers that are interacting with the enrollee and using data and analytics to identify children with care gaps and medication non-adherence. We also refer the child/family to ***our Diabetes Disease Management Program,*** which includes health coaching and interventions for enrollees and families, such as self-management tools, education, behavior change coaching, and remote telemonitoring services through our partnership with Ochsner Health System (Ochsner) and our On.Demand Diabetes Program. We work with the child, the child's family, PCP, and school nurse to ensure the child takes insulin as prescribed; eats a healthy diet; checks blood sugar levels as prescribed; and gets regular physical activity.

2.6.6.3.8 Enrollees with ACEs. ***All LHCC staff completed have completed TIC and ACEs Training.*** Addressing ACEs as a common risk factor can reduce healthcare costs, promote health equity, and improve quality of life. Further, we know these children/youth tend to have more BH problems and require more psychosocial services than other children/youth receiving Medicaid services. We have developed systems, policies and procedures, and partnerships to ensure as part of our case management engagement process we decrease the risk of re-traumatization, understand the enrollee's triggers and provide wrap around services to the child as part of our SoC approach. We are selecting CHWs with lived experiences in all nine regions of the state to apply to become certified ACE educators through Partners for Family Health Louisiana.

2.6.6.3.9 Enrollees with Food Insecurity. As part of our CM program, our HNA includes screening for SDOH. Of enrollees with an identified SDOH need from 2019-2021, the top SDOH categories were: ***Food Insecurity (39%),*** Financial Literacy (23%), Transportation (16%), Social Isolation (7%), Utilities (5%), Employment (5%), and Housing (3%). We recognize that food insecurity occurs for different reasons, including when enrollees reside in a food desert, are not able to afford to buy food, or may have specific dietary needs. Upon identification of enrollees with food insecurity, we work to understand their needs and link to available community resources, such as SNAP, food pantries, school meals, and WIC. Enrollees and families also have access to our Community Connect tool to identify local resources. Upon discharge, qualified enrollees can also receive medically tailored meals as part of our value-added benefit. Proactively, we analyze SDOH to identify food insecurity hotspots and have strategically partnered with local farmers markets to establish SNAP match programs and mobile markets in food deserts to engage enrollees and expand the availability of nutritious foods. [redacted]

[redacted]

2.6.6.3.10 Enrollees without Reliable Telephone Access. LHCC supports enrollees with enrolling in SafeLink to provide free cell phones to enrollees without telephone access. This federal program provides free cell phones with 350 free talk minutes, unlimited texting, and 4.5 GB of data per month to individuals that are in a certain low-income bracket. For those who qualify, LHCC will offer enrollees expanded benefits of up to 1GB per month beyond their SafeLink allowance. When SafeLink is not an option for enrollees, such as when someone at the same address has already received a SafeLink phone, LHCC offers a free phone through our ConnectionsPlus program for enrollees in case management. Connections Plus phones are delivered by our CHWs who will work with the enrollee to pre-program their phone to include numbers for their Case Manager, PCP, ICT, and other enrollee supports. ***Since 2012, LHCC has helped 6,685 enrollees get SafeLink phones.***

2.6.6.4.a Objective Measures and Criteria to Determine Appropriate Tier of Case Management

Once we identify enrollees with SHCNs that are eligible for case management and other enrollees that can potentially benefit from case management (described in 2.6.6.2 above), we stratify the enrollee into the appropriate tier of case management. This is based on each enrollee's risk stratification score as identified by our Centelligence Stratification Tool that considers medical, BH, substance use, functional, cultural, and social needs of each individual and evaluates health status and drivers of risk. We focus on what most accurately predicts risk: category of need, screening and assessment results, acuity of chronic conditions (e.g. controlled versus uncontrolled), SUD and/or BH conditions, maternal risk (e.g. prior preterm birth, age, or SUD), utilization (including readmission risk score), social risk factors and unmet social needs, safety risk factors (e.g. available caregiver support and environment), and racial and ethnic disparities. For example, a score of 1.00 indicates risk comparable to that of a typical enrollee; a score of 1.10 indicates ten percent greater risk and a risk score of 7.0 indicates risk 7 times that of the typical enrollee.

Case management tier assignments are made as expediently as possible but no later than within the first 90 days of enrollment and re-evaluated at every enrollee interaction and upon any change in status or need. To ensure appropriate support, we validate and, as needed, modify case management tier assignment based on the individualized evaluation of the enrollee including their strengths, needs, preferences, and goals.

The criteria and objective measures used to stratify enrollees into the appropriate Case Management tier are described below in ***Table 2.6.6.4.a***, with an enrollee profile describing a fictitious LHCC enrollee that would meet each tier.

Table 2.6.6.4.a Case Management Tier Criteria

<table>
<tr><th colspan="2">Tier 1: Low Risk Case Management</th></tr>
<tr><td>Objective measure:
No unplanned admissions or ED visits with 90 days</td><td>Centelligence Risk Stratification Score of <1 (SSI) or <1 (TANF) as determined by:
• SDOH resource need with no other complicating factors (excluding homelessness)
• Managed chronic conditions
• Enrollees with an external case manager responsible for the majority of case management activities (e.g. children enrolled in CSoC or enrollees referred to an MCO-contracted community care management agency under the DOJ Agreement)</td></tr>
<tr><th colspan="2">CM Tier 1: Low Enrollee Profile</th></tr>
<tr><td colspan="2">  Tier 1: Mary is a 52 year old with a history of hypertension and has identified barriers to transportation and buying healthy food due to her hours being decreased at her job. After completion of the HNA, Mary agreed to enrollment in the program where her Care Manager helped her develop goals regarding better control of her BP, healthier eating, and using the available transportation benefits. Mary's Care Manager worked with Mary on her blood pressure control and eating habits, provided Mary with a blood pressure monitor for her to perform self-checks, and helped her set up transportation to her upcoming provider appointments.</td></tr>
<tr><th colspan="2">Tier 2: Medium Risk Case Management (typically rising risk)</th></tr>
<tr><td>Objective measure:
1 unplanned admission in the last 90 days and Readmission Risk Score of 50 or more.
ED utilization of 4 or more visits in previous 12 months</td><td>Centelligence Risk Stratification Score of 1-7 (SSI) or 1-4.65 (TANF) as determined by:
• Individuals with intravenous drug use
• Individuals with SUD with dependent children
• One uncontrolled chronic condition
• Enrollees with a condition that causes chronic pain
• Transplant services
• New cancer diagnosis
• Complex SDOH resource needs (excluding homelessness)
• Adults, 18 years or older, receiving mental health rehabilitation services under the state plan
• ED Utilization – 4 or more visits in the previous 12 months</td></tr>
</table>

CM Tier 2: Medium Enrollee Profile



Tier 2: Ron is a 22 year old with a history of asthma triggered by vaping, depression, and obesity (weighing 300 lbs). Ron agreed to enroll in CM during a face-to-face visit with the CM at the neighborhood park after the first phone outreach. Ron agreed to participate in our smoking cessation program, referral to Pennington Clinic for weight management, and chronic care management for his asthma. During the interaction, Ron also expressed he was stressed and depressed due to his current home situation (living with his mom and her alcoholic boyfriend) and unemployment so he cannot afford to move. The CM was able to connect Ron to a BH provider close to his home to address his chronic, depression, and addictive behavior. Due to his BH diagnosis, Ron was also referred to LHCC's permanent supportive housing specialist for housing needs. While exploring Ron's strengths, the CM connects him to our workforce development program through Delgado Community College. Ron is interested in community health work and wants to start class/training in the fall. Ron agrees to weekly visits with the CM for the next month. After the visit, the CM outreached Ron's assigned PCP to schedule him an appointment and also arranged his transportation. The PCP was agreeable to the POC and will make additional referrals to treat Ron's chronic conditions after the initial visit.

Tier 3: High Risk Case Management

Objective measure: Readmission in the last 30 days and Readmission Risk Score of 50 or more. ED utilization of 3 or more visits in previous 3 months.	***Centelligence Risk Stratification Score of +7 (SSI) or +4.65 (TANF) as determined by:*** • Uncontrolled multiple chronic conditions or co-morbid conditions • Individuals with co-occurring mental health and SUD • Pregnant women with SUD/Opioid Use Disorder • Children with behavioral health needs in contact with other child serving systems including OJJ, DCFS, or the judicial system, and not enrolled in CSoC • High risk pregnancy based on risk factors including an adverse pregnancy outcome during the pregnancy including preterm birth less than 37 weeks • Enrollees receiving Private Duty Nursing • Nursing home eligible • ED Utilization – 3 or more visits in the previous 3 months

CM Tier 3: High Enrollee Profile



Tier 3: Kayla is a 32-week pre-term infant (1450 grams) delivered to mom who was opiate-dependent throughout the pregnancy and did not receive prenatal care. Mom has a history of bipolar disorder, homelessness, IV drug use, alcoholism, and previous incarceration. Kayla was transported to Children's Hospital NICU where she will remain until her conditions stabilize. Mom and baby were enrolled in CM as part of transitional care management. Mom refused rehab services but agreed to see a BH provider to address her bipolar disorder and addiction (Eleanor Health). A referral was also made to the permanent supportive housing specialist to help mom secure housing, but for the short term, LHCC was able to authorize a medical respite for mom post-discharge. The CM also connected mom to food resources, helped her apply for WIC and SNAP benefits, referred her to post-partum support group, and arranged transportation to her appointments. Kayla is assigned the same CM who works with the UM team to closely monitor her progress in the NICU and coordinates transportation for mom to Children's to participate in discharge planning when appropriate. LHCC CM team consults with DCFS on proactive strategies to support mom in retaining custody when Kayla is released from the hospital.

Ongoing Systematic Monitoring Supported by Centelligence and our Predictive Modeling Tools. We do not stop at stratifying enrollees based on current assessments and circumstances. Once an enrollee has been stratified into a case management tier, we use predictive modeling tools to systematically monitor our enrollees and identify enrollees at current or future risk. LHCC's Centelligence Stratification Tool examines large data sets daily, providing a comprehensive array of targeted clinical indicators of future PH, BH, social health, and financial risk and disparities. Our Centelligence Stratification Tool leverages machine learning to detect changes to an enrollee's condition, re-stratifying as we receive updated information. At every contact, our CM team monitors clinical information and evaluates enrollee needs and progress, using predictive models as one method of assessment to determine the next best action for each enrollee.

Our suite of ***targeted predictive models*** is used to identify, and impact potential risk factors related to SDOH, SUD, diabetes, ED visits, readmissions, and other defined categories. For example, our Opioid Risk Classification Algorithm stratifies enrollees at-risk for substance misuse and abuse before a diagnosis using a series of clinical indicators based on past diagnostic, clinical, pharmaceutical, and social history. This model has a positive predictive accuracy rate of 98% and since inception in 2017, has increased identification of enrollees with Opioid Use Disorder by over 150%. As another example, our Readmission Prevention Model assigns a probability of readmission by enrollee at the time of acute inpatient admission to assist discharge planners and CMs with prioritizing their post-hospitalization outreaches. ***This model has a positive predictive accuracy rate of 98% and maximizes efficiency of care management outreach by directing resources to those enrollees most in need.***

2.6.6.4.b Enrollee Supports by Case Management Tier

Our case management activities and enrollee engagement methods are intentional based on case management tier. We have established activities, including assessments, interventions, and person-centered planning strategies to assure each enrollee is offered case management supports that fit their individual needs and situation. Consistent with our person-centered approach, we honor each enrollee's preferences for engagement in case management. For example, if requested

by the enrollee or the enrollee's parent or legal guardian, the frequency and/or method of engagement may be increased, reduced, substituted, or declined.

All case management activities, including enrollee contacts and notes about the interaction are documented in the enrollee's record in our CM Platform to ensure a seamless enrollee experience when multiple entities are involved. Reminder tasks are set in the CM Platform to prompt CM staff of the upcoming contact schedule, assessment due dates, and POC updates, and track completion per LHCC's protocols and requirements.

Table 2.6.6.4.b Types of Case Management Supports

Supports/Interventions	Tier 1: Low	Tier 2: Medium	Tier 3: High
Contact Frequency	-At least quarterly	-In-person contact (at least monthly) -Quarterly ICT meetings	-In-person contact (at least monthly) -Monthly ICT meetings
POC Development/ Updates	-POC development within 90 days of identification -Annual POC updates	-POC completed in-person within 30 days of identification -Quarterly POC updates	-POC completed in-person within 30 days of identification -Monthly POC updates
Assessments	-Initial HNA within 30 days of enrollment Annual in-person assessments or upon a change in condition or status	-Initial HNA within 30 days of enrollment -Comprehensive assessment, including of home environment and SDOH needs -Quarterly reassessments	-Initial HNA within 30 days of enrollment -Comprehensive assessment, including of home environment and SDOH needs - Monthly reassessments
Case Manager	CM, CHW or Program Specialist	RN CM or BH CM for an enrollee with primary BH needs	RN CM or BH CM for an enrollee with primary BH needs
[redacted]	[redacted]	[redacted]	[redacted]

Case Management Programs. LHCC's CM model uses a population health perspective that considers the varying needs, preferences, cultures of our entire population. We recognize there are external factors including geographic and SDOH barriers that enrollees face in their daily lives as well as in accessing care. While we recognize our CM programs improve outcomes for our enrollees, we understand that LHCC is not the sole reason that outcomes improve. Using our Health Equity Improvement Model we address health disparities among sub-populations through data analytics, targeted and tailored outreach and interventions, and partnering with trusted organizations such as the LA Center for Health Equity, LA Healthy Communities Coalitions, Ochsner-Xavier Institute for Health Equity and Research, United Way, and Urban League to identify barriers, address SDOH, and promote solutions.

We provide a broad array of case management programs that include but are not limited to disease management programs, maternal and child health case management programs, BH case management interventions and programs, ED diversion programs, etc. For illustrative purposes, below is a description of one of several case management programs we offer to enrollees that are enrolled in case management.

Figure 2.6.6.4.b Geaux Baby and Me Outcomes

Geaux Baby and Me • Maternal Child and Health Program

Description	Program Components	Outcomes (2015-2020)
LHCCs ***Geaux Baby and Me*** program is a whole health approach to maternal and child health that provides a range of perinatal interventions and support targeted to each enrollees' specific needs and level of risk. Program components are anchored by our national ***Start Smart*** Program.	⚜ Early identification of pregnancy ⚜ Risk screening and stratification to determine appropriate interventions ⚜ Enrollee outreach, education & incentives ⚜ Progesterone injection program ⚜ OUD/SUD Pregnancy Programming ⚜ High Risk Pregnancy Program ⚜ NICU management and follow up ⚜ Doula services and lactation supports ⚜ Cribs for Kids ⚜ Home visiting programs	1% ▼ in extremely low birth rates (<1,000g) 2.5% ▼ in C-Section Rates 2.2% ▼ of enrollees with gestational diabetes 7.1% ▼ of enrollees with preeclampsia 5.8% ▼ of early pre-term births (<32 weeks) 11.3% ▼ in ED utilization by pregnant enrollees 14.5% ▼ in IP utilization by pregnant enrollees 21.3% ▲ in Postpartum Care HEDIS measure 2.5% ▲ in initiation of injectible progesterone 16.1 ▲ average number of prenatal visits per enrollee increased from 10.6 to 16.1

Transitional Care Management. Our evidence-based Transitional Care Management Program is available to all enrollees, supporting safe and appropriate care after discharge and when transitioning between levels of care. Our team-based transitions 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 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 (that includes a Housing Specialist), in collaboration with the enrollee's Case Manager, begins to plan for discharge with the ICT 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. The POC identifies circumstances in which the follow-up includes a face-to-face visit. Enrollees are followed for 30 days post discharge to ensure they complete all the follow-up appointments and services, medications and DME for example are in place. Starting in 2022, our regionally-based Rapid ED Intervention Team, comprised of CHWs and clinicians, can be deployed to the hospital to meet with enrollees to help them follow-up with post-ED instruction, connect them to primary care resources, address SDOH gaps, and offer ED alternatives in their area.

CM Program Outcomes

- *20.9% reduction in Potentially Preventable Admissions from 2017 to 2019*
- *16% reduction in ED visits and 15% reduction in inpatient visits for enrollees engaged in CM compared to those not in CM*
- *40.4% disparity reduction in Timeliness of Prenatal Care and the elimination of the disparity for Postpartum Care rates for Black enrollees compared to White enrollees from 2019 to 2020.*

2.6.6.4.c Process for Developing a Person-Centered Individual Plan of Care (POC)

We develop a person-centered POC for all enrollees eligible for case management. The POC process is driven by the enrollee with the results of the HNA and comprehensive assessment forming the basis for the POC, aligning an enrollee's self-identified needs and preferences to services and interventions. Areas addressed in the POC include all covered and non-covered services and all elements described in Section 2.7.8 of the Model Contract. The Case Manager reviews and confirms enrollee understanding of their role and responsibility, and willingness and ability to participate. Each POC documents the timeline and schedule for evaluation and monitoring. Creating an individual POC ensures each enrollee is connected to the services and supports that match with their goals, cultural traditions, and health determinants, promoting health equity across the population.

Interdisciplinary Care Team (ICT). Our CM model hinges on effective team-based care. All enrollees in case management tiers 1, 2 and 3, and transitional case management, have an ICT according to their individual needs. Members of the ICT have defined roles and responsibilities appropriate to their licensure and skill level. At minimum, the ICT consists of the enrollee and their family or authorized representatives, the enrollee's Case Manager, the PCP, and other providers involved in the care delivery. Our CM team collaborates with the enrollee and the ICT and chosen circle of support to examine the enrollee's whole person needs and develop a POC to address these needs. We also incorporate information and recommendations from external care teams (e.g., DCFS case workers) and other stakeholders (e.g., schools for enrollees with IEPs) in the enrollee's POC.

The Case Manager monitors the POC regularly to ensure the enrollee receives services, address change in status or care gaps in collaboration with the enrollee's PCP. At every contact, CM staff monitor clinical data and conduct assessments to determine enrollee needs, barriers, and progress, updating the POC as appropriate. For example, if an enrollee is not taking medications as prescribed, the Case Manager may consult with the enrollee's PCP and LHCC's clinical pharmacist and incorporate medication therapy management into their POC.

2.6.6.5 Coordinating Across the System to Support Enrollees and Prevent Duplication

Identification of Providers and Entities Providing Case Management Support to our Enrollees. One of our roles as a health plan is to collaborate with providers and other entities who are providing enrollee case management support to ensure a seamless and unified enrollee experience, develop single POCs, and eliminate waste in the healthcare system, including duplication of case management services. Our CM staff identify providers and State staff that are also providing case management support as part of the initial HNA and care planning process. When we identify other case managers involved in the enrollee's care, our Case Manager documents this in our CM platform and initiates a process to coordinate with the other entity to prevent duplication or fragmentation of services. We accomplish this by sharing assessment and POC information, inviting them to participate in the enrollee's ICT, and collaborating on the development and implementation of the enrollee's whole person POC with the proper enrollee or enrollee representative consent.

Coordinating with State Staff Providing Case Management. Our model is designed to facilitate coordination and collaboration with all entities that interface with our enrollees and ensure enrollees receive the appropriate level of care. Our dedicated liaisons act as a single point of contact between LHCC and agency case managers to support coordination

and prevent duplication. Our liaisons support coordination with entities such as DCFS, OBH, OJJ, PSH programs, Intellectual/Developmental Disability (I/DD), and others that are serving our enrollees (see ***Attachment 2.6.2.2.3.f*** for an organizational chart of our Population Health and Clinical Operations department).

Additionally, our CM Teams have direct knowledge and experience working with Foster Care children, justice involved populations and individuals with disabilities, and the systems that serve these populations. CM staff regularly communicates 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. For example, as a preferred MCO for Foster Care, we recognize the critical need to maintain continuity of care for children and youth in Foster Care and ensure the PH, BH and social needs of the child are being addressed. Our CM staff hold weekly rounds with DCFS state staff that include case conferences that focus on transitions of care and ensure we are working together to support permanency. Our BH Medical Director also meets with the DFCS Clinical Leadership Team weekly to discuss complex cases in advance of the weekly rounds. ***As a result of our partnership with DCFS, from 2017 to 2019, the rate of ED visits for children in Foster Care decreased 4.1%; the rate of inpatient visits for children in Foster Care decreased by 4.4%, and inpatient average length of stay decreased from 13.2 days to 7.3 days.***

Bi-directional Sharing of Information. We recognize the importance of timely sharing of enrollee information to support case management provided by multiple entities. LHCC offers community partners and providers secure access to our CM Platform for authorized users in the enrollee's ICT to bi-directionally share and access key enrollee demographic and clinical information. Users can check our CM Platform, which includes role-based access security, promotes information sharing and collaboration across providers and other partnering agencies, while maintaining the security and privacy of the enrollee's personal and protected information. Users can check the enrollee's eligibility status, view enrollee risks and outstanding care gaps, view up-to-date enrollee health record data (e.g., immunizations, pharmaceutical information, labs, etc.), view POCs, upload key documentation and enrollee assessments, and create free text and structured notes, among other functions. These tools are fully web based and accessible from any mobile device, with access to the online platform using a web browser. Our comprehensive security model ensures that users have access to only applicable data.

In addition to making our care plans available via the LHCC CM Platform, we are also supporting bi-directional clinical data exchange with the three most prevalent EMR systems in Louisiana to support point-of-care action on care gaps and the development a collaborative POC.

2.6.6.6 Delegation of Case Management to Improve Enrollee Care

LHCC is committed to contracting with qualified physicians, advanced practice RNs, and physician assistants that engage enrollees where they are accessing care to provide care coordination and case management functions and activities on our behalf, establishing mutually beneficial relationships where we leverage the resources and expertise held by each party. Our approach includes a ***tiered delegated case management model*** that helps providers build their capacity to take on higher levels of case management in accordance with NCQA standards. We will delegate case management activities to qualified entities that have demonstrated capacity and ability to work collaboratively with LHCC, providers, and systems of care to improve the health of our enrollees.

We will build on established relationships and develop new provider partnerships to create a system of care that addresses the whole person needs of our enrollees and aligns with our CM model. [redacted] e are also working collaboratively with the other MCOs to identify agencies to provide statewide case management services for the DOJ population.

In addition to these arrangements, we are in contract discussions with the following providers to provide a range of care coordination and case management services.

Table 2.6.6.6.a Delegation of Case Management Services

Entities	Delegation of Case Management Services
[redacted]	[redacted]

[redacted]

We have established criteria in place to determine when an enrollee is ***eligible for delegated case management versus case management services provided by LHCC***. Our criteria takes into a variety of factors that includes honoring enrollee choice and preferences; matching enrollee needs to provider qualifications and expertise; close proximity to enrollee; cultural alignment, and whether the enrollee is already accessing care from a provider that is delegated care coordination and/or case management services.

Contracting Approach, Identification, and Selection. Recognizing providers are at different points on the continuum of capability and readiness to provide delegated case management services, our case management delegation program approach is tailored to the infrastructure and identified capabilities of each provider. As part of our process, we assess the current capabilities of providers and their readiness and willingness to enter into a delegated case management arrangement using a standardized tool. Based on these findings, we provide a path to contracting and payment that meets the needs of providers, the goals of LDH, and aligns incentives for improving the outcomes and experience of our enrollees. The primary role of LHCC is to best equip and support delegates in being successful, through actionable data, training, technical support, and augmented resources. We provide necessary service and supports, including wraparound case management, disease management and care coordination resources and tools provided by the contracted entity, as necessary.

Our flexible tiered delegated case management model and approach is designed to ***meet providers where they are along the case management delegation continuum.*** We have established ***minimum provider qualifications for each tier of delegated case management*** services summarized below.

Minimum Provider Qualifications for Each Tier of Delegated Case Management Services		
Tier 1: Low Risk	**Tier 2: Medium Risk**	**Tier 3: High Risk (Complex CM)**
• CM training plan • Qualified staff to meet LHCC's caseload ratios and care coordination and case management requirements • Systems and IT capability to track all required enrollee information and share needed information with LHCC in a secure manner • CM Policies and procedures	• Tier 1 qualifications, plus • PH/BH Integration capabilities • Dedicated clinical CM staff • Patient Centered Medical Home certification • Behavioral Health Home	• Tier 1 qualifications, plus at least 2 of the qualifications in Tier 2 • NCQA Accreditation for Case Management

To ensure non-duplication of services, we delineate responsibilities of each party through a division of responsibility in the Delegation Agreement. This includes a description of each activity, who is responsible for delivering it, how it is monitored and how it fits with other non-delegated and delegated functions. The Delegation Agreement also includes metrics and how each will be reported, monitored and measured.

[redacted]

Oversight and Monitoring. LHCC is ultimately accountable for ensuring all LDH case management contract requirements are met. Our pre-delegation assessment, performance monitoring and quality oversight program is designed to confirm entities are qualified and meet expected standards and outcomes for performing care coordination and case management activities and interventions. We deploy the following activities and tools to monitor and evaluate program effectiveness and outcomes and oversee contract compliance for delegates:

Table 2.6.6.6.b Delegation Oversight and Monitoring Activities	
Pre-Delegation and Annual Audits	LHCC conducts a Pre-Delegation Audit to determine the ability to take on care coordination and case management activities. At least annually, we assess and audit delegate capabilities, compliance, performance, and outcomes. This includes both onsite and documentation audits such as medical record reviews and P&Ps. Audit tools will reflect federal and LDH contract requirements, NCQA standards and industry best practices.
Delegation Agreement and Assessment	Oversight and monitoring start with appropriately setting expectations and ensuring delegates have the tools to be successful in a delegated model. Once both parties mutually agree to move forward, a Delegation Agreement is signed outlining the responsibilities of each party. The delegation contract undergoes a comprehensive approval process that includes review and by Case Management, Operations, Finance, and Compliance. Quality Improvement Committee (QIC) reviews Pre-Delegation and annual audits, and performance reporting.
Ongoing Monitoring	Delegates are required to submit routine reporting, including, but not limited to: CM staff list and caseload ratios; completed HNA and assessments, enrollee outreach, POC updates, enrollees by case management tier, etc.
Integrated Case Rounds	LHCC staff regularly meet with delegate staff, including monthly case audits, to review cases and verify that enrollees are receiving the right care in the right place and the right time.
Contract Audits	Monthly case audits to determine adherence to contract using a customized tool.
Clinical Deep-Dive Meetings	Regular meetings to discuss performance, resource gaps, and program information for operational performance.
JOC Meetings	Quarterly and ad hoc meetings between LHCC and delegates to present actionable data, review performance, coordinate, and address issues and concerns. Annual meetings will also focus on health equity and needs analysis.
Corrective Action Plans (CAPs)	Should any monitoring and oversight activity uncover an issue of non-compliance, risk of non-compliance or evidence of poor performance, delegates may be placed on a CAP. Our goal is to support our delegates to effectively resolve any issues and maintain delegation, providing training and technical assistance as indicated.

SECTION 2.6.7

Case Scenarios



"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

Enrollee, via card to her Care Manager, Linda

2.6.7 Case Scenarios [5-page limit per scenario]

2.6.7.1 Introduction to "Ben"

For purposes of this scenario response, we will refer to the enrollee described as Ben. Ben is like many children LHCC serves today who are living with multiple, co-occurring issues. Our integrated, person- and family-centered Care Management (CM) approach is designed to rapidly identify and address his barriers to care in a way that is directly aligned with Ben and his family's goals, needs, and preferences. We will focus on supporting and empowering Ben's PCP as his treating pediatrician and care coordinator, while also facilitating the integration of family-focused and age-appropriate physical health (PH), behavioral health (BH), and social determinants of health (SDOH) services, including EPSDT services, psychiatry, and other specialty care.



Ben is 5-year-old enrollee who is experiencing escalating physical and BH needs. To date, his family has not been able to help him comply with treatment.

Systems to Identify Untreated Medical Issues. LHCC identifies Ben for Case Management as an enrollee with Special Health Care Needs. Ben is assigned to a nurse CM, and we stratify him in Tier 3: High Risk Case Management.

Access to All Needed Services. Through Ben's ICT, supported by LHCC's Medical Directors, we work with his family to develop a Plan of Care that addresses Ben's holistic needs. We will make needed fee schedule adjustments and leverage and expand his providers' telehealth capacity to ensure Ben gets the care that he needs.

Support for Providers and Caregivers. Ben's CM will work with his PCP and caregivers to identify and address the root causes of previous non-adherence to treatment recommendations. We will use a Stages of Change approach with his parents, and support his PCP and other providers through education, technology, and coordination supports.

2.6.7.1.1 Identifying Persistent and Untreated Issues

LHCC has deliberate programs, processes, and systems designed specifically for Medicaid populations. For example:

- ***Technology systems***, including our Centelligence suite of predictive modeling tools and electronic medical record (EMR) projects that offer bi-directional clinical data exchange with the three most prevalent EMR systems in Louisiana. These tools facilitate point-of-care action on care gaps and efficient quality and EPSDT tracking and reporting. For example, over 65% of Louisianans have a record in an Epic EMR in Louisiana. LHCC is implementing Epic Payer Platform as another source to help identify enrollees like Ben by getting direct access to enrollee information on utilization, diagnosis, and gaps in care from our providers' EMRs.
- ***Provider and Community Support systems***, including a robust provider network that is trained on EPSDT requirements and available LHCC services to support enrollee adherence and supported by our secure LHCC CM Platform. Through role-based, secure portals, providers and others involved with Ben's care, like his school with parental consent, can exchange information and coordinate his care. As part of our provider support, we help providers, such as Ben's PCP, coordinate care at the point-of-service by delegating CM and wrapping with additional supports and value-based payments that reward positive outcomes and care gap closures.
- ***People systems***, including field-based CM and Provider Engagement teams who maintain deep roots and relationships with community providers and supports to help us engage with enrollees. We leverage these relationships to help locate hard-to-reach enrollees and train providers to call LHCC when our enrollees have missed appointments, such as with Ben's missed otolaryngology or neurology appointments, or are non-compliant, as experienced with Ben's PCP, for potential assessment and engagement in CM.

At this critical juncture in Ben's care, we would identify him as an enrollee with special health care needs (SHCNs) using our predictive modeling tools. Predictive analytics are used to predict future behavior, costs, and needs using proprietary algorithms to identify potential risks before a formal diagnosis is made, using a series of clinical indicators based on past diagnostic, clinical, pharmaceutical, and social history. For example, Ben's obesity could be an early predictor of diabetes. As part of Ben's annual well visit, the PCP identified several active medical issues requiring treatment, including obesity. Based on a review of subsequent claims and services, our staff and systems would detect that no additional treatment had been received. At Ben's next well-child visit, his obesity has worsened, which would also signify an unmet need. ***Given the facts of the scenario, our predictive analytics would identify Ben as benefiting from CM based on his young age, high and increasing body mass index (BMI), and sleep study referral***.

Alternatively, Ben could have been referred to CM from his PCP through a CM referral form submitted via LHCC's CM Platform, which automatically generates a task for the LHCC team to initiate enrollee outreach.

2.6.7.1.2 Processes to Ensure Access to All Services

EPSDT ensures that all children under age 21 receive treatment for any physical, dental, developmental, and behavioral illness or condition detected by a screening. This includes all medically necessary and other appropriate services to meet Ben's needs, regardless of coverage under the State plan. Through our care planning process, we leverage all available resources to ensure our enrollees have access to the care they need. For children, this includes paying for all medically

necessary services to help a child reach the age-appropriate health, wellness, and developmental level. For Ben, in addition to covering his treatment and services, it is essential that we help facilitate an appropriate diagnosis, arrange access to timely services, and ensure ongoing adherence to his POC. Potential barriers, based on the scenario, are the availability of providers who will accept Medicaid and possible neglect as demonstrated through non-compliance with diagnosis and treatment recommendations. As Ben has been taken to regular well-child and other PCP visits, we are hoping we can engage Ben's family or caregivers to better understand the lack of follow-up. Below we describe how we will address these barriers and meet Ben's needs through our person-centered, trauma-informed, age-appropriate, and culturally sensitive approach.



Integrated and Person-Centered Approach. Again, based on Ben's age, obesity, and signs of non-compliance and potential neglect, Ben is stratified into Tier 3: High Risk Case Management. LHCC assigns Ben to a Case Manager who is a Registered Nurse (RN) specializing in early childhood development and trained in Adverse Childhood Experiences (ACEs) and trauma-informed care. Through our team-based approach, Ben's assigned Case Manager is the primary point of contact for his family, with an internal ***LHCC Collaborative Care Team*** bringing multi-disciplinary expertise reflective of Ben's needs, such as PH and BH Medical Directors, Licensed Mental Health Professionals (LMHP), Pharmacists, Community Health Workers (CHWs), Peer Support Specialists, BH Liaisons, and an SDOH Team. Ben also has an ***Interdisciplinary Care Team (ICT)*** with external partners and expertise to provide input on and support his person-centered plan of care (POC). Ben's Case Manager leads the ICT which, at minimum, includes Ben and his family, his PCP, psychiatrist, and other treating providers, as well as a nutritionist.

Enrollee Engagement. Upon identifying Ben, the Case Manager reviews his health record, previous assessments, and claims history in our LHCC CM Platform. We outreach to Ben's PCP, to learn about Ben and his family's strengths and needs, including who his primary caregivers are (i.e., parents, grandparents, etc.). The Case Manager reaches out by phone within one business day of assignment. If unable to reach Ben's family by phone, they will go out in person to Ben's home later that day and continue proactive outreach to other community locations, such as Ben's school. If we still cannot reach his family, we will work with the PCP to identify Ben's next appointment and plan to meet him and his family there, with a warm introduction from the PCP. Once we reach Ben's family, the Case Manager engages them to complete the HNA and schedules a time to complete the in-person comprehensive assessment, which may take more than one visit as we establish trust and rapport with Ben's family and caregivers. The Case Manager also facilitates an ICT meeting to discuss Ben's diagnoses, escalating needs, and recommended course of treatment, including further assessment of his obesity, behavioral issues, sleepiness, and eating behavior, to identify conditions and possible causes for his symptoms.

Screening and Assessment Processes. After reviewing all of Ben's records in our LHCC CM Platform and reaching out to the PCP to help understand Ben's medical, behavioral, and social needs and history, the Case Manager goes to Ben's home to conduct the age-appropriate comprehensive assessment that focuses on Ben and his family's strengths, goals and needs. We meet them where they are, engaging Ben's caregivers through a strengths-based, family-oriented approach, building a trusted relationship with them by meeting their concrete needs as they are identified (such as those related to transportation or food insecurity), and using Motivational Interviewing to elicit their goals for Ben. The Case Manager also begins to build a relationship with Ben by asking simple questions and suggesting to play a game, bringing a ball or coloring book and crayons with them to the visit.

We will assess for any neglect, abuse, or trauma present for Ben in his current family situation. We will work with the family to identify and address the root cause(s) of why they have not been able to support Ben's health and wellbeing in the past. Possible scenarios include religious reasons, cultural reasons, comfort through food, behavioral health or substance use issues in the home, health literacy, lack of transportation, fear, or shame. We will address any of these by wrapping services and supports around the family to support Ben.

The Case Manager talks with Ben's caregivers about how the family addresses his sleep and overeating issues, as well as his behavioral problems in school. We ask the family to share their goals for Ben. Understanding obesity is often a generational, family-wide issue, we may connect Ben's caregivers to our ***Raising Well Pediatric Obesity Disease Management Program*** for family-based education on healthy nutrition and physical activity habits, as well as ongoing tracking of Ben's growth and changes in his BMI. The Case Manager asks about positive things the family does together, as well as rules and how they are implemented and enforced to assess the family's overall functioning. We also screen for current attachment issues, parenting styles (using the Parent Skill Assessment), along with additional screenings for caregiver/maternal depression (Edinburg), ACEs, family substance use, an Emergency Preparedness Plan, and COVID-19. The Case Manager identifies the family's SDOH needs, such as those related to housing stability, physical safety, food security, and the reliability of the family's transportation. The Case Manager will also schedule a time outside of Ben's school hours to conduct an environmental assessment of the general safety of Ben's home environment. With consent, we

engage Ben's teacher and other school supports in the ICT, and the Case Manager will make in-person visits to his school to help his family and teachers develop strategies to address his behaviors.

During the assessment process, the Case Manager consults with the PCP to see if they need further assistance arranging specialty referrals, including otolaryngology, psychiatry, neurology, and genetics; and ensure completion of all developmental screenings in accordance with Louisiana Developmental Screening Guidelines. The Case Manager can assist Ben's family to schedule and reach these appointments and support the resolution of any barriers to attending these specialist visits, as outlined in 2.6.7.1.3.

The Case Manager documents all assessment information in LHCC's CM Platform, which contains clinical guidelines and evidence-based decision support criteria. The CM Platform provides Ben's Case Manager and ICT with a single view of the family's needs. Screening and assessment information relevant to Ben's care is shared with participants of his ICT via our secure CM Platform. Providers can receive online care gap notifications and health alerts for Ben, as well as view Ben's enrollee health record, screening and assessment results, POC, and relevant clinical practice guidelines. Other members of the "extended care team", such as Ben's teacher, can also work with Ben's Case Manager after his family executes our short disclosure authorization form (available on our website). Ben's teacher can then discuss and coordinate Ben's care with the Case Manager in full compliance with HIPAA.

Addressing Pediatric Obesity

As described in Ben's POC, LHCC will connect him to Pennington Biomedical Research Center's TEAM UP Program, an evidence-based childhood obesity treatment program that LHCC supported with a financial grant. This program has had significant impact for our pediatric enrollees experiencing obesity. According to one enrollee's parent: "It was a relief that this is being covered by the insurance as I do not know if we would be able to do this without their help. I feel like this is a win/win because if more insurance companies covered things like this, people would eat better, and their health would improve, and they may become sick less often and insurance would not have to pay for more expensive things as a result of poor health due to diet."

Coverage for All Needed Care and Services. Regardless of whether the recommended services are on LHCC's usual fee schedule, the Case Manager will collaborate closely with LHCC's UM team, Medical Directors, and Ben's ICT to ensure access to all covered services and help Ben and his family access whatever support is needed to address his untreated medical needs. This includes paying for services not covered under the state plan, as well as connecting Ben and his family to community-based organizations that offer non-Medicaid services, like the Boys and Girls Club for structured social and recreational supports and LSU's School of Veterinary Medicine's Tiger Hats program for pet therapy. The ICT will also evaluate options such as Louisiana's Coordinated System of Care (CSoC) if behavioral issues continue to escalate. During every interaction, we will continuously work with the family to identify and resolve any barriers or ambivalence they have related to helping Ben access the care that he needs, including those related to religious beliefs, cultural and family norms, education, or transportation.

Ben's Plan of Care (POC). After the comprehensive assessment, the Case Manager works closely with Ben's family and PCP to develop a POC that engages both in and out of network options to support Ben (and his family) and prevent further escalation of his existing issues. LHCC helps to prioritize Ben's needs, identify the family's goals for Ben (and his own goals where he can express them), and reduce barriers to accessing all services.

Table 2.6.7.1.2 Ben's Sample POC

Ben Family's Self-Identified Goals	SMART Goals	Identified Barriers	CM Interventions
Ben's Family's Goal: "We want Ben to stop behaving this way."	Ben's Case Manager schedules an appointment for Ben with a child psychiatrist in his area within 2 weeks. In addition, Ben will attend specialist appointments as scheduled.	• No psychiatrist in Ben's area • Transportation or concerns of COVID-19 • Lack of understanding of the importance of these appointments	• Engage in a comprehensive range of PH, BH, and family assessments to identify the root causes of Ben's symptoms and behaviors • Conduct outreach to par and non-par child psychiatrists in the area to get Ben an appointment and arrange transportation or telecommunications • Help reschedule specialty appointments referred by the PCP, provide appointment reminders, arrange transportation as needed, and accompany the family to Ben's appointment if requested • Connect the family to evidence-based family-focused therapy that is age-appropriate, such as Parent-Child Interaction Therapy or Play Therapy, that can be provided in the home or at school • Connect Ben's family to local resources like NAMI support groups and the ***Families Helping Families Center***, and link Ben to recreational supports and pet therapy • Resolve ambivalence and barriers within the family to supporting Ben's health, including providing psychoeducation and concrete support

Ben Family's Self-Identified Goals	SMART Goals	Identified Barriers	CM Interventions
			• Help the family develop a Crisis Prevention Plan that addresses Ben's escalating symptoms and behaviors
Ben's Family's Goal: "We want Ben to lose weight."	Ben and his family will learn healthy lifestyle skills to assist him with his success	• Compulsive eating behaviors	• Coordinate with his PCP to connect the family with ***Pennington Biomedical Research Center's TEAM UP Pediatric Obesity Program.*** TEAM UP provides training and education for the PCP to be able to deliver family-based therapy for the treatment of childhood obesity, as well as offers home-based weight management counseling and parent skills training to parents of young children experiencing/at risk for obesity • Ensure appropriate screening and treatment in accordance with EPSDT requirements • Connect family to ***LHCC's Raising Well Pediatric Obesity DM Program*** to reinforce the services received through the ICT
Ben's Goal: "I want to learn how to ride a bike."	Ben will build up to 20-30 minutes of physical activity he enjoys	• Ben's obesity and excessive sleepiness	• Connect Ben to a community-based provider, like Front Yard Bikes, that can help Ben get a bike and helmet • Coach Ben's family to promote play and physical activity for their entire family, including accessing resources like the YMCA, children's museums, and the state park system • Educate Ben and his family to track his bike riding progress using a Healthy Lifestyles Journal provided by LHCC's CM team

Monitoring and Follow Up. Once the POC is completed, Ben's caregivers and PCP receive a copy, also available in the CM Platform. Bi-weekly, Ben's Case Manager will host an ICT meeting to discuss Ben's progress, as well as collaborate with the LHCC Medical Directors in the event the team runs into any barriers. The Case Manager follows up with Ben and his family twice a week until they are fully engaged in Ben's care, transitioning to weekly and then bi-weekly thereafter. At a minimum, in-person visits will be scheduled monthly at the family's preferred location, with formal updates to the POC made quarterly.

2.6.7.1.3 Provider and Caregiver Assistance to Support Adherence to Recommended Referrals

Assistance with Adherence to Recommended Referrals. LHCC will leverage and support Ben and his family's continued relationship with his PCP, empowering and supporting his pediatrician as Ben's medical home. The Case Manager supports the PCP to address the root cause(s) of Ben not attending his appointments, and the ICT addresses the identified issues with Ben's family. As described, we begin by engaging Ben and his family in an age-appropriate assessment process to gather an accurate picture of what is going on, including their views of specialty care referrals, in particularly psychiatry, to identify and resolve any ambivalence or barriers to attending specialist appointments. We provide education and coaching about the purpose of the visits, how to ask questions and guidance on what questions to ask; offering concrete supports like transportation to and from the appointments or interpretation during the visit if needed; and going with the family to his appointments, if desired. We recognize there may be cultural influences and engage trusted messengers to assist in ensuring Ben has access to the care he needs. For example, a priest from their church or provider from their cultural background. After each appointment, the Case Manager will provide Ben's family with education about the results and findings, including what they mean for Ben's overall health and wellbeing, and next steps to continue to support him to stabilize and live his healthiest life. Ben's family members may also suffer from obesity, therefore we use a family approach to addressing Ben's diet and lifestyle, again leveraging trusted messengers to honor cultural and other family traditions.

If telehealth is a better option for Ben and his family, LHCC will ensure access to care by making sure the family has a smartphone (Safelink or LHCC ConnectionsPlus) with necessary software and internet connectivity for the provision and receipt of telehealth services. On an ongoing basis, LHCC's Medical Directors will consult with the PCP and other specialists on Ben's case, offering suggestions and resources to support Ben to access the integrated care that he needs. The Case Manager also provides education regarding Ben's gaps in care, offers the family email/text appointment reminders, and informs the family of the ***My Health Pays® incentive*** for enrollees when they attend their appointments. The Case Manager will follow up to ensure Ben attends all of his appointments, alert Ben's PCP if he misses a scheduled appointment, and work with Ben's family and the provider to reschedule the missed appointment and address the root cause for why Ben did not attend the original appointment.

Assistance with Obtaining Pediatric Psychiatric Care. Ben's Case Manager conducts outreach to participating and non-participating pediatric psychiatrists to get Ben an appointment. If there are delays in accessing a psychiatric provider, we will support Ben's access to one virtually through ***Quartet***, our virtual BH referral platform. Quartet's Care Navigation team

would then match Ben and his family with a pediatric psychiatrist via telehealth. Regardless of the modality of care provided, Ben's Case Manager will engage his psychiatrist in the ICT, supporting the PCP and psychiatrist to coordinate and share information through regular ICT meetings and via the CM Platform. In addition, LHCC's BH Medical Director will outreach to the treating psychiatrist as needed to consult with them about Ben's care, including treatment needs and barriers to care.



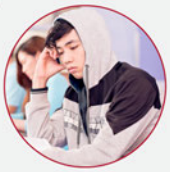
LHCC Enrollee Success Story:
In 2019, LHCC's Pediatric Psychologist Medical Director became concerned about a young enrollee, "Anne," who was not receiving sufficient care to meet her needs. The Medical Director contacted the enrollee's PCP, who was grateful to discuss Anne's situation. Anne's caregiver was her great-grandmother, who was strongly religious and mistrusting of healthcare providers. The PCP was ordering the best treatment the family would accept, but felt it was clearly not enough. In response, Anne's ICT—including LHCC's Pediatric Medical Director, Case Manager, CHW, and Anne's PCP—collaborated to support Anne. In getting to know the family in-person, the Case Manager identified a nephew who was a religious leader that the great-grandmother seemed to trust. With her consent, the Case Manager hosted a meeting with the nephew, great-grandmother, and the PCP, to build trust, explain Anne's needs, and why the PCP was recommending additional services, to set the great-grandmother's mind at ease that they were not going to take Anne away and that there would be no cost for the services. With the nephew's involvement, all these goals were achieved. By engaging a full community around Anne, including trusted messengers and the PCP, we were able to build trust and help Anne get the treatment she needed.

Alternate Scenario

Ben's Caregivers Do Not Engage. Despite LHCC's best efforts to work with the PCP and others to contact them, Ben's family may not engage. We recognize that children most often have the best outcomes with their families of origin, however, if there is neglect or habitual non-compliance, LHCC and/or Ben's PCP would need to make a DCFS referral to ensure Ben can get the care that he needs. In this case, LHCC would partner closely with DCFS, his ICT, as well as our Medical Directors, to identify an appropriate placement for Ben, which might include placement with a relative/kinship placement or therapeutic foster family who is nearby and able to care for him. We would try to keep Ben close to home wherever possible so that he can continue to go to the same school and remain close to his friends and support services. Ben's Case Manager would engage his foster family and the DCFS case worker in Ben's ICT, and LHCC's BH Medical Director would coordinate with DCFS leadership during their weekly meetings to discuss Ben's complex case. At the same time, to reunify Ben and his family of origin, we would continue to support his family to build skills and reduce their challenges as caregivers, connecting them to counseling, coaching and education, peer support, and concrete resources based on their identified needs.

2.6.7.2 Introduction to "Billy"

For purposes of this response, we refer to the enrollee described as Billy. Like other adolescents with severe irritability and impulsivity from Disruptive Mood Dysregulation Disorder (DMDD) and Attention Deficit Hyperactivity Disorder (ADHD), Billy struggles to control his emotions and behaviors in stressful situations. This is compounded by PTSD and mild to moderate cognitive deficits, which may make it harder for him to use reasoning skills. Instead, when feeling overwhelmed, he may become angry and aggressive. Without demonstrating greater self-control, Billy's mother fears his return home.



Billy is a 14-year-old enrollee, with DMDD, ADHD, PTSD, and cognitive issues, who displays aggressive behavior at home and in school.

Member Identification/Engagement. LHCC identifies Billy for Tier 3: High Risk Case Management and assigns him to an LMHP Case Manager who reaches out to him and his mother.

Enrollee Identification/Engagement. The Case Manager meets with Billy and his mother to conduct a Health Needs Assessment and comprehensive assessment of Billy's strengths, needs, and barriers to care and mother's goals for allowing him to return home.

Plan of Care. The Case Manager, Billy, and Billy's mother devise a two-track plan to discharge Billy home with more intensive services and supports. Both tracks center on Billy and his mother's goals to improve Billy's capacity for self-control and restore family safety.

In cases like Billy, our goal is to provide evidence-based services in the community and prevent the separation of family members, keeping enrollees in the community and fostering transitions to promote a smooth path home. For children with disruptive or dangerous behaviors and their families, we provide a range of intensive behavioral health (BH) services and community-based supports to restore a sense of safety necessary to help them remain together and live their highest possible quality lives. This scenario describes a family at an especially precarious juncture; Billy may have stabilized in the structured setting of the hospital, but his mother is skeptical he will be safe at home and has concerns for her job and the safety of her other children. The hospital is ready to discharge and plans to contact the Department of Child and Family Services (DCFS) to possibly place him in foster care if another plan of care (POC) cannot be immediately implemented. We recognize the urgency and complexity of this case and have compassion for Billy's mother and her position.

Person-Centered and Team Based Approach. For children and youth with BH disorders, LHCC uses a system of care model that is person- and family-centered, strength-based, and recovery-oriented to meet enrollees and families wherever they are and provide services and supports to address their goals and needs. Youth, such as Billy, are approached with hope for their recovery as they define it. Our interactions with Billy are through a trauma-informed lens. We work to understand Billy's goals, desires, strengths, and preferences and engage him in his care and treatment. Our process ensures we have the appropriate consents to build on our direct relationship with Billy as the enrollee. At the same time, we honor the voice of parents and guardians, such as Billy's mother, to make healthcare decisions in their child and family's best interests. We balance these two objectives in our care for Billy by conferring regularly with Billy, Billy's mother, and his care team about meeting Billy's health needs. This is particularly important given Billy's mother's expressed concerns regarding her ability to care for Billy safely in her own home and the impact of Billy's behaviors on her other children.

Based on Billy's primary BH needs and diagnosis, he is assigned to an ***LHCC Case Manager*** that is a licensed mental health professional with experience and training in adverse childhood experiences (ACEs) and trauma-informed care. As part of our team-based approach, Billy and his Case Manager have the added support of our internal ***LHCC Collaborative Care Team*** comprised of LHCC PH and BH Medical Directors, Pharmacists, Registered Nurses (RNs), Community Health Workers (CHWs), Permanent Supportive Housing and BH Liaisons, and an SDOH Team. The team provides behind-the-scenes multidisciplinary support and consultation to the lead Case Manager as Billy's primary point of contact. Billy also has an ***Interdisciplinary Care Team (ICT)*** that brings in external partners working collaboratively with Billy and his family to support his goals and provide input to the development of the person-centered POC and treatment options. Billy's Case Manager convenes and leads the ICT which, at minimum, includes Billy and Billy's family, PCP, and other treating providers.

To meet the urgency of this moment and avoid abandonment at the time of discharge, Billy's Case Manager engages with Billy's mother, convenes a meeting with the ICT, and consults with the LHCC Collaborative Care Team. We learn more about Billy's mother's concerns, fears, and hopes for Billy's wellbeing and the stability of her household and create an appropriate plan with the most relevant and effective services for Billy, while acknowledging and addressing mom's concerns. While she may still not agree to bring him home before the hospital arranges to discharge, we must have an alternate plan. Our approach below follows ***two tracks***:

- **Track 1:** Discharge Billy home directly from the hospital with intensive home- and community-based services to help him attain greater self-control and prevent another relapse and re-institutionalization
- **Track 2:** Assist, with mother's approval, Billy in discharging to the attending provider's recommended level of care, such as a Residential Level of Care or Psychiatric Residential Treatment Facility (PRTF) stay, allowing time for further stabilization and arranging the most appropriate services for Billy and his family in preparation for his return home

2.6.7.2.1 Assessment for and Timely Access to Needed Services

In ordinary circumstances, if Billy was our enrollee at the time and not already in case management, he would be referred to a Case Manager during his first PRTF stay by our Utilization Management (UM) department. Before that event, he would be identified to be eligible through our screening and assessment processes based on the presence of Serious Emotional Disturbance (SED) and stratified into Tier 3: High Risk Case Management. For the purposes of responding to this scenario, LHCC is picking up at the time of his current hospital stay.

Assessment. Billy's assigned Case Manager is notified of Billy's inpatient admission through our LHCC CM Platform, which receives daily admission, discharge, transfer (ADT) hospital feeds. Billy's assigned Case Manager, located in the Bunkie area, reviews Billy's health record in the LHCC CM Platform and calls Billy's mother to schedule a face-to-face meeting while Billy is still in the hospital. The Case Manager conducts an age-appropriate comprehensive assessment with Billy and his mother that includes a full assessment of Billy's medical, BH, social, and cognitive needs, including an ACEs screening. The assessment covers areas such as Billy's current medications, compliance, side effects, and other concerns; outcomes of previous pharmacological and behavioral services, including Community Psychiatric Support and Treatment (CPST); cultural/linguistic preferences; PH, BH and SDOH needs. The Case Manager and Billy's mother also discuss his social and emotional development, including Billy's early and current attachment issues; relationships with his mother, siblings, and other family members; apparent triggers for his aggression; issues at school and any involvement with BH, early childhood, or child welfare agencies and the Office of Citizens with Developmental Disabilities (OCDD). As the second part of the assessment process, with mom's permission, the Case Manager meets independently with Billy to hear in his own voice about his needs, goals, and concerns and obtain additional objective data to inform the development of his POC. The Case Manager talks with Billy about his strengths, the activities he enjoys, and what's important to him. While at the hospital, the Case Manager also meets with the facility's inpatient team, with the LHCC BH Medical Director joining virtually, to discuss observations and post-discharge recommendations and options.

An important component of evaluating Billy and creating his POC is determining his cognitive strengths and weaknesses. During the assessment, if the Case Manager noticed any red flags regarding Billy's cognition, they will contact Billy's PCP to recommend additional cognitive testing to further assess his intellectual functioning, reasoning, problem-solving skills, abstract thinking, judgment, academic achievement, and adaptive functioning.

As part of our process, we confer with current and past BH providers and Billy's PCP to gather information regarding past treatment and previous assessments. With the mother's permission, the Case Manager also reaches out to Billy's school to gather available assessment and cognitive information about him, including standardized test scores, performances in class and on exams, and assessments by a school psychologist of his IQ, reading, and math abilities, and psychological functioning. If the school has a psychologist on staff, they would be recommended to participate as a member of Billy's ICT. Finally, as part of our process, we will complete a caregiver assessment with Billy's mother to better identify her risk for burnout, which could be detrimental to Billy's need for ongoing care and support. We would then find support groups in the area for her to attend (in-person or virtually) and consider other in-home supports to meet the family's needs.

Access to Specialty and Evidenced-Based Treatment. The results and findings from Billy's comprehensive assessment inform the development of a person-centered POC with input and recommendations from Billy and Billy's ICT on community-based and (short-term) institutional care options. The POC includes recommendations on a set of specialty and evidenced-based treatment options, including clinically indicated and medically necessary services to successfully manage and treat Billy in the community. The POC, inclusive of Billy's recommended treatment plan, is designed to prevent the need for DCFS involvement, avoid unnecessary ED visits and inpatient readmissions, and maintain Billy safely in the least restrictive setting.

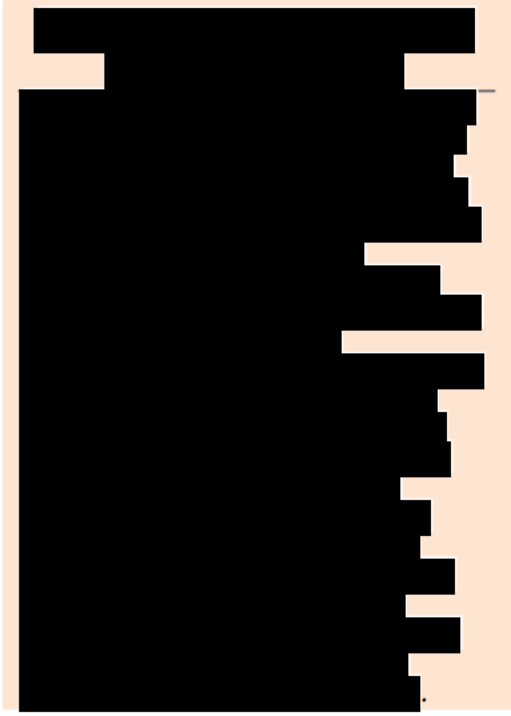
LHCC BH Providers

- ***11 LHCC BH providers*** in Bunkie
- ***56 LHCC network BH providers*** in Avoyelles Parish

Led by Billy's Case Manager, the ICT acts quickly to provide telephonic input on recommended care options. To prevent the need for DCFS involvement, the Case Manager meets again with Billy and his mother, prior to discharge, to develop and discuss a POC that is approved by Billy and Billy's mother. The Case Manager asks Billy about his preferences and his mother about what she requires to feel comfortable accepting Billy back into the home. If Billy's mother agrees to bring him home now,

the Case Manager, working with the ICT, arranges for more intensive home-and community-based services, such as ***Functional Family Therapy (FFT)***, an evidence-based, time-limited intervention performed in the home for adolescents with BH disorders and their families. To address potential barriers to accessing this service, as part of the POC, the Case Manager helps to connect Billy and his mother to the in-home FFT provider and adds the FFT provider to Billy's ICT. If a needed service is not readily available within the parish or has a waiting list, the Case Manager will seek and arrange for telehealth services from LHCC providers in other parishes. Additional services to support Billy at home are described in 2.6.7.2.2 below. Once the POC has been agreed to and finalized, a copy is made available to Billy, Billy's mother, and the full ICT on LHCC's CM Platform.

Ongoing Monitoring and Support. Assuming here that Billy is discharged home, as part of our transitional case management program, the Case Manager, working in close collaboration with the LHCC Transition of Care Team, will follow-up with Billy and his mother within 72 hours of discharge, either in person or by phone, and at least twice a week for the first week, weekly for the remainder of the first month, and bi-weekly thereafter to support and monitor POC services and the transition POC. The Case Manager also conducts a home visit within 30 days of discharge to re-evaluate Billy's progress and the POC and make necessary adjustments with input from the ICT. The Case Manager educates Billy and his mother on LHCC's 24/7 BH crisis line, talks to Billy about our Teen Crisis Text line providing a safe space for Billy, including support and coping mechanisms when things feel overwhelming, and reminds Billy and his mother that the Case Manager is also available by phone if any issues, needs, or change in status occur. The Case Manager continues to collaborate with Billy's pediatrician and the rest of the ICT to coordinate all services in the POC and to prevent unnecessary ED visits or readmissions.



2.6.7.2.2 Right Care, Right Time, Right Location

If an inpatient or residential level of care is recommended for more intensive treatment and safety, the Case Manager works with Billy's treating provider to determine if he is eligible for PRTF level of care. If PRTF is found to be appropriate by Billy's treating physician, Billy's Case Manager would outreach to in-network providers to determine if they have bed capacity and can meet his neurocognitive and BH needs. If they are unable to do so, the Case Manager will expand the search, including out of network providers with specialty programs more suited to Billy's neurocognitive and BH needs. Our UM team assists in finding an available bed. During any institutional stays, starting at the time of admission, Billy's Case Manager continually monitors Billy's progress and works closely with Billy, his mother, and the PRTF team to develop a discharge and transition plan that will support a successful transition back home. Any PRTF-recommended discharge plan will still be contingent upon Billy's input and his mother's agreement.

Exploration of Additional Services and Supports. To prevent another institutional placement, the Case Manager, with input from the ICT, will determine whether Billy qualifies for additional supports, such as waiver services through OCDD ***Children's Choice Waiver*** services, including access to a Personal Care Attendant (PCA) for 8 to 12 hours per week during the school year and more during the summer. By attending to Billy's needs, a PCA would help relieve Billy's mother's stress and enable her to shift some of her focus to keep her job and address the needs of Billy's siblings.

Behavioral Health Services. In conjunction with Billy, Billy's mother, and the rest of the ICT, the Case Manager will explore and facilitate appropriate access to BH services to support Billy's safe transition back into the community that may include the following:

- LHCC notifies Billy's PCP of contracted psychiatrists available in the Bunkie area today, including one Psychiatric-Mental Health Nurse Practitioner so the PCP can make an appropriate referral for Billy. If one of these providers doesn't match Billy's needs and preferences, the Case Manager will refer to a neighboring parish and/or supplement with ***telepsychiatry***. If Billy chooses a ***telehealth*** option, we ensure the family has internet connection capabilities. If the family does not have internet, the Case Manager will arrange to join the telehealth visits, taking a computer and auxiliary hot spot to the family's home to facilitate access.

- Once FFT is completed, Billy will again be referred for CPST services to reinforce skills learned in counseling and positive parenting approaches. Because of his PTSD, the Case Manager may also refer him for ***Cognitive Behavioral Therapy*** (CBT), an evidence-based treatment adapted for teens with trauma histories.
- The Case Manager will help Billy and his mother develop a ***Crisis Prevention Plan as part of his POC,*** including signs to indicate Billy might be in a crisis, de-escalation strategies they can implement, and resources they can contact for immediate help. The Case Manager will arrange for the family to receive a ***SafeLink or Connections Plus smartphone***, if necessary, with preprogrammed numbers for his ICT, Nurse Advice Line, BH Crisis Line, Teen Crisis Text Line, and 911.
- Billy's mother is at high risk for caregiver burnout based on the findings from our caregiver assessment. The Case Manager will refer her to Louisiana's Bureau of Family Health's ***Families Helping Families (FHF)*** program to connect her with families with children with similar challenges to provide her with support and guidance. The FHF programs will provide Billy's mother with education and parenting therapy to help her more effectively manage her son's behavior.
- Billy may also benefit from ***Youth PTSD treatment*** (YPT), a cognitive-behavioral therapy intervention for PTSD and trauma-related symptoms.
- As an internal resource, LHCC's ***ADHD Disease Management*** program can provide health coaching and self-CM supports and resources for Billy and Billy's mother.

Physical Health Needs. The Case Manager will encourage Billy and his mother to make regular visits with Billy's pediatrician to ensure he is up to date on EPSDT services including well-visits and immunizations. The Case Manager will also provide the option of switching to an FQHC or other PCP that offers integrated care, or ensure his current provider has the necessary support to care for youth with BH conditions, such as ConferMed, allowing for provider-to-provider specialty eConsults, including psychiatry.

Meeting Social Resource Needs. Billy's assessment will identify the family's need for social resources to help support his recovery. For example, we will link Billy's mother to our LHCC Employment Specialist to ensure Billy's mother has stable employment and work with Billy's FFT providers to establish a schedule that is least disruptive to his mother's work hours. For appointments outsides the home we will offer childcare resources to ensure Billy's younger siblings are safe and allow his mother to accompany Billy to appointments. We will also address all of Billy's transportation needs by arranging NEMT. We will link Billy and his family to additional community resources, using our LHCC's ***Community Connect Platform*** for closed loop social service referrals, as a supplement to ***Louisiana 211***. Additionally, with no male role model identified in Billy's life, we may work with Billy and his mother to identify male providers, including his PCA provider.

Table 2.6.7.2.2 Billy's Sample POC

Billy's/Family's Self-Identified Goals	Billy's SMART Goals	Identified Barriers	CM Interventions
Billy: "I want to stay home" **Mother: "He has to control himself to stay home"**	Create a range of home- and community-based services to reduce his aggression	Limited number of BH providers in immediate Bunkie vicinity	• Collaborate with Billy, his mother, and hospital staff to establish a timely discharge plan for Billy including appropriate home and community-based services to reduce Billy's reported behaviors • Facilitate appropriate services once Billy is evaluated by his provider for other wrap around services • Coordinate psychiatry, FFT, CPST, CBT providers in Avoyelles Parish or via telehealth to prevent placement
Mother: "I want to be less stressed by caregiving"	Connect mom with FHF and support group within 2 weeks	Mother burnout and competing priorities (job, siblings)	• Assist Billy's mother with locating a support group • Provide info about obtaining transportation • Provide appointment scheduling and reminders for Billy's mother • Explore available respite care services for Billy's mother
Billy: "I need someone to help me calm down"	Within 7 days of the hospital or TGH/PRTF discharge, Billy will attend a follow-up	Billy's mother is not able to manage his behavior	• Help Billy and his mother develop a crisis plan and educate his mother about LHCC's 24/7 crisis line and Teen Crisis Text Line • Reinforce de-escalation techniques provide by outpatient BH provider with Billy's mother

Billy's/Family's Self-Identified Goals	Billy's SMART Goals	Identified Barriers	CM Interventions
Mother: "Help my son control his temper"	appointment with a BH provider		• Facilitate a discussion w/ Billy and his BH provider on techniques for when he feels himself becoming angry such as deep breathing and mindfulness exercises • Ensure follow-up appointment is scheduled before hospital or TGH/PRTF discharge

Alternate Scenarios. LHCC will provide effective CM if Billy and his mother are faced with other choices.

Multi-Systemic Therapy (MST). If FFT does not prove effective, Billy may qualify MST, a program that provides intensive home, family, and community-based treatment for youth who are at risk for home displacement or who may be returning from an out-of-home placement. This model is based on empirical data and evidence-based interventions that target specific behaviors with person-centered interventions. These services are primarily provided in-home but may also be performed at schools and other community settings. The program also offers caregiver support groups and respite options.

Billy is Deemed Eligible for OCDD and CSoC Services. Billy's admission to the Coordinated System of Care (CSoC) program, will allow him to benefit from its wraparound approach of an integrated delivery system that provides enhanced service offerings and achieves improved outcomes for children with severe BH challenges. Combining all services into one coordinated plan allows for better communication and collaboration among families, youth, state agencies, providers, and others like Billy and their families. LHCC will continue to support Billy and his mom in coordination with CSoC.

Billy is Placed in Foster care by DCFS. If Billy's mother refuses to retrieve Billy from the hospital and there are no residential beds available before the hospital discharges, then LHCC is still well-positioned to continue caring for him. We currently have over 6,000 pediatric enrollees in foster care throughout the state; 9 of the 15 most common chronic conditions of those enrollees are BH disorders. Our CM team has experience coordinating services with DCFS and foster families to support the health and wellbeing of our enrollees and facilitate their reunification with robust home- and community-based services with their families of origin.

LHCC Collaboration with DCFS

For our enrollees in DCFS custody, LHCC has three means of closely collaborating with that agency: our weekly LHCC-DCFS Rounds to discuss all cases; weekly discussions between the LHCC BH Medical Director and DCFS leadership to confer about high complexity cases; and our LHCC DCFS Liaison to receive and disseminate DCFS updates to the LHCC CM and Medical Affairs teams.

2.6.7.3 Introduction to "Sarah" and "Alexandria"

For purposes of this scenario response, we will refer to the enrollee described as Sarah and her child as Alexandria. Sarah has experienced significant past trauma, and to add further distress and complexity, Sarah's family is faced with a devastating prognosis of hydranencephaly for her newborn. We will focus on building a strong, supportive relationship with Sarah through which we will connect her and her family to accessible and integrated psychological, medical, and social determinants of health (SDOH) supports while helping Alexandria remain as comfortable as possible given her diagnosis.



Sarah immigrated to New Orleans to live with her father and brother after being sexually assaulted. Her newborn, **Alexandria**, has recently been diagnosed with diabetes insipidus and required hospitalization and hospice care.

Care Management for Mom and Baby. LHCC identifies Sarah for Tier 3: High Risk Case Management using our proprietary risk stratification algorithm. Sarah's CM, in consultation with the full ICT, will support her to understand the treatment recommendations for both her and her baby.

Overcoming Language and Cultural Barriers. During every interaction with Sarah and her family, we will work to build trust in a way that is trauma informed and leverages trusted messengers. We will utilize Spanish-speaking CM staff and interpreters to ensure all communication is in Sarah's preferred language of Spanish.

2.6.7.3.1 Care Management for Sarah and Alexandria

We will approach Sarah's and Alexandria's needs through a trauma-informed approach that prioritizes safety, transparency and trustworthiness, peer support, collaboration, empowerment, voice and choice, and cultural respect. The goal of our interactions is to promote connections to recovery and resilience to address the impacts caused by Sarah's sexual trauma. To that end, the CM will develop specific trauma-informed interventions that recognize Sarah's need to feel connected, respected, and hopeful about her journey to recovery. Interventions also address the interplay of trauma and associated symptoms of depression, anxiety, guilt, isolation, and fear and emphasize the criticality of collaboration with Sarah, her identified support system, providers, and referral sources that will work together to empower Sarah and ensure clinical and family support for Alexandria.

Integrated Person-Centered Approach

We will provide Care Management (CM) services for Sarah and Alexandria through ***Geaux Baby and Me program***, our evidence-based maternal and child care management program designed to address pregnant and postpartum enrollees' through 12 months post-delivery. Geaux Baby and Me is rooted in Centene's award-winning Start Smart for Your Baby program that supports each family's unique, and sometimes fragile, physical health (PH), behavioral health (BH), and SDOH needs. Within the targeted program, we assign both Sarah and Alexandria to Tier 3: High Risk Case Management. Geaux Baby and Me Case Managers are trained to support pregnant and postpartum mothers and their infants across a range of needs, including those, like Sarah and Alexandria, who are dealing with a terminal diagnosis and trauma. Our approach will involve (1) assisting Sarah in accessing the resources she needs to care for Alexandria and keep her comfortable; (2) supporting Sarah to emotionally heal from her own experiences, Alexandria's prognosis, and adjust to a new life in New Orleans; and (3) working toward (when she is ready) her own health and wellbeing goals.

We will match Sarah and her baby with a highly trained, female Case Manager who is a licensed Registered Nurse (RN) and fluent in Spanish that will serve as the single point of contact. Through our team-based approach, Sarah and her Case Manager have the added support of an internal ***LHCC Collaborative Care Team*** with multi-disciplinary experts reflective of Sarah and Alexandria's needs. Over time, the Case Manager will work with Sarah to build and lead an ***Interdisciplinary Care Team (ICT)***, which includes external partners working collaboratively with Sarah and her family in the development of an individual plan of care (POC). For example, Sarah, her family (if she would like them to be involved), her PCP, Alexandria's pediatrician, and other treating providers, including the hospice care providers caring for Alexandria.

Trauma-Informed Staff

As of August 2021, 100% of LHCC staff have completed training in ACEs and Trauma-Informed Care.

Enrollee Engagement. With prior traumas and new realities, Sarah may not be receptive upon initial contact. The Case Manager meets Sarah where she is to build a trusting, supportive relationship. If the Case Manager is not able to reach Sarah by phone, she will visit Sarah's home and continue telephonic and in-person outreach until she is reached. We know from the eligibility file Sarah speaks Spanish, so all outreach is done by bi-lingual staff. It may take a few visits before we can establish a baseline rapport. The Case Manager starts to build trust by showing Sarah consistent, concrete support that is directly responsive to Sarah's self-identified needs, such as bringing a pack and play for Alexandria during their first meeting and brings lunch for Sarah to establish rapport and build trust. Once the initial meeting takes place, the Case Manager continues to meet with Sarah in person at least twice a week. Sometimes these visits entail the Case Manager just sitting

with Sarah and Alexandria, providing Sarah with a safe, supportive space to express what she is feeling and help model maternal behaviors, including how to hold or feed Alexandria. Sarah may reject or hesitate to bond with Alexandria. She may not feel she can talk to her father or brother who may have a difficult time trying to relate. The Case Manager takes this time to understand Sarah's priorities, fears, and social and emotional needs. As the relationship strengthens, we start to talk about available resources and address any medical needs.

Screening and Assessment. Through the trusted relationship the Case Manager forms with Sarah, we engage her to update or complete both her and Alexandria's Health Needs Assessment (HNA) and comprehensive assessment. The assessment addresses sensitive topics related to trauma and grief, which may be best over several separate visits. At each step, Sarah's Case Manager explains the assessment and care planning process and findings to Sarah to support her to understand and increase her health literacy as their work together continues, using plain language and teach-back methods to reinforce learning with both Sarah and her family. All communications will take place in Spanish. In addition, the Case Manager uses visual aids and can provide educational materials in a Spanish audio format. If Sarah desires, the Case Manager will engage Sarah's father, brother, or other natural supports, using the same methods of communication.

During the comprehensive assessment, the Case Manager will ask Sarah a series of questions related to her own PH and BH history, past trauma, diagnoses, current wellbeing, home environment, SDOH, care gaps, and need for community resources and supports. The Case Manager partners with Sarah to help her determine her own readiness for sharing the information. Our postpartum assessment includes screening for postpartum depression using the Edinburg tool. We confirm that Sarah is happy with her PCP and that she has a Spanish-speaking OB/GYN for appropriate postpartum care. We will assess what it means for Sarah to have immigrated to New Orleans to live with her father and brother following a sexual assault, including the psychological and trauma-related needs that are associated with these experiences. To further address Sarah's history of sexual abuse and trauma, her Case Manager will coordinate with her OB/GYN to identify a Spanish-speaking psychiatrist for referral. During the assessment process, the Case Manager identifies any concrete supports that the household might need, such as those related to housing stability, food insecurity, transportation, and community connections, and the Case Manager also performs an environmental assessment to identify if there are any issues in the home that could adversely impact Sarah and her baby. The assessment also includes the Emergency Preparedness Plan and a COVID-19 screening. When she is ready, we also talk with her about her own goals as a 17-year-old, such as learning to read and write, going to school, finding employment, and living independently.

The Case Manager also learns about Alexandria. What are her sleeping and eating habits? Who is her primary caregiver? The Case Manager outreaches to the treating physician at the hospital and Alexandria's hospice provider to gather additional information about her condition and prognosis. The Case Manager schedules an ICT meeting to discuss the case and review previously completed assessments and treatment recommendations.

Plan of Care (POC). Our work with Sarah will evolve over time based on the complexities of her situation. We will support her to prioritize her and her baby's needs and the wraparound services and supports to which we offer based on her needs and preferences. On an ongoing basis, the Case Manager educates Sarah on available benefits and coverage options if her Medicaid coverage is time-limited due to her recent pregnancy. Sarah and Alexandria's POCs will include Sarah's self-identified short and long-term goals for her and her baby, which we will continuously update with Sarah based on her needs and preferences. Sarah's Case Manager consults with the ICT during POC development to ensure we include an appropriate array of trauma-informed, integrated services and supports that can address Sarah and Alexandria's evolving BH, PH, SDOH, and trauma needs.

Table 2.6.7.3.1.a Sarah's Sample Plan of Care (POC)			
Sarah's Self-Identified Goals	**Sarah's SMART Goals**	**Identified Barriers**	**CM Interventions**
"I want to help my baby."	Sarah will engage with an OB/GYN that is knowledgeable in trauma-informed care within 2 weeks	• Cultural and language barriers • Health literacy barriers	• Connect Sarah to a female OB/GYN in her area, like Ochsner or CrescentCare Health and Wellness Center, who is fluent in Spanish and can serve as her PCP, offering post-partum care, an assessment of her current PH and BH needs, preventive care screening, and (when she is ready) family planning services, like long term contraceptives • Provide ***Geaux Baby and Me*** supports, including incentives for postpartum visits, 24/7 virtual support through Pacify, which offers bilingual (Spanish and English) on-demand phone access to maternal and pediatric experts, and coordination with the local resources like WIC and support groups • When she is ready, help Sarah develop trusted relationships with peers, including individuals like Sarah who may have lost an infant or suffered sexual abuse • Support transportation to/from Sarah and Alexandria's appointments through LDH's NEMT vendor
"I want to stop thinking about my sexual assault."	When she is ready, Sarah will connect to a Spanish-speaking Trauma Focused Therapist	• Prior trauma from Sarah's experience, compounded by the trauma of Alexandria's prognosis	• Connect Sarah with a Spanish-speaking BH provider with a trauma focus, such as the West Jefferson Behavioral Health Center, and offer the support needed for her current mental health, and social and emotional needs for her baby who is now in hospice care • Link Sarah to community resources related to sexual trauma, such as the Family Justice Center in New Orleans, which offers Spanish-language trauma-informed counseling and advocacy support for sexual assault survivors, a weekly schedule of free healing activities for survivors (e.g., yoga, art group, singing group), as well as a 24/7 sexual assault survivor crisis line
"I want to be independent and learn to read."	When she is ready, Sarah will build capacity and resources to support herself to live independently	• Impact of the death of her baby on her emotional wellbeing • Language barriers	• Connect Sarah to literacy services through YMCA Educational Services (YES) and help her to enroll in a flexible school program that meets her needs. Support her to work towards her education and career goals • Support Sarah and her family to access immigration, legal, and interpretation supports from Catholic Charities • Connect Sarah to LHCC's Housing Specialist for support to find housing options in a Spanish-language community where she feels comfortable (close to her father, brother, or other natural resources if she desires their support) • Refer Sarah to LHCC's workforce development specialist to help her find gainful employment • Utilize the LHCC Community Connect Platform to find additional culturally sensitive and Spanish-speaking SDOH resources for Sarah and her family

Based on Sarah's preferences and goals related to Alexandria's care, the Case Manager works with the ICT to develop a POC that will provide Alexandria with integrated and coordinated care based on her stage of illness, while ensuring Sarah has a good understanding of her baby's overall medical condition and prognosis. Sarah's POC will be closely linked to and integrated with Alexandria's, but to ensure Alexandria receives the services and supports she needs, the Case Manager will support Sarah and the ICT to develop a separate POC for Alexandria.

Table 2.6.7.3.1.b Alexandria's Plan of Care			
Sarah's Goals for Alexandria	**Alexandria's SMART Goals**	**Identified Barriers**	**CM Interventions**
"I want to help my baby be as comfortable as she can be."	Case Manager will offer Sarah resources to wrap around hospice and encourage her to use what is available to meet her and her infant's needs	• Alexandria's terminal diagnosis	• Coordinate with Alexandria's hospice care providers to ensure all services are integrated • Engage with Sarah to better understand her wishes for Alexandria (given her diagnosis) and educate her about available options within the LHCC network and other community supports, such as a child life specialist • Model for Sarah ways of positively interacting with and supporting her baby to promote attachment • Provide Sarah a safe sleeping arrangement for Alexandria through Cribs for Kids and other needed baby items such as a car seat or diapers to keep Alexandria safe
"I don't want my grief to get in the way of me bonding with my baby during the time we have together."	Case Manager will support Sarah to connect to grief and bereavement support resources to cope with the impending loss of her baby	• Alexandria's terminal diagnosis	• Offer to connect Sarah to grief-support resources when she is ready, including Ochsner's monthly grief support group at their Main Campus Chapel, Louisiana Share Pregnancy & Infant Loss' Online Support Group, Saul's Light bereavement support, and Anna's Grace virtual grief resources for families who experience infant loss, such as their virtual garden • Ensure Sarah has access to a Spanish-language mental health provider that is trained in trauma-informed care to support her during this time (i.e., West Jefferson Behavioral Health Center) • Engage Sarah's father and brother to be her support system at home With Alexandria's hospice provider, support Sarah with Alexandria's burial arrangements, including Sarah's preferences for how she wants to remember and commemorate Alexandria after her passing

Monitoring and Follow Up. Once the POCs are established for Sarah and Alexandria, the Case Manager continues to follow up with Sarah regularly, twice a week until mother and baby are stable, then transitioning to weekly and bi-weekly thereafter when Sarah is ready. These meetings will occur in Sarah's preferred location, which could be in her home but also may be at her OB/GYN's office or another community-based location where she feels safe and comfortable. Within 30 days of developing the POC, the Case Manager will meet with Sarah to re-evaluate the POC and Sarah's and Alexandria's progress. The Case Manager also collaborates with her ICT to discuss Sarah's progress and coordinates with LHCC's Medical Directors if the ICT encounters any barriers.

2.6.7.3.2 Overcoming Language and Cultural Barriers



We confirm and document enrollee and caregiver communication preferences during our first call, recognizing any language information received through the eligibility file for initial outreach. As described, we will connect Sarah with a Spanish-speaking Case Manager, and her ICT will consist of entities that can provide services and supports in Spanish. When a Spanish-language option is not readily available, we will use interpreters, including those available in person through local community-based organizations like Catholic Charities. Based on Sarah's longer-term educational goals, we will also link her (when she is ready) to an educational program or community-based organization

Increasing Access to Care

LHCC shares translation and interpretation service information in the preferred language to every non-English speaking enrollee with the goal of increasing healthcare engagement. In response, one enrollee stated, "This is so exciting to know that LHCC has this type of service in place. I speak English very well now, but when I first came to America I could not. My mother still doesn't speak English well and I assist her with translation. I love living in the US, and it is the best thing I could have ever done. The message was left in Arabic and this is the first company to make contact in Arabic. To know that LHCC has focus on my culture and is assisting with language barriers is an awesome idea. Thank you all for having this available to me."

that can assist her as a newly emigrated individual to gain literacy skills. We can also make these resources available to Sarah's father and brother if they are interested.

Responsive Care and Services. The best way to help overcome language and cultural barriers is to understand the best way Sarah learns. Building on how Sarah retains information and responds, the Case Manager will provide continuous education and follow-up after each of Sarah's and Alexandria's appointments, to ensure that she fully understands the assessment results and providers' recommendations for both her and her baby. This may include verbally going over what was discussed during the service and/or providing her tools to help her adhere to the POC, such as visual reminders and diagrams related to treatment recommendations. While Sarah, her father, and her brother cannot read or write, there is still value in connecting them with a mobile phone and helping to train on how they can use the phone to help set reminders; dictate and playback notes; and quickly access the Case Manager or LHCC's 24/7 Nurse Advice Line or BH Crisis Line, which are both staffed with Spanish-speaking representatives. Based on Sarah's preferences, the Case Manager will involve other family members living in the home in family meetings, assessing and applying their learning styles, so that they too understand the overall prognosis and needed care for both Sarah and her infant.

The Case Manager engages Sarah to identify her cultural, religious, or other preferences regarding end-of-life care for her baby. We connect Sarah and her family to community resources that can help with their overall understanding and acceptance of the baby's medical condition and prognoses, such as those offered via the Hispanic Apostolic services, the YMCA, Catholic Charities, or other local faith-based organizations. On an ongoing basis, we work with Sarah to identify trusted messengers, which include both formal and informal supports who can support her and her infant's care as part of the ICT. For example, living with her father and brother, Sarah may lack and desire female role models in her life. Overall, the Case Manager will focus on establishing a trusting relationship with Sarah through compassion, where she feels protected and understood, and helping her with coping and acceptance.

Culturally Sensitive Provider Network. In addition to LHCC staff, which includes a diverse workforce of highly trained and bi-lingual staff, LHCC supports providers in their efforts to provide culturally responsive and linguistically appropriate care and covered services to enrollees. Network providers are advised on how to access language services in the provider operations manual and through routine provider updates and online newsletter articles. In 2020, LHCC completed training on the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care for 397 providers impacting 157,695 enrollees.

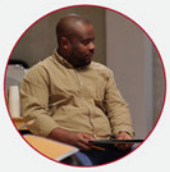
Alternate Scenario

If Sarah is Dis-Engaged. At age 17, suffering from trauma related to a sexual assault, immigrating to a new city, living in a home with only males, and giving birth to an infant with a year to live, Sarah may be overwhelmed and just shut down. If Sarah is non-responsive or ceases interactions with her Case Manager, we will continue to perform periodic check-ins with Alexandria's hospice provider and Sarah's OB/GYN. We may also outreach to her father to check in on Sarah and Alexandria's current state and see how we can help. We do not want to retraumatize Sarah by forcing ourselves on her, but practicing compassionate care and patience and follow where Sarah leads.

2.6.7 Case Scenarios [5-page limit per scenario]

2.6.7.4 Introduction to "Gerald"

For purposes of this response, we will refer to the 49-year-old enrollee described as Gerald. Despite having chronic, complex physical health (PH) and behavioral health (BH) conditions, including brain injury, neuropathy, and schizophrenia, as well as limited mobility, he requested a transition from a nursing home to the community to live independently. His current acute conditions and increased alcohol use, however, are undermining his ability to reside in the community stably. He recently had multiple Emergency Department (ED) visits and a stay in a withdrawal management residential facility was evicted from two apartment complexes, and may soon be evicted again. Without sober living and stable housing, Gerald is at risk for exacerbations of all his health conditions.



Gerald is a 49-year-old enrollee, with schizophrenia, neuropathy, foot pain, limited mobility, and alcohol abuse, who is at risk of being evicted because of inappropriate behavior when inebriated.

Member Identification/Engagement. LHCC identifies Gerald for Tier 3: High Risk Case Management. His LMHP Case Manager and RN Case Manager reach out to him to schedule an in-person assessment.

Assessment. The Case Managers conduct a comprehensive assessment to evaluate his physical and behavioral health and social resource needs and learn Gerald's goals. They discuss the findings at LHCC Integrated Care Rounds and Interdisciplinary Care Team meetings.

Plan of Care (POC). A person-centered POC is co-created to meet Gerald's goals, including pain reduction and stable housing. He also agrees to more intensive behavioral health services. Motivational Interviewing will be used over time to increase his readiness for addressing his alcohol problem.

LHCC supports our enrollees with complex health conditions who choose to live independently in community settings with effective supports and services. We are committed to engaging Gerald in the manner he decides with comprehensive case management and other services to address his PH, BH, functional and social needs so he can live contentedly on his own as he wishes.

Person-Centered and Integrated Approach. To help our enrollees become active agents in improving their own health, LHCC uses a person-centered approach that is strength-based, recovery-oriented, trauma-informed, and adheres closely to enrollees' goals. Their hopes, dreams, and preferences are at the center of any plan of care (POC) we co-create with them. When our enrollees feel that we hear, understand, and care about them and their objectives, they are more likely to engage with our Care Management (CM) staff, utilize our assistance optimally, and derive greater benefit from their PH and BH care and social services.



We view the health of all our enrollees holistically, regarding their PH, BH, functional, and social resource needs as interrelated and synergistic forces that must be comprehensively addressed. This is especially true for enrollees, such as Gerald, with significant co-occurring disorders; his comorbid and interacting Alcohol Use Disorder (AUD), physical pain, housing instability, schizophrenia, functional needs including several activities of daily living and, possibly, cognitive deficits make managing his overall care truly complex. We foster this integrated approach in the following ways:

- Our weekly ***LHCC Integrated Care Rounds***, led by our CM staff, brings together the varied perspectives of our internal ***LHCC Collaborative Care Team***, including our CM, Utilization Management (UM), Transition of Care (TOC), PH and BH Medical Directors, SDOH Community Connections team, and other disciplines such as pharmacy, to address the holistic needs of enrollees in case management.
- The insights of this internal LHCC team are augmented by the diverse views of an external ***Interdisciplinary Care Team (ICT)***, created with and for each enrollee receiving case management services. The ICT is comprised of the enrollee, any family member or friend that the enrollee would like to join the team, the PCP and other PH, BH, LTSS, and social service providers. The ICT meetings' interprofessional discussions are facilitated by the enrollee's assigned Case Manager who functions as the enrollee's single point of contact.
- We recognize the importance of timely sharing of enrollee information to support CM provided by multiple entities. LHCC offers enrollees, community partners, and providers access to our LHCC CM Platform for authorized users on the ICT to bi-directionally share information to support the care planning process. Users, including OASS Support Coordinators, can check our CM Platform, which includes role-based access security and promotes information sharing and collaboration across providers and partnering agencies. We maintain enrollee privacy and security and strive to eliminate redundancies and keep the focus on enrollee goals.

- PCPs play a key role in coordinating and integrating PH and BH care. Our Case Managers communicate regularly with PCPs and encourage all enrollees—especially those with complex health needs, such as Gerald—to engage with their PCPs and other specialists routinely. To promote PCP engagement, we also share daily admission, discharge, and transfer (ADT) data for appropriate follow-up and action.

Enrollee Identification and ICT Selection. As an enrollee with complex needs, Gerald would have been identified by LHCC for outreach and CM services through one of several avenues:

- Based on the results of his ***Health Needs Assessment (HNA)***, which given his current circumstances and diagnoses would trigger a comprehensive assessment and engagement in CM
- By the ***Department of Justice (DOJ)*** program that enabled him to transition back to community living when realizing the nursing facility in which he was residing was not his least restrictive setting
- By LHCC through state eligibility files and internal reporting, data, and analytics that identify him as an individual with special healthcare needs with co-morbid diagnoses of AUD, schizophrenia, brain injury, neuropathy, functional needs, and mobility limitations
- By Audacious Inquiry for ADT feed due to Gerald's ED utilization

Regardless of the referral source, all information on Gerald is documented in our integrated LHCC CM Platform, including his risk stratification score based on our ***Centelligence Stratification Tool*** and resulting case management tier. With his co-occurring and complex social conditions, Gerald's risk score qualifies him for Tier 3: High Risk Case Management. A licensed mental health professional (BH Case Manager) with experience assisting individuals with SMI, substance use, and brain injury, is selected as his primary Case Manager who functions as the single point of contact and is responsible for leading Gerald's ICT. Using our team-based approach, an LHCC Registered Nurse supports the Case Manager to ensure PH needs are being addressed. When Gerald's BH issues resolve, the two may switch roles and the RN may become the lead Case Manager for Gerald. With Gerald's unstable housing situation, an LHCC ***Permanent Supportive Housing (PSH) Specialist*** is also engaged. Gerald's Office of Aging and Adult Services (OAAS) Support Coordinator is included as a member of the ICT to better coordinate his overall services, including the delivery of home and community-based services (HCBS) to support community integration and his goals to live in his own home with supports and services.

2.6.7.4.1 Addressing Enrollee PH, BH, and Social Needs

Enrollee Engagement. Gerald's Case Manager reviews Gerald's personal health information on the LHCC CM Platform to learn his background and contact information. The Case Manager then calls him at his apartment to schedule an in-home visit. When Gerald does not answer the phone or respond to a voicemail, the Case Manager calls again and leaves a second message, as well as reaching out to Gerald's PCP's office/pharmacy to see if there is another phone number for him. When Gerald is finally reached, the Case Manager explains the call's purpose—to learn about his health needs and assist him with obtaining the PH, BH, and social services to meet his health goals and ensure coordination of his home and community-based services. The Case Manager also explains there will be many questions to answer and inquires if he would like a family member or other individual to attend, prefers a specific language, and needs any cultural or disability accommodations. We offer a home visit to conduct a comprehensive assessment with the Case Manager in his apartment or other preferred location, make any needed language accommodations, and arrange for any added participants from the ICT. Gerald's Case Manager calls him the day before the visit as a reminder and confirms the appointment.

Screening and Assessment Process. Before meeting with Gerald for the screening and assessment, his Case Manager reviews available records, including his previous PASRR documentation, medical and BH records from his nursing facility, and any electronic medical records from previous and current providers. The Case Manager reaches out to OAAS to obtain its assessments of Gerald's needs.

The Case Manager verifies if an initial HNA has been completed; if not, then the HNA is completed in combination with the comprehensive assessment. The assessment includes questions on:

- **BH conditions**, including Gerald's current and past symptoms of schizophrenia; alcohol and other substance use; history of suicidality; his beliefs about alcohol's impact on his schizophrenia, mood, and behavior; medications and other treatments; last and next psychiatry appointments. The Patient Health Questionnaire (PHQ-9) for depression, Columbia-Suicide Risk Severity Rating Scale, and the CAGE (Cut down; Annoyed; Guilty; Eye-Opener) Substance Abuse Screening Tool are included as part of the assessment, as indicated.
- **PH conditions**, including Gerald's current pain; neuropathy; reasons for frequent ED visits; history and reasons for falls; any brain injury-induced symptoms; medications and prescribers; amnestic periods; COVID-19 screening; other health issues; and perceived care gaps.

- The Case Manager reaches out to Gerald's PCP to determine how Gerald has been monitored for his neuropathy, mobility, any neurological complications secondary to his past brain injury, and BH issues. The Case Manager also explores whether a diagnostic evaluation of his pain and neuropathy has been completed, if Gerald is likely using his pain medications as prescribed, and if he is a candidate for Physical Therapy (PT) and Occupational Therapy (OT) evaluations to reduce his foot pain. The Case Manager also inquires whether the PCP has offered Gerald alternatives to going to the ED.
- To reconcile Gerald's medications and evaluate his medication adherence, the Case Manager consults with the LHCC Collaborative Care Team (e.g., RN Case Manager and pharmacist) to reviews his pharmacy records on the LHCC CM Platform to learn whether he fills his prescriptions for schizophrenia, pain, and other conditions as prescribed.

- **Social determinants of health**, including Gerald's current home environment; history and nature of his difficulties with landlords; the events and actions leading up to his arrest; and his need for additional community-based social service resources.

Gerald's Case Manager wraps up the comprehensive assessment by asking Gerald for his goals, explaining that his goals will be the focus of his POC. The Case Manager later confers with the rest of the ICT to review Gerald's comprehensive assessment findings and determine his level of need. Initially, Gerald's progress would be reviewed during weekly ICT meetings, and then less frequently over time as he stabilizes.

Plan of Care Development. After his assessments have been completed, the Case Manager meets with Gerald again to develop a person-centered POC based on Gerald's stated goals and preferences. We try to understand the root causes of Gerald's excessive drinking using Motivational Interviewing to assess his readiness for change. The Case Manager shares Gerald's wishes to remain in his own apartment and explains LHCC's role to help put services in place that can keep him independent, in addition to his HCBS waiver services. To develop the POC, the Case Manager works with Gerald and other members of the ICT to address the following needs.

Physical Health. Based on uncontrolled foot pain and resulting ED use, this is likely foremost in our proposed POC. After conferring with Gerald's PCP, the Case Manager coordinates referrals from the PCP to a neurologist for an evaluation of his neuropathy; a pain management specialist to better control his pain through medications and other interventions; skilled nursing to assist with pain management, medication monitoring, and safety issues; and PT and OT to evaluate and treat. [redacted] hrough LHCC's evidence-based, value-added benefits for chronic pain, Gerald can also access acupuncture, therapeutic massage, and a membership to a local, accessible gym. An OT, in collaboration with Gerald's OASS case manager to ensure non-duplication of services, can do an environmental scan of his apartment for potentially installing adaptive equipment (e.g., elevated toilet seat, shower grab bars) and eliminating tripping hazards (e.g., throw rugs) to reduce the likelihood he will have additional falls. Restricted mobility and foot pain may make it difficult for Gerald to follow up with his PCP in a timely manner. His Case Manager offers to refer him to the ***statewide home-based primary care practice*** run by Carpenter Health Network, which can collaborate with his PCP, if he prefers. The Case Manager also suggests enrolling him in LHCC's ***Medication Therapy Management Program***, in which a pharmacist will review his medications, help him avoid adverse events, and optimize his therapeutic outcomes. The Case Manager also helps him create a ***Crisis Prevention Plan*** to address triggers for crisis situations, such as mounting pain or psychotic symptoms, to help him remain safe and avoid ED visits. To help him handle emerging difficulties, LHCC can also provide him with a SafeLink smartphone, preprogrammed with phone numbers for him to contact his Case Manager and members of his ICT, the Nurse Advice Line, the BH Crisis Line, and 911.

Behavioral Health. Given his recent behavioral problems and potential eviction, the Case Manager in consultation with his ICT, recommends to Gerald that he receive more intensive BH services. During an ICT meeting, the treating PCP and LHCC BH Medical Director discuss ***Assertive Community Treatment (ACT) or Psychiatric Intensive Outpatient Program (IOP)*** for psychiatric evaluation and treatment and counseling to address his schizophrenia and alcohol misuse. The Case Manager explains that many individuals who have transitioned from a nursing facility to the community are socially isolated, negatively impacting their mental health. In response, the Case Manager offers to connect Gerald with ***peer support services*** and/or a Center for Independent Living in his area with the assistance of LHCC's Peer Support Liaison or through his regional Local Governing Entity (LGE). To bolster his circle of support, the Case Manager offers to help Gerald reach out to ***family and friends*** and become a member of the ***Brain Injury of Louisiana's*** virtual support group. The Case Manager also recommends he consider attending at least one meeting of a local Alcoholics Anonymous group.

Social Determinants of Health. Gerald is at risk of being evicted from his apartment. The Case Manager works in collaboration with one of LHCC's PSH Specialists to help him address his current housing issues and establish greater

housing stability; confers with his OAAS Support Coordinator about housing resources; connects him with tenancy support services to ensure he can manage important tasks, such as paying bills; and assists him with completing a ***Vulnerability Index-Service Prioritization Decision Assistance Tool*** (VI-SPAT) and enrolling in the ***HUD Homeless Management Information System*** to assess HUD **Permanent Supportive Housing** options if he is evicted again. We offer to connect him to one of our local ***LHCC Community Wellness Centers*** to learn about local social resources to assess and address any food insecurity, lack of transportation, or other social service needs. We also connect him with LDH's NEMT vendor for transportation to his medical appointments and instruct him to use other sources of social resource information, including the LHCC ***Community Connect Platform*** for closed-loop referral and a supplement to ***Louisiana 211***.

Gerald is given the opportunity to ask questions about the recommendations, which, upon his approval, form the basis of his POC. Once finalized, Gerald and his PCP receive a copy and are also informed how to access it via the LHCC CM Platform. The Case Manager will coordinate the PH, BH, and social services he will receive and communicate regularly with his OAAS Support Coordinator to ensure coordination of services across the continuum of care and ongoing support for his independence.

Gerald's POC reflects his self-identified goals, which his Case Manager helps to align with Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) goals. We work with Gerald to prioritize his needs, identify his goals, and reduce barriers to accessing services and supports.

Table 2.6.7.4.1 Gerald's Sample POC

Gerald's Self-Identified Goals	Gerald's SMART Goals	Identified Barriers	Interventions
"I don't want to go back to the Nursing Home"	Gerald to connect with ACT or IOP services within 2 weeks Within 2 weeks, explore options for PSH	Ongoing, untreated alcohol abuse and denial of the problem	• Case Manager will research ACT and IOP providers in Gerald's area to find an appropriate placement • Use Motivational Interviewing to assess Gerald's readiness for ongoing AUD services • Case Manager will collaborate with an LHCC PSH Specialist to assist Gerald with finding stable housing options • Case Manager will coordinate with Gerald's OASS Support Coordinator to ensure integration and coordination of his HCBS that address his activities of daily living and support his independence; Gerald's HCBS plan of care is integrated into his overall POC, including a backup plan in the event his personal care worker does not show up
"I want the bad pain in my foot to let up"	Gerald will have decreased foot pain within 2 weeks	Ongoing, untreated alcohol abuse and denial of the problem	• Case Manager to connect Gerald with a neurologist and pain management specialist • Case Manager to coordinate with PCP for home health (through LHC Group or Carpenter Health Network) nurse, PT, and OT to ensure effective pain management is achieved • Case Manager to help Gerald develop a Crisis Prevention Plan with alternatives to ED for immediate pain reduction while addressing root causes • Case Manager to facilitate referral to an orthopedist for Gerald to be evaluated for supportive footwear to decrease his foot pain • Case Manager to suggest social resources and AA

Monitoring and Follow-up. Gerald's Case Manager and/or other ICT members follow-up with Gerald twice a week for the first week, then weekly for the remainder of the first month, and bi-weekly thereafter. These follow-up visits occur via telephone or face-to-face, based on his preferences, but an additional in-home visit is scheduled after 30 days to assess his progress and re-evaluate the POC. After that, the re-evaluations are conducted at least quarterly or upon a change in Gerald's condition. Gerald is informed he can contact his Case Manager at any time between re-evaluations if needs arise.

Alternate Scenarios

LHCC will adjust Gerald's case management supports and interventions based on his responsiveness, preferences, progression towards goals, and other challenges. For example:

Gerald Becomes Less Engaged in Case Management Services. Not all enrollees with complex conditions agree to engage in case management services or remain engaged over time. If Gerald disengages from case management, the Case Manager would still have options to assist him with improving his health that include:

- Gerald's Case Manager will periodically reach out to him again by phone, letter, or meeting him during one of his home-based provider visits or at the ED to renew the offer to work with him. If his pain worsens or another emergency occurs, he may allow the Case Manager or peer support specialist to help him. Gerald's Case Manager must establish greater trust with him with trauma-informed practices, e.g., empathizing with his reluctance and fear.
- Gerald's Case Manager will coordinate his PH, BH, LTSS and social services, regularly conferring with the LHCC Collaborative Care Team and Gerald's providers, even if he declines to be directly involved in the case management. The Case Manager will get input and implement their suggestions for a POC.

Gerald is evicted from his current residence and is homeless. Gerald's Case Manager will immediately contact an LHCC PSH Specialist and other members of the LHCC SDOH Community Connections Team (e.g., Food Access Specialist, Transportation Specialist, Housing Specialist, Violence Prevention/Safety Specialist, and Job Readiness/Employment Specialist). The Community Connections Team will help find Gerald emergency housing, including through LHCC's Homeless Medical Respite Program, in which we provide homeless enrollees with respite and wraparound supports in hotels and assisted living facilities. Gerald's Case Manager will also contact his BH providers to inform them he is stressed and needs to be immediately re-evaluated and supported. Once Gerald is in emergency housing, an LHCC PSH Specialist will assist him with securing a new apartment or PSH. The Case Manager and Gerald's BH providers will help him better anticipate the consequences of his excessive drinking. With ICT support, this crisis may become a turning point for him.

2.6.7 Case Scenarios [5-page limit per scenario]

2.6.7.5 Introduction to "Dorothy"

For purposes of this response, we will refer to the enrollee described as Dorothy. At just 42 years old, Dorothy has faced many health challenges during her lifetime, including Cerebral Palsy (CP) with spastic quadriplegia and severe joint contractures, skin breakdown, hip dislocation with dysplasia, and undiagnosed dysphagia. Dorothy is fully dependent on others for her activities of daily living. Her speech is dysarthric, with poor breath support, and can sound unintelligible. Transportation has been an issue, as has been timely access to dental and specialty medical care and a fully operating wheelchair. With her adult companion care, specialized medical equipment, and day habilitation and transportation services provided through the New Opportunities Waiver (NOW), she has been able to live independently in her own apartment. Her orthopedist believes she now needs surgery and months of post-operative rehabilitation.



Dorothy is a 42-year-old woman with Cerebral Palsy with spastic quadriplegia who is experiencing skin breakdown because of lack of access and timeliness to services and an appropriate wheelchair.

Enrollee Identification Engagement. Dorothy is identified for Tier 3: High Risk Case Management through information on the eligibility and enrollment file and our Centelligence Stratification tool.

Assessment. Through Dorothy's comprehensive assessment, the RN Case Manager identifies her physical health and social resource needs, including a new wheelchair, home health services, and accessible transportation, to meet her stated health goals.

Plan of Care. The RN Case Manager works closely with Dorothy and her mother, other members of her Interdisciplinary Care Team, and LHCC's internal team of Medical Directors and other staff to co-create an integrated Plan of Care for case management and clinical services that is person-centered, strength-based, and equitable.

LHCC is committed to enabling our enrollees to live their fullest, healthiest lives by providing them the right clinical and Care Management (CM) services. For Dorothy, we want to match her self-determination with the supports of our Case Manager and supporting clinical and CM staff, the NOW Case Manager, PCP, and treating providers to develop a person-centered plan of care (POC) with Dorothy that supports her identified goals and preferences and addresses her whole person needs.

2.6.7.5.1 Addressing Dorothy's Complex Health Needs

Person-Centered, Strength-Based, Equitable, and Integrated Approach. Our ability to address Dorothy's needs starts with understanding what Dorothy wants, including priorities for her health, wellness, and quality of life. We honor and support the self-determination of all our enrollees to choose how they want to manage their own healthcare, the providers they see, and the treatments they utilize. Their goals function as the roadmap for the development of their POC. This is especially true for our enrollees, such as Dorothy, with chronic, physically limiting conditions who too often face health inequities when they aren't provided accessible environments and adaptive equipment to function at their highest potential level of capability. LHCC is committed to removing physical and logistical barriers and deliver timely services in the most integrated community setting possible.

Team-Based Support. Dorothy's care needs span multiple health and social service systems. Our model is designed to integrate care through the use of ***Interdisciplinary Care Teams (ICTs)*** supported by technology solutions that facilitate secure information-sharing and communication and coordination among providers, systems of care, and settings. Every enrollee in case management is assigned a Case Manager who acts as the ***single point of contact, convener, and facilitator*** on behalf of the enrollee. The Case Manager is supported by a team of LHCC supports providing consultation and input via the ICT. This ***LHCC Collaborative Care Team*** is comprised of multidisciplinary LHCC staff and clinicians to support each enrollee's whole person needs, including a Transportation Specialist and Medical Directors to help Dorothy and her Case Manager navigate the complexities of Dorothy's current situation. The members of Dorothy's ICT are appointed by Dorothy. At a minimum, we would like to engage Dorothy, her mother, PCP, neurologist, orthopedist, NOW Support Coordinator, and the day habilitation program director and staff.

From the eligibility file, we know Dorothy is a recipient of NOW services. Given her medical, functional, and social needs she is stratified into Tier 3: High Risk Case Management and assigned to a RN Case Manager with experience working with enrollees with functional challenges. The Case Manager engages, assesses, and creates a POC in collaboration with Dorothy and the rest of the ICT to address her complex needs based on her goals.

Enrollee Engagement. The Case Manager prepares to outreach to Dorothy by reviewing her health record in our LHCC CM Platform. The Case Manager calls Dorothy to schedule an in-home visit and conduct a screening and assessment. The call

may be answered by her NOW companion care provider given Dorothy's speech impairments. We can suggest using the speakerphone to enable Dorothy to speak directly with the Case Manager and allow the aide to repeat unclear answers. We ask about Dorothy's preferences for an in-home assessment and whether she would like anyone else to participate. We recommend her mother and schedule a day and time that won't interfere with Dorothy's day habilitation program or her mother's work hours. The Case Manager verifies with her that her mother is an authorized representative with whom ICT members can share Dorothy's Protected Health Information (PHI). If not, then the Case Manager asks Dorothy if she would like her to be and documents this in the CM Platform. Given the unacceptable delay in getting Dorothy a functional wheelchair, the Case Manager takes additional time to explain Dorothy's rights and how to file a grievance and contact her Case Manager if her needs are not being met. It is important Dorothy understands her Case Manager is a direct path to timely support and there is never a need to sit and wait for a needed service.

Screening and Assessment Process. Prior to the in-home visit, the Case Manager reviews available records from Dorothy's medical and support services, including chart notes from her neurologist, orthopedist, PT, and any other providers, and assessments and POC information from OCDD for NOW services. The Case Manager also reviews findings from Dorothy's previously completed Health Needs Assessment (HNA), if available.

At the onset of the in-home visit, the Case Manager asks Dorothy what her goals and preferences are, explaining the POC functions to help her achieve those aims. The Case Manager asks whether Dorothy would like her mother to provide information, interpret her speech, or play another role. The Case Manager completes the comprehensive assessment to identify Dorothy's holistic needs:

- **Physical health (PH) conditions**, including Dorothy's spasticity and joint contractures; any other symptoms of CP; medications and prescribers, including history of taking baclofen; history of and current swallowing difficulties; history of and current dental care/hygiene (if any); history of and current skin breakdown; hip and other sources of pain; wheelchair and other adaptive equipment needs; COVID-19 screening; having an Emergency Preparedness Plan; other health issues; and any care gaps
- **Behavioral health (BH) conditions**, including any history of mental health disorders or treatments; assessment of cognition; understanding of sleep patterns; history of and current substance use; and current mood, using the Patient Health Questionnaire (PHQ-9)
- **Social determinants of health (SDOH),** including Dorothy's current home environment; primary relationships and risk of social isolation; and access to food, transportation, and other basic needs

After conferring with the ICT, the Case Manager schedules another in-home visit to develop the POC. Prior to this meeting, the Case Manager would have reviewed the NOW treatment plan to ensure we don't duplicate services. With no current evidence of BH conditions, the POC would address the following needs, as prioritized by Dorothy:

Increased Mobility. Dorothy's current wheelchair, ill-fitting and in disrepair, is causing skin breakdown, putting her at risk for serious infections, and possibly contributing to the severity of her joint contractures. [redacted] The assessment includes current wheelchair positioning needs and potential re-positioning to prevent further skin breakdown. We prioritize and authorize the ***replacement of Dorothy's current wheelchair with one customized to her positioning needs*.** Additionally, interim repairs to Dorothy's current wheelchair or approval for a wheelchair rental would be arranged to immediately improve her comfort and mobility. The PT would also assess Dorothy's need for additional adaptive equipment, as well as to conduct an environmental assessment of her apartment for safety and accessibility, in coordination with her NOW provider.

Reducing Skin Breakdown. To heal Dorothy's current skin breakdown, the Case Manager confers with Dorothy's PCP for home health ***Wound, Ostomy, Continence Nurse*** orders to assess her wound and coordinate care accordingly per PCP's recommendations. If a wound care nurse isn't available, we can explore the availability of an outpatient wound care clinic, as well as accessible transportation to and from the clinic site. Through the wound care nurse or clinic, we would develop robust wound care and skincare regimens. PT can also assess for additional DME needs such as a hospital bed, hoyer lift, trapeze bar, and appropriate support surface, and provide training to the NOW provider, Dorothy, and Dorothy's mother on skincare, safe transferring, and bed mobility. After wounds have healed, we can talk about how to get Dorothy out of her chair 10 hours a day, suggesting options to help build up her strength reflective of her personal goals, such as aquatic therapy or braces.

Increasing Oral Health. Dorothy's poor oral hygiene could be a source of dental and other health issues. The Case Manager locates a dental provider near Dorothy, such as an FQHC, and arranges for wheelchair-access transportation. The Case

Manager also offers to provide instructions for her mother and companion care provider so they can help Dorothy with improving her oral hygiene and dental maintenance. If Dorothy's dental issues are exacerbating her complex health conditions, we will pay for a dental evaluation to help establish medical necessity and pay for medically necessary dental care services.

Reducing Swallowing Difficulties and Evaluating Breath Support. Dorothy's swallowing difficulties could lead to aspiration pneumonia. As part of the home health visit through [redacted]. The SLP could also provide speech therapy to improve Dorothy's intelligibility through addressing her poor breath support or recommend an ***assistive device***, such as a communication board.

LHCC Resources and Infrastructure: On.Demand Hypertension

LHCC's On.Demand Hypertension provides a HIPAA-secure cellular-enabled, home blood pressure monitor to enrollees to promote daily self-monitoring of blood pressure and real-time feedback to the enrollee's PCP. Each time an enrollee obtains a blood pressure reading, On.Demand automatically monitors the reading, transmits the data, and analyzes biometric patterns to provide an appropriate level of intervention.

Improving Primary Care. The Case Manager offers to assist Dorothy with scheduling and arranging accessible transportation to attend her PCP visits or arrange for a telehealth appointment to review her current health conditions and wellness care and help coordinate her neurology, orthopedics, and other medical services. [redacted]

Improving Specialty Care. Timely access has been an issue, due to transportation and lack of local providers willing to take Medicaid. See 2.6.7.5.2 below for improved access and timeliness for Dorothy's neurologist and orthopedic appointments, including follow-up therapies. For her hypertension, we can offer Dorothy our remote home monitoring program, ***On.Demand Hypertension***.

Ensuring Medication support. As part of her POC, we enroll Dorothy in LHCC's ***Medication Therapy Management Program***, in which a pharmacist reviews her medications to help her avoid adverse events and optimize her therapeutic outcomes, including monitoring and adjusting her baclofen levels with input from her PCP or neurologist.

Travel and Social Support. To enable Dorothy to travel safely to healthcare services that are not home-based, it is crucial that she have easy access to wheelchair-accessible transportation that can accommodate her physical needs. Because her mother's car isn't wheelchair-accessible, the Case Manager provides referrals to disability-related community resources--such as a local Center for Independent Living (CIL)—to identify grants for a ***wheelchair-accessible vehicle*** or have modifications made to her mother's current vehicle. As her mother works two jobs and can't always help, the Case Manager reminds Dorothy that transportation to healthcare visits is covered as a Medicaid benefit and offers to connect her with LDH's transportation vendor, which has wheelchair-accessible transport, for non-emergency medical visits.

Table 2.6.7.5.1 Dorothy's Sample POC

Dorothy's Self-Identified Goals	Dorothy's SMART Goals	Identified Barriers	Interventions
"I want a wheelchair that works and feels comfortable"	Dorothy will receive a PT evaluation for a new specialized wheelchair within the next 30 days	• Current wheelchair is in disrepair and no longer fits Dorothy • Availability of new wheelchair	• Case Manager to assist Dorothy/mother with obtaining PCP order for PT evaluation of wheelchair and other DME needs • PT to educate Dorothy on optimal wheelchair maintenance
"I would like to have better teeth and be able to smile more"	Dorothy will have a dental exam in the next 30 days	• Dorothy's ability to follow through with the appointment • Limited accessible dental offices in the area • Lack of PCA support for oral hygiene	• Assist Dorothy/mother with locating accessible dental services and scheduling • Assist Dorothy/mother with accessing/scheduling transportation with LDH's NEMT Vendor • Educate Dorothy, her mother, and adult companion care provider on oral hygiene

Dorothy's Self-Identified Goals	Dorothy's SMART Goals	Identified Barriers	Interventions
"I want it to be easier to swallow and breathe"	Dorothy will see a neurologist and SLP about her swallowing and breathing in the next 2 weeks	• Dorothy's ability to follow through with the appointment • Lack of available providers and transportation	• Assist Dorothy/mother with identifying and scheduling appointments with a closer neurologist, and home-based SLP • Assist Dorothy/mother with accessing/scheduling transportation with LDH's NEMT Vendor
"I want less pain and more mobility"	Dorothy will approve a plan for her contractures in the next 2 weeks, which may include surgery or continued PT and orthotics	• Long recovery time and ineffectiveness of current PT regimen	• Assist Dorothy in her decision and timing for surgery • LHCC Medical Director to reach out directly to the orthopedic provider to help identify other options • Assist in arranging for a second opinion as appropriate

Monitoring and Follow-up. After the meeting with Dorothy to discuss the POC, the Case Manager and/or other members of the ICT follow-up with her twice a week for the first week, then weekly for the remainder of the first month and bi-weekly after that via telephone or in-person, depending on Dorothy's preference. After 30 days, another in-home visit is scheduled to evaluate Dorothy's progress and re-evaluate the POC. From that point on, additional reconsiderations of the POC occur at least quarterly or upon any change in Dorothy's health status. Dorothy is informed she can always contact the Case Manager between re-evaluations if needs arise.

2.6.7.5.2 Improved Access and Timeliness of Services

Dorothy's health has been jeopardized by long-standing challenges with access to specialty medical services and timeliness of obtaining an adequate wheelchair. The Case Manager suggests prioritizing these challenges in her POC for safeguarding her wellbeing. The Case Manager outlines these strategies:

- Ask Dorothy if she is satisfied with her current neurologist, recognizing the current distance challenge. If not, the Case Manager will work with Dorothy and her PCP to locate a new neurologist available closer to home or via telehealth. LHCC has a relationship with several large health systems to access Louisiana-based specialists via telehealth visits. We will also research the LHCC network provider list and directly contact neurology practice managers with nearby office locations to determine if those practices are accepting new patients or if they could make an exception and identify any non-participating, qualified neurologists close to Dorothy's apartment who are accepting new patients who we can extend a contract to, or at a minimum arrange for a single case agreement. If Dorothy is pleased with her current provider, we would help arrange regular transportation as described above.
- Analyze Dorothy's healthcare appointment patterns and then contact her current providers to encourage utilization of telehealth to greatly decrease Dorothy's (and her mother's) travel burden.
- The Case Manager tracks and closes the loop in a timely fashion on all DME and other referrals. As noted above, the Case Manager will ensure prioritization of repairing Dorothy's current wheelchair or renting a more appropriate one in the near-term until a new wheelchair can be fitted and purchased.
- Assist Dorothy in her decision and timing for surgery, which will involve post-surgical inpatient rehabilitation followed by home health therapy. While we would expect the new wheelchair can help to support issues with posture and relieve some of the discomfort with her contractures, surgical intervention may be the best solution. We can have an LHCC Medical Director reach out directly to the orthopedic provider to help identify other options, such as orthotics that may provide some relief, and arrange for a second opinion if she is opposed to surgery [redacted] s a member of the ICT, the day habilitation Director or staff would be aware of the scheduled inpatient stay and facilitate space at the day habilitation program upon her return.

Dorothy agrees with this POC, including having a home-based PCP collaborate with her outpatient PCP; her mother also expresses satisfaction. The Case Manager will give them a copy of the finalized POC; it is also made available on LHCC's Enrollee and Provider Portals. The Case Manager will work closely with her PCP to coordinate Dorothy's physical health, support (e.g., PCA, day program), and SDOH services, and set up a regular cadence of communication and collaboration with her NOW Support Coordinator.

Alternate Scenarios

LHCC will provide effective case management if Dorothy faces other challenges. For example:

Dorothy's skin breakdown significantly worsens. Dorothy is hospitalized for antibiotic therapy and surgical debridement of the wound bed, requiring placement of positive pressure therapy and vacuum-assisted closure of her wound. The Case Manager will ensure this information is documented in the LHCC CM Platform to inform her PCP and other providers. We will also notify the NOW Support Coordinator to put a hold on adult companion care services and day habilitation services while Dorothy is hospitalized. To provide support and share information about potential changes to the POC, the Case Manager will visit Dorothy at the hospital and call her mother. The Case Manager will also work closely with LHCC's UM team to monitor Dorothy's progress and with LHCC's Transition of Care (TOC) team to plan for post-discharge services. These include discharge to a rehabilitation facility or home, continued wound care, IV or oral antibiotics, and, prior to her return home, delivery of a hospital bed with a level 3 support surface for pressure redistribution for optimal wound healing.

Dorothy chooses and has complications following surgery. While the surgical interventions are successful in reducing Dorothy's hip dysplasia and some of her joint contractures, Dorothy has such high levels of pain during her rehabilitation stay afterward that she is unable to fully participate in the therapy program. The Case Manager and LHCC TOC team will work closely with Dorothy, her PCP, her NOW Support Coordinator, and the rehabilitation team to plan for her transition home with increased PCA support and home health services through LHC Group, including PT and occupational therapy (OT). The Case Manager will facilitate a discussion between Dorothy and her mother and the orthopedist or Dorothy's PCP about pain management options. If Dorothy's pain continues to trouble her and prevent her recuperation and rehabilitation, then an LHCC Medical Director may confer with the orthopedist or PCP about seeking a consultation with a pain management specialist.

2.6.7.8 Introduction to "Camesha"



Camesha is a 13-year-old enrollee with eating disorder issues, who was admitted to an inpatient unit via a PEC. Following her discharge, Camesha's parents supported her to comply with treatment recommendations, but due to access barriers, she was not able to access recommended psychiatry and eating disorder treatment.

Addressing Camesha's Acute and Chronic Needs. LHCC will engage Camesha and her family in Tier 3: High Risk Case Management services, and Camesha is assigned to a BH Case Manager. We will support her to develop a Provisional Plan that will help her access the services she needs to stabilize, while also providing discharge planning and transitional support to help her connect with longer term, holistic resources in her community.

For this scenario, we will refer to the enrollee described as Camesha. As with many enrollees that we serve, both Camesha and her parents are initially unaware of the seriousness of her condition, but due to her presenting bradycardic and hypothermic in the pediatrician's office, the PCP submits a Physician Emergency Certificate (PEC). LHCC understands that procuring effective local eating disorder treatment for Louisiana Medicaid enrollees has been a challenge, and there are no current inpatient behavioral health (BH) state-based programs that are equipped to address both nutritional and mental health issues associated with anorexia nervosa for a teenage girl. As such, if we are not able to place Camesha at The Maples (a new PRTF in Baton Rouge), who will accept teenage girls with eating disorders into their treatment program, as an alternative option we will support Camesha to stabilize through immediate treatment that may be provided out of state or outpatient, as appropriate. We will also connect both her and her family to longer term services and supports that are accessible, promote continuity of care, and increase the family's overall health literacy.

Integrated and Person-Centered Approach. We identify Camesha as needing case management through our internal reporting processes as a result of her multiple hospitalizations and current care status, as well as her eating disorder diagnosis. Given her complex physical health (PH) and BH needs, Camesha is stratified into Tier 3: High Risk Case Management. She is assigned to a Licensed Mental Health Professional (LMHP) who will function as her lead Case Manager. Using a team-based approach, Camesha and her Case Manager have behind-the-scenes support from our internal ***LHCC Collaborative Care Team,*** comprised of LHCC resources representing Camesha's whole person needs. Camesha and her family are also part of an ***Interdisciplinary Care Team (ICT)*** that brings in external partners working collaboratively to provide input to the development of the person-centered plan of care (POC). Camesha's Case Manager leads the ICT which may include Camesha and Camesha's family, PCP, treating providers, Camesha's teacher and/or her school nurse/counselor to promote continuity in her education and support for her while she is in school; and other natural supports like a close family neighbor.

2.6.7.8.1 Addressing the Acute and Chronic Components of Camesha's Care

The Case Manager initially outreaches to Camesha and her parents by phone, and the next day visits the family in person, at the hospital or in her home (if she has been discharged). LHCC's Medical Directors also outreach to the treating physician(s) at the acute care and child and adolescent hospitals to consult on the case.

Immediate Health Needs and Concerns. Due to her acute PH and BH needs, as well as the access barriers she and her family are experiencing, Camesha's Case Manager schedules and facilitates an ICT meeting, consisting of Camesha and her parents, her pediatrician, and the hospital provider(s). At this meeting, which will take place at the hospital if Camesha is still there, the ICT discusses with Camesha and her parents the various treatment options based on available services and supports (including those both in and out of state), and together the ICT develops a provisional plan to help Camesha stabilize. If Camesha did not receive a child psychiatry consultation while she was at the hospital, the Case Manager will help arrange a consultation with a network provider, which could occur in person or virtually via telehealth The Case Manager also engages Camesha to complete a Health Needs Assessment (HNA) and the comprehensive assessment.

Screening and Assessment. LHCC's staff have been trained to use a strengths-based, age-appropriate approach, and using these guiding principles, the Case Manager takes time to discuss what is important to Camesha, learning both her strengths, activities she enjoys, and her needs, while also collecting information about what has worked in the past to help her remain healthy and what has not worked. Further, the Case Manager educates Camesha and her family about her conditions and treatment recommendations, making sure they fully understand and are engaged during the assessment and care planning process.

The Case Manager engages Camesha using the Columbia-Suicide Risk Severity Rating Scale, developing a suicide prevention plan with Camesha and her parents if any risk is identified. We screen for depression symptoms using the Patient Health Questionnaire (PHQ-9), and we assess overall behavioral functioning via the 17-item Pediatric Symptom Checklist. During

the comprehensive assessment, the Case Manager inquires about family meals, including details about Camesha's eating issues and how they impact the quality of her life and mood (and that of the parents), and how LHCC can assist in improving the overall wellbeing of the family. In addition, the Case Manager engages the family in a Caregiver Risk Assessment to gather information about their needs, strengths, and goals related to their role as caregivers for Camesha.

As part of our process, we assess the family's needs and issues related to SDOH, like housing, food, employment, and transportation. The family had previously expressed concerns about their ability to pay for their daughter's eating disorder treatments, which raises concerns about their financial stability. We explore these issues as part of the comprehensive assessment, with the Case Manager inquiring about financial difficulties. [redacted] In addition, as needed, the Case Manager arranges for Camesha and her family to receive a SafeLink smartphone, preprogrammed with phone numbers to contact the Case Manager, Nurse Advice Line, BH crisis line, and Teen Crisis Text line.

Following Camesha's comprehensive assessment, the ICT meets again to review the findings of the comprehensive assessment and align them with her prior evaluations provided by the child psychiatrist and nutritionist, as well as the recommendations of her treating inpatient/residential provider. Until Camesha has been successfully stabilized in the community for a few months, the Case Manager establishes regularly scheduled (as dictated by Camesha's acuity) meetings together to review and address Camesha's case and evolving issues.

Treatment Options. Based on ICT input, Camesha's Case Manager works with her parents to decide on the next steps. If hospitalization is recommended, the Case Manager collaborates with the UM team to place Camesha at The Maples PRTF in Baton Rouge. If we are not able to place Camesha at The Maples, we will leverage our strong relationships with a number of out of state treatment facilities that specialize in evidence-based treatment for adolescents with eating disorders, such as Veritas Collaborative in Georgia or Universal Health Services' (UHS) Center for Change in Utah. Under this scenario, the Case Manager would work with our Network and Contracting teams to cover Camesha's treatment through a single case agreement, and we would provide the family with transportation, housing (if Camesha's placement spans a long time period), and/or virtual supports. For example, we could supply an iPad to facilitate virtual visits with Camesha and her facility treatment team and provide transportation for her parents to return to the facility at discharge to participate in the discharge process and have access to education on what to expect when Camesha returns home.

[redacted]

An outpatient approach to treatment may be appropriate in this case with a connection to a non-profit organization called the "Family Tree" in Lafayette that can provide assistance related to eating disorders and is also connected to the University of Lafayette professors that bring unparalleled expertise supporting teenagers with eating disorders. If Camesha and her family are unable to travel to the Lafayette area, LHCC will support the family to connect to this program via the available NEMT benefit or telehealth, providing necessary assistance with broadband access (through the emergency broadband benefit) to support their connections if needed.

For either of these options, LHCC will pay for all services so the family will not be faced with those expenses. We also partner closely with Camesha's pediatrician to ensure they have input into the development of the provisional treatment plan and agree with the recommended approach. During every step of the way, the Case Manager educates Camesha and her parents about the reason certain treatments are being recommended, as well as address their concerns that may cause barriers to accessing necessary services. This includes educating them about how care is covered so that they do not have to be concerned about the affordability of getting Camesha the treatment that she needs.

Camesha's Plan of Care (POC). Using this information, the Case Manager helps Camesha and her family develop a person-centered POC based on Camesha's self-identified goals ***(Table 2.6.7.8.1)***. For example:

Table 2.6.7.8.1 Camesha's Sample POC

Camesha and her Family's Self-Identified Goals	Camesha's SMART Goals	Barriers	CM Interventions
"I don't want my eating disorder to control my life anymore"	Camesha will connect with appropriate treatment providers to initiate treatment for her eating disorder within one week	• No providers located near Camesha and her family • Camesha's apprehension to treatment, including stigma and shame related to her eating disorder	• Provides Camesha and her parents with information on available treatment options for eating disorders and connects Camesha and her family to an appropriate provider(s) • Supports Camesha's PCP by offering access to support services such as eConsults or resources on delivering family-based treatment in a primary care setting • Helps Camesha connect to a local peer support group for teens living with eating disorders • Assists with keeping Camesha connected with her medical home and carrying out discharge orders and outpatient treatment plan • Assists Camesha and her parents to locate group therapies that specialize in eating disorders • For all services, the Case Manager assists the family with using LHCC's transportation vendor to access all appointments
"I want to go to college"	Once Camesha is medically and psychologically stabilized, Camesha will begin working towards college readiness	• Camesha's severe eating disorder, which could cause disruption in her school work	• Supports Camesha to remain connected to her school of origin during her inpatient treatment, engaging her teacher (with Camesha and her parent's consent) in the ICT • Connects Camesha virtually with the ***Young Women Choosing Action program***, a LHCC partnership with YWCA of Northwest Louisiana to address long-term wellness outcomes for teen girls ages 13-19. The program is a culturally and gender-responsive trauma-informed education and leadership program.
From Camesha's Parents: "We want Camesha to improve her health overall"	Camesha will attend appointments with PCP and nutritionist within 2 weeks of being discharged from the inpatient setting	• Camesha's apprehension to treatment	• Keeps Camesha and her family connected to her nutritionist from her inpatient treatment team via phone or telehealth visits • Assists with scheduling an appointment with PCP to monitor Camesha's overall health and ensure she receives the recommended EPSDT services for her age and developmental level • Uses Motivational Interviewing techniques and provides Camesha's parents with education to empower them as Camesha's primary caregivers • Connects Camesha and her family to a MHR provider who can provide them with family therapy, and helps to integrate services and supports via ICT meetings and the LHCC CM Platform
From Camesha's parents: "We want to learn how to better support Camesha to overcome her eating disorder."	Camesha's parents will feel empowered as caregivers and support her treatment adherence	• Parent's lack of understanding of the seriousness of Camesha's condition	• Provides Camesha's parents with education about her care, following up with them after each of her appointments to ensure they understand the assessment results and treatment recommendations • Connects Camesha's parents to a community support group for caregivers of children with eating disorders

With the family's consent, the Case Manager reaches out to friends of the family to help bolster Camesha's circle of support. This includes engaging her teacher and the school nurse (with Camesha and her parent's consent), who can serve

as part of her ICT and support her in an ongoing way after she returns to school. In addition, ***LHCC's Community Engagement*** staff will partner with schools across the state to host regular in-service trainings about health-related topics, including but not limited to identifying eating disorders among youth and providing referrals to appropriate care. Through this initiative, Camesha's teachers and other school personnel will be equipped with the tools they need to identify and respond when Camesha needs support.

Post Treatment Discharge Planning Support. With the information provided in the scenario, we anticipate the best option for Camesha would be admission to The Maples as they specialize in eating disorder treatments that will address her needs. The Maples focuses on providing individualized care that supports family involvement and integrates educational support, with the goal of equipping each person and family with the take-home skills they need to continue recovery and thrive in the home environment.

Upon her admission, we engage her and her family in our ***Transitional Case Management Program***, through which LHCC's TOC Team supports the ICT to ensure Camesha can successfully discharge back to her community once she is sufficiently stabilized. During her time at The Maples, Camesha's Case Manager and the TOC Team work with her family to make sure they and Camesha's other providers (e.g., her PCP, psychiatrist, school nurse) remain connected and are able to participate in her treatment in a way that works for their situation. Additionally, LHCC's Medical Directors regularly consult with the treating provider, coordinating with LHCC's Collaborative Care Team and ICT on an ongoing basis.

Prior to Camesha's discharge home, the TOC Team works with Camesha's Case Manager to schedule and facilitate several ICT meetings that take place at the facility or virtually to discuss Camesha's ongoing needs with her and her parents, as well as the providers and other supports involved in her care. During the meeting, we discuss with Camesha options for community services and supports that can meet her needs once she is discharged. The TOC Team and Case Manager support the family to develop a ***Transitional POC*** in coordination with the treating provider and Camesha's entire ICT. The Transitional POC includes Camesha's post-discharge care appointments and linkages to other services as appropriate, medication reconciliation, education and self-management strategies, and addresses Prior Authorization needs. The goal of the Transitional POC is to keep Camesha safe and well as she transitions back to her home community. We document the Transitional POC in the LHCC CM Platform that is accessible to Camesha and her family; the ICT and other providers involved in Camesha's care. We also provide a written copy of the plan to Camesha and her parents prior to her discharge.

Re-Assessment. Based on her unstable condition, within 48 hours of Camesha's discharge, her Case Manager visits her in person at her family's home. The purpose of the visit is to make sure Camesha has access to all of the services and supports she needs to remain stable in the community. The Case Manager also engages Camesha and her family to complete a new comprehensive assessment, leveraging the screening and assessment information collected previously, as well as her Provisional and Transitional POC.

Crisis Intervention Planning. To support her chronic needs, the Case Manager helps Camesha and her family to develop a Crisis Plan, which addresses potential triggers; the frequency of interventions identified to prevent crises (outpatient appointments, etc.); an action plan to mitigate a crisis situation should one occur, including resources to contact in the event of a crisis (e.g., community crisis resources, BH Crisis Line); and contact information for the ICT.

Monitoring and Follow-up. In accordance with her POC, the Case Manager follows up with Camesha and her family twice a week for the first week, weekly for the remainder of the first month, and bi-monthly thereafter. Follow-ups will occur based on Camesha and her family's preferences, including a combination of telephonic and face to face visits, but an additional in-home visit will be scheduled after 30 days. The Case Manager also collaborates with Camesha's ICT to discuss her progress and consults with the LHCC Medical Directors in the event the team runs into any barriers.

Alternate Scenario

Camesha's Eating Disorder Greatly Worsens. If Camesha's eating disorder continues to become more acute, she may require longer term treatment. In this case, we will support Camesha and her family to remain connected during the treatment process, including potentially paying for transportation and a hotel for her parents to visit her for family therapy sessions. LHCC's TOC team will work with Camesha, her family, and the Case Manager, as well as the treating facility, to develop a transition plan that will wraparound the services and supports she needs in order to remain stable following her discharge. On occasion, this may mean continuing to support her treatment out of state on an outpatient basis for a period of time, in order to help her continue specialty treatment if Louisiana providers do not offer the care that she needs, and/or supporting her to continue to attend appointments with the out of state provider via telehealth. LHCC will enter into an SCA with the out of state provider to ensure that Camesha can access the care that she needs at no cost to the family.



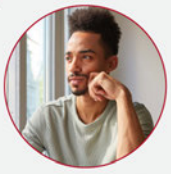
LHCC Enrollee Story

LHCC has direct experience serving enrollees like Camesha with eating disorders. One recent enrollee had been hospitalized for her eating disorder several times earlier this year. After her last inpatient treatment for anorexia she began to have weekly therapy appointments as well as her regular medical appointments. Her weights are obtained at both medical and therapy appointments, ensuring a higher level of monitoring. The therapist, physician, and her dietitian conference about her progress and struggles regularly. As a result, all team members are aware of how the patient is doing, what she needs to continue to work on, and what the plan is going forward. The enrollee is currently managing the eating disorder and self-harm behaviors well, is stable, and is able to be at home.

2.6.7 Case Scenarios [5-page limit per scenario]

2.6.7.9 Introduction to "James"

For the scenario presented by LDH, we will refer to the enrollee as James. James, like many enrollees served by LHCC, has multiple complex and chronic conditions that require ongoing care, enhanced support, and close coordination. At this time, James does not have an established relationship with his assigned PCP, has high ED use, is unstably housed, and lacks a reliable phone. James feels he has been treated unfairly, subjected to discrimination, and received poor and neglectful care. Our first goal with James will be to meet his basic needs and establish rapport and trust.



James is a 25-year-old African American enrollee with Sickle Cell Disease (SCD), frequent ED utilization, and SDOH needs. James stated he has faced discrimination and received poor and neglectful care.

Engagement. James is identified as having Special Healthcare Needs and is assigned to a RN Case Manager who will partner with an Interdisciplinary Care Team to engage James in Tier 3: High Risk Case Management.

Addressing James' Needs. Following a comprehensive assessment, we will partner with James to develop an individualized Plan of Care that reflects his self-identified goals, connects him to resources, and ensures access to the right care, at the right time, at the right location.

Promoting Health Equity. We help James build trust in the healthcare system by providing culturally-appropriate care, connecting him to equitable care and services, and addressing his feelings of racial discrimination and medical neglect.

2.6.7.9.1 Addressing James' Whole Person Needs

Integrated and Person-Centered Approach. The compounding circumstances of James' case will require a nimble, high-touch, and patient approach, delivered by someone at LHCC who shares his cultural background to act as a trusted messenger. Our team-based model leverages regionally-based medical, behavioral, and social support Care Management (CM) and clinical LHCC staff, serving holistic needs through an ***LHCC Collaborative Care Team***, delivered through a single point of contact (Case Manager). The Case Manager also consults with an ***Interdisciplinary Care Team (ICT)*** comprised of external partners and supports involved in James' care. With significant trust issues, it may take time for James to establish a regular source of primary care and invite others into his circle. We will help foster those relationships and engage the clinical support needed to meet his health, wellness, and health equity goals, reflected in a person-centered Plan of Care (POC). While James has a distrust of the health system, he may have other support systems, such as family or church, which we work with James to identify and engage. We want James to feel supported by connecting him with peers and providers he can relate to and feel comfortable and confident in the care and services he receives.

We stratify James into Tier 3: High Risk Case Management based on his SCD diagnosis and frequent ED use and assign an RN Case Manager. An African American Case Manager with experience serving enrollees with SCD is selected. With ten ED visits in the past six months, we prioritize James for in-person outreach.

Screening and Assessment. With no phone, housing instability, and distrust of the health system, we are most likely to first connect with James in the ED. However, we do not wait for James to present in the ED. We will go to local shelters and James' last known address to engage him in person, prepared with words of encouragement to reassure James the Case Manager is there to support his needs. If James presents in the ED, the Case Manager receives an ADT alert indicating James is in the ED, and we deploy our Rapid ED Intervention (REDI) team to facilitate any needs he has and offer support. We recognize this may be our only opportunity to engage with James. While our goal is to complete a Health Needs Assessment (HNA) and comprehensive assessment during our initial visit, with his mistrust and experiences with discrimination, we go into the situation not expecting anything from James but a chance to earn his trust and establish rapport. We use a trauma-informed approach and look to James for cues as to what level of screening and assessment is appropriate for this first meeting. An assessment may span several in-person meetings, but if we do not take the right approach the first time, we may not get another meeting.

Meeting Immediate Needs and Building Trust. If we meet with James in the ED, he may be experiencing intense pain related to his current vaso-occlusive crisis. We approach James free of judgment or bias and try to establish a rapport by appealing to his immediate needs. If this is pain, we talk to him about what we can offer enrollees for pain, including value-added benefits such as massage. If he is having trouble filling his prescribed pain medications, we offer assistance with getting prescriptions filled. Based on the scenario, James has basic needs that also need to be met. When we meet enrollees at local shelters, on the street, or in the ED, we are prepared to address such needs. We can offer a care package that includes an LHCC ConnectionsPlus phone. We also offer to walk with James to the cafeteria or across the street and

buy him a meal as we talk about how we can help. Based on a diagnosis of SCD and housing instability, upon discharge from the ED, James is eligible for Medical Respite. With this value-added benefit, we can offer James a safe place to sleep.

Based on the poor treatment James has experienced, he may want someone to simply listen to his grievances. We can actively listen and assist James in filing formal grievances. As an internal follow-up, we will track and trend discrimination and quality grievances against the providers he identifies for further action. We take these types of grievances very seriously and will thoroughly investigate and respond accordingly. This may include additional provider training or other corrective action, including for cause termination.

Over time, the Case Manager assesses James' PH and BH history, social determinants of health (SDOH), Adverse Childhood Experiences (ACEs), cultural and linguistic needs, and screens for hearing and vision needs, COVID-19, depression, and substance use. We leverage available medical history to fill in gaps and start to populate the screening and assessment so James is not forced to restate and revisit his whole history. While James has had multiple strokes, if our assessment shows any functional deficits, we work with the PCP for a PT/OT evaluation, which can be provided through home health or an outpatient clinic. James' Case Manager evaluates James' unmet housing needs by assessing his current living situation; explores James' educational background and if he would like to pursue educational or job training opportunities; and identifies other unmet needs such as food and clothes, having already connected James with a new smartphone.

Improving Outcomes for Enrollees with SCD

Since 2012, LHCC's SCD program has resulted in:

- *33% increase in SCD assessments,*
- *31% increase in hydroxyurea utilization,*
- *18% reduction in SCD-related ED utilization per member per month (PMPM) and 13% reduction in SCD crisis-related ED utilization PMPM,*
- *51% reduction in SCD-related inpatient utilization PMPM and 45% reduction in SCD crisis-related inpatient utilization PMPM.*

We also observed a 34.9% decrease in ED visits, a 30.6% decrease in inpatient admissions, and a 19.1% decrease in Urgent Care visits among enrollees in CM that receive services through Our Lady of the Lake Hematology Clinic.

Access to Services at the Right Care, Right Time, and Right Location.

Basic Needs. James does not have a reliable mobile phone and is unstably housed. By providing James with an LHCC ConnectionsPlus phone, he can now connect regularly with his Case Manager and other supports. Similar to a SafeLink phone, which can take up to two weeks to obtain, James will have free immediate access to 4.5 GB of data, 350 minutes, unlimited text messages, unlimited calls to LHCC Member Services, and 24/7 access to 911. Our Case Manager leverages LHCC's Community Connections Platform and works closely with a regional LHCC Community Health Worker (CHW) and SDOH Housing Specialist for housing options tailored to James' needs and location [redacted]

Establishing PCP and Specialist Care. Knowing that establishing care with a PCP is a critical step in improving James' health outcomes, James' Case Manager focuses on connecting him to a PCP that he feels comfortable with and aligns with his cultural preferences. For instance, if James expresses that he prefers an African American provider, his Case Manager would work to match him. The Case Manager can help James interview potential providers and can schedule and attend appointments with him at his request. The Case Manager also locates local hematologists to connect James to appropriate treatment and symptom management of his SCD. ***LHCC contracts with 42 unique groups and 184 individual practitioners for hematology***. For example, LHCC partners with ***Our Lady of the Lake Hematology Clinic***. Through partnerships such as these, James has access to the latest SCD treatment and care which enable him to maintain as normal a life, free from crises, as possible. To ensure James feels his needs are being heard, understood, and addressed, James' Case Manager again offers to attend appointments with him.

Education. The Case Manager supports James to understand his SCD diagnosis and other conditions by reviewing the disease process and how to prevent complications and crises. We teach him to verbalize his needs to providers and help build a "plan" for provider visits, listing out key issues and questions to be addressed. The goal is to support James to be a voice for his health improvement. We educate James on how and when to seek care from his PCP, specialist providers, or Urgent Care Center instead of the ED. James has direct phone access to his Case Manager and LHCC's 24/7 Nurse Advice

Line, which is integrated with our CM Platform, enabling referrals and actions to be communicated with James' Case Manager for timely follow-up.

Medication Adherence. The ICT discusses the use of hydroxyurea to reduce the frequency of pain crises. An LHCC pharmacist reviews James' pharmacy utilization and claims data and the team develops a plan to monitor and support ongoing medication adherence which is communicated to James by the Case Manager.

Pain Management. In addition to medication adherence and connecting James to a Hematologist to manage his SCD pain crisis episodes, the Case Manager will explain the availability of evidence-based therapies for chronic pain management, including massage, acupuncture, and chiropractic care through our value-added benefit. James may also be interested in memberships to the YMCA or a similar exercise facility. The ICT meets to determine if James is a candidate for advanced treatment options shown to reduce pain crises, such as exchange transfusions or other biologic infusions.

Peer Support. LHCC has a memorandum of understanding with the ***Sickle Cell Association of South Louisiana (SCASL)*** to coordinate services between our Case Managers and their CHWs. SCASL offers monthly support groups, providing James the opportunity to connect with other African American individuals living with SCD. ***Based on James' experience with SCD and discrimination due to his diagnosis, race, and chronic pain, he may be interested in one day becoming a peer support specialist himself. LHCC looks for success stories within our membership to recruit for peer positions and Neighborhood advocates, who serve as trusted messengers and change activators in underserved areas.***

Sickle Cell Action Plan. As a best practice to help manage SCD and reduce ED use, the ICT develops an action plan that outlines the course of action for mild, moderate, and severe pain. The action plan is housed in the CM Platform, made available to all members of the ICT, and is updated at each clinic visit. James' Case Manager informs James the action plan below will promote quality care through timely pain and symptom management.

- **Mild**: James is doing well overall and should continue his current preventative daily medications included in his POC, in addition to any alternative therapies he may have elected, such as massage or acupuncture. Encourage James to drink plenty of fluids and get lots of rest.
- **Moderate**: James has moderate pain. Use the pain scale included in the action plan, notify James' PCP or hematologist, and discuss if James has oral pain medications he can take with clear instructions. Understand what other methods James has used to successfully reduce pain in the past and incorporate into the POC.
- **Severe**: James' pain is worsening despite having completed prior instructions, received oral pain medications, and increased fluids. Identify the appropriate facility or ED James should go to if he requires urgent attention. James to contact his LHCC Case Manager to facilitate appropriate care and treatment by ensuring clear communication between facility providers and James' PCP and/or hematologist.

James' Individual Plan of Care. Aligned with direct input and self-determined goals from James, the Case Manager and ICT develop James' POC ***(Table 2.6.7.9.1)***, including evidence-based interventions for SCD management. Our POCs reflect enrollee self-identified goals, which Case Managers help to align with goals that are Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART).

Table 2.6.7.9.1 James' Sample POC

James' Self-Identified Goals	James' SMART Goals	Identified Barriers	CM Interventions
"I don't want to be in pain"	• James will be connected to a hematologist to manage his SCD pain crisis episodes and reduce his ED utilization within two months • James and his PCP to review a list of orthopedists for evaluation of his avascular necrosis of the hip and chronic pain within three months • James will assess available therapies such as massage, acupuncture, or chiropractic care	• Potential engagement concerns and treatment plan adherence due to James' experiences with discrimination and the healthcare system	• James' Case Manager will attend the initial appointment with James' providers to ensure they understand his needs and address his distrust with the healthcare system • Educate James on appropriate ED use and provide him a smarphone (Safelink or Connections Plus) with direct access to his Case Manager, Nurse Advice Line, and his providers • Collaborate with an orthopedic specialist and facilitate Durable Medical Equipment referrals if needed • Monitor to ensure James is following recommended treatment regimens • Educate James on NEMT transportation benefits and LHCC value-added benefits

James' Self-Identified Goals	James' SMART Goals	Identified Barriers	CM Interventions
"I want to feel understood and supported"	• James will connect with local Peer Support groups for individuals with SCD within three months	• Pain level from chronic conditions may impact James' ability to engage in peer groups • History of mistrust and experience with discrimination	• Locate local SCD peer support groups and assist James with transportation • Assist James in filing grievances regarding past care and services • Escalate James' concerns and do what we say we will do to help build trust
"I want a stable place to live and have access to the things I need "	• James will connect with housing resources within two months for permanent housing options	• Availability of safe, affordable housing • History of mistrust and experience with discrimination	• Provide James with Medical Respite based on immediate housing needs to stabilize his SCD • Connect James to alternative housing resources • Facilitate application for Supplemental Security Income (SSI) benefits if needed
"I want to receive quality care"	• James will become engaged with his PCP and hematologist and schedule appointment within two months • As indicated, PT/OT evaluation within three months	• James stated he has not received appropriate care because of his race which may affect engagement with providers and treatment	• Match James to a PCP and hematologist and facilitate referral if needed • Attend appointments with James as an advocate • Help James become his own advocate

Once the POC is completed and approved by James, his PCP, and his hematologist, James receives a copy and the Case Manager makes the POC available for members of the ICT through the LHCC CM Platform.

Provider Support. We offer James' providers tools and resources that support James' access to care, remove barriers to his adherence, and support the practice of evidence-based medicine. For example, we will connect James' newly identified PCP with the ***Tulane Sickle Cell Center of Southern Louisiana***. The Center offers 24-hour phone consults for physicians throughout Louisiana. The Center stays abreast of the latest treatments and research in SCD, often participating in national studies, and can provide the most scientifically advanced treatments for sickle cell patients. Our secure web-based Provider Portal, available through our LHCC CM Platform, offers self-service capabilities and clinical applications that include online care gap notifications and health alerts if James misses a scheduled appointment. The system also includes an enrollee health record with James' POC, patient analytics, and care and disease management referral options.

Monitoring and Follow-Up. Once James' POC is established, James' Case Manager follows up with James twice weekly for the first week, then weekly for the remainder of the first month, and then at least monthly or more as determined within James' POC and based on his wishes. Follow-up is conducted in person in James' preferred setting. The Case Manager continues to collaborate with the ICT to assess James' status and make monthly updates on his POC based on pain levels and needs. James' Case Manager completes a quarterly formal in-person re-assessment of James and ensures he has direct contact information for all of his providers and supports should he have any questions or concerns.

2.6.7.9.2 Systems and Policies to Foster Health Equity



LHCC promotes cultural humility at all levels of our organization to ensure the delivery of services in a culturally appropriate and effective manner. We have systems in place to address health equity through enrollee, provider, and community-level interventions. When working with James and considering his experiences, we practice through a health equity lens by being sensitive to his cultural preferences and exhibiting cultural humility in all interactions. Beyond racial bias, James has felt prejudice for his SCD diagnosis and chronic pain. Others like James have felt judgment going to the ED for pain, their pleas for chronic pain relief being interpreted for drug-seeking behavior. According to a study[1] highlighting the disparities in funding between SCD and cystic fibrosis (CF), driven in large part by structural violence, National Institutes of Health funding per person afflicted with CF was over 10 times greater than SCD over the study period. We understand the role we play in promoting health equity for enrollees like James and do so through the following systems and policies.

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6346732/#R56

Cultural Competence and Linguistic Assistance Services (CCLAS) Program. Going beyond traditional CLAS standards, our CCLAS Program aims to reduce healthcare disparities and provide high-quality healthcare to diverse enrollees like James through our diverse workforce and staff and provider training.

Diverse Workforce. Our hiring practices ensure we have a diverse workforce representative of the enrollees we serve and we assign CM staff based on enrollee preferences. We partner with local organizations and our Employee Inclusion Groups to attract, develop, and retain diverse talent at all levels of our organization. Our workforce is ***54% Black, 41% White, 5% Other, and almost 70% of our staff have personal experience with Medicaid in Louisiana.***

Staff and Provider Training. We provide staff and provider training on topics such as ***Cultural Sensitivity*** which addresses the impacts of cultural differences in healthcare; ***Unconscious Bias,*** recognizing individual biases and how to challenge biases in the workplace; and ***Unnatural Causes***, providing a discussion on the impact of how race and social class impact our health. Enrollee-facing staff is also trained on ***Person-Centered Thinking***, ***Motivational Interviewing***, and ***Trauma-Informed Care (TIC)***. We remind providers about their responsibility to take annual cultural sensitivity training via Provider Orientation, newsletters, and an annual provider update.

Health Equity and Diversity Committee. Reporting up through our Quality Assessment and Performance Improvement Committee, our cross-functional Health Equity and Diversity Committee, co-chaired by our ***VP of Health Equity*** and VP of Population Health, promotes accountability for health equity across the organization. The Committee reviews policies; utilization data segmented by race/ethnicity, geography, and other sub-populations; enrollee grievance trends and satisfaction survey results; and solicits feedback directly from communities on what works and does not work. Also reporting into our Committee are our Neighborhood Councils who are community-led partners specifically assembled to identify and address health disparities at a neighborhood level.

Established Policies. As part of our CLAS Standards and policy, we conduct initial and ongoing organizational self-assessments of CLAS-related activities and integrate cultural and linguistic competence-related measures into internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. Our ***Business Ethics and Conduct Policy (BECP)*** ensures care is provided in a non-discriminatory manner and applies to all LHCC staff, contractors, and provider organizations. We require these individuals to complete an annual attestation confirming their commitment to the BECP or comparable Code of Conduct. Individuals are subject to immediate corrective action, including termination, if they demonstrate discriminatory behaviors. The ***Network Selection and Retention Policy*** includes specific guidelines and processes to ensure our provider network is sufficient to meet the diverse needs of Louisiana Medicaid enrollees.

Alternate Scenarios

James Becomes Less Engaged with Case Management. James' Case Manager would use Motivational Interviewing skills to explore his disengagement and self-reported barriers. LHCC recognizes James' right to refuse Case Management and would continue to seek opportunities to re-engage with James during events such as ED visits, repeat hospitalization, provider referral, or possible enrollment into another CM program. We would also continue to coordinate care with James' providers and ensure his discrimination concerns are escalated to our internal grievance team. James' Case Manager would engage trusted messengers involved in James' care, such as identified family members, friends, and religious or spiritual supports to assist with ongoing outreach and engagement of James, reinforce the benefits of Case Management, and assist with identifying and addressing barriers to care and services.

2.6.7.10 Introduction to "Anna"

For this scenario presented by LDH, we will refer to the enrollee as Anna. Anna is pregnant and has co-occurring behavioral health (BH) and substance use disorders (SUD), complicated by ongoing Social Determinant of Health (SDOH) needs. Enrollees not connected to a reliable source of care with complex health and social conditions similar to Anna often have high emergency department (ED) use. Using our multi-disciplinary, recovery-oriented approach, LHCC will meet Anna where she is to support her health and wellbeing and connect her to care and treatment, to optimize positive outcomes for her and her baby.



Anna is a 25-year-old enrollee who is pregnant and has co-occurring SUD and BH disorders. Anna has used the ED multiple times for drug intoxication or withdrawal and has SDOH needs.

Early Identification. LHCC identifies Anna as having Special Healthcare Needs and stratifies her into Tier 3: High Risk Case Management. Anna is assigned to a RN Case Manager with experience supporting enrollees with high risk pregnancies and BH/SUD needs.

Addressing Anna's Needs. Using our multi-disciplinary, recovery-oriented approach, we address Anna's prenatal/postpartum, BH, SUD, and whole health needs.

Linking Anna's Newborn to a Pediatrician. We help Anna and her identified supports understand the importance of infant and well child visits and connect her with a pediatrician. We partner with Anna, her support system, and her pediatrician to ensure her newborn develops appropriately.

2.6.7.10.1 Early Identification

Early identification is a cornerstone of our Care Management (CM) program. We identify Anna through a combination of people, processes, and technology.

People. ***Finding an enrollee like Anna is not likely to happen from a desk***. While we may *identify* her through predictive analytics and other technologies described below, to *engage*, we must find her. The best way to do this is to be out in the community. Our field-based teams, including Community Health Workers (CHWs), visit homeless shelters, food banks, and local gathering spots. We knock on doors, buy lunch, and build trust and rapport. In addition to our staff, any individual or entity can refer Anna for LHCC CM services, including but not limited to, providers, hospitals, EDs, State agencies, community-based organizations (CBOs), enrollee family members, or Anna herself. We promote our services and educate enrollees, providers, and community partners on referring enrollees through onboarding, ongoing training and outreach, information on our public website, and enrollee and provider materials. We educate internal staff, such as Provider or Community Engagement, on how to connect enrollees to CM for assessment and services, ensuring there is no wrong door.

Processes. There are numerous triggers in Anna's scenario that would lead us to identify her for CM.

New Enrollee Welcome Call and Health Needs Assessment (HNA). We outreach to new enrollees to introduce LHCC and identify any immediate needs. We engage all enrollees in an HNA to detect enrollees appropriate for additional assessment and CM. The HNA screens for current/past PH/BH conditions, SDOH needs, special health care needs (SHCNs), language preferences, and other needs. With unstable housing, we will not likely reach Anna by phone to complete the HNA but our HNA incentives may motivate her to complete it online or via our mobile app, and we will engage with her in the community.

Notice of Pregnancy (NOP). Providers and enrollees are encouraged to complete NOP forms to promote early engagement, education, and support. Our enrollee outreach and collateral campaigns are used to promote NOP completion and access to prenatal/postpartum care. We offer financial incentives for NOP submission that include $30 for enrollees and $75 for providers. While Anna does not have a regular source of care, NOPs can also be submitted by EDs. Upon receipt of a NOP, regardless of the source, we start immediate outreach.

CM and Population Health Processes. Based on data and tools described below ***(Table 2.6.7.10.1)***, our CM staff reviews predictive modeling and other reports daily to identify enrollees like Anna for outreach. For example, when we are notified of an enrollee with elevated risk in the ED, we deploy a Rapid ED Intervention (REDI) Team to the ED to engage the enrollee in person. Regional teams will include multi-disciplinary BH and PH professionals, CHWs, and peers to address both clinical and social needs through follow-up visits and service coordination.

Table 2.6.7.10.1 LHCC Technology-Based Identification Tools

Technology-Based Identification Tools
Centelligence Predictive Modeling and Stratification. Running daily, this tool uses proprietary algorithms and advanced predictive analytics to synthesize and analyze various data inputs identifying and prioritizing enrollees for potential outreach and intervention. The tool systematically evaluates enrollment and eligibility data; claims data; laboratory data; medications; electronic health records (EHR) feeds; ADT feeds; utilization management data; SDOH data via assessments

Technology-Based Identification Tools
and Z Codes; NOP forms; and historical fee-for-service data received from the state and/or transition data received from other MCOs. These data enable us to build a comprehensive risk profile for Anna and prioritize her as an individual with special healthcare needs (SHCN), based on pregnancy, frequent ED use, ED diagnosis of intoxication or withdrawal, and possibly housing instability identified through a homeless indicator on the eligibility file.
Opioid Risk Classification Algorithm (ORCA). ORCA stratifies enrollees with or at-risk for substance misuse before a diagnosis using a series of clinical indicators based on past diagnostic, clinical, pharmaceutical, and social history. With limited claims data for Anna, outside of frequent ED visits, ORCA would quickly identify Anna as someone at higher risk for substance abuse.
CM Reporting Tools. LHCC's systematic reporting and analytics flag enrollees like Anna for CM outreach. Anna would be identified on our ED reports (based on high utilization), BH reports (based on diagnosis), and CM reports (based on risk level and/or pregnancy).
Epic Payer Platform. Over 65% of Louisianans have a record in an Epic electronic medical record (EMR) in Louisiana. The Epic Payer Platform allows for consistent and reliable data sharing through bi-directional data exchange between health plans and providers. LHCC will implement Epic Payer Platform as another tool to identify enrollees like Anna. Through this platform, we have access to all data for a current enrollee from any other payer that has provided coverage to the enrollee within the preceding 5 years. This includes SDOH data to help identify enrollees like Anna with housing insecurity and lack of transportation.
Admission, Discharge, and Transfer (ADT) Feeds. LHCC uses real-time hospital ADT alerts for timely identification and assessment of enrollees admitted to the hospital or presenting in the ED. Through our participation with Audacious Inquiry, we receive ADT transactions in real-time. When our Clinical Data Gateway receives an ADT event notification, it is automatically and electronically loaded into our CM platform which creates a task for CM follow-up and a flag in the Provider Portal for PCP action.

2.6.7.10.2 Steps to Address Anna's Needs

As stated above, the first step in addressing enrollee needs is identification. For enrollees like Anna, this is the easiest step. The next preparatory steps are finding and engaging. For purposes of this response, we will first address how we deploy our high touch outreach and engagement model to find and connect with Anna, then describe the specific steps taken to fully understand and address her holistic needs, in priority order.

Integrated and Person-Centered Approach. We identify Anna upon enrollment with LHCC, outreach to complete the HNA, identify her high-risk needs, complete a comprehensive assessment, and engage her in Tier 3: High Risk Case Management. We assign a lead Case Manager (primary point of contact) who is a Registered Nurse (RN) with experience supporting enrollees with high-risk pregnancies and SUD. We also consider any language or cultural preferences. Anna's Case Manager has the support of our internal ***LHCC Collaborative Care Team,*** which includes a Licensed Mental Health Professional (LMHP); CHW specializing in maternal/child health; SDOH staff, including housing, education, and transportation specialists; pharmacist and PH and BH Medical Directors. Led by Anna's Case Manager, Anna also has an ***Interdisciplinary Care Team*** (ICT), inclusive of Anna, Anna's OB/GYN and treating providers, and other external partners who support Anna's goals and provide input on the development of her person-centered Plan of Care (POC). Upon learning of Anna, Anna's Case Manager outreaches to Anna within one business day for enrollment into our maternal and child health and case management program, ***Geaux Baby and Me***.

Improving Maternal and Child Outcomes

LHCC's Geaux Baby and Me maternal/child health program assists enrollees to gain access to prenatal care, provides education on healthcare needs, assists with social needs and concerns, and coordinates referrals to appropriate specialists and other services, such as specialty BH services and community resources. To supplement one-on-one and online education, we offer a Geaux Baby and Me mobile application that provides on-demand information and support. Through this and other maternal child health programs, between 2018 and 2020 we saw a 10.4% reduction in our NICU rates, as well as an 8.11% improvement in the Postpartum Care HEDIS measure for our enrollees.

Outreach and Engagement. In reality, there are many more steps in this process. Without stable housing, Anna may be difficult to reach. If we are unable to reach Anna by phone, we use the Louisiana Balance of State Continuum of Care (LA BOSCOC) Coordinated Entry System as a tool to locate enrollees with unstable housing and deploy a CHW to find Anna out in the community. The CHW visits Anna's last known address, local gathering spots, nearby shelters, and other CBOs. If we are not successful in our efforts to locate Anna in the community and without a regular source of care to involve, our next

opportunity may be the ED. When LHCC receives an ADT alert that Anna is in the ED, the CHW or REDI team goes directly to the ED. Not knowing what to expect, as Anna may be intoxicated or experiencing withdrawals, we go to the ED to meet Anna and let her know she is not alone. By arriving there as her ally, we establish a rapport that will improve our chances of a future connection where we can assess her needs and engage her in care planning. We begin by helping Anna meet her basic needs. We may offer to buy her a meal, get her a phone, and ensure she has safe housing. During our next meeting, we may arrange to take her to an OB/GYN appointment.

Screening and Assessment. Over time, we complete a comprehensive assessment, to understand Anna's needs, challenges, barriers, and short and long-term goals. This includes prior treatment for her mental health and SUD conditions, medications she may or may not be taking, and past experiences with providers that may be deterring her from a regular source of care. This also includes an assessment of her SDOH needs, feelings about her pregnancy, and family or other support systems. This information is used to form the basis of her POC.

Individual Plan of Care (POC). Developing a POC can be overwhelming and may not be an immediate priority for enrollees struggling to find food or shelter. After addressing her basic needs, Anna's Case Manager guides Anna through each step to prioritize her needs, identify her goals, and reduce barriers to access. Based on what we learn from Anna, a sample POC may include:

Table 2.6.7.10.2 Anna's Sample POC

Anna's Self-Identified Goals	Anna's SMART Goals	Identified Barriers	CM Interventions
"I want a place to live and have the things I need"	• Anna will have access to housing within one week • Anna will have access to a phone and transportation within one week	• Unstable housing and lack of transportation	• Secure shelter for Anna using LHCC's 90-day Medical Respite Bed value-added benefit • Connect Anna with a Housing Specialist • Assist Anna in obtaining a SafeLink phone • Educate Anna on transportation benefits
"I want my baby to be okay"	• Anna will attend all recommended appointments, ultrasounds, and testing • Anna will enroll in Nurse-Family Partnership (NFP) and Parents as Teachers for parenting support, and advice within three weeks • Anna will enroll in WIC/SNAP programs within one month	• Lack of transportation • Current substance use • Food insecurity	• Connect Anna to OB/maternal-fetal medicine provider who specializes in high-risk pregnancies, such as Associates in Women's Health, LSU OB/GYN clinic, or Eleanor Health • Schedule first visit and follow-up with Anna weekly to remind her of upcoming visits and arrange transportation • Refer to WIC/SNAP programs and assist with enrollment • Secure nutritious meals for Anna using LHCC's post-discharge meal value-added benefit • Link to additional pregnancy wrap-around supports • Connect Anna to needed pregnancy and baby items
"I want to feel normal"	• Anna will establish care with appropriate BH providers such as Eleanor Health as her BH home by the time she delivers	• Limited resources for pregnant women with SUD	• Connect Anna to a psychiatrist/BH home • Enroll Anna in a pregnancy SUD program • Consult with LMHP every two weeks to discuss Anna's progress and identify additional resources • Develop Crisis Prevention Plan with Anna
"I don't want to lose my baby"	• Anna will establish care with a PCP and choose a pediatrician for her baby before delivery • Anna will be fully vaccinated against COVID-19 within one month, based on current guidance	• Current substance use	• Educate Anna on the value of PCP care and assist Anna in scheduling an initial PCP appointment before delivery • Assist Anna in finding a pediatrician • Educate Anna on COVID-19 vaccination during pregnancy

Prioritized Steps. The POC above describes how we jointly prioritize steps for addressing Anna's needs.

1. Linking Anna to SDOH Resources including Housing and Transportation

First, Anna must have stable housing. The Case Manager facilitates Anna's access to our value-added benefit of a Medical Respite Bed for 90-days upon discharge from the ED. Once settled, the Case Manager works with an LHCC Housing Specialist to assist Anna with finding permanent housing using resources such as Catholic Charities and Social Health Bridge. Anna's Case Manager completes the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPAT) and helps

Anna enroll in the HUD Homeless Management Information System. [redacted] Anna's Case Manager educates her about transportation benefits available through her Medicaid benefits and ensures Anna has access to a reliable mobile smartphone through SafeLink wireless or LHCC's ConnectionsPlus programs. Anna's Case Manager helps Anna download our digital tools to access personalized pregnancy tracking features based on her due date, such as weekly prevention and pregnancy milestones. Anna can also set other personal goals; earn rewards for healthy behaviors, including prenatal and postpartum care; and use her rewards to pay for items such as food, baby supplies, rent, utilities, and transportation.

2. Ensuring Anna has a Healthy Pregnancy



Specialized Care for High-Risk Pregnancies. Anna's Case Manager locates an OB/Maternal-Fetal Medicine provider who specializes in caring for high-risk enrollees like Anna. The Case Manager schedules an appointment and ensures Anna has transportation. Before the appointment, Anna's Case Manager works with Anna to write down her health conditions, medications, and questions she has for the OB provider, without fear of the stigma associated with her SUD. The Case Manager informs Anna the OB provider is there to support her health and answer any questions she would like to ask. The Case Manager offers to attend appointments, as her advocate, as needed. After the first appointment, Anna's Case Manager collaborates with the OB provider on Anna's POC and communicates this information to Anna. Throughout Anna's pregnancy, the Case Manager contacts Anna every two weeks to provide individualized pregnancy education, remind her of upcoming appointments, and coordinate transportation. Anna's Case Manager educates Anna on LHCC's 24/7 Nurse Advice Line for help with urgent medical concerns and when to go to the ED. If Anna is located near Shreveport or Monroe, Anna's Case Manager will refer her to Ochsner's Telestork and ConnectedMoms program to reduce pregnancy-related complications and premature delivery.

Wrap Around Supports. To ensure Anna has access to healthy foods during and after pregnancy, Anna's Case Manager links Anna to LHCC's post-discharge home delivered meals value-added benefit, and refers her to the WIC and SNAP programs, helping her navigate the enrollment process. As an added layer of in-person support, Anna's Case Manager refers Anna to Nurse-Family Partnership (NFP) and Parents as Teachers (PAT) for parenting support, advice, and information both during pregnancy and after delivery. Anna's Case Manager also ensures Anna has needed baby items such as a Safe Sleep Survival kit, which includes a crib, Halo Sleepsack, Soothie pacifier, Charlie's Kids Book, Safe Sleep DVD, and Safe Sleep educational materials.

3. Addressing Anna's Substance Use and Behavioral Health Issues



Establishing a BH Home. To support Anna's BH and SUD needs, based on Anna's preference, we can connect her to a psychiatrist or a BH health home such as Eleanor Health who serves high-risk pregnancies using evidence-based practices such as medication-assisted treatment (MAT), psychiatric evaluation, and ongoing treatment for her BH needs, inclusive of individual/group therapy, and coordination of community-based resources. Anna's ICT optimizes her therapeutic outcomes and avoids adverse medication events by conducting a comprehensive medication review. In addition, the ICT collaborates with Anna and her BH providers to explore the use of long-acting injectable medication to support Anna's treatment adherence related to her BH conditions. Anna's Case Manager also links her to peer support services through LHCC or her BH Health Home to stabilize Anna's medications and SDOH issues before delivery.

4. Addressing Anna's Additional Whole Health Needs



Anna's Case Manager addresses Anna's whole health needs by educating her on the importance of establishing care with a PCP for both herself and her child. We assist Anna with selecting a PCP, based on her preferences, and help schedule an initial visit and transportation. Based on current CDC guidance, Anna's Case Manager educates Anna on COVID vaccination during pregnancy and encourages her to discuss it with her OB provider. Anna's Case Manager monitors for gaps in care and follows up with Anna and her providers. We also help Anna connect to a pediatrician before delivery (see 2.6.7.10.3).

Crisis Prevention Plan. Included in Anna's POC is a Crisis Prevention Plan detailing BH and/or PH symptoms Anna experiences when in emotional or medical crisis, her potential triggers for crises, and information related to her current treatments and services, including for pregnancy. The plan includes information to guide Anna if she experiences a PH crisis related to pregnancy, such as bleeding, dizziness, and vision changes. The plan describes the steps to receive support for urgent or emergent care. The plan includes contact information for her BH and PH providers, community crisis resources, LHCC's 24-hour Nurse Advice Line and BH Crisis Line numbers, and contact information for her ICT.

2.6.7.10.3 Linking Anna's Newborn to a Pediatrician

Our Geaux Baby and Me program will help establish a strong foundation for Anna and her newborn. Recognizing Anna's newborn may develop neonatal abstinence syndrome (NAS) as a result of Anna's substance-exposed pregnancy, we will support Anna and her child through NICU management, follow-up, and evidenced-based methods of care such as ***Eat, Sleep, Console (ESC)*** training. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services and the Louisiana Development Screening Initiative play crucial roles in promoting a lifetime of health for Anna's newborn. To ensure Anna's newborn is linked to a pediatrician, Anna's Case Manager takes the following steps:

Table 2.6.7.10.3 Steps to Link Anna's Newborn to a Pediatrician

Timing	CM Activity
Before Delivery	• Educate Anna on the importance of a pediatrician for her baby and well-child visits • Connect Anna to WIC benefits and SNAP • Provide Anna with a list of pediatricians and our Geaux Baby and Me tool kit to help Anna select and interview a Pediatrician • Focus on Anna's thoughts and feelings about her pregnancy and her baby • Prepare Anna for the possibility her baby may be admitted to the Neonatal Intensive Care Unit (NICU) following birth due to substance exposure • Collaborate with Anna's BH Providers to administer the Adult Attachment Interview and discuss results with Anna • Inform Anna about LHCC pre-and postpartum support available to expectant mothers and their babies through our *Geaux Baby and Me* (including home visitation through NFP, PAT, and Child First).
Post-partum	• Administer the Edinburgh Postnatal Depression Scale • If the baby is admitted to the NICU, assist Anna with accessing LHCC transportation services to visit the baby • Before NICU discharge, help Anna schedule the baby's first Pediatrician appointment and offer to attend visit • Ensure baby is scheduled for future appointments before leaving the first visit • Provide Anna with telephone numbers for Pediatrician's After-Hours Nurse Line • Monitor well-baby visits for the first 18 months following birth and collaborate with the Pediatrician's office to ensure the baby achieves the appropriate weight, growth, and developmental progress per EPSDT guidelines • If attachment issues complicate the baby's development, make the pediatrician aware of Child-Parent Psychotherapy providers available in the LHCC network to refer Anna and her baby • Address any additional gaps in care for Anna and her baby

In addition to supporting Anna directly, we work with our network of OB providers to encourage and support the linking of newborns to a pediatrician 60 days before the expected delivery date.

Alternate Scenarios

Involvement with the Department of Children and Family Services (DCFS). Anna's newborn is at risk of developing Neonatal Abstinence Syndrome (NAS). If DCFS becomes involved following delivery, we will leverage our expertise serving children, youth, and families with DCFS involvement by ensuring equity, safety, stability, and compassionate family-centered care. Anna's Case Manager and ICT will continue to engage Anna in treatment for her SUD and BH conditions, nurture Anna's bond with her baby, and partner with DCFS to remove barriers to reunification. If Anna decides to place her baby with a relative caregiver, LHCC will coordinate with DCFS Kinship Navigator, such as the Kinship Care Subsidy, which provides financial assistance to children who live with a qualifying relative caregiver. We will ensure her baby receives pediatric care and will link the relative caregivers to programs and resources offered through DCFS. Anna's Case Manager will coordinate Anna's care and link her to ongoing services and support reflected in her POC.

Alternative CM Support. Once Anna is in stable housing, her Case Manager may link her to Strongwell's Substance Exposed Pregnancy Program (SEPP), designed to support pregnant women with opioid misuse and SUD. Available beginning in 2022, SEPP can help Anna develop coping skills, build resiliency, access appropriate medication, and address SDOH before birth. SEPP would also surround Anna with a clinical team, including a Psychotherapist, Certified Peer Recovery Specialist, Resource Advocate, and Nurse Educator that would collaborate with Anna's ICT to ensure Anna's care is closely coordinated. The Clinical Team would also educate Anna about Hepatitis C screening, use of 17-p, and long-acting reversible contraception.

2.6.7 Case Scenarios [5-page limit per scenario]

2.6.7.11 Introduction to "Lisa"

For the scenario presented by LDH, we will refer to the enrollee described as Lisa. Lisa is diagnosed with a Serious Mental Illness (SMI), has several co-occurring physical (PH) and behavioral health (BH) conditions, and high utilization of acute care services. Based on this scenario, while not currently in a nursing facility, Lisa fits criteria for the LDH Department of Justice (DOJ) At-Risk population. LHCC identifies enrollees like Lisa weekly for Care Management (CM) services and supports using specific At-Risk criteria, per the LDH DOJ Agreement Compliance Guide. Using our integrated and person-centered approach for DOJ-at-risk enrollees, LHCC will engage Lisa to understand the reasons behind her use of acute care, address her identified needs, and support her ongoing success in the community through adherence to treatment recommendations. Per our State-submitted engagement strategy for At-Risk populations, we support assertive outreach, frequent, in-person visits, recurrent care team meetings, and population-driven analytics to inform us of the effectiveness of our strategies and where to best shift our efforts to ensure safety in the least restrictive setting.



Lisa is a 57 year old enrollee with poorly controlled diabetes, hypertension, coronary artery disease, bipolar disorder, smoking, and low back pain. We identify Lisa as a DOJ At-Risk enrollee and assign her to a primary RN Case Management who will engage her in Tier 3: High Risk Case Management.

Understanding Utilization. We conduct root cause analysis and leverage our integrated approach to Case Management to understand Lisa's use of acute care.

Addressing Lisa's Needs. We will leverage our experience serving enrollees similar to Lisa to connect her to services and supports that address her physical, behavioral health, dental, and social needs.

Increasing Engagement and Supporting Adherence. We help Lisa achieve her individualized goals by using evidenced-based practices such as Person-Centered Care Planning, Motivational Interviewing, and the Strength-Based model.

Integrated and Person-Centered Approach. Based on her diagnoses and high utilization, Lisa is an individual with Special Healthcare Needs who would be identified for CM services through initial Health Needs Screening, risk stratification, as well as ED reports. Using a risk stratification score calculated by our ***Centelligence Stratification Tool***, we stratify Lisa into Tier 3: High Risk Case Management based on her uncontrolled chronic conditions, co-occurring BH diagnosis, and acute care utilization over the past six months. With integrated needs across much of our membership, LHCC uses a team-based approach with a lead Case Manager acting as the primary point of contact. Based on poorly controlled PH conditions, Lisa is matched with a Case Manager who is a Registered Nurse (RN). Lisa and her Case Manager have the added support of the ***LHCC Collaborative Care Team***, which includes an LHCC Licensed Mental Health Professional (LMHP) who will provide support and consultation related to Lisa's BH needs, a locally based Community Health Worker (CHW) who will help arrange community resources, an LHCC Pharmacist to help monitor medications, and LHCC Medical Directors for clinical consultation and support. Lisa is placed at the center of an ***Interdisciplinary Care Team*** (ICT) that is comprised of LHCC and external partners that will work in partnership with Lisa to support her health and wellness goals and provide input on the development of her person-centered plan of care (POC). Lisa determines who is part of the ICT but at a minimum, it will include Lisa, her Case Manager, PCP, and other providers involved in her care. Through the ICT, we also engage Lisa's identified support system, such as family members, church or religious supports, and community leaders throughout the assessment, ICT, and care planning process.

2.6.7.11.1 Enrollee Engagement and Root Cause Analysis to Understand Utilization

Lisa's Case Manager seeks to understand the root cause of Lisa's frequent use of acute care by initially reviewing her medical records, claims data, medication lists, prior assessments, and other available information using LHCC's CM Platform that supports collaborative care and utilization management.

Assertive Outreach and Comprehensive Assessment. Next, the Case Manager conducts assertive outreach to educate on our CM program and enroll Lisa in CM services. After engaging Lisa via telephone, the Case Manager schedules an in-person visit at Lisa's home to complete a comprehensive assessment to evaluate Lisa's PH and BH needs, care gaps, home environment/safety needs, and any social determinants of health (SDOH) concerns. The assessment seeks to understand if Lisa's acute care utilization is a result of her poorly managed chronic conditions, a need for pain control, or if Lisa is experiencing symptoms related to her bipolar disorder. We also assess Lisa's educational level, health literacy, and financial situation to determine if these factors or other stressors are contributing to high ED utilization. The Case Manager considers Lisa's functional level and whether or not she may need additional support to maintain her independence and live in the community.

Provider Collaboration. Lisa's Case Manager determines if Lisa is established with a PCP and specialists. If Lisa is already connected to these providers, we engage them as integral members of the ICT and seek input on Lisa's current treatment plan, treatment history, and level of adherence. If she does not have reliable access to care, the Case Manager helps identify primary and/or specialty care providers that meet her geographic, PH and BH clinical, and cultural needs, including integrated primary care and telehealth options.

2.6.7.11.2 Addressing Lisa's Physical Health, Behavioral Health, Dental, and Social Needs

Linkage to PCP and Specialty Providers. As stated, if Lisa is not already established with existing providers, especially a PCP, the Case Manager will provide a list of conveniently located PCPs for Lisa to choose from. We may also suggest specialist providers, such as an endocrinologist and cardiologist to help manage her poorly controlled diabetes mellitus, hypertension, and coronary artery disease, aligning with her preferences. With Lisa's agreement and based on our root cause analysis, the Case Manager collaborates with the PCP to offer integrated in-home care available through our partnerships with ***Carpenter Health Network*** and ***Upward Health.*** These partner programs can help Lisa reduce her use of the ED and decrease risk for hospital readmission. Lisa's chronic conditions also likely require multiple medications. LHCC's pharmacist will review Lisa's pharmacy utilization data and assist with identifying drug interactions, duplicative therapy, and adherence issues.

Home-Based Integrated Care

LHCC is partnering with Upward Health (Upward) to offer 24/7 in-home access to whole-person care, including medical, BH, and SDOH. Upward's care delivery team will co-manage participating enrollees with LHCC's Collaborative Care Team.

Ensuring BH Support. Individuals like Lisa who have co-occurring BH conditions are more likely to have negative outcomes related to their PH conditions. To help her manage her bipolar disorder, Lisa's Case Manager collaborates with the ICT to locate and connect Lisa to a psychiatrist. Once established, the psychiatrist will be extended an invitation to join the ICT and participate in care team meetings to further address Lisa's needs. We can also connect Lisa to peer support with lived experience. A trained peer can provide practical strategies for management of Lisa's bipolar disorder, emotional support, and act as a role model for treatment adherence.

Bringing Resources to Louisiana

Craving to Quit *is an evidence-based digital program that teaches enrollees how habits are formed, and how to break them. Geared for adults, this award-winning program teaches awareness of cravings and habits to help participants quit smoking or vaping through weekly coaching calls, self-guided video lessons and exercises, and expert community support.*

Encouraging Tobacco Cessation. LHCC is committed to helping enrollees like Lisa live tobacco-free through multiple cessation avenues. Lisa's Case Manager uses Motivational Interviewing to explore Lisa's willingness to quit smoking, then explains and connects to appropriate resources such as the Louisiana Tobacco Quitline, 1-800-QUIT-NOW; the Smoking Cessation Trust; physician-provided virtual tobacco cessation counseling; FDA-approved tobacco cessation medications; and our ***Craving to Quit*** program. If Lisa is not ready to quit, the Case Manager will continue to remind Lisa of available resources and the benefits of quitting.

Offering Pain Management Programs. Lisa's Case Manager connects Lisa to LHCC programs that help individuals experiencing chronic pain. LHCC's Back Pain Program provides telephonic outreach, education, and support to promote recovery from low back pain. An Exercise Physiologist will be added to the ICT to complete a baseline assessment and collaboratively develop an appropriate treatment plan considering Lisa's back pain history, current pain level, medication use, emotional state, and other physical concerns. Lisa will also receive coaching and education related to ergonomics, exercise mechanics, and stress management. We also offer Lisa additional evidence-based treatment options for chronic pain management as value-added benefits, such as acupuncture, massage therapy, physical therapy, and a monthly exercise membership to her local YMCA or similar facility.

Providing Education. Lisa's Case Manager educates Lisa on managing her chronic conditions, including how to monitor her blood sugars, proper diabetic and low sodium diets, and medication adherence. Lisa is advised on when to seek care from her PCP, specialists, or an Urgent Care Center instead of going to the ED; use of LHCC's 24/7 Nurse Advice Line (NAL) for assistance in seeking care from the most appropriate setting; and availability of LHCC's BH Crisis Hotline staffed 24/7/365 days per year for immediate access to our BH clinicians who provide expert emergency/crisis assessments, de-escalations, and referrals. LHCC's 24/7 lines are integrated with our CM Platform, enabling information, referrals, and follow-up actions to be communicated with Case Managers.

Referral to Community Resources. To address any SDOH needs identified during Lisa's comprehensive assessment, Lisa's Case Manager consults with our CHW to connect Lisa to resources through LHCC's Community Connect Platform.

Additionally, if Lisa is interested in exploring her eligibility for Supplemental Security Income (SSI), we will facilitate applying for SSI benefits.

Developing Lisa's Individual Plan of Care (POC). Within 30 days of completing the comprehensive assessment, with Lisa driving and her ICT providing input and consultation, Lisa's Case Manager develops an individual POC ***(Table 2.6.7.11.2)***. We work with Lisa to prioritize her needs, identify her goals, and reduce barriers to accessing services and supports. Lisa's POC reflects her self-identified goals, which her CM helps to align with Specific, Measurable, Action-Oriented, Realistic, and Time-Limited (SMART) goals.

Table 2.6.7.11.2 Lisa's Sample POC

Lisa's Self-Identified Goals	Lisa's SMART Goals	Identified Barriers	CM Interventions
"I want to improve my overall health and stay out of the hospital"	• Lisa will be connected to a PCP and appropriate specialists for management of her diabetes, coronary artery disease, and hypertension within 30 days • Lisa will decrease her use of the ED to manage her chronic conditions within three months	• Limited understanding of the complexity of her disease processes	• Provide a list of PCPs and specialists to Lisa based on her geographic location and cultural and other preferences • Connect Lisa to Pain Management Programs • Educate Lisa on appropriate ED use and provide information on NAL, BH Crisis Hotline, urgent care centers near her home, and explore PCPs with extended office hours • Provide materials on Lisa's chronic conditions that are tailored to her literacy level and learning preferences • Ensure medication adherence and stabilize medications
"I want to improve my mood"	• Lisa will schedule and maintain psychiatry appointments within two months	• Transportation	• Connect Lisa to a Psychiatrist based on her location and preferences, leveraging telemedicine as needed • Assist Lisa with accessing NEMT benefits through LHCC • Offer Lisa options for Peer Support
"I want to learn how to better manage my diabetes"	• Lisa will attend a diabetic education program within one month • Lisa will enroll in the Diabetic Disease Management program within 60 days	• Additional education is needed regarding diabetic management	• Ensure Lisa has diabetic supplies such as glucometer, lancets, alcohol preps, and insulin • Connect Lisa to diabetic education through her local hospital • Refer Lisa to Disease Management Program for long-term diabetic education
"I want to be able to support myself and have access to the things I need"	• Lisa will apply for SSI benefits within eight weeks	• Lack of income	• Assist Lisa in applying for SSI benefits • Connect Lisa to SDOH resources including access to Community Connect
"I want to quit smoking"	• Lisa will enroll in a smoking cessation program within six weeks	• Ongoing motivation to stop smoking	• Refer Lisa to smoking cessation programs and benefits

Once the POC is completed, Lisa receives a copy and with her consent, the POC is made available to Lisa and the ICT through the LHCC CM Platform.

Monitoring and Follow-Up. Once Lisa's POC is established, the Case Manager follows up with Lisa twice weekly the first week, then weekly for the remainder of the first month, and then at least monthly as needed. The Case Manager proactively schedules an additional in-person visit after the first 30 days to check-in and re-evaluate Lisa's POC, adjusting as needed. We continue to engage with Lisa in her preferred setting. Through our ***Virtual Front Door*** program, Lisa has the option to participate in video Zoom calls with her Case Manager. At a minimum, the ICT will meet monthly to ensure Lisa is

receiving needed medications and services, including transportation, and that she is satisfied with her services and providers. The POC continues to reflect Lisa's individual preferences and her changing needs. The Case Manager monitors Lisa's living situation to ensure it is safe, stable, and that she remains satisfied. The Case Manager completes attestations of monthly updates to Lisa's POC and communication of the POC to Lisa and her PCP. After Lisa has been receiving High Risk Case Management services for 12 months, we reassess her ongoing CM needs based on Lisa's self-identified needs, additional screenings and assessments, and other ICT or provider recommendations. We also evaluate Lisa's progress toward POC goals; patterns of ED use, crisis services, and acute care utilization; and quality indicators, including critical incidents involving Lisa. On an ongoing basis, we evaluate Lisa's overall risk, and her risk for developing a particular disease or health outcome, using LHCC's suite of Centelligence Predictive Analytics tools.

Common Medicaid Enrollee Profiles

Co-Occurring Health Issues. Lisa's chronic and complex issues are highly representative of many enrollees currently served by LHCC and we leverage this experience to address Lisa's needs. We understand that the PH and BH issues faced by Medicaid enrollees are not independent of one another and that they often have multiple chronic, co-occurring conditions. As criteria for CM, chronic PH and BH conditions are more prevalent for enrollees actively engaged in LHCC Case Management. We conducted an impact analysis of LHCC's CM Program on enrollee care and found that within 24 months, ***Case Management reduced ED utilization by 16% and inpatient utilization by 15%,*** an indicator that LHCC's CM Program helps enrollees like Lisa access the right care, at the right time, at the right location.

Social Issues. Many Medicaid enrollees like Lisa have unmet social needs and face challenges related to SDOH, which leads to poor health outcomes. We assess for SDOH needs during every enrollee interaction. Of enrollees with an identified SDOH need from 2019 to 2021, the top SDOH categories included food insecurity, financial literacy, transportation, social Isolation, employment, and housing/utilities. We use these types of results to remove identified barriers to care, connect enrollees like Lisa to existing community-based resources, and inform the development of new community-based initiatives and partnerships to address unmet social needs.

2.6.7.11.3 Promoting Lisa's Success in the Community

Increasing Engagement. Lisa's Case Manager uses evidence-based practices such as Motivational Interviewing, Person-Centered Thinking, and the Strengths-Based Model to engage with Lisa. We meet Lisa where she is by conducting face-to-face interactions via home or provider visits and embedding staff in her community. We approach Lisa as a unique individual who guides her self-identified needs and goals. We tailor information and leverage evidence-based interventions, including peer supports that reflect Lisa's willingness to engage, level of health literacy, disparities endured, and cultural preferences. For example, according to Mental Health America, quantitative and qualitative evidence indicates that peer support reduces re-hospitalization rates, increases use of outpatient services and improve engagement. We continually ask Lisa to evaluate her progress toward her goals and collectively designate action steps that Lisa agrees to take responsibility for.

Supporting Adherence. We collaborate with Lisa to determine the frequency of follow-up based on her goals and POC. Through supportive listening, we evaluate how Lisa is coping and focus on building our relationship with her. We encourage Lisa to be an active participant in her health by encouraging her to make calls to providers on her own and relay information back to her Case Manager to ensure understanding. We select and tailor interventions and resources based on Lisa's readiness to adhere to treatment options and recommendations. Through our new remote monitoring programs, ***Diabetes On.Demand*** and ***Hypertension On.Demand,*** we can offer additional resources to improve Lisa's self-management skills and help her adhere to treatment plans. Similar programs are also available through Ochsner's Hypertension and Digital Medicine programs. Our ***My Health Pays*** program rewards Lisa for healthy behaviors and adherence to her POC regimens. For example, Lisa will receive $50 for completing comprehensive diabetes care measures including an annual HbA1c test, kidney screening, and retinopathy screening as part of her comprehensive diabetes care, as well as $25 per calendar year for engaging in tobacco cessation counseling or for filling a prescription for tobacco cessation medication.

Real Rewards for Real Life

Through My Health Pays, Lisa can use the rewards she earns for utility bills, rent, transportation, groceries, and items at Walmart.



LHCC Enrollee Story

LHCC has significant experience in serving enrollees like Lisa. As a recent example, an enrollee transitioned to LHCC from another MCO as a result of a referral from her friend who was also enrolled with LHCC and received CM services. The enrollee was unable to establish care with an orthopedic surgeon to address her severe hip pain and difficulty with walking. Once enrolled in Case Management, her Case Manager addressed the enrollee's needs by connecting her to a local orthopedic surgeon and working with the PCP to have her evaluated by a PT for the mobility issues and recommendation for appropriate durable medical equipment to ensure her safety. After meeting with the surgeon the enrollee was happy to report that he would move forward with her surgery if she would enroll in a smoking cessation program. The Case Manager connected the member to our smoking cessation program that worked with her for three months. The enrollee is now tobacco free and looking forward to her upcoming hip surgery.

Alternate Scenarios

Lisa Becomes Less Engaged with Case Management. LHCC recognizes Lisa's right to refuse participation in CM and would continue to seek opportunities to re-engage with Lisa during triggering events such as ED visits, repeat hospitalization, provider referral, or possible enrollment into another CM program. For example, if Lisa presents in the ED, we will be notified via real-time ADT alerts and will deploy a Rapid ED Intervention (REDI) Team to the ED to engage with Lisa in-person. Regional teams REDI teams include multi-disciplinary BH and PH professionals, CHWs, and peers to address both clinical and social needs through follow-up visits and service coordination, taking this opportunity to re-engage with Lisa. LHCC would also engage trusted providers and community agencies involved in Lisa's care to assist with outreach and ongoing engagement, reinforce the benefits of CM, and assist with identifying and addressing barriers to care and services.

Lisa Requires Home and Community-based Services. If Lisa experienced an overall health decline and a functional assessment indicated she required home and community-based services to help her live safely in the community, LHCC would assist with coordinating integrated and person-centered supports that continued to reflect her individualized goals.

SECTION 2.6.8

Network Management



"We have seen the most member-centered and value-based innovation and collaboration with LHCC. They are open-minded and focused on finding sustainable solutions that leverage our clinical resources. We're able to develop new models and services for appropriate and effective in-home care.

We're breaking down some of the biggest barriers to care for underserved patients."

- Benjamin Swig
Acadian Ambulance, Director of Healthcare Innovation & Strategy

2.6.8 Network Management

2.6.8.1 How LHCC Ensures Timely Access to Culturally Competent Care

LHCC built our comprehensive network on the premise that ***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.*** We have ensured consistent, timely and culturally competent access to primary and specialty care for ***all*** enrollees for the last ten years by:

- ***Focusing on health equity and population health needs through strategic contracting and other network*** expansion and infrastructure investments, informed by data-driven population health and social determinants of health (SDOH) assessments and analyses (see Section 2.6.5 and 2.6.8.2.7). We use continuous network monitoring, formal recurring cross-departmental assessments, and soliciting external input to expand network analyses beyond traditional geographic mapping (see 2.6.8.2.2). This ensures our network includes a broad representation of providers that have historically served Medicaid enrollees, are familiar with the unique characteristics, disability needs, and cultural considerations of each covered population, and have the expertise to consistently deliver quality care through a health equity lens.



- ***Creating Medicaid-tailored access*** leveraging an in-depth understanding of Louisiana's provider landscape, enrollee demographics, and the specific cultural, health, and unmet social needs of each eligible population to honor existing referral patterns. By offering high-value propositions to providers, we have successfully contracted with numerous practices that previously did not accept Medicaid, including premier primary and specialty care providers such as the ***Baton Rouge Clinic (BRC), The Carpenter Health Network (Carpenter), LHC Group***, and ***Louisiana Women's Healthcare Association***. We complement this access with comprehensive telehealth solutions (see 2.6.8.2.3).
- ***Maintaining a high-value network*** by focusing on recruiting and retaining providers that provide the most efficient, culturally competent, and highest quality care to our enrollees – aligning with LDH's goals to advance evidence-based practices, high-value care, and service excellence. For example, through our ***QualityPATH Value-Based Payment (VBP) models***, we incentivize providers to improve access to primary and specialty care and advance individual and population health outcomes. We also continually work to enhance and evolve our network through innovative infrastructure and capacity building initiatives (see 2.6.8.2.3) that expand access.



- ***Prioritizing Provider Satisfaction and Retention***, which has resulted in most of our provider contracts being in place, without interruption, since 2012. We ***listen*** to our providers, engage them as partners, and include them on our physician-led Board of Directors and Committees that inform our strategic direction and day-to-day operations. These established partnerships offer LHCC the ability to outreach and collaborate with our network to proactively and promptly resolve access barriers or network adequacy issues.

LHCC has executed contracts with more than 3,958 primary care providers (PCPs); 3,170 licensed behavioral health (BH) providers (including psychiatrists); 2,182 ancillary providers; 135 hospitals; 292 FQHCs; and 17,897 specialists – ***offering LHCC enrollees the largest Medicaid provider network in the state***. We maintain our comprehensive, high-quality network through our commitment to improving provider satisfaction, enrollee experience, and health outcomes. ***LHCC is the highest ranked Medicaid MCO for provider satisfaction***. LHCC 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 F.

2.6.8.2.1 Network Development Work Plan

We embrace LDH's efforts to continuously enhance adequacy standards to ensure 100% of all Medicaid recipients have access to all provider types. However, with the more rigorous standards detailed in Attachment F, LHCC has identified new areas of non-compliance with distance standards that did not previously exist. ***LHCC will always ensure our enrollees receive the covered services they need from the most highly qualified providers, overcoming any obstacles we may encounter***. Regardless of the challenge, we know how to continually enhance our network. For example, the increased specialist requirements from Amendment #3 (December 2020) resulted in four network gaps; ***LHCC successfully scaled up our network to close all gaps within three months***. The higher standards in this RFP resulted in distance gaps, and by submission, ***we have closed gaps for 7 provider types through targeted recruitment and retention, as well as innovative access expansion strategies***. ***Table 2.6.8.2.1-1*** summarizes our work plan for meeting the more stringent distance

standards in the Model Contract by provider type (see 2.6.8.2.3 for our strategies to address network gaps). All efforts are ongoing: we will continue to scale up, maintain, and improve our network throughout our contract.

Table 2.6.8.2.1-1 Strategies to Build, Scale up, or Maintain Adequacy by Provider Type

Provider Type	Strategies to Build, Scale up, or Maintain Adequacy	Timeline
Primary Care (Adult and Pediatric)	– ***LHCC meets distance requirements for adult and pediatric primary care in all rural parishes, and we exceed ratio requirements for adult and pediatric PCPs in all regions.*** – [redacted]	Scale up primary care network in urban parishes to adequacy by Readiness (Q4, 2021)
Acute Care Inpatient Hospitals	– ***LHCC is contracted with every acute care hospital in the state.*** – ***Strategies.*** We will maintain and support this network to expand their capacity, value, and quality through our comprehensive ***QualityPATH VBP models***, continuous collaboration using Joint Operating Committee (JOC) meetings, and our field-based, high-touch provider engagement approach.	Maintain current contracts with all acute care hospitals through life of the contract (ongoing)
Ancillary	– ***Our network includes over 1,000 Louisiana pharmacies and we meet adequacy standards for radiology and laboratory, statewide.*** – **Strategies.** We are scaling up our ancillary network through initiatives such as in-home services (dialysis), mobile radiology services.	Offer in-home dialysis services (done) Scale to adequacy by Readiness (Q4, 2021)
Specialty Care	– ***LHCC meets distance standards for nine different specialties Statewide.*** – ***Strategies.*** We are scaling up our network by expanding specialty access with existing partners (e.g., Imperial Health, BRC, and Ochsner Health System [Ochsner]), as well as through traveling specialists and comprehensive telehealth solutions.	Scale to adequacy by Readiness (Q4, 2021)
Psychiatrists and Licensed Mental Health Specialists	– ***LHCC is contracted with all 10 Local Governing Entities (LGEs), across 49 locations, and the highest percentage of Evidence-Based Practice (EBP) MHR providers.*** – ***Strategies.*** We will supplement our network through our comprehensive telehealth solutions with LSU Healthcare Network and LCMC.	Scale to adequacy by Readiness (Q4, 2021)
Substance Abuse and Alcohol Abuse (Adult and Pediatric) Treatment Providers	– ***LHCC is contracted with all 10 of Louisiana's Methadone Clinics.*** – ***Strategies.*** We are scaling up our current network of ASAM providers by seeking contracts with all licensed/qualified providers, leveraging current ASAM contracts, and targeting communities with distance gaps. We will implement Single Case Agreements (SCAs) as needed, and supplement access with telehealth. Note: ASAM Level 2WM (H0014) is listed on the LDH fee schedule as a covered service for only one provider. [redacted]	Scale to adequacy by Readiness (Q4, 2021)
Behavioral Health Rehabilitation Services	– ***Strategies.*** We are conducting outreach to MHR providers to confirm potential legacy status (including requesting documentation), scaling up our current network by seeking contracts with MHR providers, targeting communities with distance gaps, and will implement SCAs as needed.	Scale to adequacy by Readiness (Q4, 2021)

2.6.8.2.2 Ongoing Monitoring to Proactively Identify Network Gaps

As further detailed in 2.6.8.2.5, our approach to identifying network gaps and access issues goes beyond geomapping and builds upon our local understanding of Louisiana, the Medicaid program, enrollee needs, and the provider landscape in each region. Network analyses includes monthly review of enrollment and enrollee geographic movement trends to identify early signs of capacity issues based on population needs, as well as:

- **Distance Standards.** We monitor provider and facility access against the distance requirements detailed in Attachment F, using Quest Analytics and monthly geomapping to analyze and target network adequacy issues at the state, regional, local, and provider-type levels.
- **After-Hours Clinic Availability.** To monitor access to ***after-hours and weekend primary care and clinic availability,*** we apply our time/distance monitoring process at least monthly to a subset of providers and capture data on those

offering services outside regular business hours. We also perform quarterly audits using statistically valid sampling to confirm availability. ***From 2017 to 2021, we grew our network of extended hours providers by 90.8%.***

- **Panel Status (Open/Closed).** We validate panel status during recurring outreach efforts via email, fax, and telephone; quarterly during site visits by Provider Engagement (PE) Specialists; and through telephonic secret shopper audits. We open panel status through outreach, education, and VBP arrangements. If a provider is treating only existing patients, we re-audit the provider next quarter to determine whether open panel status has changed. ***Currently, 94% of specialists and 72% of PCPs have confirmed open panels.***
- **Monitoring to Promote Health Equity.** We also analyze and report critical factors that impact equitable access to care, such as population/demographic characteristics, disparity analyses, languages spoken, SDOH needs, patterns of care, and provider cultural and language capacity and concordance — including ratios, appointment availability, panel status, willingness to accept Medicaid enrollees, and urgency of the need for services. Network cultural concordance and access monitoring is integrated into our quality program via our Health Equity and Diversity Committee, data exchange and review, and network quality improvement activities.

Compliance with Distance Standards. Due to enhanced distance standards in Attachment F, some ***new*** network gaps exist related to distance standards. Despite identified challenges, our current network is in alignment with enrollee and utilization growth trends. Of those gaps identified, most are in LDH-designated urban parishes that have rural characteristics, e.g., in Cameron, Plaquemines, and Grant Parishes, and/or where there are no available providers with which to contract. Potential network adequacy gaps have been identified in 2.6.8.2.2.

2.6.8.2.3 Strategies to Increase Provider Capacity and Address Network Gaps

When we identify a network gap or access issue, we deploy the following overarching strategies to ensure enrollees have consistent access to the care they need, when and where they need it:

- ***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. We may incentivize PCPs to open panels, expand their scope of services, or serve more enrollees; ask providers contracted in other LHCC programs to participate in Medicaid; and engage in targeted recruitment efforts.
- ***Longer term strategies*** that often improve access for ***all*** Medicaid enrollees through innovative provider partnerships and capacity expansion initiatives to increase or create access where none existed. We may help finance additional brick and mortar provider sites; support providers and/or community partners to increase access points; execute innovative value-based arrangements that incentivize capacity expansion (e.g., after-hours clinic availability); and create or provide funding for new telemedicine, telehealth, and/or other technology solutions that increase access anywhere.

Below, we describe the innovative partnerships, investments, and capacity expansion initiatives we have implemented (or are developing) to address the network gaps and access issues identified in 2.6.8.2.2.

Strategies to Increase Capacity for Multiple Provider Types

[redacted]

AbsoluteCare (AC) Clinics. To address the identified need for providers with enhanced skills and experience to manage complex populations, we are ***creating new access for the community***. In addition to primary care, AC will provide care coordination, integrated BH services, social support services, nutrition, radiology, onsite labs, and other needed care.

Telehealth. Our ***statewide*** telehealth strategy (encompassing telemedicine, telemonitoring, and tele-consults), uses solutions that are compliant with Model Contract 2.9.5.4 to address specific network gaps, recognizing the unique health and technology needs and disparities across population groups, provider settings, and local communities. Since the pandemic, we have experienced a significant increase in telehealth demand. To meet this demand, and continuously offer enrollees and providers ***24/7 access*** to virtual care, our comprehensive multi-modal approach ***supports local capacity building and infrastructure***, then addresses remaining accessibility or service needs with ***additional targeted solutions*** for

enrollees and providers. Our solutions help enhance provider capacity and increase access to care for ***all*** Louisianans regardless of health coverage. For example, through our partnership with AT&T, we will increase the availability of secure, ***high-speed broadband*** in rural areas. Through our ***Technology Enablement Fund***, we offer providers funding for telehealth infrastructure or equipment, including computers, tablets, mobile devices, and assistive technologies. ***Table 2.6.8.2.3-1*** highlights some of our local Louisiana partnerships that expand provider capacity and enrollee access.

Table 2.6.8.2.3-1 Summary of Telemedicine, Telemonitoring, and Tele-consult Services

Solution/ Partner	Services Provided
[redacted]	[redacted]
[redacted]	[redacted]
Eleanor Health Louisiana	Leveraging their proven ***BH medical home model***, this partnership will provide medication assisted treatment (MAT); psychiatric evaluation and ongoing treatment; individual and group therapy; recovery coaching, telehealth, community-based support, and care coordination with the PCP.
Quartet	Quartet provides access to remote BH services, such as online therapy and virtual BH with Louisiana licensed and credentialed providers.

Mobile Solutions. To address gaps in primary care, BH, and/or dental services, LHCC has developed targeted partnerships to offer mobile solutions that expand access in all nine LDH regions. We are working with key providers such as ***Teche Action Clinic*** in Region 3, and ***SWLA Center for Health Services*** in Region 5, to expand their primary care mobile offering, increasing access for all Medicaid recipients in these areas.

Targeted Strategies to Increase Adult and Pediatric Primary Care Capacity

Expanding Access to Primary Care through Urgent Care. In areas with severe shortages of PCPs (such as in Cameron, De Soto, East Feliciana, and Plaquemines Parishes), we will offer financial assistance to our urgent care providers to expand access and create adult and pediatric primary care services. ***Our network of urgent care providers has increased from 55 in 2015 to 131 locations in 2021.*** We will build on this network to expand services in current sites to include primary care and to add new locations in rural geographies.

Rural Hospitals and Walk-in Clinics. We continuously evaluate our network to identify areas where we can expand provider capacity and build access – particularly in rural Louisiana. For example, we provided funding ***to St. Martin Hospital***, a critical access hospital in Breaux Bridge, for an additional APRN for their walk-in primary care Community Health Clinic. The clinic can now offer after-hours and weekend availability for critical services. We will continue to evaluate and identify similar opportunities across the state to expand primary care access.

[redacted]

Complex Pediatric Care. Through statewide partnerships with Louisiana's primary providers, enrollees – especially our most vulnerable – get the care they need, when and where they need it. For example, through our arrangement with ***LCMC***, we ensure children who need long-term ventilator support at home have access to a team of nurses, social workers, and other practitioners who complete home visits and manage their care 24/7.

Targeted Strategies to Increase Specialty and OB/GYN Provider Capacity

[redacted]

Targeted Strategies to Increase Behavioral Health and Substance Use Treatment Capacity

Local Governing Entities (LGE). LHCC is supporting 10 LGEs across 49 locations to increase provider capacity via additional Peer Support Specialists that will support adults in treatment for mental health and/or substance use.

[redacted]

Crisis Stabilization. In addition to contracting with a statewide network of BH crisis response providers, we are working with key BH providers, including START Corporation, to expand capacity to offer crisis stabilization services.

SUD and ASAM providers: To increase access to addiction specialists, LHCC contracted with several new providers, including Second Chance Recovery Center, Creed Group of Louisiana, St. Christopher's Addiction Wellness Center, and Serenity House Monroe. To expedite access, we executed SCAs while providers completed the contracting and credentialing process to become network providers. Using this approach, we will continue to grow our ASAM network of contracted providers, while removing barriers to these needed services.

BH Workforce Development. LHCC implemented targeted workforce development and training initiatives to address licensed BH specialist shortages, including: 1) scholarships at Southeastern Louisiana and McNeese Universities for Family NPs to complete the Post Master's Psychiatric Mental Health Nurse Practitioner (PMHNP) Certification Program; and 2) offering an 18-month training program on Child-Parent Psychotherapy for BH providers to treat children. Our collaborations with NAMI Peer Support and the Mental Health Association of Greater Baton Rouge expands provider capacity through peer support and professional development programs.



Integrated PH/BH Pediatric Practices. LHCC provided grants of up to $100,000 each to three pediatric practices (Red Stick Pediatrics, Children's Clinic of Southwest Louisiana, and Pediatric Center of Southwest Louisiana) to ***hire and co-locate BH specialists*** (LCSWs) to expand integrated primary and BH care for children, as well as paying an enhanced rate for BH services. ***Prior to this, the clinics did not offer co-located BH services.***

2.6.8.2.4 Network Development Challenges

We have successfully developed a comprehensive, statewide provider network that consistently delivers access to timely and culturally competent primary, BH, and specialty care. However, pervasive provider shortages across Louisiana present the most significant challenge: ***more than half of Louisiana's parishes are designated as geographic health professional shortage areas*** for primary, dental, and behavioral healthcare. Often these provider shortages disproportionately impact certain populations, such as Black enrollees. However, in many parishes, the providers needed to meet distance standards simply do not exist. Using a health equity lens, we deploy Community Health Workers who work with our provider network team to extend into our neighborhoods, offering culturally tailored and concordant services and address care gaps that support providers. We continually monitor for and address these challenges through innovative access and capacity improvement initiatives (see 2.6.8.2.3), as well as through our ***Health Equity Neighborhood Initiatives*** (see Section 2.6.5.5).

Some Louisiana providers are unwilling to participate in Medicaid, often citing perceived barriers associated with administrative burden, missed appointments, and financial impacts. Through high-touch provider engagement (See Section 2.6.9), enhanced reimbursement, and innovative value-based incentive models, we mitigated these issues and have successfully recruited and retain a robust statewide network. As evidence, ***we ranked first*** on 42% of all measures in the 2020 LDH Medicaid Provider Satisfaction Survey — significantly higher than the MCO with the next highest number of top ranked measures. We also minimize the burden of no-shows through our enhanced transportation benefit and targeting outreach to help enrollees make and keep appointments.

2.6.8.2.5 Strategies for Monitoring Compliance with Network Standards



As described in 2.6.8.2.3, ongoing locally-informed data analysis and transparent collaboration with LDH and provider partners are key to our strategy for monitoring compliance with provider network standards in Attachment F. Monthly, LHCC pulls network adequacy data, including full network listing and gain/loss information for reporting to LDH.

Monitoring Compliance with Distance and Linkage Ratio Standards

As detailed in 2.6.8.2.2, we monitor our network daily, supplemented by ***quarterly*** GeoAccess mapping of distance standards of primary, BH, and specialty providers, and recurring review of LDH linkages reports.

Monitoring Compliance with Access and Timeliness Standards

We (LHCC and our third-party vendor) use statistically valid sampling to conduct appointment availability and after-hours access audits quarterly, via "secret shopper" calls to providers, auditing the entire network over the course of one year. The auditor asks the provider for the next three available appointment times for the appointment category being audited, depending on the provider type, to confirm compliance with access and timeliness standards. In assessing network adequacy and compliance, we identify and separately report on specialists and BH with limited provider agreements (e.g., SCAs) and those who offer appointments only in hospital settings. Our Contracting and PE Teams also collaborate to confirm PCPs can access specialist and BH appointments. ***Of the 27 PH and 6 BH providers who were non-compliant in 2020, 100% are now compliant.*** Further, we analyze appointment access grievance data and PCP requests for specialty access ***monthly*** and appointment-related CAHPS survey results ***annually*** to identify/proactively resolve access issues in collaboration with providers. ***LHCC did not receive a single enrollee/provider grievance, appeal, or request for arbitration in 2020 regarding network adequacy or access.*** When issues are identified, PE Specialists re-educate non-compliant providers on access standards and require them to confirm compliance within 90 days; we re-audit within 90-180 days to verify compliance.

Cross-functional Accountability for Monitoring Network Compliance

LHCC's ***annual assessment*** and resulting Network Development and Management Plan (Network Plan) guide our contracting efforts, and ***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 adequacy standards and quality objectives. We hold our entire staff responsible and implement a *"no wrong door"* approach to ensuring enrollees have timely access to services. When staff identify an access issue, they notify our

Contracting Team directly, allowing automatic communication of network needs. Our Contracting staff also participate in recurring interdisciplinary meetings with staff to discuss access, such as:

- **Health Equity and Diversity Committee.** Meets ***quarterly*** to ensure network meets enrollees' race/ethnicity, gender, multilingual, and disability needs; works to reduce barriers and ensure culturally tailored care.
- **Medical Management.** Conducts a ***monthly*** regionally-focused, data-driven network analysis, including review of SCAs and enrollee utilization metrics that may impact adequacy.
- **Performance Improvement Team.** With cross-functional leadership, meets ***monthly*** to review network and provider performance data against access and availability standards and implement targeted solutions.
- **Quality Assessment and Performance Improvement Committee.** Convenes ***quarterly***, to collaborate with Quality, Executive Leadership, Utilization Management, Medical Management, Care Management, and Provider Engagement and Management staff to continually refine and improve our network design and provider performance.

Meeting activities also include monitoring improvement plans, enrollee satisfaction data, provider cultural competency metrics, peer comparison data, quality of care incidents, and provider satisfaction feedback.

Incorporating Stakeholder Feedback. LHCC staff regularly solicit network input from local stakeholders such as Enrollee, Physician, and Health Equity Committee members; state and local medical and provider associations; providers; and community organizations. Using the foundation of "***Nothing about me, without me***," we solicit feedback from Community, Enrollee, and Provider Councils on network quality and access barriers, focusing on identifying cultural barriers. As part of our Health Equity Neighborhood Initiatives, we will also solicit feedback from our Neighborhood Equity Councils. In collaboration with stakeholders, we develop strategies and interventions to reduce these barriers. ***Quarterly***, staff facilitate JOC meetings with hospital systems and other large provider groups. As a routine part of every agenda, we discuss potential adequacy and access issues, enrollee characteristics and patterns of care, and barriers such as health equity and SDOH issues.

Data Sources and Tools Utilized to Monitor Compliance. In addition to the monitoring efforts detailed above and in our response to 2.6.8.2.2, our Network Team and cross-functional staff collect, aggregate, and analyze multiple sources of data and information, as described in ***Table 2.6.8.2.5*** below.

Table 2.6.8.2.5 Data Sources and Tools Utilized to Monitor Compliance

Tool or Data Source *(and frequency)*	How Data/Tool Supports Network Adequacy Analyses
Quest Cloud Reports and Zelis Network 360® Tool (*monthly*)	Provides a comprehensive analysis of network strength and identifies provider targets for recruitment by specialty and geography.
Parish-level Geomapping; Ratios; and Panel Status Reports (*monthly*)	Confirms the availability of network providers by type, considering distance from enrollees' residences, and identifies potential gaps and/or capacity issues.
Appointment Availability and Timeliness Audits (*quarterly, annual*)	Proactively identifies potential capacity and access issues as well as provider compliance with network standards; confirms adequate access to after-hours/weekend care.
Network Adequacy, Membership, and Capacity Reports (*semi-annual*)	Confirms compliance with LDH ratio standards; identifies potential network capacity issues.
Population Health, Health Equity, SDOH, and Cultural Competency Needs Assessments (*continuous; annual report*)	Culturally and Linguistically Appropriate Services (CLAS) evaluation that overlays network access with membership characteristics such as race, ethnicity, religion and language to identify gaps in network concordance, quality of care and access. Metrics include cultural geomapping, discriminatory and cultural grievances and health disparities identified within clinical panels.
Current and Anticipated Enrollment by Zip Code (*monthly*)	Considers enrollee demographics and healthcare needs, helps to anticipate potential service or network expansion needs.
SCAs, Out-Of-Network Utilization Reports, Authorized Transportation Reports (*quarterly*)	Identifies potential availability issues by region/provider type (categorized by type for population served, services authorized); enrollee patterns of care trends; and contracting/workforce development opportunities.
CAHPS/Satisfaction Surveys (*annual*); Grievances Trend Reports (*quarterly*)	Identifies enrollee and provider satisfaction issues and complaint trends related to access, accessibility, and appointment availability.
Claims and Encounter Data (*monthly and ad hoc as needed*)	Detects patterns of care, under-use, or inappropriate use of services, and potentially preventable event trends that may indicate a network deficiency.

2.6.8.2.6 Recruiting and Retaining a Medicaid Tailored Network to Address Network Gaps

Recruitment Strategies for a Medicaid Tailored Network. As we identify potential network gaps, our local contracting teams target Medicaid providers for personalized, face-to-face recruitment, supported by our Medical Director. Specifically, we:

- ***Focus recruitment efforts on existing Medicaid providers***, particularly in rural areas, by monitoring provider referral patterns and SCAs for contracting opportunities, for example, and by using the various certification lists by EBP provider types to create target lists for outreach. In addition, network prospecting includes referrals from provider partners such as Ochsner, LCMC, LGEs, and FQHCs.
- ***Consider enrollees' prevalent languages spoken, cultural diversity, health disparities, and disabilities,*** including actively recruiting providers that qualify as Veteran and Hudson initiative participants.
- ***Identify and engage non-par providers*** through claims indicating a non-par status, review of other Louisiana MCO networks, and LDH's website provider lists. PE Specialists work closely with providers under an SCA to demonstrate our strengths as a partner, to help support the provider's decision to join our network.
- ***Use comprehensive third-party data sources,*** such as CMS data, and competitive analysis tools (e.g., Zelis Network 360) to help inform our targeted provider recruitment.
- ***Deploy Community Connections and Health Equity staff*** to develop population-specific and regional recruitment strategies to resolve gaps related to SDOH factors tied to access.
- ***Collaborate with our statewide associations, statewide/national partners,*** and affiliate Medicaid contracts to identify high performing PCPs, specialists, and BH providers, as well as ancillary services.
- ***Incentivize providers and negotiate flexible contracting arrangements*** to proactively outreach to and recruit providers, particularly in rural areas or those contracted in other programs.
- ***Offer tuition reimbursement, residencies, and other incentives*** to recruit through local medical schools.
- ***Outreach to out-of-state providers***, as approved by LDH, from our affiliate networks to fill gaps in rural and/or underserved areas — particularly where there are patterns of care for border communities.

Excellent Provider Retention

Less than one percent of network providers have terminated contracts with LHCC for reasons other than closing their practices or moving out of state.

Retention Strategies. Foremost, we retain providers through our ***proactive, high-touch, local, provider-facing team of PE Specialists*** who live in the regions they serve and focus on provider support, education, and satisfaction. In addition to frequent PE Specialist engagement, our field-based, regional Clinical Performance Liaisons (CPLs) further support providers to improve practice efficiencies and meet or exceed the quality metrics required for VBP advancement. In addition, our four Provider Educators (dedicated to claims, physical health, BH, and VBP) will offer targeted support to facilitate provider success in meeting LDH quality/access goals. ***We often go above and beyond to retain providers, especially when we have identified a vulnerable provider in a HPSA or other underserved community***. For example, Hurricane Laura irreparably damaged the Oceans (BH facility) in Calcasieu Parish, so we provided funding that allowed them to open a new office in Kentwood, remain open, and continue serving ***all*** Medicaid enrollees needing this essential service.

[redacted]

Supporting the Basics. LHCC knows timely and correct payment is fundamental to retaining satisfied providers, and we pay ***100% of clean claims within 30 days***. We continuously monitor timely and accurate payment and will offer providers access to our highly trained Provider Claims Educators, Claims Analysts, as well as Coding analysts, to improve claims submission/payment. To further reduce administrative burden, 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 to help providers meet their professional goals.

2.6.8.2.7 Ensuring a Network to Serve a Diverse Membership

LHCC ensures our provider network is providing culturally and disability competent services, with cultural humility, for our enrollees through strategies that incorporate:

- Network analysis specific to gaps in providing culturally responsive care and continuous monitoring efforts.
- Offering providers continuous support via financial investments, education, tools, and technology.
- Sharing of data/best practices and individualized consultation to ensure the delivery culturally- and disability-responsive/sensitive services

Monitoring for Diversity. Through efforts that include geomapping and heat maps, LHCC continuously analyzes our enrollee population in each region for population health trends related to cultural groups (see 2.8.6.2.5). We then overlay and compare this with network provider data to develop a CLAS evaluation barrier analysis and workplan. 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 and support strategies to improve access to culturally- and linguistically-responsive health care services.

We obtain feedback from providers and enrollees, for example through CAHPS and provider-surveys, and vehicles such as our Enrollee and Provider Advisory Councils, Health Equity and Diversity Committee, and Population Health and Clinical Operations Committee. Through this continual external feedback and cross-functional internal collaboration, we are able to better understand the cultural, disability, and SDOH needs of communities we serve and obtain suggestions to improve health equity, as well as cultural and ADA access.

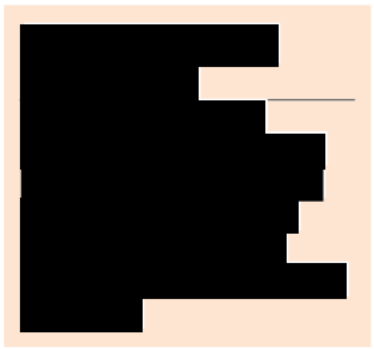
Additional monitoring efforts that ensure providers are meeting enrollee needs include:

- Requiring providers to attest to ADA compliance, and tracking accessibility
- Tracking and trending enrollee/provider grievances related to culturally sensitive care, services available to enrollees with LEP, and ADA accessibility
- Verifying reasonable accommodations for enrollees with mental disabilities such as: accommodating service animals; scheduling appointments later in the afternoon for someone who takes medication at night for sleep; permitting caregivers to accompany enrollees to appointments.

Quality Assurance. We also measure HEDIS outcomes and conduct an annual CAHPS Survey and stratify results according to race, ethnicity, and language preference to identify disparities in performance across specific groups of enrollees. We actively monitor grievances and appeals related to CLAS standards, cultural and disability sensitivity, and ADA compliance. If we identify a deficiency, our PE Specialists educate and support the provider, develop a CAP if needed, and follow-up within 90 days to confirm compliance.

Supporting Providers to Meet Cultural, Linguistic and Disability Needs

LHCC supports providers to promote culturally sensitive services to ***all*** enrollees, including for those with disabilities. [redacted] To educate and support providers, we:



- Provide free ***Cultural and Disability Competency*** trainings, including sessions about cultural humility, implicit bias, health equity, and considerations when caring for patients with disabilities. We offer CEUs and since 2019, LHCC has delivered over 800 cultural and disability competency trainings. We will require providers to complete health equity training using a "no wrong door" approach, allowing them to fulfill training requirements across MCOs through any entity, including another MCO, their own organization, or another provider group or CBO.
- Distribute best practice resources such as our ***Developmental Disabilities Health Care E-Toolkit***, ***Cultural and Disability Competency Toolkit***, and ***Provider Effective Communication Toolkit***.

- Offer ***language resources/tools*** to our providers, such as our ***Language Identification Tool***, which includes the top 19 non-English languages spoken in Louisiana to help providers identify languages enrollees are speaking and link the provider to appropriate interpretation and translation services.
- Improved 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.
- Offer providers ***enrollee-level and population data*** about enrollee demographics and health disparities to inform their work with individual enrollees and the community.
- Implement ***Pay for Performance*** programs around provider interventions to reduce health disparities, for example, our Black Mothers Maternity Model.

Meeting Members Multilingual Needs. Providers can view enrollees' language preferences through the Provider Portal and access free in-person, real-time telephonic and video remote access to professional interpreters in 150+ languages including Spanish, Vietnamese, French Creole, and American Sign Language. At no cost to the enrollee, interpreters assist providers onsite or by phone, to discuss technical, medical, or treatment information, 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 Louisiana Relay

2.6.8.2.8 Protocol for Terminating Providers without Cause

We consider LDH and our providers as partners in managing care for Medicaid enrollees. As such, ***we will exceed contract requirements and will not terminate providers without cause***. When a for-cause termination is warranted, our provider termination process adheres to all federal, State, and Model Contract requirements, including related to timing and notification. For enrollees receiving services from a terminating provider, we contact them through phone and mail to explain their options for selecting a new provider, assist the enrollee to choose a new provider that meets their needs, including provider specialty and enrollee sexual orientation, gender identity, age, and cultural/linguistic preferences. We confirm the provider has open panels and meets specified distance requirements to ***ensure a seamless transition with no disruption in care***. We schedule appointments with the new provider and coordinate care for enrollees with open authorizations. For enrollees with special healthcare needs, LHCC's Care Management Teams will meet with the enrollee, and/or their chosen support (as requested), to discuss and revise the Plan of Care, addressing any changes in services or providers. However, ***under no circumstance, will LHCC terminate a network provider without cause***.

SECTION 2.6.9

Provider Support

"I try my best to keep my patients out of the ER and help them live a healthier life. To do that requires that I am knowledgeable, so my patients are knowledgeable as well.

The level of detail and variety of provider trainings offered by LHCC make them a wise investment of my time. They explore important topics to providers, like helpful tips for quality measures, mistakes to avoid when filing claims, and information on improving outcomes for patients with diabetes.

LHCC leads the way in understanding what it takes to provide the best care to our patients."

- Shetila Burrell, FNP
Heart to Heart Care Clinic, Baton Rouge

2.6.9 Provider Support [12-page limit]

2.6.9.1 Comprehensive Approach to Provider Support and Engagement

As an experienced Louisiana Medicaid MCO, LHCC engages our providers as essential partners in improving the health and quality of life for our enrollees. To ***ensure appropriate support*** throughout their participation in our network we begin developing relationships with providers as soon as they enter into a contractual agreement with us, and we nurture those relationships for the duration of their time with us. Respecting providers' expertise and paying them promptly supports them in delivering the best care. Thus, we provide continuous, unlimited support to ***ensure timely authorizations and payments***, and ***proactively address concerns to minimize complaints.***

1st in Provider Satisfaction

LHCC ranked first among all MCOs for overall provider satisfaction in the LDH 2020 Provider Satisfaction Survey.

LHCC leadership and staff throughout our organization work together to provide comprehensive provider support aligned with our Quality Assessment and Performance Improvement (QAPI) and ***QualityPATH*** Value-Based Payment (VBP) programs, as described herein. As a result of our wraparound support, LHCC ***ranked first*** in provider satisfaction in the LDH 2020 Medicaid Managed Care Provider Satisfaction Survey. With a significantly higher response rate than any other MCO, we ***ranked first on 42% of all measures—significantly higher*** than the MCO with the next highest number of top ranked measures**.**

Our provider engagement, training, and support programs, and their related components (website, etc.) will comply with all requirements, including but not limited to those in the Model Contract and MCO Manual.

2.6.9.1.1 Process to Determine Adequate Provider Relations Staffing Coverage

LHCC hires more staff locally than any other MCO. Beyond that, we hire our Provider Engagement (PE) Specialists specifically from the regions they serve so they understand issues providers and enrollees face. We use a proprietary modeling tool to optimize staffing based on consideration of factors that impact the level of support providers need (e.g., population health, community cultural and social determinants of health [SDOH] needs), as described in 2.6.9.3. Based on the number of providers by types and levels of engagement they need, we staff for projected numbers of visits per provider per year; plus time for travel, ad hoc visits, and follow-up. We continuously monitor network performance and our own performance in maintaining provider and enrollee satisfaction and promoting health equity, staffing and training our teams accordingly. For example, we added ***Behavioral Health (BH)*** and ***FQHC PE Specialists*** to our regional PE Teams, supported by ***Clinical Performance Liaisons*** and BH Integration coaches to augment support for our safety net providers and promote BH/physical health (PH) integration and quality improvement. Where staffing needs can fluctuate rapidly, such as in the Provider Contact Center, our ***dedicated Workforce Analysts*** use sophisticated tools to predict and maintain adequate staffing in real time.

2.6.9.1.2 Strategies to Provide Effective and Timely Communication

Our time-tested strategies for ***effective, timely provider communication*** focus on building strong relationships via personalized outreach, education, and support. LHCC leadership is active in the communities we serve, listening to providers. Our Integrated BH/PH Provider and Practice Management Councils, and Joint Operating Committees (JOCs) provide feedback to help us target communication. Our PE Model features a single point of contact for each provider to streamline outreach and facilitate communication. We keep our providers up to date on LHCC and State policies and procedures, and support them in quality improvement efforts to fully benefit from our ***QualityPATH*** Program and provide excellent care. We systematically target outreach via personalized visits and messaging campaigns, also directing them to additional information. For example, we alert providers of LDH Medicaid Provider Bulletins and notices, such as the Bureau of Family Health's Developmental Screening toolkit, post the toolkit link on our website, and include information in our newsletters and direct email**.** We further facilitate provider-plan communication via our secure Provider Portal, Contact Center, provider handbook and other supportive materials.

Face-to-face engagement. Meeting with providers fosters effective communication and partnership. We meet at least monthly with our most critical providers and quarterly with other key providers, keeping them up to date with changes in policies or procedures. During these meetings we also provide ongoing technical assistance and clinical support, as needed, for provider success and satisfaction**.** We will continue to follow LDH guidance on face-to-face visits during the pandemic and to complete remote visits when providers prefer it.

Best Provider Portal Experience

Providers ranked LHCC's Provider Portal as first in 5 of 6 measures, including overall experience, among all MCOs in the LDH 2020 Provider Satisfaction Survey.

Secure Provider Portal. Ranked the best among all Medicaid MCO provider portals, our secure Provider Portal supports administrative self-service capabilities including eligibility inquiry, authorization, and claim submission and status. Clinical applications include online care gap notifications and health alerts, enrollee health records, patient and provider analytics, care and disease management referrals, and clinical practice guidelines. We also securely distribute to PCPs Admission, Discharge, and Transfer (ADT) event information that we receive in real time, supporting care coordination and provider-enrollee engagement for post-discharge care. We will enhance our web-based prior authorization (PA) support with InterQual Connect®, which incorporates InterQual Criteria in a fully automated, interactive workflow that supports real-time medical appropriateness review and determination.

Through our toll-free ***Provider Contact Center,*** we respond timely to provider inquiries, questions and concerns. Our Provider Service Representatives respond to non-routine PA inquiries 24/7, with a UM Nurse available to assist with urgent issues, and a Medical Director to address urgent medical necessity determination requests. For example, our BH Senior Medical Director approved, in real time, an additional three-day stay in an inpatient facility for an enrollee who could not access appropriate follow-up care upon discharge. Without this after-hours intervention, the enrollee was at risk of substance abuse relapse and readmission.

LHCC's Comprehensive Provider Education Program. Since 2019, we have provided more than 600 provider trainings, plus individualized outreach for BH and PH providers. In 2020, as our providers, enrollees and their families struggled with the impact of the pandemic, we responded with targeted training to help our communities. For example, we worked with the Mental Health Association of Louisiana to create a series of six micro-trainings for peers and providers supporting homeless individuals in isolation awaiting COVID-19 test results or in quarantine. We also collaborated with the Louisiana Managed Medicaid Association (LMMA) to develop and host joint trainings with other MCOs to help providers adopt telehealth to safely treat patients.

First Rate Training

BH providers ranked LHCC's training program first among all MCOs on all measures in the LDH 2020 Provider Satisfaction Survey.

Core Topics Training. All providers and their staff complete orientation and ongoing training, compliant with Model Contract Section 2.10.7, that covers contractual requirements and operations, and focuses on functions most relevant to them in their daily practice, such as service integration, billing, medical management, pharmacy requirements, quality, etc. We tailor training by provider type and local needs and ensure that providers know how to request additional training at any time.
Integrated Clinical Training. Clinical field staff, including dedicated PH, BH and VBP Provider Educators and our PH/BH Integration Coaches, provide training on clinical quality measures (HEDIS, VBP measures), cultural humility and implicit bias, pharmacy requirements and screening requirements for PH and BH providers. Every LHCC provider, regardless of specialty, has access to our BH clinical provider training program and coaching as needed to support BH/PH integration. Last year, we offered ***443 BH clinical training opportunities with 2,013 BH and PH providers in attendance, and awarded 3,170 hours of CE credit***. Topics include detection and treatment of BH disorders, including risk of opioid dependence, in primary care settings; Adverse Childhood Experiences; special needs of children in foster care; and Trauma-Informed Care.

Cultural Sensitivity and Health Disparities Education. LHCC's provider education program includes education and support initiatives to help providers address health disparities and population health issues. All providers receive annual cultural sensitivity training and we intertwine SDOH and health equity issues into all of our engagement, as appropriate. We also promote and provide a link to the DHHS Office of Minority Health's "Think Cultural Health" Program on our website, and our training catalog includes targeted modules, such as "Moving from Cultural Competency to Cultural Humility," and "SDOH and Mental Health." We will offer CEUs for implicit bias and health equity training. Starting in 2022, we will require all network providers to complete health equity training using a "no wrong door" approach, allowing providers to fulfill requirements through any entity, including another MCO, their own organization, or another provider group or community organization.

The Cost of Poverty Experience (COPE) Training. LHCC's Leadership team completed COPE immersive poverty simulation training that was eye-opening to the challenges our enrollees face, we committed to promoting it statewide. We will partner with prominent provider associations (e.g., Louisiana Primary Care Association, Louisiana Chapter of the American Academy of Pediatrics, Louisiana State Nurses Association, Louisiana Mental Health Association, etc.) to offer COPE Cultural Sensitivity Training virtually and as a free session at educational conferences. This nationally recognized interactive simulation guides participants through realistic challenges and decisions confronting people in poverty, focused on scenarios of poverty and family, Black maternal health, SDOH, the effects of addiction, mental health, and food insecurity. The training will be free to host organizations and participants, conducted multiple times a year, and we are pursuing CEU credits in Louisiana.

Population Health Initiatives to Address Disparities. LHCC's Population Health Management (PHM) framework and Health Equity Improvement Model guide us in addressing population health and health equity issues. ***Table 2.6.9.1.2*** describes provider education elements of initiatives to improve population health and health equity.

Table 2.6.9.1.2 Selected Population Health Provider Education Initiatives

Healthcare Ready and Centene Disaster Preparedness Partnership	We are initiating a two-year project to help improve emergency preparedness and capacity of Louisiana FQHCs to respond to natural and health disasters, including hurricanes, flooding, and COVID-19. The project includes initiatives to strengthen FQHC integration with government-managed response and relief efforts; increase supply resilience for hazards, especially in high risk/underserved communities; and provide capacity-building, training, and technical assistance for providers and operational staff. Other partners are the Association of Clinicians for the Underserved and Healthcare Ready, a non-profit organization that works to safeguard the health of all people by readying the healthcare system to respond to and recover from disruption.
LHCC's Sickle Cell PHM Program	Sickle cell disease (SCD) is a genetic blood disorder affecting approximately 100,000 people in the United States, mainly Black people. In Louisiana, approximately 80 infants are born with SCD every year and approximately 9,900 Medicaid-enrollees had an SCD-related claim between 2014 and 2017.[1] Our comprehensive Sickle Cell Program, includes provider education, partnership and support. We educate primary care and ED clinicians about SCD and our Sickle Cell Program, treatment best practices and care standards. Program successes include a ***33% increase in enrollees with SCD assessment, 31% increase in hydroxyurea utilization, 18% reduction in SCD-related ED utilization, 13% reduction in SCD crisis-related ED utilization, 51% reduction in SCD-related inpatient utilization, and 45% reduction in SCD crisis-related inpatient utilization***. We also partner with providers such as Our Lady of the Lakes Hematology Clinics (OLOL) to ensure enrollees have access to the latest sickle cell treatment. We observed ***a 34.9% decrease in ED visits, a 30.6% decrease in inpatient admissions, and a 19.1% decrease in Urgent Care*** visits among enrollees in CM that receive services through Our Lady of the Lake Hematology Clinic. ***Based on OLOL's success in improving enrollee outcomes, we are developing a VBP initiative, described in Section 2.6.9.2.2, to support additional providers.***
LHCC's Comprehensive Maternal/Child Health Program	We are committed to ***addressing health disparities and improving birth outcomes*** among Black enrollees statewide. In 2020, the mortality rate for Black infants was more than twice that of White infants (11.1 vs 5.1 per 1,000 live births) in Louisiana, and Black infants were more likely to be born low birth weight or preterm.[2] As part of our comprehensive Maternal/Child Program, LHCC will partner with the March of Dimes to offer "Breaking Through Bias in Maternity Care" training to all of our network providers. This training will help providers recognize and mitigate implicit bias in maternity care settings and it provides authentic and compelling content for providers caring for women before, during and after pregnancy. We will also promote the Bureau of Family Health's Developmental Screening Tool via implementation training hosted with partner providers.

2.6.9.1.3 Processes to Support Providers with High Claims Denial Rates



We support our providers every way we can to prevent claims issues from becoming denials [redacted]

We provide comprehensive claims training and support continuously, including any time a provider requests it. Part of our training focuses on avoiding common causes for denial, which we verify weekly by provider type to ensure training is up to date. This year we are adding a Provider Claims Educator to our PE Support Team to provide focused education on accurate submissions. Our secure Provider Portal features a Claims Status Tracker that allows providers to submit, view, and receive email notifications for reconsiderations of claims.

When we identify an internal configuration error, we alert providers and reprocess impacted claims within required timeframes. We are fully ready to meet the 15-days resolution requirements in the new contract. During field visits, PE

[1] https://ldh.la.gov/assets/docs/LegisReports/ACT117RS20131242020.pdf
[2]https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/IMR_MCH/population/IMR-Hispanic_MCH/state/LA

Specialists use ***Provider Claims Scorecards*** with actionable information for providers to improve the accuracy of their claim and encounter submissions, and our Claims Liaisons proactively work with providers directly, as needed, to resolve small batch and low dollar threshold claims in real time.

Identifying and Targeting Providers with High Denial Rates. LHCC's Provider Solutions Team monitors claims denials via weekly reports to identify providers with high denial rates and trends that point to broader issues. In addition to proactively outreaching to providers most impacted by claims denials, we develop special education and engagement campaigns to address new and emerging trends. For example, we have provided focused campaigns on telehealth billing; taxonomy, CLIA, COVID-19 vaccination, and Electronic Visit Verification (EVV). To resolve more complex claims or emergent issues, staff analyze root causes to develop actions to remediate them. For example, our collaboration with LMMA, noted previously, arose from an identified need to help providers accurately process claims for telehealth services. We also collaborate with the Louisiana Hospital Association to offer technical assistance claims webinars on Louisiana billing guidelines.

A Health Equity Approach to Reviewing Claims. LHCC is working to improve health equity in ***everything we do***. To better address health equity via claims reviews, we are expanding beyond provider-based analysis of claims denials and rejects to use enrollee level data analysis to identify and address any disparities in how specific enrollee groups may be impacted by claims denials and rejects.

"Out of all the MCOs, LHCC is by far the easiest one to work with from a clinic/provider perspective. LHCC Provider Relations…and claims departments are very resourceful, timely and efficient."

- Lisa Lang, Director of Program Development | CommuniHealth Services, Monroe

2.6.9.1.4 Wraparound Support to Promptly Resolve Provider Disputes

In addition to our focus on building relationships with providers to systematically identify and mitigate concerns before they rise to the level of disputes, our Louisiana-based Provider Solutions team reviews and resolves all provider complaints locally and in compliance with State requirements. We address each complaint individually and monitor trends to identify and remediate root causes of issues that may drive them. Due to our relentless focus on dispute resolution, ***in the first 6 months of 2021, the number of provider complaints was 27% lower than the number of complaints during the same period last year, 54% lower than 2019, and 76% lower than 2018.*** Also, the volume of claims re-work requests (complaints, reconsiderations, appeals, independent review requests) in the first half of 2021 is 41% lower than during the same period last year, and 64% lower than in 2019. Our comprehensive provider support ensures that we have fewer disputes progress to Independent Review Requests than any other MCO.

Excellence in Dispute Resolution

From 2018-2020 LHCC had the lowest number of Independent Review Requests-- 59% fewer than the MCO with the next lowest number.

Process for Evaluating and Resolving Disputes. Our Provider Solutions team receives disputes from all sources, assigns cases and tracks them 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. We work with providers and enrollees to prevent and immediately address assignment issues. Using this approach, ***we have had only six provider requests for reassignment in the last four years (2018-2021)***. Our LDH-approved process for evaluating and resolving enrollee assignment disputes within 10 days includes continuous panel review, and targeted provider and enrollee engagement.

Continuous Panel Review. We analyze provider panels and reassignments at least quarterly, per LDH guidelines, to identify and correct auto-assignment issues, flagging them as a potential agenda item for a provider visit or JOC meeting. To preserve enrollee-provider relationships, we offer misaligned individual enrollees reassignment to their most-visited or most recently seen PCP, based on use of services over the last 12 months, ***in collaboration with providers*** to ensure that they have the capacity to meet enrollee needs. We flag reassigned enrollees in our Provider Portal, which we update in near real-time so providers have accurate panel views and may dispute assignments within 15 business days.

Targeted Provider and Enrollee Engagement. We review panels with providers and identify hard-to-reach and/or non-compliant enrollees who would benefit from more intensive engagement, deploying supports to reach those enrollees and help them make and keep appointments. In addition, we compare providers managing similar enrollee populations to share best practices and target additional support as needed. Our providers know that we will work with them to resolve panel

issues, and we monitor provider feedback and utilization patterns to ensure that our assignment methodology supports population health, equitable access to quality care, and enrollee and provider satisfaction.

Independent Review (IR) Request. Our Provider Solutions Team manages the IR process in compliance with La-RS 46:460.81. We assign a key staff member to investigate each request, collect relevant facts and documentation, and make a decision to uphold or overturn our initial payment decision. If the provider is dissatisfied with first level review outcomes, they may submit an IR request to LDH. Due to our personalized support, we have the ***fewest IR requests among all MCOs, year over year from 2018-2020***, according to annual LDH transparency reports. Last year, for example, we had only six requests, despite having the most providers and enrollees. That is 46 fewer than the next MCO, and 211 fewer than the MCO with the most requests.

2.6.9.2 Key Strategies to Support Providers to Improve Quality and Reduce Costs

We help providers improve quality and reduce costs via a multi-pronged approach informed by and tailored to provider and population health needs. Foremost, our PE Model, described in Section 2.6.9.3, establishes a coordinated account management process that integrates across quality, risk adjustment, provider performance and VBP to provide comprehensive support. We streamline administrative tasks for our providers through a dedicated single point of contact for each provider, and supportive technology and tools to share data and performance analytics. Due to our wraparound approach, 100% of our enrollees receive services via a pay-for-performance model. To help providers deliver early and ongoing success, we designed and implemented our supports to:

- Foster innovation and the culture of quality that exists in our network
- Decrease fragmentation and increase integration across care settings via incentives and other supports, especially for BH needs and to support population health
- Leverage our relationships with providers and other stakeholders to develop delivery system innovations through our ***QualityPATH*** VBP and other initiatives and partnerships
- Link independent PH and BH providers to practice coaching and infrastructure supports
- Address health equity to reduce disparities and priority SDOH

[redacted]

Please see Section 2.6.12 for a detailed description of our ***QualityPATH*** VBP Program and alternative payment initiatives to support providers in providing quality care.

2.6.9.2.1 Strategies to Support Primary Care Providers (PCPs)

Our strategies to support PCPs in improving quality and reducing costs through participation in delivery system reform have been built in collaboration with providers, and reflect their needs and achievable goals. ***Table 2.6.9.2.1*** summarizes a selected sample of some of our support initiatives.

Table 2.6.9.2.1 Sample of Selected LHCC Strategies and Initiatives to Support PCPs

Strategy	Description of Initiatives
Provider Engagement & Practice Coaching to support PCPs	Our PE Team includes an integrated team of specialists, including BH and dedicated ***FQHC PE Specialists*** who ensure personalized engagement and support for PCPs in large and small practices, rural and urban settings, etc. Our PE support team includes ***BH/PH Integration Coaches*** and a ***VBP Provider Educator*** to help practices provide integrated care and participate in our PH/BH Health Home VBP models. Our ***Clinical Performance Liaisons (CPLs)*** coach providers on best practices to improve quality and achieve delivery system reform, working collaboratively with PCPs to meet quality targets under VBP arrangements. Our Medical Directors and Health Equity and Population Health Leads also help PCPs address clinical, health equity, and SDOH issues.

Strategy	Description of Initiatives
Primary Care Infrastructure Support	[redacted] **Emergency Support for Providers.** LDH required that providers not be negatively impacted by reduced incentive payments due to the pandemic. To further provide stability for our network PCPs and other providers, we are the only MCO to exceed LDH requirements by supplying providers with monthly cash flow (paying the higher of the provider's pre-COVID reimbursement amount or incentives achieved) rather than quarterly or annual payouts. We are also working with partners to implement a disaster response program to increase FQHC capacity to handle and recover from public emergencies, as described in ***Table 2.6.9.1.2.*** **Investing in Healthcare Professionals to Enhance Capacity.** LHCC funded an additional Nurse Practitioner (NP) at St. Martin Hospital's primary care Community Health Clinic in Breaux Bridge. This position enables the clinic to offer afterhours and weekend availability. Based on feedback from our Provider Advisory Committee, we also enhanced rates for after-hours services, permanently to help PCPs cover additional staffing for extended and weekend hours. [redacted]
Innovative VBP Models for Independent and Rural PCPS	[redacted]
Population Health Initiatives	**Maternal Health**. As part of our Maternal Health Initiative, we will support primary care clinics by hosting and promoting implementation training and support provided through the Bureau of Family Health at our ***LHCC Community Wellness Centers*** or at the clinics. In addition, we will incentivize clinics in areas where we have identified disparities to implement screenings during well-child visits. **Childhood Obesity.** We provided financial support to and are partnering with LSU's Pennington Biomedical Research Center (PBRC) to support PH and BH providers in managing childhood obesity, and in researching best practices. Through the TEAM UP program more than 300 children in the Baton Rouge and New Orleans areas will get help with weight management through several of our pediatric primary care clinics. PBRC is examining two common treatments for children who have obesity to determine the more effective approach to inform improvement in care delivery and quality outcomes. According to PBRC, 34% of Louisiana children (10-17) have overweight or obesity, compared to 20% nationally. [redacted]
Promote PH/BH Integration	**Incentives.** PCPs and PCMHs receive payments for timely completion of BH screens, such as PHQ 9 and SBIRT, and referral for treatment. We will reimburse all OB/GYNs and PCPs, including pediatric providers at ***Tulane Early Childhood Collaborative (TECC)***, that use SBIRT and appropriately refer enrollees to BH services. **Co-locating PH and BH providers.** In 2018, LHCC provided grants to three pediatric practices (Red Stick Pediatrics, Children's Clinic of SWLA, and Pediatric Center of SWLA) to hire and co-locate BH specialists (LCSWs) to expand integrated primary care and BH services for children. These efforts were so successful that one practice is considering adding a LCSW at one of their other clinics that serves Medicaid enrollees, and we now provide permanent enhanced rates for the services, allowing all three providers the opportunity to add other LMHP's to their practices. We also offer scholarships at Southeastern Louisiana and McNeese Universities for Family Nurse Practitioners who currently work

Strategy	Description of Initiatives
	for a LHCC-contracted FQHC to complete the Post Master's Psychiatric Mental Health Nurse Practitioner (PMHNP) Certification Program.

2.6.9.2.2 Strategies to Support Behavioral Health and Other Specialty Providers

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.

Table 2.6.9.2.2 Sample of Selected LHCC Strategies and Initiatives to Support BH and Specialty Providers

Strategy	Description of Initiatives
Provider Engagement to Support BH and Specialty Providers	PE Team experts advise BH and specialty providers on delivery system reform issues specific to their practices, such as privacy challenges for mental health and substance abuse data sharing. Expertise on these Support Teams include BH PE Specialists, CPLs, Medical Directors, and Health Equity and Population Health Leads with expertise in BH/PH integration, evidence-based practices, trauma-informed care, cultural and equity access barriers, etc.
[redacted]	[redacted]
[redacted]	[redacted]
Population Health/Health Equity Initiatives	[redacted] in conjunction with LHCC's award winning Geaux Baby and Me program, with the aligned goal of reducing pregnancy-related complications, premature deliveries, low birth weight deliveries, and infant disease. This is part of our comprehensive ***population/health equity initiative*** to improve maternal health outcomes that are disparately poor among Black women. Please see ***Table 2.6.9.1.2*** for additional details. In addition, we are exploring initiatives with [redacted] to help our maternal and child health specialists link enrollees to SDOH-related services, such as WIC. **Sickle Cell Program.** As part of our comprehensive ***SCD program*** (see ***Table 2.6.9.1.2***), we partner with OLOL, providing care management to support their Hematologists and Nurse Practitioners in delivering evidence-based care. Based on OLOL's successes we will work with additional SCD specialists to receive payments for managing episodes of care aligned with population health goals. ***We will establish bundled payments for specialists who address health equity issues and improve outcomes for enrollees with SCD.***

2.6.9.2.3 Strategies to Share Timely and Actionable Provider Performance Data

We deliver timely, accurate actionable data in transparent, accessible formats that support provider accountability for improving quality and reducing costs; plus support from our regional PE Teams to interpret the data and reports to support transformation, VBP readiness and performance improvement. Our PE Model focuses on continuous quality improvement,

and PE Specialists generate scorecards and personalized agenda topics for each visit to keep providers up to date on their performance and how we can help them.

We also make it easy for providers to track and manage their performance via our interactive analytics dashboards in our Provider Portal—ranked first for provider experience. For example, our ***Provider Analytics Dashboard*** enables providers to assess cost and utilization trending, quality measure performance, disease prevalence, readmissions, and health trends. Our ***Patient Analytics Dashboard*** enables providers to see patient disease registries and care gaps at the PCP or practice level, and identify opportunities to improve population health. Hospitals, specialists, and BH Providers use customized reports and data, offered electronically. Our Quartet platform enables us to share performance data with key BH Providers. We use automated, continuous monitoring systems to track Portal usage and file exchanges, and our PE Team follows up with providers to ensure effective use of data platforms. Below we summarize performance measures we share with providers.

Table 2.6.9.2.3 Key Provider Analytics Reports and Data Available to Support Performance	
VBP Performance	Financial views, measures and targets, number of gaps to close and patients to reach to achieve target, unearned dollars by measure and bonus calculation by measure
Hospitalization	View count and rate by disease and facility to track admissions, readmissions, ED use
Population Health	Patient disease registries (e.g., care gaps, PH/BH diagnoses, medication and labs, high risk patients)
Financial Reporting	Monthly expenses, YTD performance, eligibility and capitation file, revenue to identify cost drivers
Utilization	Enrollee list, population health categories, and utilization statistics (e.g., ED visits) vs benchmarks

2.6.9.3 Quality-Focused Model of Support and Service

LHCC designed our PE Model with a supportive integrated team structure that extends across multiple functional departments and designated PE Specialists as single points of contact for every provider. Our network stratification strategy guides our engagement levels and staffing, as described in Section 2.6.9.1, and supports our population health and health equity strategies, PB/BH integration, and quality improvement (including VBP). To determine the right level and type of support for each provider, we use a thoughtful approach driven by careful analysis of our network and provider performance. Specifically, we consider factors such as:

- Level, amount and types of services provided and total number of enrollees served (e.g., BH, specialty or high-volume providers)
- Regional differentiators (e.g., critical access needs, rurality), special needs of enrollees and their communities (e.g., population health issues, equity, SDOH needs), and community access to care patterns
- Participation in initiatives or programs (e.g., support for partnership, VBP efforts, QAPI)
- Level of familiarity with Medicaid (e.g., support for new providers), and claims payment and accuracy trends and provider performance history

PE Specialists meet at least monthly with our most critical primary care practices, hospitals and other providers; and quarterly with other key providers. Though our PE Model helps us target engagement, we never limit the frequency of engagement and ensure that providers know how to request support or training at any time.

Tools to Inform Effective Engagement. We design every provider touch-point in our engagement approach for efficiency and effectiveness. Our PE Specialists will use the ***Uniform Provider Performance Meeting Agenda***, an electronic checklist with the provider's specific claims, care gaps, quality metrics, performance earnings, and other measures that drive health outcomes and provider satisfaction. The agenda serves as a record for each provider encounter and feeds into our Provider 360 platform, described in 2.6.9.12. Provider feedback also informs visits and helps us identify training needs, as described in 2.6.9.3.4.

2.6.9.3.1 Staff that Play a Role in Provider Engagement & 2.6.9.3.2 Presence and Role of Field Staff

LHCC staff and leadership proactively engage providers to promote improvement in clinical services and related health outcomes, streamline administrative processes, pay providers promptly and resolve issues quickly. Leadership meets with providers regularly, and at least quarterly participates in JOC meetings with key providers. These meetings and our provider-led Board of Directors and Integrated Provider Council ensure that our providers help inform LHCC process and policy on enrollee needs, quality and population health initiatives, cultural humility, and strategies to improve provider engagement and satisfaction.

Coordinated Network Optimization. To maintain our focus on continuous quality improvement consistent with LHCC and LDH goals, our ***Network Optimization Team (Optimization Team)*** comprised of leadership from our Medical Affairs Finance, Operations, Quality, Pharmacy, Network Management departments, along with our Medical Directors and our

Chief Medical Officer (CMO), meet quarterly to discuss performance and the needs of providers down to the individual practice level. Based on these meetings, we determine which providers would benefit from targeted engagement from executive staff, and coordinate improvement efforts [redacted]

Experience and Expertise. As a Louisiana Medicaid MCO for nearly 10 years, we have brought together a PE staff with valuable expertise in providing excellent service to our providers. Our staff members bring a broad diversity of experience to our team, including decades of clinical, network management and organizational administration experience in hospitals, long-term care facilities, and community organizations. For example, our Director of Provider Engagement is a licensed social worker and former Chief Operating Office for Volunteers of America (VOA) in Baton Rouge. VOA affiliates provide a range of human services (counseling, housing assistance, youth mentoring, food assistance, etc.) in the communities they serve. Our deep and diverse collective experience makes us better at understanding, connecting with and supporting our providers and enrollees, and we care about them as fellow Louisianans. Our ***Regional Provider Engagement Teams***, described in ***Table 2.6.9.3.1-2***, can leverage the expertise of LHCC departmental leads from throughout our organization to engage providers directly to address particular issues when a more focused approach is needed.

Ensuring a Well-Trained PE Staff. We provide robust training for our PE Specialists and other PE staff and continually review their performance against quality metrics designed to support provider satisfaction and the integrity of our engagement model. To further ensure staff are equipped to advance excellence in our PE Model, LHCC will support select PE Team staff to complete appropriate nationally recognized certification programs, such as Drexel University's online Disability and Health Equity Policy Certificate Program, etc. ***Table 2.6.9.3.1-2*** summarizes field and support staff that plays a role in provider engagement and their responsibilities.

"Louisiana Health Care is very easy to work with…. Our representative, Rebecca Burns, always goes above and beyond in a timely manner for any questions or issues that arise."
- Ginger Jones, Coordinator, Springhill Medical Center

Table 2.6.9.3.1-2 LHCC Teams, Staffing and Responsibilities

Team	Provider Relations and Operations Functions
Provider Engagement (PE) Team	Our Provider Engagement (PE) Team includes core field staff in our ***Regional PE Teams.*** Headed in each service area by a Regional Manager, our ***PH and BH PE Specialists*** are the dedicated engagement leads for their assigned providers. They address all provider questions, concerns and recommendations; help identify performance improvement opportunities, and prioritize JOC agenda topics with LHCC leadership. Reflecting the importance of our FQHCs as critical safety net providers, we will include an ***FQHC Specialist*** on each regional team who understands their unique needs and can help them improve service delivery and benefit from VBP initiatives. In addition, a ***CPL*** dedicated to each regional team will visit providers to present evidence-based data, support practice transformation and VBP performance, review population health reports, and develop and support practice-level initiatives in case management, disease management, care gap closure, and other clinical initiatives. ***Additional PE and Education staff*** that support our regional PE Teams include ***Provider Educators*** dedicated to PH, BH and VBP who provide continuing education opportunities for providers and staff and focused education on topics critical to provider success. Specialized training offered throughout the state supports professional development and maintains a high level of expertise in our network. For example, our *BH Clinical Educators* provide support for a Trauma Informed Care approach to serving children in foster care. To allow our PE Specialists to maintain focus on quality improvement, we will hire a *Provider Claims Educator* to provide focused education as needed to help providers with accurate submission to prevent denials and ensure prompt payment. In addition, our new ***PH/BH Integration Coaches*** will provide education to support practice transformation and individualized coaching to PH and BH providers to help them better integrate care for our enrollees.

Team	Provider Relations and Operations Functions
Network Contracting Team	Our Network Contracting Team is in the field working with providers to ensure that our network provides adequate access for the full spectrum of covered services across all enrollees, and that providers have panel capacity to deliver consistent, timely, and culturally sensitive care to assigned enrollees. Contract Coordinators work with providers to keep their panels current and to submit panel data accurately to facilitate claims submissions downstream and prevent denials.
Provider Services Team	Our Provider Services Team manages our Provider Call Center that assists with general and claims-related inquiries, program operations and requirements, and access to interpreter services. The Call Center also cover emergent provider issues, enrollment verification and non-routine PA requests 24/7.
Provider Performance and VBP Team	Our Provider Performance and VBP Team, with our regionally dedicated CPLs, provide data analytics and interpretation, and other practice management and consultative support to those providers participating in our ***QualityPATH Plus*** and ***Premier*** VBP Models. Our CPLs play a critical role in supporting our providers to move along the continuum to risk.
Data Analytics Team	Our Data Analytics Team aggregates utilization and quality data, consolidates reporting from Operations and Finance, and develops and analyzes reports to support quality and value goals. They provide analytics for the PE team to identify, discuss and establish provider improvement goals and track their progress. Our ***Provider Solutions Team*** manages and resolves provider issues related to complex claims, including root cause analyses, and provides wraparound support to providers with high claims denial rates. ***Claims Liaisons*** work directly with providers, to proactively resolve claims issues as they arise and to provide targeted education during provider visits as needed.
Selected Sample of Additional LHCC Teams that Directly Support Providers	
Care Management (CM) Team	Our Care Management (CM) Team regularly support providers. For example, ***Community Health Workers*** on site at Women's Hospital support three of our OB/GYN clinics in providing excellent care to enrollees and linking them to community supports. Case Managers/CHWs are integral to our Disease Management programs, supporting both providers and enrollees to improve outcomes. They also help providers link enrollees to community services to address SDOH needs.
Health Equity and Population Health	Health Equity and Population Health staff will consult with our PE Team, as well as ***enrollees***, providers, and community stakeholders to advise on performance improvement related to health equity and population health, SDOH, and Community VBP models. Our Network Management Team will include a ***Health Equity Project Coordinator.***
Medical Management/ UM	Beginning this year, we will designate a Medical Director to each Regional PE Team to engage with our regional PE Engagement teams and the providers they serve, and make medical necessity determinations and PA approval decisions, thus supporting providers to provide timely care and submit clean claims.
Quality Team	***EPSDT and HEDIS Coordinators*** in our Quality Team collaborate with providers in hosting health fairs and other events to encourage enrollees to access needed services. They help providers target enrollees with care gaps and assist enrollees in accessing services by scheduling, arranging transportation, etc.

2.6.9.3.3 How LHCC Tracks Interactions with Providers

LHCC documents every interaction (electronic, physical and telephonic) with providers as well as identified issues and resolution. Provider-facing staff log engagement in our Provider 360 platform, a single relational repository for all provider data across all core provider functions. Appropriate staff can view engagement history integrated across all interactions. This enables our Contact Center staff and operational and clinical departments to handle inquiries efficiently, outreach to providers when needed, and manage provider data and contracts. Regional PE Managers track engagement timeliness and frequency and issues resolution. PE Specialists carry laptops, often tracking engagement in real time. Using a standard process, staff update interactions within 24 hours.

2.6.9.3.4 How LHCC Collects and Analyzes Data and Provider Feedback to Identify 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 trending data as

leading indicators of provider satisfaction and training needs. Using Centelligence, we can create reports that identify provider training opportunities.

We also collect qualitative feedback from our Provider Advisory Council, onsite PE Team meetings and ongoing outreach to providers, post-training evaluations, executive and medical leadership discussions with network providers, juvenile justice and child welfare advocates and experts, and stakeholders. We also solicit provider and stakeholder feedback through our active involvement in community and professional groups, such as the Louisiana Association of Healthcare Quality where our Provider Network Performance Manager is Treasurer. In addition, LHCC uses enrollee feedback on providers from our annual CAHPS survey to identify provider training opportunities.

Identifying Specific Training Needs. Our Provider Performance and Data Analytics Team analyzes and reviews Centelligence reports to identify large-scale training opportunities. Our PE staff curates trainings for our providers, including offering clinical coursework aligned with LDH population health priorities, such as improving PCP visits, maternal and child wellness, and cancer screening. Additionally, each PE Team identifies needs at the regional and provider level. They review key drivers in Provider 360, such as complaints and reasons for claim denial, to pinpoint need to retrain providers in specific processes or direct them to appropriate coursework from our extensive on-line course catalogue. Frequency of requests also helps identify need for training.

2.6.9.3.5 Metrics Used to Measure Overall Satisfaction of Network Providers

LHCC Provider Relations staff continuously monitor how well we support provider satisfaction, as described throughout this response. Metrics used include overall satisfaction, provider loyalty, access to linguistic assistance, provider enrollment, provider communication and training, claims processing and reimbursement, complaint/dispute resolution, network/coordination of care, and utilization and quality management processes. We also monitor and track claims and complaint data, call center after-call surveys and call category data and the results of any other ad hoc or statewide survey as directed by LDH.

We also contract with a third-party vendor to conduct an annual provider satisfaction survey. Our 2020 SPH Analytics Provider Satisfaction Survey Report includes measures that mirror those in the LDH Provider Satisfaction Survey. Our survey results show that we exceeded the SPHA's Book of Business Benchmark in nearly all measures; however, we learned that PCPs sometimes have difficulty finding a specialist. As a result, we are analyzing our "Find a Provider (FAP)" queries to determine what specialists PCPs request most often, and created a button on our FAP site that opens an email for PCPs to send to us for assistance, and informs them that we will contact them within 72 hours. Our Quality Assessment and Performance Improvement Committee monitors satisfaction metrics and findings to identify areas for improvement.

2.6.9.3.6 Approach and Frequency of Training on LHCC and Louisiana Medicaid Managed Care

Our approach to provider training on Medicaid and LHCC requirements is to train early in the contracting process, during orientation within 30 days of placing providers on active status, and at every appropriate opportunity. This ensures that providers and their staff understand the requirements, including marketing limitations and identifying special needs enrollees. Our PE Representatives outreach regularly, as noted herein, always informing providers of program requirement changes. As noted in Section 2.6.9.1.2, we use a variety of tools/materials to keep providers informed. We provide ad hoc training and refresher training whenever a provider needs or requests it or we identify an issue, as described in Section 2.6.9.3.4. We proactively engage providers to provide individualized or group training, including focused training (in-person, webinars, etc.) on claims and PA. PE Specialists conduct hands-on demonstrations of web and portal tools, forms and claims submission and PA requests, and we offer online courses that providers can complete any time. For example, required LOCUS training for non-licensed BH providers is available online 24/7, and we monitor for completion.

SECTION 2.6.10

Utilization Management

"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!"
@LA Healthcare Connections

- Elana
Enrollee, via Facebook

2.6.10 Utilization Management [15-page limit]

LHCC's Utilization Management (UM) Program encompasses the structures and processes to facilitate the delivery of high-quality, cost-efficient, and effective care across our entire membership. Our well-established and documented UM program and policies are in full compliance with the Model Contract requirements, including those in 2.12 Utilization Management; the MCO Manual; NCQA standards; and State and federal requirements, including 42 C.F.R. §438.210. The mission of the LHCC UM department and related programs is to assure enrollees are receiving clinically appropriate services, at the most appropriate level of care, while improving health and quality of life for all. To ensure LHCC is carrying out the mission, all UM staff complete health equity training, including Cultural Sensitivity, Culturally and Linguistically Appropriate Services (CLAS) Standards, Unconscious Bias, Unnatural Causes Series (offered to view independently or taking coordinated action through a Learning Circle), Trauma-Informed Care (TIC) and Introduction to Adverse Childhood Experiences (ACE).

2.6.10.1 Authorizing Services in Accordance with the Model Contract

Our strategies to meet and exceed contract requirements, reduce administrative burden, and ensure timely authorizations for the provision of high-quality care at the right time, right level, and in the right setting include:

Minimizing Authorization Requirements. To remove barriers to access, LHCC limits the number of services requiring authorization. We routinely review the authorization list to identify services that may be included to reduce the administrative burden on providers. We review utilization data and trends to determine which services we can add to the auto-authorization list. LHCC communicates changes to our service authorization list to providers via our Provider Portal, Provider Newsletter, and through ongoing conversations with providers.

In addition to all requirements (e.g., court-ordered BH subject to medical necessity) and exceptions for service authorization (e.g., no service authorization for EPSDT screening) as outlined in the MCO Manual and Model Contract, including Sections 2.12.3, 4, 7 and 8, we do not require a service authorization for selected outpatient surgeries performed in a participating ambulatory surgical center; American Society of Addiction Medicine (ASAM) Level 1 services; and portable oxygen for pediatric enrollees. Also pursuant to EPSDT requirements, we cover all medically necessary services for enrollees up to 21 years of age. We never require authorization for emergency services and cover all services needed to diagnose, stabilize, and treat enrollees with emergency medical conditions. While we contractually require providers to submit authorizations for inpatient physical health (PH) and behavioral health (BH) non-emergency admissions (excluding normal newborn deliveries), we leverage Admission, Discharge, and Transfer (ADT) data exchange to streamline this process, as described below.

To support providers and enrollees, LHCC does not require service authorizations for the continuation of medically necessary covered services of a new enrollee transitioning into LHCC, regardless of whether services are provided by an in-network or out-of-network provider for 30 calendar days and up to 90 days for enrollees with special healthcare needs.

Streamlining Physician-Administered Medication Authorizations. LHCC covers medically necessary physician-administered medications that are on the FFS fee schedule. These medications, when included on the Single PDL, will have the same preferred status and service authorization criteria as the Single PDL, even when billed and paid as a medical benefit. Our pharmacists and Medical Directors review these authorizations for enrollees to receive condition-appropriate medications. For all enrollees under the age of 21, we consider individualized needs based on medical necessity.

Reducing Administrative Burden. To reduce burden for providers, facility staff, and enrollees, LHCC requires only the minimum necessary information to process service authorization 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 UM team or Medical Directors outreach to providers to elicit needed information. Enrollees can make a service authorization request orally or in writing if the provider fails to submit one and the UM team outreaches to the provider for any needed information to make a determination. We educate enrollees about the availability of this process in our Enrollee Handbook and during the grievance process.

Streamlining Approval Processes

InterQual Connect, available through our Provider Portal, incorporates InterQual criteria in a fully automated, interactive workflow that provides a real time determination for select services.

Our flexible process is designed to help providers put patients first. They can call to request a service authorization, use our secure web-based Provider Portal, or submit by fax. Our service authorization Check Tool, available to all providers regardless of network status, allows providers to verify what requires service authorization in real-time. In addition, we have added a PA pop-up window, to prompt providers with reminders to attach supporting clinical documentation to avoid authorization delays.

Automation. To provide rapid approvals, we are implementing InterQual™ Connect through our Provider Portal in November 2021. The system has built-in criteria that guide providers through an efficient process, immediately flagging submissions for services that do not require authorization. Receiving real time determinations provides cost savings to the provider and ensures enrollees receive timely services. Upon approval, our system provides an authorization number and effective dates of service. We electronically store time and date of requests, LHCC's decision, clinical data used to support the decision, and notification timeframes for providers and enrollees. If we do not receive the necessary information, our dedicated UM Team outreaches to the provider to obtain information to approve the request.

Provider Workflow Integration. To help reduce service authorization denials with our providers using the Epic System EMR, LHCC will implement the Epic Payer Platform (Platform). Over 65% of Louisianans have a record in an Epic EMR in Louisiana.



Among multiple other functions, the Platform will enable providers to be automatically alerted to LHCC service authorization requirements for documentation while the provider considers the patient's treatment, all within the context of the provider's Epic EMR workflow, including LHCC medical necessity requirements related to the proposed treatment. Once the provider decides on a proposed plan of treatment, the Platform works with the Epic EMR to assemble the requisite data needed for the service authorization request, assembles that data into a request template, allows the provider to complete any missing items, and submits the request to LHCC. Any additional information requests and status are accommodated via the provider's Epic workflow, interactively allowing providers to submit the right information at the right time, without having to hunt for the data in their EMR.

Integrating ADT Data in Real-Time to Power Clinical Workflow. We encourage hospitals to participate in real-time ADT data exchange. With these ADT feeds, we can populate the authorization request and ***eliminate the need for providers to submit inpatient admissions paperwork***. ADT information can be a prime source of data in terms of trending emergency department (ED) utilization. In addition, the individual "real-time events" allow LHCC a point-in-time glimpse of how well our strategies to lower ED utilization are working.

In 2021, we began utilizing ADT transactions in real-time through our participation in the Louisiana Health Information Network (LHIN) to drive workflows in our LHCC CM and UM Platform such as inpatient admission authorization requests for efficient, accurate review by our UM team, alleviating the burden on our providers of calls and faxes. We also use the ADTs to automatically produce discharge planning alerts and tasks, and ED admission alerts for appropriate action by our Case Managers. In addition, we securely distribute ADT events to the enrollee's PCP and other providers engaged in the enrollee's care, via our secure Provider Portal to enhance effective care coordination. We are rolling out this ADT functionality as LHIN participating hospitals are ready, with ten facilities completed in August, and with an accelerated pace that will have all LHIN participants online with us by the end of 2021. ***Based on our experience to date with automated ADT workflow, we anticipate freeing up over 5,100 hours of clinical staff time per year that can be used for other enrollee care and provider support purposes.***

Interoperable Technology Makes It Possible. We use innovative industry standards such as CMS interoperability standards to enable our support of ADTs as described above, including Fast Healthcare Interoperability Resources (FHIR) and Representational State Transfer Application Programming Interfaces (RESTful APIs). We are active participants in two of the key HL7 FHIR initiatives, the CARIN Alliance and the Da Vinci Project, along with other leading healthcare providers, vendors, and payers – to ensure that we work collaboratively with the industry and continuously expand new use cases for clinical data exchange (such as our support for real-time ADT processing).

Use of Nationally-Recognized, Commonly-Used Criteria. Described in detail in 2.6.10.2.1 below, we use InterQual and other nationally recognized criteria and Inter-Rater Reliability (IRR) to test consistency. Because these criteria are 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 or enrollee care.

[redacted] Our Medical Directors, Network Management, and Care Management (CM) staff provide in-person assistance to providers and enrollees on UM processes. Through these interactions, LHCC continues to observe local patterns of care (which we reflect in our application of criteria) and continue to be responsive to provider concerns with our requirements or processes.

Meeting Timeliness Standards for Authorization Requests. LHCC adheres to service authorization policies and procedures for prior, concurrent, and post-authorization that comply with 42 C.F.R. §438.210, Model Contract Section 2.12.6, and court-ordered requirements. We conduct timely reviews in compliance with State and federal laws, contract requirements, and as appropriate, based on the severity of the enrollee's condition and urgency for treatment, as documented in the request. We constantly monitor turnaround times through UM reporting reviewed by the UM leadership team for immediate action. Interventions may include increased staffing; UM-specific process improvements, using Six Sigma and other quality-control methods; increased and innovative automation, including ADT feeds and our InterQual Connect through the Provider Portal; increased chart auditing; enhanced reporting capabilities specific to UM; and provider and staff education. Most recently, LHCC acted quickly in response to the Amendment 3 Contract revisions regarding the change in turnaround time requirements. ***In response to the 1- and 2-calendar day turnaround times (TAT), we increased UM operations to 7 days a week and added staff to fill these extended hours.*** We also provided initial and ongoing education to providers on submitting appropriate clinical details, used a guided review to allow for a decision on first review, and streamlined our process through the implementation of an automated solution. We have also implemented advisor review audits and streamlined documentation to support an efficient secondary review process if medical necessity is not met.

Workflow Process. ***Figure 2.6.10.1.A*** depicts our service authorization process from initial receipt of request to final disposition, including for expedited authorizations, and ***Figure 2.6.10.1.B*** depicts our informal reconsideration process.

Figure 2.6.10.1.A LHCC Service Authorization Workflow

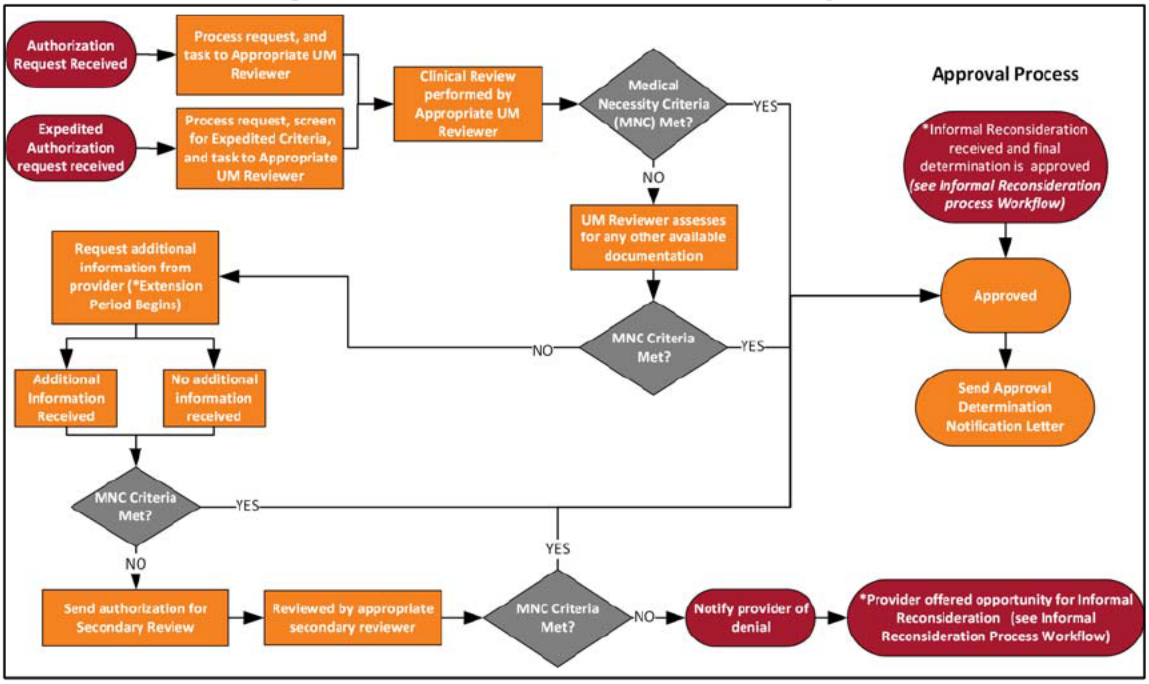
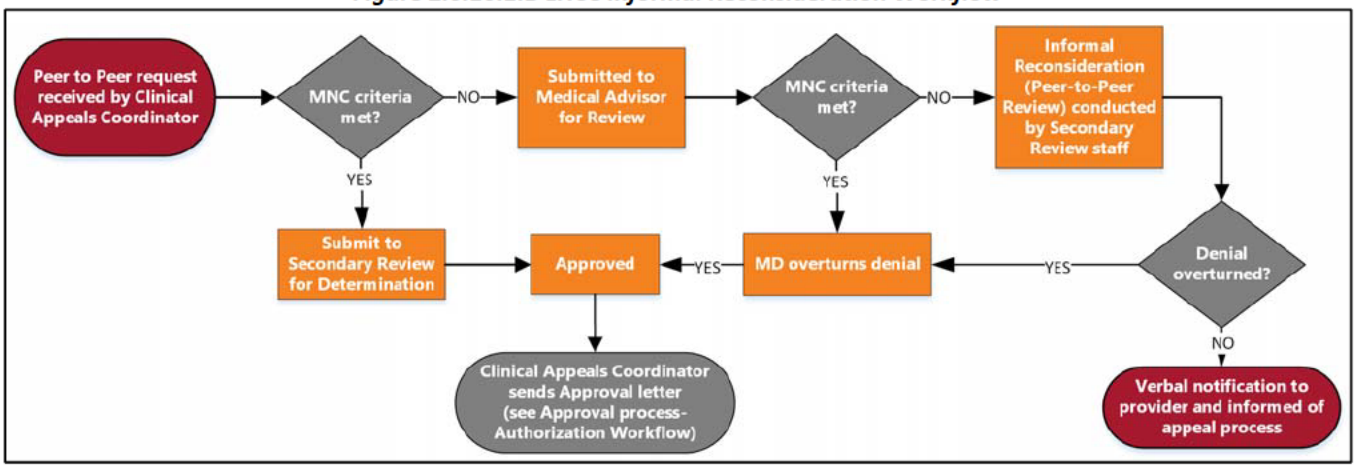


Figure 2.6.10.1.B LHCC Informal Reconsideration Workflow



2.6.10.2 Meeting and Exceeding UM Requirements



Through our UM Program, 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. Our program monitoring and processes comply with Model Contract section 2.12 and the MCO Manual; regulatory requirements and accreditation standards, including NCQA Health Plan Accreditation requirements for UM; federal regulations including 42 CFR 422, 431, 438, 455, and 456; and relevant State requirements. In alignment with our ***shared priority for integration of PH and BH services***, our programs fully integrate PH and BH to promote timely, appropriate, whole-person care.

Key Strategies for Meeting UM Requirements. Our collaborative UM approach uses a person-centered focus led by a local fully integrated PH/BH UM Team. We satisfy UM requirements and improve enrollee care by:

- **Serving as the Enrollee's Advocate to Obtain Timely, Needed Services.** Our UM clinicians, which include Registered Nurses (RNs), Licensed Mental Health Professionals (LMHP), Physical Therapists, Pharmacists, and Licensed Practical Nurses (LPNs) obtain information to approve requests for enrollees to receive what they need when they need it.
- **Using UM to Identify Disparities and Promote Whole-Person Care.** We perform data segmentation of our service authorization denials by race/ethnicity to identify if there are disparities in the denial of services. If disparities are found, we target provider support and resources to address the disparities.
- **Ensuring Local Provider Leadership on Clinical Policy**. LHCC's Integrated PH/BH Provider Council (Council) consults local physicians to ensure clinical policy reflects local practice patterns and standards of care, addressing provider concerns. Dr. Gary Wiltz, from Teche Action Clinic, serves as an advisor on the Council. Our Vice President of Health Equity and Vice President of Population Health and Clinical Operations (PHCO) are standing participants.
- **Supporting Providers.** Collaboratively, our UM and Provider Engagement Team offer training and support to providers to simplify UM processes. We offer comprehensive clinical training and easy-to-use web-based resources, which our providers can access at any time and free of charge. Our Medical Directors offer one-to-one outreach to collaborate and educate providers on criteria and policies. We include external providers representing PH, BH, and pediatric provider types on our PHCO Committee to ensure we are listening and incorporating critical provider feedback.
- **Supporting Continuous Improvement through Industry-Leading Technology.** We use our Centelligence platform and data analytics tools to track and trend data, inform UM activities and support planning and evaluation of improvement activities. This includes looking for under- and over-utilization, drilling down into root causes in collaboration with Population Health, CM, and quality, and designing interventions and activities to address, using external input through our advisory committees. Our proprietary tools also allow us to look at data at the sub-population level, including reviewing by race, ethnicity, language, disability status, and geography.

UM Program Scope. Our comprehensive and integrated UM Program applies to all eligible enrollees across all eligibility groups, age categories, and range of diagnoses. Our UM 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 sub-populations and court orders, which includes:

- Conducting UM and review functions for the Coordinated System of Care (CSoC) population and applying an initial risk screen for CSoC eligibility. We task 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.
- Facilitating service authorization for PASRR-recommended services.
- Performing pre-screening and timely notices of determination for, and authorization of, psychiatric residential treatment facility (PRTF) services in compliance with the Model Contract Requirements. 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.

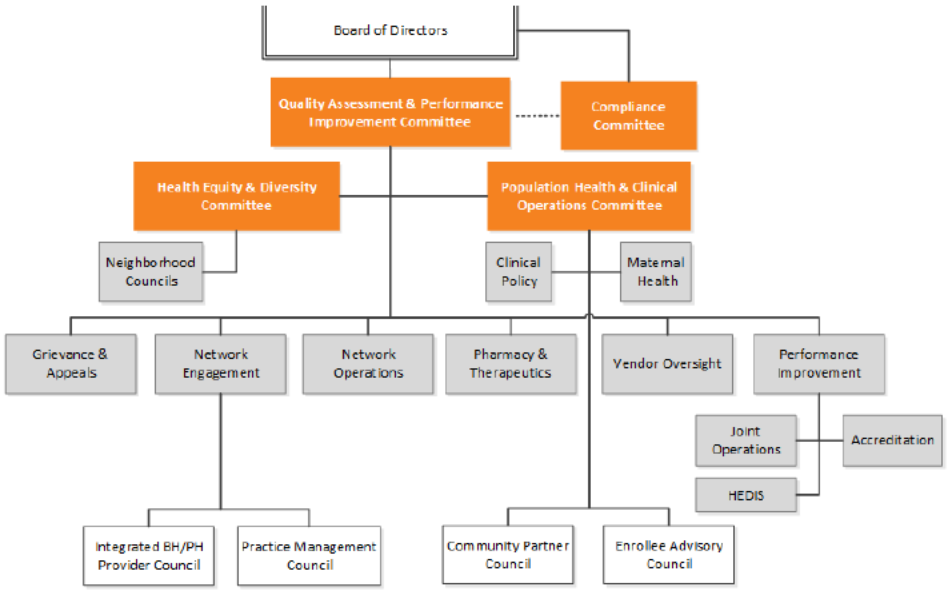
LHCC maintains or requires providers and contractors to maintain, an individual medical record for each enrollee, in accordance with the MCO Manual and in compliance with Model Contract requirements.

UM Program Oversight. Our Board of Directors has ultimate authority for our UM Program and delegates oversight of the UM Program to the PHCO Committee, which includes network providers. The PHCO Committee reviews and approves all UM policies, procedures, and performance and makes improvement recommendations to our Quality Assessment and Performance Improvement Committee (QAPIC). Our PHCO Committee also monitors the UM activities of both LHCC UM

staff and our providers under the direction of our Vice President of Population Health and Clinical Operations. Our Senior Leadership Team monitors day-to-day UM Program activities, and Louisiana-licensed professionals with deep roots in Louisiana provide clinical oversight of our UM Program. These professionals have long-standing relationships with Louisiana providers and many years of experience providing direct care for the Medicaid population.

PHCO Committee. During quarterly PHCO Committee meetings, the UM team reports on inpatient and outpatient utilization trends; reviews performance of the UM Program, such as authorization TAT, IRR evaluation results, NCQA audit results, percent of requests approved and denied, and appeal and overturn rates; and reviews and approves Clinical Practice Guidelines (CPGs) including medical necessity criteria. When adverse trends are identified, the PHCO Committee initiates root cause analysis and development of interventions to correct the trend, such as additional staff training, provider education, or policy updates. With ultimate accountability for quality, our QAPIC reviews all education and clinical program (e.g., UM, Population Health, Care Management, Disease Management) materials, programs, and policies to ensure they are consistent with adopted CPGs. Our Health Equity and Diversity Committee will also review and provide input and recommendations to ensure health disparities are identified and addressed. Other departments are consulted and tasked to help develop and implement action plans.

Figure 2.6.10.2 LHCC Committee Structure



Policies and Procedures (P&Ps). LHCC has established and maintains compliant UM P&Ps in place today. We submit all written P&Ps to LDH or its designee for approval as outlined in Act 319 and the Model Contract. P&Ps are reviewed at least annually by the Clinical Policy Committee and cover all elements of Section 2.12.1.2 of the Model Contract. We further comply with all document retention requirements, maintaining documents for a minimum of 10 years and destroying documents only with express written permission from LDH.

2.6.10.2.1 UM Criteria to Ensure the Right Care, in the Right Setting, at the Right Time

Proposed Criteria. 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; 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 Integrated PH/BH Provider Council ensures 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. Prior to adopting these criteria/guidelines, we ensure relevance to the specific characteristics of our enrolled populations through review and approval by our Clinical Policy Committee, PHCO Committee, and QAPIC. This process includes input from local practicing providers with experience serving these populations. For adverse determinations, we distribute specific underlying criteria to the provider, enrollee, or enrollee's authorized representative with all denial letters and upon request. LHCC has adopted PH and BH CPGs from national medical specialty or government organizations and as required in the Model Contract and MCO Manual. LHCC has also adopted and measures compliance with CPGs for specialized BH services. We have adopted the following CPGs from LDH's reporting tool for 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%.

How Criteria is Applied. LHCC UM Staff and Medical Directors apply approved criteria to review processes to ensure covered services are medically necessary and are not arbitrarily or inappropriately approved, denied, or reduced in amount, duration, or scope because of a diagnosis, type of illness, or condition. As described above, we use evidence-based guidelines, review criteria, and apply sound clinical judgment to determine medical necessity of requested services requiring service authorization.

Determining Appropriateness of Treatment and Site of Treatment. We ***look beyond clinical factors*** and assess social and other non-clinical factors to adequately determine appropriateness and necessity. We consider characteristics of the local delivery systems available, enrollee-specific circumstances, as well as other factors that may require deviation such as disability, acute condition, co-occurring conditions, life-threatening illness, or risk of institutionalization. Other considerations include factors that affect appropriate treatment and site of care, as described in the table below.

Table 2.6.10.2.1 Considerations in Applying Criteria to Determine Appropriate Treatment and Site of Care

Characteristics of the local delivery system:	Enrollee-Specific Considerations:
• 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 those 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
Considerations for Determining Appropriate Treatment:	**Considerations for Determining Appropriate Site of Care:**
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.

IRR Testing. We perform IRR testing annually to monitor the consistency of criteria application for all LHCC staff who participate in the medical necessity review of services. All staff performing medical necessity reviews are tested within ninety (90) days of initial InterQual or ASAM criteria training. All staff must obtain a score of 90% in each tested subset or complete additional training and retesting within thirty (30) days 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.

Staffing with Integrity. LHCC does not incentivize staff to deny, limit, or discontinue services. State licensure guidelines are strictly followed to ensure only licensed clinical professionals in good standing with no history of disciplinary action through their licensing body and only those with appropriate clinical expertise are allowed to make determinations. LHCC staff who support the UM process have no history of disciplinary actions with their licensing board. If disciplinary action should occur, these staff are removed from the UM team.

Initial and Ongoing Training for UM Staff. As new UM team members embark on their learning journey, we engage them in a number of trainings specific to their role, including hands-on training on our care and utilization management platform and training on external provider EMR platforms as well as the EPIC payer platform. In-depth training is also provided on our criteria platform (InterQual), clinical policies, and the annual IRR testing policy. We conduct monthly audits of UM team members for additional training, coaching, and disciplinary needs. Our staff receives ad-hoc training on changes to the UM process as updates to policies and contractual requirements are enacted. We also provide monthly 30-minute Lunch and Learn sessions facilitated by the Medical Advisor teams. The Medical Advisor teams educate the UM staff on specific

common diagnoses and treatments. The goal is to ensure that UM staff are abreast in best practices and know what to look for when completing medical necessity reviews. CE Direct is our learning platform made available to licensed and unlicensed clinical staff to receive continuing education units, monthly assigned training, and focused review training that prepare clinicians for certifications. Monthly course offerings include Transitions of Care; Health Literacy; and Working with Inter-Professional teams. Through our e-learning management system, UM staff can participate in training on Cultural Sensitivity, Unconscious Bias, and Unnatural Causes training. Additional training includes management of BH-specific conditions, ASAM, person-centered thinking, and TIC/ACEs.

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, we activate our auditing process. Outcomes from audits may result in additional training or process improvements, which may lead to additional staff 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.

2.6.10.2.2 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. Our Centelligence health informatics platform allows filtering by parish or providers, to track and trend ED claims and utilization data. We track statewide ADT data provided by Audacious Inquiry to identify enrollees with an ED visit in the previous 24 hours. We drill down on root causes and develop initiatives to address.

Enrollees with High Utilization. Our statewide 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.

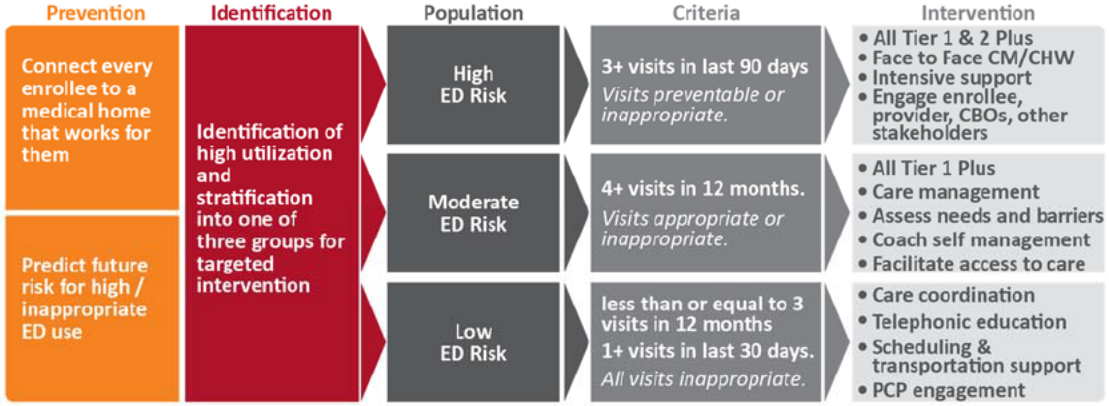
Prevention. Upon enrollment, LHCC connects enrollees to a medical home that works for them by educating them and supporting the selection of an appropriate PCP. We offer provider incentives to promote after-hours and weekend access. Prevention also includes identifying enrollees on a path to high utilization. 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 CM and CHW support as needed. UM supports this function by receiving ADT alerts and collaborating with CM to help curb inappropriate utilization. For example, through early identification via ADT data, we can deploy our Rapid ED Intervention (REDI) team to meet with enrollees while still in the ED. Our regional teams will include multi-disciplinary BH and PH professionals, CHWs, and peers, supported by UM staff, to address both clinical and social needs through follow-up visits and service coordination.

4.9% Decrease

From 2017 to 2019, ED utilization decreased each year with an overall reduction of 4.9%. PCP visits increased each year with an overall increase of 1.2%. In 2020, we observed significant reductions in ED and PCP visits, which in part we attribute to the COVID-19 pandemic.

Figure 2.6.10.2.2 ED Diversion Program



Addressing Disparities in ED Utilization. We also overlay health equity data from our ***Health Equity Dashboard*** and consider disparities identified. For example, in 2020, LHCC identified a 3.7% disparity in our rate of Follow-Up After ED Visit for Mental Illness (FUM) when comparing Black enrollees to White enrollees. Additionally, we noted that from 2019 to 2020, the magnitude of racial disparity increased. In response we introduced our ***Multicultural Toolkit*** for Reducing Non-Emergent ED Use. This toolkit was created to address messaging and intervention concerns for Black and Hispanic enrollees. The toolkit offers enrollee and provider interventions that tie back to specific considerations, such as faith and community-related health beliefs and family structure. To engage enrollees who are inappropriately utilizing the ED for low acuity needs, we conduct targeted educational campaigns every week. All enrollees who had a low-acuity ED visit in the previous week are sent materials promoting ED alternatives, like urgent care, their PCP, and our 24/7 nurse advice line. The design of these materials is informed by behavioral economics principles, including default bias, loss aversion, and decision paralysis.



[redacted]

Engaging Providers. LHCC alerts providers of ED use via the real-time ADT flag on the Enrollee Health Record on our Provider Portal. For providers with multiple linked enrollees with high ED use, we offer in-person supports, technical assistance, and training through our Clinical Performance Liaisons and our Provider Engagement Team. This team addresses provider performance such as care gaps, ED use, and primary care utilization in comparison with peers, appointment availability, ADA or cultural competency concerns, 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, brings 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 view cost and utilization metrics across multiple areas including primary care, specialty care, inpatient, outpatient, ED, pharmacy, and labs. Providers can also view, at a high level, the number of admissions/readmissions, the overall admission/readmission rates, and drill down into admission/readmissions by disease and facility.

2.6.10.2.3 Completing PASRR Level II Screenings and Concurrent Reviews

PASRR Level II Screenings. LHCC has Case Managers across the state who are trained in conducting PASRR assessments and a PASRR coordinator who is responsible for scheduling assessments for enrollees with qualified assessors, performing quality checks of required documentation, submitting completed documents to the Office of Behavioral Health (OBH), communicating with OBH, and collaborating w/ CM and UM on any recommended services. [redacted] When LHCC receives PASRR documentation from OBH, we confirm eligibility and a PASRR Coordinator ensures completion of the PASRR II assessment.

LHCC's PASRR assessor reviews all relevant enrollee information in LHCC's CM Platform; completes the PASRR assessment, LOCUS, and supplemental documentation; and returns all documentation including a recommendation on appropriate placement to our PASRR Coordinator within four calendar 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. The enrollee's Case Manager coordinates with the provider and UM for any service authorizations needed, follows up with the enrollee to assist with coordinating PASRR-recommended services and facilitates access to specialized BH services. Through custom reporting and alerts in our CM Platform, 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. For enrollees residing in a nursing facility who require specialized BH services, the Case Manager coordinates access to services per 42 CFR §483.120. If an enrollee is denied nursing facility placement, the Case Manager works with the enrollee, their caregiver/family support system and their Interdisciplinary Care Team (ICT) to ensure they can access all covered services and supports to enable them to remain safely and comfortably in the community. Specialized BH services are authorized within 15 days following recommendations as a result of the determination or admission to the nursing facility, whichever is later.

Concurrent Reviews. LHCC's UM staff determine the 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 days 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 the 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 UM team contacts the requesting provider to further justify the 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 appropriate level of care. Concurrent review timelines consider both NCQA and LDH requirements, meeting whichever is more stringent.

2.6.10.2.4 Meeting Mental Health Parity Requirements

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 comply with all requirements in Section 2.2. of the Model Contract and per 42 C.F.R. Part 438 Subpart K, for all enrollees. We ensure that medical necessity determinations for mental health (MH) and SUD benefits are available to all enrollees in no less restrictive a manner than 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 the Model Contract. 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: Service authorization, 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: 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. LHCC is dedicated to providing comprehensive, ***whole health solutions***, and as part of that commitment, we have developed a comprehensive Enterprise Parity Compliance Program to support the MHPAEA. Investments and developments have been made in staffing, training, reporting, and analysis to enhance procedures and develop a collaborative approach to uphold federal parity regulations and laws. All LHCC staff and provider training are consistent with the requirements of MHPAEA. We educate staff and providers to understand the significance of NQTLs and the importance of compliant UM, authorization, and access practices. LHCC requires staff and network providers to complete training on topics such as UM criteria and MHPAEA as part of initial onboarding and at least annually or upon any change in program or requirement.

2.6.10.2.5 Identification and Mitigation of Over-Utilization



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 CM 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. We also identify over-utilization through staff contact with enrollees and providers. Our Provider Performance Team may identify trends as part of an 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 and Targeted Categories. When inappropriate utilization is identified, LHCC takes action to connect the enrollee to CM programs to improve outcomes and quality of care. We use geographical analysis and hot-spotting, and health equity factors to identify provider access, availability, and other SDOH impacting utilization. Below, we summarize mitigation strategies followed by targeted categories.

Table 2.6.10.2.5 Strategies for Mitigating Over-Utilization

Programs	Clinical Policy	Provider Education	Provider Incentives	Enrollee Education	Identification of Disparities
Develop or modify CM programs that target high utilization such as ED Diversion or Prescriber/Pharmacy or Pharmacy-only Lock-In	Adopt or revise clinical policy to reflect local characteristics and incorporate provider input on effective practices	Develop or update provider training on evidence-based treatment of diagnoses driving high utilization	Incentivize PCPs to expand after-hours and weekend availability; incentivize development of new urgent care capacity and telehealth	Implement outreach campaigns and develop or revise education materials	Use Multicultural Toolkit in development of all outreach and education materials

Mental Health Rehabilitation (MHR) Services. LHCC created our MHR Dashboard to monitor overutilization and track our compliance with submission of the attending provider's NPI. LHCC collaborated with LDH to provide input on development of this rule to ensure enrollees only receive MHR services from one provider at a time. 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, Population Health and CM staff, and our Medical Directors to develop mitigation strategies. We also use this dashboard to identify NPIs associated with higher volumes of billing issues and provide education to providers on billing practices.

MHR Practice Transformation. In addition to the MHR Dashboard, our BH Medical Director developed a pilot with key MHR providers that included an innovative evidence-based Cognitive Behavioral Therapy (CBT) workbook. Participating MHR providers complete assessments with enrollees – adding structure and giving these providers the ability to add rigor to their practice; empowering them to move toward licensure and advancing the workforce. The goal is to address the needs of enrollees with anxiety, depression, oppositional behaviors, and conduct disorder behaviors by adding another level of treatment using evidence-based practice. Through the pilot, we can gain a better understanding of enrollees in MHR and identify high-quality providers that are willing to complete assessments and receive a quarterly incentive payment. Preadmission assessments are conducted using a standard form and then again post-discharge to determine impacts. In addition to post-program feedback surveys for enrollees and MHR providers, pre-and post-measures for baseline and progress include:

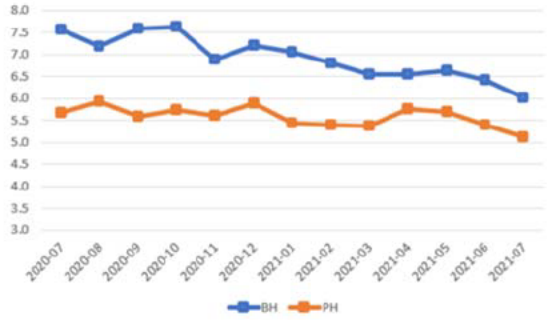
- Adult depression: Hamilton Rating Scale for Depression (HARD; Hamilton, 1960)
- Adult anxiety: Hamilton Rating Scale for Anxiety (HARS; Hamilton, 1959)
- Childhood / Adolescent anxiety and depression: The Revised Child Anxiety and Depression Scale (RCADS; Ebesutani et al, 2012)

- Conduct and Oppositional issues in children and adolescents: Disruptive Behavior Disorders Rating Scale (DBRS-PV; Friedman-Weieneth et al, 2009)Our UM Manager is available to providers on individual basis if needed There are currently four providers enrolled in the pilot.

Identifying Alternate Levels of Care. In August of 2020 we implemented our collaborative BH Alternate Level of Care (ALOC) rounds, where LHCCs BH Medical Director, UM team and CM team discuss complex BH enrollee cases to identify solutions for more appropriate levels of care rather than inpatient. The goal of the rounds is to connect with the enrollee to ensure services are in place to prevent unwarranted ED visits and IP stays. ***Since implementing ALOC rounds, ACT utilization for these enrollees has increased from 14.3 average per month to 20.2 average per month – an increase of 41% and Mental Health Intensive Outpatient (IOP) went from Avg 25.8 units per month to 47.3 after round implementation, resulting in a 45% increase for these enrollees.***

Addressing BH/PH Inpatient Admissions. In January 2021, we implemented our 3x per week ***Integrated Care Rounds*** to address inpatient stays with our Medical Directors, UM, CM and Transitions of Care (TOC) teams. These care rounds include comprehensive case reviews focused on how to move enrollees to a safe and appropriate discharge. Our TOC team reaches out to enrollees to address any PH and BH needs while the enrollee is still inpatient so services are in place when the enrollee discharges. As part of these discussions, we include Pharmacy in the discharge planning process to ensure service authorization for medications (if needed) is initiated to prevent delay and to facilitate a 90-day supply of medications (when appropriate) are available at discharge. We have noted a significant decrease in the average length of stay since the implementation of this initiative, as shown in ***Figure 2.6.10.2.5.A***.

Figure 2.6.10.2.5.A BH and PH Average Length of Stay Trends from 2019-2021



High ED and Readmissions. LHCC uses a multi-tiered approach to monitor and address high ED utilization and readmissions. Our strategies and approach for monitoring high ED overutilization were described previously in response to 2.6.10.2.2, and are similar to our approach to preventing, monitoring and addressing readmissions and risk for readmissions.

To address readmissions, we implemented a Readmission Prevention Program (see ***Figure 2.6.10.2.5.B***). 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 incorporates ADT and EMR data.

We evaluate RRS and input from facility staff, attending physicians, other providers, and our care management team to identify the type and duration of post-discharge supports [redacted]

Figure 2.6.10.2.5.B Readmission Prevention Program

In-Hospital Engagement. *CHWs connect with these high-risk enrollees to engage them in Care Management.*
Medication Reconciliation. *Enrollees discharging from an inpatient facility will have their discharge medications reconciled by our CM team in collaboration with Pharmacy.*
Transition of Care Team. *Our dedicated Transitions of Care Team and CMs collaborate with our UM staff on discharge planning and seamless transitions.*

[redacted]

Face-to-Face Coaching/Support. *Care Management team conducts in-person coaching on 'red flags' and readmission risks and provides coordination assistance.*
Link to SDOH Resources. *CHWs, Transition of Care Team, CCR nurses, and CMs identify needed SDOH resources and ensure enrollee access.*

[redacted]

Prescription Drugs. This is a key area we target for identification of overutilization and mitigation. LHCC maintains a Drug Utilization Review (DUR) program which includes prospective, retrospective, and educational initiatives. The prospective DUR program implements LDH directed clinical edits voted upon by the LDH DUR board, including opioid safety edits which comply with the federal SUPPORT Act. The retrospective DUR program monitors enrollee medication utilization for therapeutic appropriateness. LHCC implements all LDH DUR board-approved initiatives. Intervention letters to prescribers are sent when retrospective DUR criteria are met. Quarterly educational DUR programs are posted for providers which aim to improve prescribing and/or dispensing practices. In addition to LDH DUR programs, LHCC uses our nationally recognized Behavioral Health Medication Monitoring Program (BHMM). This program provides comprehensive case reviews, discusses alternative therapeutic options with prescribers, identifies potential SDOH barriers, and refers enrollees to case management for further interventions if needed. This program monitors stimulant prescribing for children under age 6, and persons age 18 or older, as well as monitoring the prescribing of antipsychotic medications to persons under 18 years of age. The BHMM program reviews metabolic monitoring and labs for identified enrollees on antipsychotic medications to enable early identification of potential comorbidities. Our Pharmacy Lock-In Program detects and prevents prescription abuse by restricting enrollees to one pharmacy and/or one primary prescriber with up to three specialists for a defined period of time.

Our Medication Therapy Management (MTM) program is comprehensive and patient-centered. Partnering with community pharmacists, the program ensures that medications are appropriately used to optimize therapeutic outcomes through comprehensive medication reviews and targeted interventions. LHCC MTM targets enrollees with multiple chronic disease states including behavioral health conditions, cardiovascular disease, diabetes, respiratory disease, and autoimmune disorders.

2.6.10.3 Experience with Utilization Management in Louisiana Medicaid

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; DOJ target population, and the Medicaid expansion population. LHCC also leverages our affiliate health plans' 35 years of experience, managing utilization for over 14 million Medicaid beneficiaries in 29 states. We use a fully integrated, collaborative approach to work cross-departmentally to address 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.

Both PH and BH providers rated LHCC highest for Overall UM Process in the most recent LDH Provider Satisfaction Survey.

2.6.10.3.1 Utilization Management Challenges

LHCC continually monitors for challenges to address high utilization and increasing medical trends.

Table 2.6.10.3.1 Challenges Identified with High Utilization and Increasing Medical Trends

Challenge	How Challenge is Identified
Discharge Planning and Breaks in Care	Historical trends based on monthly discharge planning audits.
Provider Errors	NPI mismatch reports, operational analysis, and provider reported need for near real-time feedback.
Post-Discharge Care Needs	Readmission rate reports, high dollar case reports, integrated care and ALOC rounds.
Segmented Care Delivery	Readmission reports, staff experience, and communication across teams, coordinated reporting structure, training on whole enrollee care.

2.6.10.3.2 Initiatives 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. The UM team acts as the gatekeeper that obtains clinical data first and promotes that data to support Population Health Initiatives. The UM Team communicates with the Medical Director and provider network about identified trends. UM is the hub that keeps updated clinical information at everyone's fingertips. Below, we summarize initiatives to manage challenges described above in 2.6.10.3.1.

Table 2.6.10.3.2 Challenges Identified with High Utilization and Increasing Medical Trends

Challenge	Initiative Description
Discharge Planning and Breaks in Care	Enrollee facing team with co-located CCRs, and EMR access to some other facilities. Transition of Care team supports provider through discharge planning process.
Provider Errors	InterQual connect web portal where providers can do clinical review and obtain a real time response.
Post-Discharge Care Needs	LHCC is working with vendors for delegated UM activities and facilitation of discharge planning. Agreements with home health agencies will support enrollees who require a higher level of care post-discharge, as well as concurrent enrollment into CM [redacted]
Segmented Care Delivery	Team restructuring for better collaboration, ongoing professional development, and trainings on complex enrollee care needs. Fully integrated BH and PH UM, which is operationalized 7 days/week. Integrated care rounds to address BH and PH needs of enrollees. UM participates in the entrollee-centric ICT which brings together a collaborative team of internal and external stakeholders as well as the enrollee/authorized representative for POC development and progression towards goals.

2.6.10.3.3 Initiatives to Address use of Low Value Care

LHCC identifies and addresses overutilization of low value services, as guided by LDH's Quality Strategy, including measures called out in Attachment H Quality Performance Measures. 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, employing clinical decision support, payment models, coverage policies, clinical practice guidelines, value-based contracting, provider training, and provider profiling to diminish low-value care spending, other initiatives not previously described include the following:

Non-pharmacologic Alternatives to Opioids for Chronic Pain Management. We are committed to fighting the opioid epidemic in Louisiana and helping LDH achieve its goal of better health outcomes for enrollees by offering multiple, evidence-based alternatives to opiate therapies for chronic pain. Our program for chronic pain management employs evidence-based treatment options that include acupuncture, massage therapy, and physical therapy to alleviate pain and restore activity levels. We offer memberships to the YMCA or similar local exercise facilities or exercise kits for home use. In addition to these physiological benefits, LHCC provides access to a suite of highly interactive, individually tailored and evidence-based virtual BH tools to help users address depression, anxiety, stress, SUD, chronic pain and sleep challenges, while also supporting the physical and spiritual aspects of whole-person health. More details on this program are included in Section 2.6.3.1.1.

Radiology for Low Back Pain. We also identified imaging for enrollees with low back pain as an opportunity for improving the value of care to our enrollees. The objectives of the lower back pain program are to optimize functional ability; reduce reoccurring episodes of pain; and reduce the number of lost workdays. We do this by offering a set of programs and interventions which include behavioral change health and exercise coaching; exercise mechanics and less intensive behavioral change health coaching; exercise recommendations with follow-up coaching; depression screening via telephonic health coaching; and emotional and stress management telephonic consults via a specialty coach as needed. Through the utilization of these programs, we are often able to provide immediate high value treatment to our enrollees and avoid the need for a referral to radiology.

2.6.10.3.4 Initiatives to Address Long Term ER Stays Based on BH Bed Availability

[redacted]

Increasing Network Capacity. LHCC actively works to expand the support system to better meet the needs of our enrollees. When an enrollee identifies a provider the enrollee is already engaged with who is not in our network, we outreach to the

provider and encourage participation in the network. ***LHCC is currently contracted with all 10 LGEs representing 49 locations throughout Louisiana.*** We supplement our network through our comprehensive telehealth solution with LSU Health Healthcare Network and LCMC. We are actively scaling up our current network of ASAM providers by seeking contracts with all licensed and qualified providers, targeting communities with distance gaps. We will also offer providers incentives for ASAM certification, as needed to meet the need.

Figure 2.6.10.3.5 PDHC Utilization per 1,000

Service Year	Utilization Rate
2019	941.74
2020	527.49
2021	387.02

Psychiatric Intensive Outpatient (IOP) as an In Lieu of Service. We provide psychiatric IOP as a step-down option from ED and inpatient stays and to increase the intensity of services to avoid an ED or inpatient admission. ***We provide IOP through partnerships with Oceans Healthcare, Compass Healthcare, and Acadia in 16 locations throughout the state***. We are exploring expansion to three additional locations through our existing partnership with Oceans. To date, 764 unique LHCC enrollees have received IOP services, which have demonstrated shortened inpatient lengths of stay, decreased preventable admissions, and increased enrollee satisfaction. ***For example, for enrollees with a full 12 months of eligibility, from August 2018 (program inception) to February 2020, we saw a reduction of 41% in admissions and 38% in ED visits.***

Promotion of Assertive Community Treatment (ACT). When an enrollee receiving ACT services enters the ED with a BH condition, 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 2018 to July 2021, ED visits for enrollees receiving ACT decreased by 38%.***

Rapid ED Intervention (REDI) Team. Helping to coordinate these services for enrollees in the ED is our REDI team. Leveraging ADT feeds, we monitor for high-risk enrollees in the ED, including enrollees with a BH diagnosis, for REDI dispatch to meet the enrollee in the ED to complete assessments, coordinate care, and expedite placements, as needed. The team includes multi-disciplinary BH and PH professionals, including, housing and peer support staff, able to help connect enrollees with needed services, both short and long term.

2.6.10.3.5 Initiatives to Support Providers with High Prior Authorization Denial Rates

Supporting Providers through Education. LHCC provides support and training to help providers understand our UM decisions are made in the best interest of our enrollee, and their patient. Our goal is for the enrollee to receive appropriate evidence-based clinical care that fulfills medical necessity. Our team works with the provider community to avoid denials and ensure our enrollees receive necessary care without delay. A recent example of this commitment came after using UM, claims, and appeals data to identify a high percentage of Pediatric Day Health Centers (PDHC) denials. Realizing providers may need support in making decisions as to the appropriate referral of children to PDHC's, we gathered a list of physicians with high referral and denial rates to PDHC's. Our pediatric Medical Director and Chief Medical Officer called these physicians to review the LDH/LHCC medical necessity criteria for PDHC referral. The treating physicians contacted were most appreciative of the education and had a much better understanding of the reasons for previous denials. After this education, we observed a significant decrease in inappropriate referrals to PDHC's. Subsequent medical director review of PDHC requests indicated the majority of requests, post-training, were appropriate and adherent to the LDH/LHCC PDHC criteria. This style of educational partnership with our provider community is but one example of LHCC's commitment to enrollee centric, provider-driven, high-quality, cost-effective care.

Provider Communications Through the LHCC Provider Newsletter and Surveys. LHCC encourages providers to stay engaged in bidirectional conversation around service authorization and denial rates. We provide a weekly newsletter, which frequently includes updates relating to improving the service authorization process and decreasing denial rates. We encourage providers to participate in provider surveys and we demonstrate a continuous feedback loop by creating carousel messaging based on feedback from surveys. When we have an event, such as a provider fair, this is what providers see.

SECTION 2.6.11

Quality

*"Louisiana Healthcare Connections has been my lifeline...
They really care and that means more to me than anything. They sent a doctor to my home recently for any other concerns I had away from cancer because they really want you to be healthy.
I've never seen an insurance company be that way.
Very special people work there."*

- Rachel
Enrollee, Covington

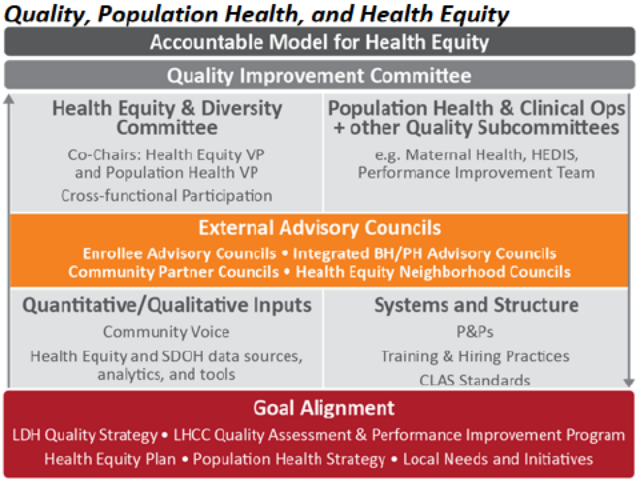
Hear more from Rachel on YouTube: https://lahealth.cc/rachel

2.6.11 Quality [15-page limit; clinical practice sample guidelines, NCQA rating attachment, and certificates of accreditation are exempt from section-specific and total page limits]

2.6.11.1.a Organizational Commitment to Quality Improvement

LHCC is committed to advancing health outcomes, health equity, and quality of care for all LHCC enrollees. Since our inception, our culture, systems, and processes have been structured around our purpose to ***transform Louisiana's health, one person at a time*** and achieve the Quadruple Aim. Our well-established Quality Assessment and Performance Improvement (QAPI) Program meets all State, federal, NCQA, Model Contract, and MCO Manual requirements, and is directly aligned with LDH's Quality Strategy, and our Population Health Strategic Plan and Health Equity Plan ***(Figure 2.6.11.1).*** Accountability for our QAPI program begins with our Board of Directors (BOD) who delegates operational authority to our QAPI Committee (QAPIC). Based on the principles of Continuous Quality Improvement (CQI), our QAPI Program articulates priority areas for quality improvement (QI); establishes clear aims, goals and objectives; details the standards and mechanisms for desired outcomes and integration with our population health management (PHM) strategy and health equity plan; 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 in areas such as preventive health, maternal and child health, acute and chronic care, physical health (PH) and behavioral health (BH) integration, access and availability of care, over-and under-utilization, continuity and coordination of care, transitions of care, patient safety, enrollee and provider satisfaction, social barriers to care, and administrative and network services.

Figure 2.6.11.1 LHCC's Organizational Alignment of Quality, Population Health, and Health Equity



Accountability Across the Organization. As a quality-driven, NCQA accredited organization since 2014, LHCC has adopted CQI as a core business strategy for our entire health plan. 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, reported through the QAPIC, to ensure a focus on quality across the organization. Each department is also responsible for ongoing monitoring, analysis, and development of recommended interventions to improve the quality of care and service to enrollees. All quality employees and plan leaders are trained on QAPI methodologies including an annual Quality Workshop, which covers topics such as NCQA, HEDIS® measurement, CQI, Plan Do Study Act (PDSA), and Lean Six Sigma. Additionally, LHCC staff complete ongoing and ad-hoc Health Equity training beyond CLAS Standards on topics such as Cultural Sensitivity, Unconscious Bias, Unnatural Causes Series, Adverse Childhood Experiences (ACEs), and Trauma-Informed Care (TIC). Across LHCC, ***63 staff have completed various levels of Six Sigma training, eight staff have CPHQ certification, and 100% of staff have completed TIC and ACEs training.*** As a deliberate focus of who we are and what we do, all CQI activities are developed through a ***health equity lens*** and aligned with NCQA's Multicultural Health Care Distinction (MHCD). With our initial survey in November 2021, ***we are on track to achieve MHCD in January 2022.***

5 out of 5 Rating

LHCC rated 5 out of 5 for enrollee satisfaction with plan PCPs and overall care in 2019 NCQA Health Plan Rating for Consumer Satisfaction.

2.6.11.b Overall Approach to Quality Improvement

LDH's priorities, goals, and objectives are fully integrated into our QAPI Program and infused throughout LHCC's 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 healthcare informatics platform. 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 Enrollee Advisory Council, Community Partner Council, and Integrated BH/PH Provider Council. We will listen and embed the perspectives and voices of the community and obtain their input through our Neighborhood Councils.
- ***A focus on issues identified by LHCC or LDH*** including but not limited to: disparity reduction, maternal and child health, HIV, vaccination, developmental screenings, Hepatitis C, and preventive dental services.
- ***QM/QI requirements of the Contract applied to both PH and BH services.***

Model for Improvement. The purpose of CQI programs is to improve healthcare 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: 1) What are we trying to accomplish? 2) How will we know that a change is an improvement? 3) 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 PDSA 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.

Using Data to Drive Improvement. We collect timely and actionable data to assess outcomes, identify disparities, determine improvement focus areas, drive clinical quality interventions, and evaluate results. Through Centelligence, we access integrated datasets, including those for HEDIS, EPSDT services, claims timeliness, Performance Improvement Project (PIP) informatics, and other critical aspects of our operations. Centelligence also supports our population health and health equity strategy and stratifies quality performance measures and utilization data by geography, age, sex, race, ethnicity, language, and disability status (RELD) to identify and report risks and disparities at population, enrollee, and provider levels. We deliver data to our network providers through our secure Provider Portal, including enrollee care gaps that are updated every 24 hours through our NCQA certified Interpreta system; enrollee health records with medical, BH, and pharmacy utilization; inpatient and emergency department (ED) Admission, Discharge and Transfer (ADT) for assigned enrollees; and access to online dashboards with quality and cost performance information at the group and individual practitioner level. ***For providers using three of Louisiana's most popular EMR systems (Epic, eClinicalWorks, and Athena Health), we support bi-directional connectivity via our Clinical Data and Interoperability Gateway. Our support of this data exchange allows providers to act on care gaps within their own EMR workflow, and to send us HEDIS and other LDH quality data efficiently with minimum provider burden.***

2.6.11.c Specific Strategies to Advance Louisiana Medicaid's Quality Strategy and Quality Measures

We collaborate with LDH, Louisiana Medicaid MCOs, the Louisiana Managed Medicaid Association, and other key contributors to improve health outcomes for enrollees. 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 that targets and engages enrollees, providers, and community partners to improve outcomes and advance the aims, goals, and objectives of Louisiana Medicaid's Quality Strategy.

Enrollee Strategies. We support enrollees to take an active role in their healthcare through multidisciplinary outreach and supports (e.g., quality liaisons, Community Health Workers (CHWs), Enrollee Service Representatives, Neighborhood Advocates) as well as leveraging our Digital Health and Wellness Platform and our My Health Pays® rewards program described in 2.6.11.2.2 below. General and targeted education materials include social media campaigns, targeted texting and email campaigns, information provided in the Enrollee Handbook, Enrollee Newsletter, and on the Enrollee Portal. To support a culturally competent and tailored approach to enrollee engagement, we stratify enrollee outcome measures by RELD to facilitate impactful interventions to drive improvement.

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; offering a variety of value-based payment (VBP) models; and collaborating in the development of innovative strategies to improve the delivery of care. For example, in 2021, we identified lower COVID-19 vaccination rates for enrollees that are homebound or have transportation barriers. Recognizing the need to meet our enrollees where they are, we partnered with Acadian Ambulance to expand home vaccination offerings. LHCC and Acadian have outreached to over 2,000 enrollees across regions with the lowest vaccination rates and are committed to continuing in-home vaccines until the threat of COVID-19 has subsided while expanding this model to address other identified needs.

[redacted]

[redacted]

Table 2.6.11.c Current and Planned Strategies to Advance Incentive-Based Quality Measures

LDH Objectives & Incentive-Based Quality Measure	Examples of LHCC's Current and Planned Strategies **Indicates planned strategies*
Objective: Ensure appropriate follow-up after ED visits and hospitalizations through effective care coordination and case management **Incentive Measures:** FUH, FUM, FUA	- Post-discharge monitoring and ADT feed reviews for care gap identification & support (e.g., outreach/follow up appointment scheduling, transportation) - BH Community Engagement team conducts field visits (currently virtual) to support successful transition to home setting and enrollee compliance with follow-up appointments - Provider incentives for FUH, FUM, FUA included in VBP models - Provider education via face-to-face, webinars, newsletters, etc. - Stratify by race, ethnicity, language, and disability status (RELD) to identify disparities - [redacted] - Deploy Rapid ED intervention (REDI) team inclusive of BH and PH professionals, CHWs, and peers, to the ED to engage an enrollee in-person to address both clinical and social needs through follow-up visits and service coordination*
Objective: Ensure maternal safety and appropriate care during childbirth and postpartum **Incentive Measures:** Cesarean Rate for Low-Risk First Birth Women	- Geaux Baby and Me comprehensive maternal and child health program - Stratify C-section utilization patterns to identify practitioner and facility outliers for targeted review and collaboration to reduce C-section rates. - Enrollee incentives for Notification of Pregnancy (NOP), prenatal and postpartum visits - Provider education via face-to-face, webinars, newsletters, etc. - Provider incentives for NOP submission, - Provider incentives for prenatal and postpartum care included in VBP models - Stratify by RELD to identify disparities - [redacted]
Objective: Improve immunization rates **Incentive Measures:** CIS, IMA	- Multidisciplinary review and identification of immunization care gaps - Multi-modal outreach, education, and reminders via IVR, email, mailers, social media, etc. - Provider education via face-to-face, webinars, newsletters, etc. - Provider incentives for CIS and IMA included in VBP models - Stratify by RELD to identify disparities - Home visit for all new enrollees in first 90 days* - Nurse home visiting resource in each Parish*
Objective: Improve cancer screenings **Incentive Measures:** CCS, COL	- Multidisciplinary review and identification of prevention care gaps including COL & CCS - Promote enrollee screenings through multi-modal outreach, education, and reminders via IVR, email, mailers, social media, etc. - Enrollee/provider incentives for preventive screenings (colorectal and cervical cancer) - Provider education via face-to-face, webinars, newsletters, etc. - Stratify by RELD to identify disparities - Collaborate with other MCOs to support Volunteers of America's (VOA) Determined Health CHW program to increase COL in Region 3* - Develop a culturally tailored toolkit to promote CCS for Black, Hispanic, and Asian enrollees*
Objective: Improve hypertension, diabetes, and cardiovascular disease management and control	- Multidisciplinary review and identification of chronic condition care gaps including CDC & CBP - Promote alternate enrollee engagement strategies including home testing kits (A1C), telehealth, and remote monitoring/digital blood pressure devices - Promote chronic condition management through multi-modal outreach, education, and reminders via IVR, email, mailers, social media, etc. - Enrollee My Health Pays incentives for diabetes management milestones - Provider incentives for CBP, CDC poor control included in VBP models

LDH Objectives & Incentive-Based Quality Measure	Examples of LHCC's Current and Planned Strategies *Indicates planned strategies*
Incentive Measures: CBP, CDC	- Provider education via face-to-face, webinars, newsletters, etc. - National Institute of Diabetes and Digestive and Kidney Diseases research study to understand the impact of SDOH needs for enrollees with type 2 diabetes - Stratify by RELD to identify disparities - [redacted]
Objective: Improve HIV control **Incentive Measures:** HIV Viral Load Suppression	- Multidisciplinary review and identification of HIV+ enrollees, antiviral medication adherence - Provider education via face-to-face, webinars, newsletters, etc. - Launched Social Health Bridge to connect high-need enrollees, including those with HIV, living in low-income housing to social services integrated with their care plan, ensure care gap closure, and reduce reliance on the ED - Stratify by RELD to identify disparities - Implementation of AbsoluteCare contract and clinic open* [redacted]

2.6.11.2.1 Assessment of Utilization and Opportunities for Improvement

As part of our systematic approach to CQI, our HEDIS Steering Committee reviews all data, including utilization rates, to identify and prioritize opportunities to improve performance. We assess the utilization of services of enrollees via trend analysis reports; inpatient, outpatient, and ED claims data; quality performance measures; grievances and appeals; enrollee and provider feedback; and medication utilization data. To identify disparities and inform interventions to promote equity, we stratify utilization rates, quality performance measures, disease prevalence, and other health indicators using RELD and geography data.

Data Sources and Benchmarks. We combine data from multiple internal and external sources including PH, BH, and pharmacy claims/encounters; electronic health records; UM and CM activities (e.g., assessments); lab and immunization data; and additional sources such as ADT feeds and census data. We establish thresholds for selected measures and set targets based on historical trends, LDH goals, local experience in Louisiana, and national benchmarks. For example, we target the NCQA 50th Percentile (or 2% improvement year over year) for prioritized HEDIS/quality measures and establish annual PHM benchmarks and goals that include disparity reductions in alignment with Attachment H.

Areas for Opportunity. Below is a *sampling* of prioritized areas of opportunity to improve utilization rates based on ongoing assessment and surveying of local health trends and identified needs.

Communicable Disease Prevention. Analysis of historical HEDIS data around preventive care, including Chlamydia Screenings (CHL), revealed an improvement opportunity for our membership. See 2.6.11.4.4 for a description of data analysis findings, QI interventions, and improvement in outcomes.

Follow-Up After Hospitalization for Mental Illness. LHCC analysis of inpatient utilization and readmissions data identified presence of BH diagnoses as a key driver. 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 2.6.11.2.3 for a description of interventions we initiated to improve access to BH step down services.

Chronic Disease Care. Hypertension is the 4th most prevalent chronic condition in the LHCC population. Detailed analysis of our Controlling High Blood Pressure (CBP) HEDIS measure revealed areas with large numbers of non-compliant enrollees. See 2.6.11.3.3 for data analysis, QI interventions, and improved outcomes.

2.6.11.2.2 Provider VBP Program and Enrollee Incentives

A key strategy in our QI and PHM programs, LHCC's enrollee incentives and provider VBP programs are aligned and in compliance with applicable state and federal requirements as well as the Model Contract and MCO Manual requirements, promoting healthy behaviors, quality outcomes, and appropriate utilization.



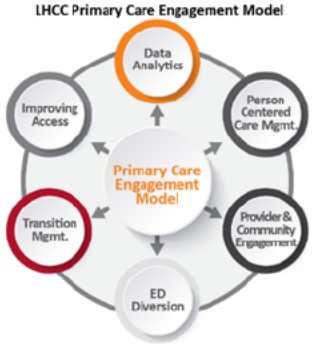
Provider Shared Savings and Quality Incentives. LHCC partners with our providers to encourage and recognize evidence-based, quality healthcare, including appropriate delivery of preventive care and screenings and follow-up treatment and services. [redacted] Our package of financial and non-financial provider incentives includes:

Non-Financial Incentives	LHCC makes a point to recognize our high-performing providers to show our appreciation, learn from, and share best practices. Our annual Physician Summit Award for Excellence in Care acknowledges healthcare professionals for the exemplary care they deliver. Each year we honor both a PCP and an OB/GYN. Other non-financial incentives include recognition of PCMH status in our Provider Directory and preferential assignment of new enrollees who have not selected a PCP to higher-quality providers.
Financial Incentives	LHCC is committed to creating better financial, quality, and administrative alignment between our plan and providers, starting with a flexible VBP program that meets providers where they are in their ability and readiness to move along the continuum of value and risk. For instance, LHCC pays enhanced rates for after-hours and weekend primary care visits, a Category 2 model. Our Pay-for-Performance (P4P) program rewards providers for achieving benchmarks in preventive care and condition management measures. Category 3 and 4 models offered shared savings payments for high-quality care in the right setting at the right time

My Health Pays Rewards. LHCC offers My Health Pays, our enrollee rewards program that actively promotes personal healthcare responsibility and ownership by offering enrollees financial incentives for healthy behaviors and adherence to care plan regimens. To ensure access to incentives for all enrollees, incentives are promoted during all LHCC-enrollee interactions and in our new enrollee materials. Enrollees can use rewards to pay for childcare, rent, and utilities or to purchase a variety of health-related products from our online Reward Catalog, Walmart, and other retail stores [redacted] With LDH approval, we will enhance our My Health Pays program to better align with our PHM strategy, tailoring incentives to support the needs of enrollees disproportionately impacted by disparities. We will use feedback from our Enrollee Advisory and Neighborhood Councils to evaluate effectiveness and make enhancements. Proposed incentives for 2022 include:

Incentives	Incentives Description
Healthy Activities	$5 New Enrollee Portal Account Registration. Register within 60 days of enrollment in the plan. $25 Health Needs Assessment in first 30 days ($15 for 90 days). $30 Infant Well Visit Series (birth to 15 months). 6 visits with assigned PCP by 15-month birthday. $50 Immunizations for Adolescents. All vaccinations listed in HEDIS IMA measure by 13th birthday. $25 Sexually Transmitted Disease Screenings. HIV, chlamydia, and gonorrhea screening. $25 Smoking Cessation Prescription. One prescription once per calendar year. $50 Breast Cancer Screening. Complete 1 screening per calendar year. $50 Cervical Cancer Screening. Complete 1 screening per calendar year. $50 Colorectal Cancer Screening. Complete 1 screening per calendar year.
Pregnant and New Moms	$30 for completion of Notification of Pregnancy form. $10 for each Maternal Health Prenatal Pregnancy Visit (up to 11 visits). $50 for Maternal Health Postpartum Visit (up to 8 weeks after delivery). $50 CM Perinatal Substance Use Disorder Program Participation. Enroll in pregnancy CM and complete care plan milestones.
Chronic Conditions	$50 Annual Comprehensive Diabetes Care Ages 18-75. Complete all of the following once in the calendar year: HbA1c test, Kidney screening, and Retinopathy screening (dilated eye exam).
Behavioral Health	$50 ADHD Follow-Up after New Prescription (6-12 years). Complete follow-up visit with the prescribing physician within 30 days of an initial prescription fill for an ADHD medication.
CM Health Grant	$50 SDOH emergency relief grant. This incentive will be manually issued by a case manager to help an enrollee overcome a specific barrier to health. Limited to once per calendar year.

Digital Health and Wellness Platform. LHCC will offer enrollees a comprehensive Digital Health and Wellness Platform (available on both mobile and web portal platforms), that promotes daily health and wellness through tailored educational messaging; reminders regarding medications, appointments, and community/health events; sleep, diet, and exercise tracking; healthy rewards; and targeted engagement and reminders regarding LHCC's Population Health programs. Enrollees have the opportunity to earn activity-based rewards for tracking activities such as movement, diet, sleep, and participating in LHCC health-related challenges, and can spend rewards through the app or using an LHCC issued debit card. To increase Health Needs Assessment (HNA) completion rates, the HNA is built into our Digital Health and Wellness Platform, providing enrollees an additional opportunity to complete the assessment. To ensure access to the platform, we will provide



enrollees with additional data via the SafeLink smartphone or a referral to our ConnectionsPlus program if they do not qualify for SafeLink. Enrollees can also access the platform at broadband-enabled computers that will be located at each of our ***nine Community Wellness Centers***.

2.6.11.2.3 Evidence-Based Strategies to Target Super-Utilizers and Reduce PPEs

To target super-utilizers and reduce potentially preventable events (PPEs), LHCC has developed a comprehensive Primary Care Engagement Model, blending six core components (see ***Table 2.6.11.2.3)***: (1) data analytics and reporting; (2) person-centered care management; (3) provider and community engagement; (4) ED diversion; (5) transition management; and (6) improving access to primary care and BH step down services. This targeted approach is tailored for enrollees with multiple complex PH and/or BH conditions; addresses cultural and social needs; creates a plan of care and support framework to reduce inappropriate and duplicative services, including PPEs; and connects the enrollee with primary care.

Table 2.6.11.2.3 Components of LHCC's Primary Care Engagement Model to Target Super-Utilizers and Reduce PPEs

1. Data Analytics and Reporting	Engaging super-utilizers to change their care utilization patterns requires strong data models and processes. LHCC identifies, monitors, and trends PPEs and other high-utilization metrics through Centelligence, which identifies PPEs including avoidable ED visits, admissions, and readmissions trends. Through our participation in the Louisiana Health Information Network (LHIN), we receive ADT transactions in *real-time* through LHIN's partner, Audacious Inquiry, a leading provider of HIE technology. These real-time ADTs are electronically received by our CM Platform which drives automated workflows such as inpatient admission authorization requests for efficient, accurate review by our UM Team, greatly alleviating the burden of calls and faxes on our providers. We also use the ADTs in our CM Platform to automatically drive discharge planning alerts and tasks, and ED admission alerts for appropriate action by our Case Managers.
2. Person-Centered Integrated Care Management (CM)	Our integrated CM model supports person-centered, whole-person care that is recovery-oriented, culturally responsive, and encourages personal responsibility and enrollee engagement. LHCC's CM staff provide multidisciplinary support and consultation for enrollees who are super-utilizers, linking the enrollee to a PCP/medical home, BH provider, and other treating providers as appropriate to re-establish access to primary care and appropriate use of outpatient services. Examples of CM interventions include comprehensive post-discharge follow-up, including medication reconciliation to avoid readmissions; health coaching and education, including management of complex chronic PH and BH conditions; coordination of primary care services and appointment scheduling; and linkage to community resources to address barriers to care. A 2019 analysis ***showed a 16% decrease in ED visits and a 15% decrease in inpatient visits for enrollees active in CM.*** From 2017 to 2019, LHCC saw a ***20.9% reduction in Potentially Preventable Admissions.***
3. Provider and Community Engagement	Sharing of actionable clinical information with key providers and community partners is critical to ensure clinical decision-making is based on complete information such as care gaps, recently developed complications, and service utilization. Our technology solutions support coordination and sharing of health information with the enrollee, providers, and others involved in the care of the enrollee. As described in 2.6.11.1, for providers using Epic, eClinicalWorks, and Athena Health EMRs, we ***support bi-directional data sharing*** and connectivity via our Clinical Data and Interoperability Gateway. Our LHCC CM Platform incorporates our secure Provider and Community Partner Portals and supports our CM workflow processes and collaboration. Our secure Provider Portal supports a growing number of clinical applications including online care gap notifications and health alerts; ED high utilizer alert if an enrollee has had three or more ED visits in 90 days; and access to the Enrollee Health Record including completed assessments; visits; medications, immunizations; labs results; and care plans. Our Community Portal offers authorized community partners similar secure access to promote information sharing and collaboration across partnering agencies, such as Catholic Charities of New Orleans
4. ED Diversion	ED diversion is a two-part strategy: (1) prevent high utilization before it occurs, and (2) identify and target strategies to mitigate high utilization. In response, LHCC has developed a comprehensive program to educate enrollees and offer alternatives such as after-hours urgent care (encouraged through VBP), and access to 24/7 Nurse Advice Line and BH crisis services. We promote enrollee engagement with their PCP and assist with selection and appointment scheduling. Additionally, our systematic strategies are designed to mitigate factors that drive non-urgent ED use such as reduced access to primary care, complex needs requiring care coordination, and SDOH barriers, including cultural differences. For example, we recognized that Black and Hispanic enrollees tended to use the ED for non-urgent cases, so we developed a ***Multicultural Toolkit to reduce non-emergent ED***. As a result of our efforts, ***from 2017 to 2019 we realized a 17.6% reduction in low acuity non-emergent ED visits.***
5. Transition Management	Our evidence-based Transition of Care Program is available to all enrollees and supports safe and appropriate care after discharge and when transitioning between levels of care. This includes post-discharge follow-up and monitoring with a special focus on co-morbidities, complex conditions, and

Table 2.6.11.2.3 Components of LHCC's Primary Care Engagement Model to Target Super-Utilizers and Reduce PPEs	
	coordination for high utilizers to identify and close care gaps. To address the ***post-acute health needs of enrollees experiencing homelessness we developed our respite care and intensive care management value-added benefit*** to successfully transition as many enrollees as possible to safe and stable housing. [redacted]
6. Improving Access to Primary Care and BH Step Down Services	***LHCC has the highest rate of enrollees receiving primary care with 71% of our enrollees visiting a PCP in 2020*** *(Annual MCO Transparency Report).* [redacted] also improve access to BH step-down services. For example, we identified a gap in care for enrollees needing a level of care between psychiatric inpatient and outpatient services. We partnered with LDH and providers, including Oceans and Compass Healthcare, to offer psychiatric IOP as an in lieu of service. We also leverage existing relationships to increase the availability of psychiatric residential treatment facility (PRTF) beds across Louisiana to increase access to this intermediate level of care. These programs identify and refer psychiatric patients to the right level of care, reducing ED utilization and inpatient admissions. As a result of these initiatives and others, enrollees are receiving vital follow-up care as evidenced by improvement in our ***FUH 30-day and 7-day rates which increased 5.31 and 5.27 percentage points respectively from 2018 to 2020***. Additionally, these initiatives have contributed to racial disparity reductions in BH, and from 2019 to 2020, we observed the ***elimination of the racial disparity for Black enrollees related to FUH; 7.5% disparity reduction for Antidepressant Medication Management (AMM) Acute Phase; and 17.9% disparity reduction in AMM Continuation Phase.***

2.6.11.3 Louisiana Medicaid Quality Assessment and Performance Improvement (QAPI) Program

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 2.6.11 above. One example of a clinical initiative implemented in the past 24 months that yielded improvements in care is our ***Cribs for Kids program***. In Louisiana, the mortality rate for infants in their first year is 7.6 per thousand, compared to 5.6 nationally. There is also a significant racial disparity, with infant mortality among Black enrollees when compared to White enrollees. LHCC identified that infant mortality was higher in the northern part of the state (regions 7 and 8). With sleep-related incidents identified as the leading causes of death in babies up to 12 months in age, we distributed Safe Sleep Survival kits to pregnant enrollees in northern Louisiana about a month before their due date. Kits include a Cribette, Halo Sleepsack, and Safe Sleep educational material. ***Over two years, we saw a 56% lower infant mortality rate in northern Louisiana.*** In 2.6.11.3.3 below, we provide two additional examples of data-driven clinical initiatives that we have initiated within the past 24 months.

2.6.11.3.1 Analysis of Gaps, Areas for Improvement, and Reducing Disparities through our QAPI

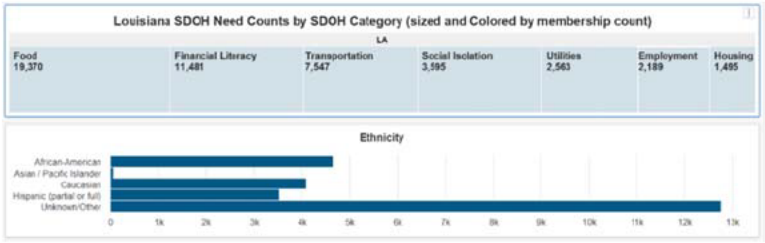
LHCC takes a data-driven approach to identify gaps in the delivery of service, gaps in quality of care, areas for improved management of chronic and selected acute diseases or conditions, and reduction in disparities in health outcomes. We combine integrated datasets in Centelligence with other quality 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 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. Results are used to inform enrollee and provider-centric strategies and initiatives to address the management of chronic and acute conditions, and reduce health disparities. Additionally, our QI and Provider Engagement Teams use reports to identify high-performing providers, determine the providers' best practices that contribute to their success, and use their initiatives to disseminate local best practices across the network.

[redacted]

To analyze gaps, patterns, and trends in social barriers to care, we use our ***SDOH Dashboard*** to aggregate SDOH data from claims and assessments. The Dashboard shows enrollee SDOH need category (e.g., food, housing); associated comorbidities (e.g., cardiac conditions,

substance use); and cost and utilization metrics (e.g., average cost PMPM, ED visits). This allows staff to identify the correlation between SDOH needs and chronic and acute conditions, as well as identify how SDOH barriers impact enrollee utilization of services. The dashboard also allows users to analyze SDOH needs by population segments such as age, race/ethnicity, and gender. If care gaps are identified, our staff and PCPs use real-time data ***to quickly identify and easily prioritize care needs and address emerging health issues*** at the earliest clinically appropriate time. Enrollee-facing staff can view care gaps and areas of health risk during each enrollee interaction and arrange for follow-up services and referrals to close care gaps, including preventive services, cancer screenings, and chronic disease management. Providers access timely care gap information via the Provider Portal (described in 2.6.11.1) and can close these gaps during upcoming visits. To identify disparities and inform interventions to promote equity, we use Centelligence to conduct analyses and stratify quality performance measures, utilization metrics, chronic and acute disease prevalence, and other health indicators using RELD and geography data. Our Health Equity Dashboard displays trended performance across HEDIS measures by race and ethnicity, and overlays SDOH census data to help target interventions that are impactful in promoting health equity, and measure outcomes of disparity reduction initiatives.

Figure 2.6.11.3.1 SDOH Dashboard



2.6.11.3.2 Identifying Underlying Reasons for Variations

LHCC uses data to support our CQI approach to identify underlying reasons for variations in the provision of care to enrollees. Advanced analytic solutions, including hot-spotting technology and our ***Health Equity Dashboard***, identify and report significant health risks and disparities at the population, enrollee, and provider levels and analyze results across sub-populations, geographies, races, and ethnicities. This data is then aggregated and analyzed to inform strategic interventions using validated improvement science tools, founded in the PDSA and Lean Six Sigma models when identifying underlying reasons for variations. Tools include Failure Modes and Effects Analysis, Root Cause Analysis, Five Why's, Driver Diagrams, Cause and Effect Matrices, Fishbone (Ishikawa) Diagram, process mapping for cause-and-effect analyses, and control plans. In addition, the Voice of the Customer (enrollee and provider feedback) is essential to identifying underlying reasons for variations and informs LHCC's approach to reducing variation in the provision of care to enrollees.

2.6.11.3.3 Implementing Improvement Strategies Based on Analytical Findings

Based on analytical findings, LHCC's QAPIC and Performance Improvement Team (PIT) solicits input from all LHCC departments and external subject matter experts, enrollees, providers, and community partners when considering interventions. With this input, QI and other staff identify barriers to performance and develop interventions that specifically address 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. Results of interventions are reported up to the QAPIC for review and further action.

Sample QAPI Initiatives. Data-driven examples of how we have applied our process and improved health outcomes in the LHCC population with initiatives that were started in the past twenty-four (24) months include:

Increasing Compliance for Chlamydia Screening (CHL)	
Rationale	Chlamydia is the most commonly reported sexually transmitted infection (STI) affecting both men and women. Louisiana is ranked 3rd in the US for Chlamydia prevalence (CDC 2019 rankings). Screening for sexually transmitted infections, including Chlamydia, is a significant population health focus in the state. Nationally, the rate of infection among Black women was six times higher than that of White women in 2019.
Identifying Reasons for Variations (2.6.11.3.2)	Although many STIs can be treated, enrollees may not be aware of risk factors or may not exhibit symptoms prompting them to seek screening and/or treatment which can cause a variation in the provision of care. Using data analytics, we identified the HEDIS CHL measure as an area of opportunity. The QI staff identified the following barriers to care: health literacy, racial disparity, implicit provider bias. Interventions were created to specifically address these barriers.
Implementing Improvement Strategies Related to	• Developed provider education, including implicit bias training • Included STI measures (HIV, chlamydia, and gonorrhea screening) in our VBP program to reward providers for achieving benchmarks in preventive management measures • Created $25 enrollee incentive for completing STI screenings

Findings (2.6.11.3.3)	• Launched monthly multi-modal outreach campaigns tailored to enrollee communication preferences and targeted to enrollees with preventive care needs, including a chlamydia screening. Messaging has educational reminders for enrollees to schedule an appointment to complete the screening, while also offering warm transfer to live resources for assistance. • Created enrollee care gap flags in our Customer Relationship Management Platform enabling Customer Service Representatives to educate the enrollee and/or link the enrollee to care by connecting them with CM staff for assistance.
Outcomes	***The CHL rate has demonstrated year-over-year improvement with a 2.24 percentage point increase realized from 2018 to 2020.***
Increasing Compliance with Controlling High Blood Pressure	
Rationale	Hypertension increases the risk of heart disease and stroke, which are the leading causes of death in the United States. 10.7% of LHCC enrollees have a hypertension diagnosis, the 4th most prevalent chronic condition in LHCC membership. Hypertension was more prevalent among LHCC Black enrollees and those living in rural areas of the state. Hypertension is also common among enrollees with diabetes.
Identifying Reasons for Variations (2.6.11.3.2)	An analysis of our CBP HEDIS outcomes revealed provider outliers with an increase in enrollees exhibiting poorly controlled blood pressure for focused intervention. QI staff used heat maps to identify high-density areas of providers with the greatest number of enrollees with hypertension throughout the state. The QI staff identified a provider knowledge gap related to CBP HEDIS measure specifications as a barrier. Interventions were implemented to address the provider knowledge gap.
Implementing Improvement Strategies Related to Findings (2.6.11.3.3)	• Targeted outreach by the quality and network teams to the top 5 lowest-performing provider locations monthly. Resources and enrollee data were provided to help providers complete the care and documentation needed to close the CBP care gaps for their enrollees. • Launched virtual provider workshops with targeted education and resources to support providers with best practices and documentation tips to successfully close enrollee care gaps. • LHCC has hosted 257 quality-related provider trainings since 2019 offering HEDIS education and resources to support providers, including updates to the measure technical specifications, care coordination, patient education, documentation requirements, procedures and equipment, and the use of telehealth. • Included the CBP measure in our VBP program to reward providers for achieving benchmarks in condition management measures. • [redacted]
Outcomes	***The CBP rate improved 3.65 percentage points from 2018 to 2020***

2.6.11.4.1 Overview of QM/QI Approach

The scope of our QAPI Program is comprehensive and addresses the quality and safety of clinical care and quality of services provided to all enrollees across all programs and benefits, as described in 2.6.11.1 through 2.6.11.3.

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 are aligned with LDH's Quality Strategy and include but are not limited to the following:

- Ensure access to care
- Improve coordination and transitions of care
- Facilitate patient-centered, whole-person care
- Promote wellness and prevention
- Improve chronic disease management
- Partner with communities to improve population health and address health disparities
- Pay for value and incentivize innovation
- Minimize wasteful spending

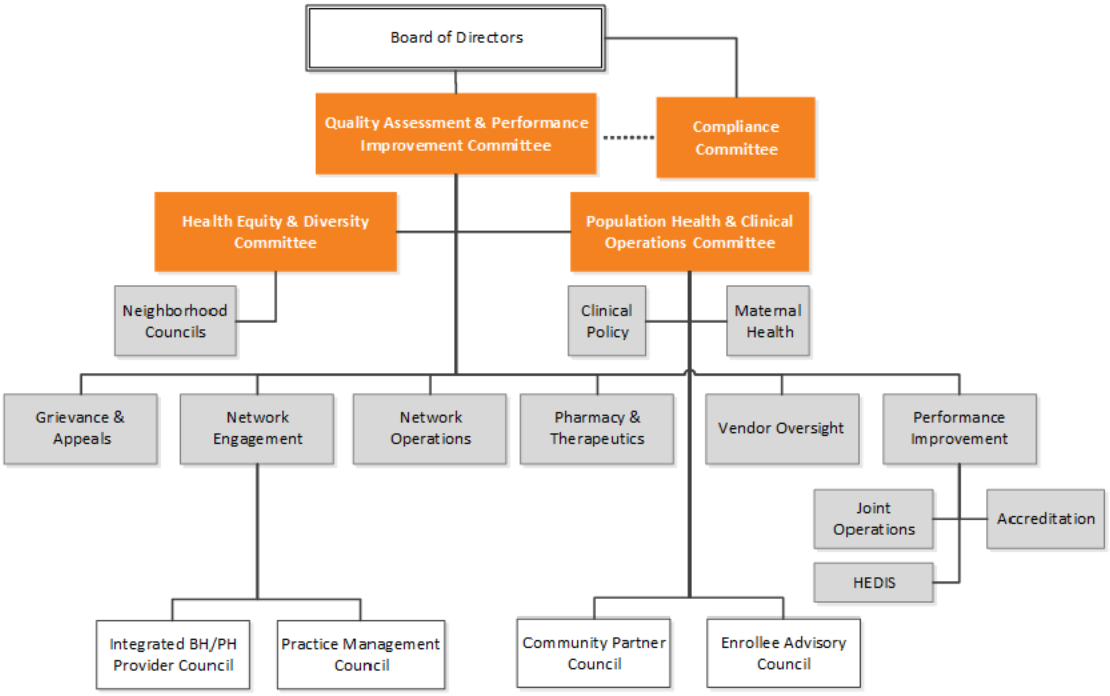
QM/QI Quality Committees. LHCC's BOD oversees the development, implementation, and evaluation of the QAPI Program, providing strategic direction and ensuring that quality is incorporated into operations throughout LHCC. LHCC's QAPI Program permeates the organization as depicted by our Quality Committee structure shown below. Quality oversight is delegated to the QAPIC.

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 strategic

direction in assessing the quality and appropriateness of care and service delivered. The QAPIC meets at least quarterly and includes four network physicians representing a range of practitioners, including specialties such as pediatrics, BH, and OB/GYN, within the network and across the regions in which LHCC operates. LHCC also includes other non-clinical committee members such as key department leaders, enrollees, and community advocates.

Committees and Subcommittees. The QAPIC directs several subcommittees, including our Health Equity and Diversity Committee, which are task-oriented and focused on identifying, reviewing, and addressing areas of concern. LHCC's QAPI structure includes several advisory councils, including: Neighborhood Advisory Councils with direct oversight by the Health Equity and Diversity Committee, Community Partner Council, Enrollee Advisory Council, Integrated BH/PH Provider Council, and Practice Management Council. LHCC uses feedback from these groups to address population health needs, identify disparities, and improve health equity and health outcomes.

Figure 2.10.11.4 LHCC QM/QI Committee Structure



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 QAPI Program Description, Work Plan and Annual Evaluation.

QAPI Program Description. Outlines the structure and processes used to monitor and improve the 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.

QAPI Work Plan. To implement the comprehensive scope of the QAPI Program, the Work Plan incorporates the strategic direction provided by the BOD. The Work Plan outlines timelines and clearly defines the activities that must be completed by each department and all supporting committees throughout the measurement year.

QAPI Program Evaluation. Our annual Program Evaluation includes a summary of all QI activities, the impact the program has had on enrollees' care, provider performance, and analysis of the achievement of stated goals and objectives, and the need for program revisions and modifications.

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 direct mailings.

2.6.11.4.2 Staff Responsible for Administering QM/QI Program

Chief Medical Officer. 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 ongoing enrollee care monitoring and other focused studies

Vice President, Quality Improvement. Reports to the Plan President/CEO and is responsible for directing the activities of LHCC's QI staff in monitoring and auditing LHCC's healthcare delivery system, including, but not limited to, internal processes and procedures, provider network(s), service quality and clinical quality.

Senior Director, Quality Improvement. 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 and Process Improvement. 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.

[redacted]

2.6.11.4.3 Capacity to Participate in Annual HEDIS Performance Measurement

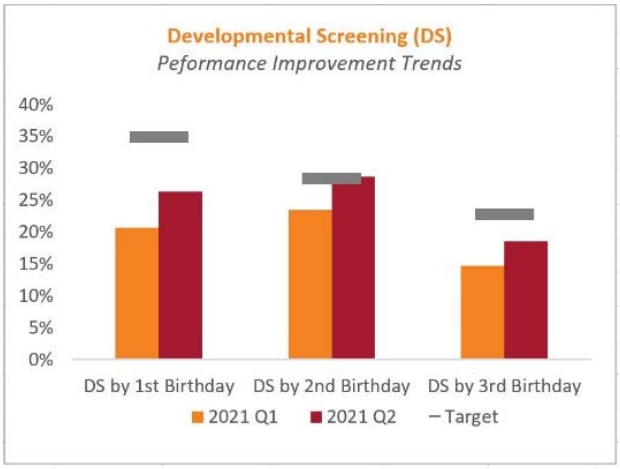
LHCC has reported HEDIS performance data for seven years using an NCQA certified HEDIS engine and worked with a Certified HEDIS Compliance Auditor. Our QAPI Program infrastructure, staffing, and approach enable us to continue to support LDH's annual HEDIS performance measurement and reporting initiative. 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'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. 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: Manager of HEDIS Operations, EPSDT Coordinator, QI Abstractor, Project Coordinator, HEDIS Coordinator and Health Check Coordinator.

2.6.11.4.4 Example of Successful Quality Improvement Activity

Developmental Screenings. LHCC is committed to the continuous monitoring of its performance related to standards of care and service for enrollees. In 2021, LHCC participated in four state-led PIPs including a new PIP for 2021: Improving Receipt of Global Developmental Screening in the First Three Years of Life. The performance indicators measure the percentage of children screened for risk of developmental, behavioral, and social delays using a standardized global developmental screening tool. The performance indicators are stratified, based on enrollee age, measuring developmental screenings conducted in the 12 months preceding or on an enrollee's first, second, and third birthdays. ***Figure 2.6.11.4.4*** outlines the 2021 Q1 and Q2 outcomes for this PIP.

Developmental screenings across all three indicators/age groups have improved on average 5% quarterly, with established targets already surpassed for the Second Birthday cohort. In accordance with continuous process improvement, LHCC has made a subsequent upward adjustment of the goal in support of continuous improvement. Outcome analysis has attributed the increased screening rates in this age cohort to potential delays in well visits during the pandemic, with the second birthday cohort likely reflecting both the first and second-year screenings. Provider knowledge deficit related to approved screening tools, new billing guidelines, and early intervention programs (EIPS) were identified as barriers to screenings. ***Over 500 providers have received education on the guidelines, coding, and referrals to EIPs.*** Utilization of the global developmental screening CPT codes by providers has been monitored and reported monthly, with gradual improvement in the percentage of claims submitted with the proper codes.

Figure 2.6.11.4.4 Development Screenings PIP Outcomes



2.6.11.4.5 Quality Improvement Plans and Projects

Identification and Topics. Our QI staff present results of our annual QAPI evaluation, Population Health Assessment, Utilization Assessment, and other data analyses (e.g., complaints, enrollee/provider/community input) to the PIT who identifies initiatives and makes recommendations to the QAPIC. The QAPIC assists to prioritize initiatives focusing on those with the greatest need or expected impact.

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. In addition to LDH PIPs, LHCC will continuously analyze data and use feedback from our external councils to identify additional opportunities to implement proactive PIPs, and share best practices and lessons learned with LDH and other MCOs. Projects topic areas may include:

- Prematurity/Infant Mortality (e.g. safe sleep environment)
- Reducing low value care (e.g. appropriate 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 monitors each project's 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. In accordance with the PDSA model, progress is evaluated and presented to multidisciplinary workgroups and reported to the QAPIC for input and development of strategic actions to drive improvement and/or address any identified barriers.

2.6.11.5 Clinical Practice Guidelines (CPGs)

LHCC provides clinical practice and preventive health guidelines to network providers via the provider website. Guidelines are adopted from recognized sources and board-certified practitioners, including the LHCC CMO, review and approve adoption through the LHCC CPC and the QAPIC. Guidelines are updated annually, or upon significant new scientific evidence or changes in national standards. The portal also provides access to InterQual SmartSheet(s)™ which is the evidence-based support tool that is used when clinical policies do not exist for particular services. LHCC adopted the *2021 Recommended Child and Adolescent Immunization Schedule for ages 18 years and Younger* from the Advisory Committee on Immunization Practices (ACIP). See ***Attachment 2.6.11.5*** for our adopted CPGs and sample CPG.

2.6.11.5.1 Adopting and Disseminating CPGs to Providers and Enrollees

The LHCC CPC is responsible for researching evidence-based guidelines. The Plan QM/QI designee or clinical policy staff update guidelines based upon significant new scientific evidence or change in national standards. Additionally, LHCC collaborates with LDH and the other Louisiana MCOs, designated providers, and organizations committed to advancing evidence-based practices for improved health outcomes for enrollees. Guidelines are reviewed by LHCC's CPC and QAPIC at least annually. The LHCC CPC, in collaboration with Medical Affairs, Quality, PHCO and Network Development stakeholders ensure guidelines are available on demand via the LHCC website. 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. Providers are notified of CPG updates via weekly provider newsletters and email. We design enrollee education and health promotion campaigns around evidence-based practice guidelines to encourage enrollees to comply with best practices. We distribute CPGs to enrollees through the Enrollee Handbook, newsletters, the LHCC website or hard copy upon request. When there are updates to guidelines, we use targeted outreach and social media campaigns to share information with impacted enrollees in formats that are easy to read and understand, as illustrated in ***Figure 2.6.11.5.1***.

Figure 2.6.11.5.1 Disseminating CPGs to Enrollees via Social Media



2.6.11.5.2 Incorporating Scientific Evidence and Expert Opinions

The LHCC CMO participates in the Centene Corporate CPC with affiliate plan leaders to identify and review 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, including the opinions of network and external experts and providers. LHCC's CPC reviews proposed CPGs for adoption to determine relevance to the needs of our enrollees. LHCC's CPC includes Louisiana practicing network primary care and specialty providers, who provide valuable input on current community clinical practices and provide clinical guideline inputs. Any external participating member of our CPC must comply with our conflict of interest policies, including disclosures, to participate on our committee.

2.6.11.5.3 Evaluating Adherence to CPGs and Interventions

As obligated by contract, providers are expected to adhere to LHCC's published guidelines and are 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 analysis, a sample of medical records may be evaluated for adherence to specific guidelines. If performance measurement rates fall below LHCC and/or state goals, corrective action plans and/or interventions will be implemented for improvement, as applicable. Potential quality of care events are investigated and may include evaluation of compliance with evidence-based practices where applicable. LHCC promotes CPG documentation and offers continuing education to providers as appropriate. Provider adherence to the CPG's is emphasized during new Provider Orientation, Virtual Provider Workshops, and other Provider Quality training sessions throughout the year. CPG update notifications are published in weekly provider newsletters and on the Provider Portal. Targeted education that includes CPGs relevant to specific providers underscores the importance of compliance. For example, the utilization of standardized global developmental screening tools by providers is monitored and reported monthly, with gradual improvement in the utilization.

2.6.11.5.4 Updating and Revising Guidelines

CPGs are updated based on significant new scientific evidence or change in national standards annually. A multidisciplinary review of CPGs is conducted including representation from subcontractors, LHCC CPC QI, Medical Management, Pharmacy, Medical Affairs, Provider Engagement, and Enrollee 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.

2.6.11.6 NCQA Health Insurance Plan Ratings for LHCC and Accredited Medicaid Affiliates

NCQA Health Insurance Plan Ratings for LHCC and our Accredited Medicaid affiliates have been provided ***Attachment 2.6.11.6*** has been provided as part of the electronic copy submission in lieu of hard copy.

2.6.11.7 NCQA Certificate of Accreditation for LHCC and Medicaid Affiliates

NCQA accreditation certificates for all Centene accredited health plans may be viewed in ***Attachment 2.6.11.7***.

2.6.11.8 NCQA Accreditation for Material Subcontractor to Provide Behavioral Health Services

LHCC does not utilize a material subcontractor to provide behavioral health services.

SECTION 2.6.11.6

Quality Response Template

"My greatest satisfaction comes from being able to help members understand how to use their benefits to get the care they need so they can stay as mentally well as possible.

When you can sense that light bulb moment happening and they finally realize they have access to resources they so desperately need and want... it's fantastic."

- LHCC Behavioral Health Care Manager, Lafayette

SECTION 2.6.11.6

LHCC Quality Response Template

Per the RFP, the Proposer may submit this information as an attachment in electronic format in lieu of hard copy.

SECTION 2.6.12

Value-Based Payment



"The leaders at LHCC take the time to understand your organization. That is important, as every health system is unique. It's refreshing to sit down and talk at an executive level, make decisions, and collaborate on the best way to care for our communities.

Throughout our history, we have been able to move together toward more advanced value-based models in a way that actually fits our health system."

-Greg Feirn
CEO, LCMC Health

2.6.12 Value-Based Payment [10-page limit]

2.6.12.1. LHCC's VBP Strategic Plan Achieved Improved Quality and Increased Participation

137% Increase

LHCC has increased VBP payments by 137% since 2015.

Since LHCC established our Value-Based Payment (VBP) Strategic Plan in 2012, we have demonstrated improved quality and increased provider participation year-over-year, as we support our providers along the HCP-LAN APM model continuum. LHCC collaborates with providers to design goals, metrics, payments, and supports for our VBP program specifically to meet the unique needs of Medicaid providers and enrollees. Our success stems primarily from strong collaborative provider partnerships, investments in actionable data, and high touch technical expertise that supports provider success.

We also closely collaborate with providers to continuously refine program measures and performance targets to reflect and advance LHCC's population health and support care transformations that address the needs of our Medicaid enrollees. We design our ***QualityPATH*** VBP models (detailed below) through a ***health equity lens***, for example, our ***Black Enrollees Maternity Model*** aligns incentives to address maternal health racial disparities. This model measures and improves outcomes for Black enrollees and their infants by incentivizing OB/GYNs to meet disparity reduction targets for maternal, infant, and child health quality metrics stratified by race and ethnicity. LHCC's VBP Strategic Plan aligns with the HCP-LAN APM Framework and complies with all Model Contract and MCO Manual requirements. In ***Table 2.6.12.3.1.C*** and in 2.6.12.3.3 we identify specific VBP models for implementation and which APMs by provider type will be in place by contract operational start date.

[redacted]

LHCC Strategic Approach to Value-Based Payment

A foundational element of LHCC's VBP Strategic Plan is starting providers with the right APM model and helping them evolve to take on greater responsibility for quality and costs. LHCC designed our QualityPATH suite of APM models to address varying provider size and structure, from solo practitioners to the largest health systems, so that all providers can successfully participate. See ***Figure 2.6.12.1*** below for our tiered suite of APM models.

[redacted]

Provider capacity is paramount to successful evolution along the APM continuum. LHCC connects providers with the right QualityPATH model based on their assessed readiness for risk, and in close collaboration with each provider, determines the model that works best for them. Our standard and customized QualityPATH models are described in 2.6.12.3.1 below.

Our support tools to advance providers along the VBP path align with the needs of providers at each tier, focusing on what matters most to each provider. We offer providers the data and technical supports necessary to achieve success as they accept greater responsibility for quality and costs. [redacted]

2.6.12.2. LHCC'S Strategy for Expanding *QualityPATH* Models

LHCC's strategy to expand our QualityPATH VBP program combines two steps: creating models for all provider types and supporting individual provider performance improvement and advancement to greater levels of risk. Over the first three contract years, LHCC plans to continue promoting adoption of QualityPATH models by our non-PCP provider practices, including OB/GYNs, hospital systems, post-acute care, BH, and other provider types. [redacted]

[redacted]

LHCC meets providers where they are and discusses with each provider objectives, capabilities, key challenges and goals. We meet with the provider face-to-face and use tools, such as the ***Accountable Care Atlas (Atlas) Provider Readiness Tool,*** to evaluate their strengths and opportunities, including quality and cost baselines, care delivery, and data exchange capabilities. Together, our Provider Engagement (PE) Team, including our Provider Performance and VBP staff, customize a plan for advancing to greater levels of risk, using readiness tools to guide planning for governance, finance, care delivery, and technology functionality important for risk models. LHCC's strategies to improve provider quality and evolution to shared savings and risk models include:

[redacted]

2.6.12.3. LHCC VBP Goals for all Contract Years

Our VBP goals align with the state's goals for delivery system reform and advancing to value over the life of the contract. Our goals fully support and align with LDH's Quality Strategy and our Population Health Strategic Plan and Health Equity Plan, and include the following:

[redacted]

2.6.12.3.1. VBP Thresholds for Provider Payments in Qualifying VBP Arrangements

[redacted]

Model Contract. In addition, we continue moving more providers along the continuum, to meet and exceed the 60% participation target by the end of the contract period. ***Table 2.6.12.3.1.A*** demonstrates our commitment to exceed the required thresholds in each contract year by supporting providers in maximizing their revenues and the quality of care delivered and maintaining risks at manageable levels for providers. ***Table 2.6.12.3.1.C below specifies our QualityPATH models to ensure we meet these thresholds.***

[redacted]

**Based on 350,000 membership*

Our expected payments in 2023 and subsequent years are based on our experience with the readiness levels of Louisiana providers and their improvements in quality achieved to date. Key to our success is the capability and capacity of our providers to take on additional risk and responsibility related to population health, effectively engaging enrollees, closing care gaps, and managing total cost of care. Successful providers across all QualityPATH models have the potential to

achieve significant earnings over FFS every contract year. LHCC ensures providers can earn incentives that commensurate with achievements, and are financially viable and worthwhile.

Designing *QualityPATH* Models for Medicaid. We design VBP models to help Medicaid providers successfully manage population health, health equity, and SDOH challenges that Medicaid enrollees face. LHCC financial arrangements incent high-quality, efficient care, enable accountability, and establish targets that fairly reward providers. QualityPATH models address all LDH financial requirements in the Model Contract including risk adjustment, prospective payments, stop-loss, financial modeling, enrollee assignment, and provider attribution policies. We communicate shared savings and risk-sharing parameters, and clearly articulate how we determine provider financial performance and set targets. See ***Table 2.6.12.3.1.B*** below for QualityPATH design principles and financial components.

Table 2.6.12.3.1.B. QualityPATH Design Principles and Financial Components for Medicaid Providers
• Target quality metrics to address Louisiana population health priorities, including health equity and SDOH
• Design for provider diversity, offering models for differing provider types and sizes, capacity for risk (using the Provider Readiness Tool), payment options
• Tiered benchmarks at differing starting points to increase opportunities for providers to earn incentives
• Financial targets at levels that allow for payments for already high performing providers
• New providers receive current performance data and are immediately included in the next assessment period incentives
• Participation in risk models dependent on provider's ability to manage risk, with no enforcement without readiness
• Avoidance and resolution of any VBP payment issues immediately during the provider engagement process
• [redacted]
• Provider protections such as stop-loss and risk corridors to ensure providers can earn incentives
• [redacted]

LHCC *QualityPATH* Suite Aligned with HCP-LAN APM Framework

Each QualityPATH tier is aligned with one or more HCP-LAN Categories from 2C Pay for Performance (P4P) programs to more sophisticated 3B Shared Savings/Downside Risk and 4 Population Health arrangements. At every level, LHCC APM models meet LDH criteria as ***qualifying and preferred*** and are linked to performance on HEDIS quality measures as required in Attachment H.

QualityPATH Prime* APMs** are HCP-LAN Category 2C entry level models that pay providers for meeting targets on HEDIS and other quality measures. ***QualityPATH Plus APMs are HCP-LAN Category 3A and B models that pay providers shared savings and for meeting quality and cost targets. Providers ready to accept risk share responsibility for performance below targets. ***QualityPATH Premier APMs*** create innovative relationships with larger providers and health systems interested in more advanced, collaboratively designed APM models, evolving to accountability for population health. Each model is customized with the provider and may include components of 3B Shared Savings/Downside Risk and 4A or 4B Population-Based payments.

In ***Table 2.6.12.3.1.C*** below, LHCC describes our current and planned QualityPATH Models by LDH Preferred Model status, HCP-LAN Category, and implementation dates. After the table, we describe key provider partners.

[redacted]



[redacted]

Key Provider Relationships

LHCC systematically targets and engages key providers in VBP that have demonstrated success and capability to achieve health equity and population health improvements aligned with enrollee needs. In ***Table 2.6.12.3.1.D.*** below, we provide examples of these key partnerships and the value they bring to LHCC enrollees.

[redacted]

2.6.12.3.2. Improving Outcomes Through VBP Mo

LHCC establishes quantitative, measurable, clinical outcomes for QualityPATH models in collaboration with our physician providers and aligns outcomes with LHCC population health strategy, and health equity plan – all aligned with LDH Quality Strategy and Att. H measures. Providers show improved quality under our VBP arrangements. [redacted]

[redacted]

Addressing Health Equity, Population Health, and SDOH

All QualityPATH models support LDH and LHCC quality strategy goals and objectives by incenting performance improvement on metrics and targets selected to achieve these goals and support care transformations. LHCC stratifies measures by factors relevant to health equity, such as race, ethnicity, and gender, to analyze and measure improvement on health disparities. LHCC will share health equity data with providers through our VBP reporting processes, including stratified Att. H. measures related to pregnancy, child and adult preventive care, and BH.

[redacted]

[redacted]

In ***Table 2.6.12.3.2.A***, LHCC lists the outcome measures we seek to improve through implementation of each QualityPATH Model. [redacted]

[redacted]

[redacted]

2.6.12.3.3. *QualityPATH* and LDH Preferred Models in First Three Years of Contract

[redacted]

2.6.12.3.4.a Provider Performance Support for Successful Delivery System Reform



Face-to-face interaction with providers is the cornerstone of our provider engagement strategy. LHCC fosters trust and transparency with ongoing support, technical assistance, and data analytics that we customize for each provider to support their path to improved quality and costs under QualityPATH models. LHCC will comply with all requirements to support providers including attribution lists, identifying high risk enrollees, financial model technical assistance, and staffing.

LHCC Regional Provider Engagement (PE) Teams. Since our first Louisiana Medicaid managed care contract in 2012, LHCC has hired, trained, and located field-based provider engagement staff in the regions and parishes they support. PE Teams engage, educate, and support providers on practice transformation, data analytics and report interpretation, and VBP readiness and performance improvement. Our Teams include:

Provider Engagement (PE) Specialists who serve as the single point of contact to coordinate supports and account management, and include Specialists with specialized ***BH and FQHC expertise***. Our ***CPLs*** address quality, deliver evidence-based data, train on practice transformation, review population health reports, and co-develop care and disease management, care gap closure, and quality initiatives with providers to improve APM performance and potential payments.



Regional PE Specialists coordinate supports from LHCC Medical Directors and experts on coding, BH/PH, and VBP performance. ***BH and PH Medical Directors*** offer face-to-face education and consultation directly with PCPs and other physicians. Our departmental ***Health Equity Program Managers*** consult with the PE Team, providers, and community stakeholders on health equity, population health, and SDOH-related performance improvement.

Tailored Engagement and Support. In LHCC's experience, aligned incentives combined with provider engagement support make the critical difference in improving provider performance. Our PE Teams evaluate providers to identify improvement opportunities, meet regularly with providers to review performance, follow-up on support items, and focus on provider performance evaluation and monitoring. CPLs offer expert advice on practice transformation and workflow to improve quality and outcomes, manage costs, and enhance success. CPLs and PE Specialists, supported by the Network Performance Analyst, use our health informatics platform to identify improvement opportunities and track progress on VBP targets. We tailor assistance and data to each provider and meet quarterly, monthly, or more often to reflect differing needs for data interpretation and practice transformation support, based on model complexity and risk level:

- ***Quarterly,*** with ***QualityPATH Prime*** providers to share best practices; review progress on quality targets; and discuss specific care gaps, HEDIS measures, and care and disease management supports.
- ***Monthly,*** with ***QualityPATH Plus*** providers to review quality metrics, financial performance, care management programs, progress toward VBP targets, and recommendations for improvements.
- ***Monthly,*** with ***QualityPATH Premier*** provider leadership over the full range of quality, value, technology, and infrastructure supports, with tailored and extensive support for providers at this level of risk.

"LHCC works with us and gives us information we didn't have available 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. LHCC works together with us to improve care while saving costs."

Greg Ivey | Chief Operating Officer, Pediatric Center of Southwest Louisiana

2.6.12.3.4.b Technical Assistance and Data Support Offered to Providers

LHCC delivers timely, actionable, and accurate data in transparent and accessible formats that enables Providers to be accountable for improving quality and reducing costs. LHCC meets contract requirements for providing Information to providers, and our tools enable providers to query a variety of data sets.

ADT Data. Our systems support ADT and other HL7 and FHIR clinical transactions, and we make ADT data available to providers via our provider Portal.

Sharing Claims Data. LHCC automates weekly or monthly claim extracts, via SFTP, so our larger providers receive claims data incurred by assigned enrollees for upload into their own population health platform.

Interpreta Care Gap Analytics. LHCC delivers prospective care gap analytics through Interpreta, available via Availity's Multi-Payer Portal and Provider Portal, the same data our clinical teams access to review and support performance. Data is re-computed daily and updated in near-real-time, significantly improving providers' ability to address enrollee care gaps faster and metrics in their VBP arrangements. ***LHCC will offer providers Technology Transformation Grants to support EMR adoption, HIE connectivity and use of Telehealth, building upon provider capabilities to help move along the VBP continuum to greater levels of quality and risk.***

Provider Analytics Dashboard, powered by Centelligence® available on our Provider Portal, delivers actionable data, helping providers identify performance factors. Data visualizations make information easily digestible, bringing relevant information to the provider's attention. Measures include:

Table 2.6.12.3.4. Key Provider Analytics Reports and Data Available to Support Performance	
VBP Performance	Financial views, measures and targets, number of gaps to close and patients to reach to achieve target, unearned dollars by measure and bonus calculation by measure
Hospitalization	View count and rate by disease and facility to track admissions, readmissions, ED use
Population Health	Patient disease registries (e.g. care gaps, PH/BH diagnoses, medication and labs, high risk patients)
Financial Reporting	Monthly expenses, YTD performance, eligibility and capitation file, revenue to identify cost drivers
Utilization	Enrollee list, population health categories, and utilization statistics (e.g. ED visits) vs benchmarks

Patient Analytics Dashboard, powered by Centelligence, is a population health analytics dashboard on our Provider Portal, where providers can see patient disease registries at the PCP or practice level, view care gaps, and identify opportunities to improve population health. Providers can engage with enrollee-level data on PH and BH diagnoses, medication and labs, with the ability to identify high-risk enrollees, sort patients by multiple, specific metrics simultaneously; and save sample reports to run in the future, improving efficiency.

SECTION 2.6.13

Claims Management and Systems and Technical Requirements



"Out of all the MCO's, LHCC is by far the easiest one to work with, from a clinic/provider perspective. LHCC approves services timely and efficiently. Their provider relations, client services and claims departments are very resourceful, as well as timely and efficient."

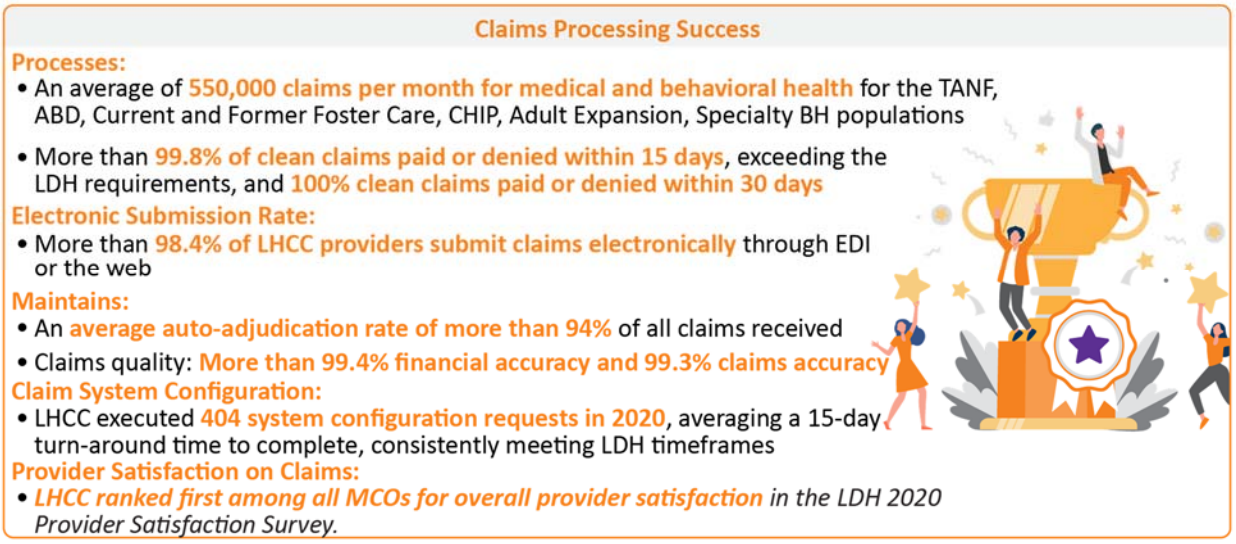
- Lisa Lang
Program Development Director
CommuniHealth Services, Monroe

2.6.13 Claims Management and Technical Requirements [10-page limit; data flows and charts are excluded from section-specific and total page limits]

2.6.13.1 Claims Adjudication System for the Louisiana Medicaid Program

Today, LHCC serves more than 530,000 Louisiana Medicaid enrollees, with customized claims operations and systems in place since 2012. See ***Figure 2.6.13.1*** below.

Figure 2.6.13.1 LHCC Claims Processing Highlights



Louisiana Claims Expertise. LHCC's local Claims and Provider Data Management teams conduct provider enrollment, contract configuration, claims research and outreach in tandem with our Provider Engagement Team, working collaboratively to achieve the results above. Our LHCC claims staff include our Claims Directors, Claims Business Analysts, Claims Resolution Analysts, Claims Liaisons, and Contract Implementation Analysts. Our LHCC Claims Team has more than nine years' experience in Louisiana Medicaid claims processing and is LDH's point of contact for claims matters. We have also added an additional Claims Director to oversee LHCC Claims Projects. In addition, our Claims Research Specialists assist providers in resolving claims issues, while Claims Liaisons analyze trends and resolve any systemic problems. Our Contract Implementation Analysts implement system configurations, including those for benefits, fee schedules, and provider setup. The LHCC Claims Team works as a cross-functional team in partnership with Care Management, Provider Engagement, and Information Technology to customize our processing for Louisiana-specific needs. The teams work in an agile manner to solve problems and deliver solutions that can be tested, implemented, and validated with enrollees and providers.



Claims processing is arguably our single most important data capture point as it drives quality and utilization monitoring efforts, provider education, enrollee care initiatives, and supplies LDH with encounter information.

Optimized for Louisiana. LHCC's integrated Management Information System (MIS) accurately processes and pays Medicaid claims in compliance with HIPAA and LDH requirements outlined in the Model Contract, Section 2.18, Louisiana Medicaid fee schedules, Medicaid Provider Manuals, and all published Medicaid Informational Bulletins. We adhere to Model Contract requirements of 90% of clean claims in 15 business days and 100% in 30 calendar days. Our Claims Processing System (claims system) has configuration and editing capabilities for all claims transactions. For example, ***our system is easily configured to accommodate new payment methodologies as needed, such as DRG payments for out-of-state hospitals and Home Health episodic care.*** Our MIS supports Electronic Data Interchange (EDI) and Electronic Funds Transfer (EFT) capabilities, as well as real-time clinical edits and fraud, waste and abuse detection. We will be fully compliant with the new LDH Provider Enrollment requirements so that we only pay claims for providers who are actively registered with the state. We have successfully implemented these requirements in other states, including Kansas using the same MMIS vendor as LDH's. We can support an Application Programming Interfaces (API) strategy for receipt of provider enrollment data from LDH's MMIS, or implement a traditional SFTP approach, depending on LDH's preferences.

Continual Monitoring and Action. LHCC's Management Team reviews claims reports daily to identify trends and monitor performance. Our Claims Team reviews daily pend reports to identify any processing delays, inappropriate claims denials,

and any aging claims inventory, and we escalate and resolve any outstanding issues. If we detect any "spikes" in pending claim volumes, we shift staff workloads to maintain service levels. We coordinate weekly cross-functional calls with Claims Processing and System Configuration Teams to identify root cause of aging claims and any corrective actions needed. When a claims issue arises, we contact the provider and resolve the issue quickly, with one result being that LHCC has the ***lowest number of Independent Review (IR) requests among all MCOs, year over year***, based on 2020 LDH IR End of Year reports**.**

Due to the COVID-19 pandemic, changes in provider policy were implemented to respond to the emergency, including the use of telehealth. To prevent delays in provider claims payments, LHCC identified 551 providers with claims denials related to this change and educated them on the correct way to bill for telehealth services.

LHCC also ranked first among all MCOs for overall provider satisfaction in the LDH 2020 Provider Satisfaction Survey.

Collaborating for Training on Timely Topics. As part of our provider support initiatives in 2020 and 2021, our Claims Team conducted virtual and onsite training on Louisiana Medicaid claims topics. With the Louisiana Managed Medicaid Association (LMMA), we conducted training sessions on Telehealth, E&M coding changes, and a workshop on claims and billing. In conjunction with the Louisiana Hospital Association (LHA) and the LMMA, our team participated in the Annual Payor Day Training for Facilities.

Working with LDH and MCOs. LHCC aligns our claim payment policies with LDH covered benefits. Our Claims Team collaborates with LDH and our fellow MCOs to strategize about improvements. We meet bi-weekly with LDH to work on process improvements, new system implementations, and encounter issue resolution.



Enterprise Support. LHCC's claims process is supported by our parent, Centene with 35 years' experience processing claims data for our Medicaid state partners, including LDH. Leveraging Centene's systems helps ensure we exceed claims processing requirements, regardless of claims volume. This is also a core component of our business continuity strategy to ensure our provider payments are not adversely impacted by hurricanes, flooding, or other disruptive events.

Independent Claims Audit Group. Our Claims Audit Department is a part of Centene's Internal Audit division and provides feedback to LHCC on claims performance. Claims Audit staff perform post-payment audits of LHCC's paid, denied, appealed, and adjusted claims using a random sample and assessing claims for processing, payment and financial accuracy, as well as compliance with LDH contractual obligations. Claims Audit staff review claims based on LDH payment rules and/or provider contract terms and monthly audit findings summarize financial and procedural accuracy**.** LHCC uses the feedback to remediate any identified issues. ***Our claims quality metrics are more than 99.4% for financial accuracy and 99.3% for claims accuracy.***



Enhancements. We continue to introduce innovations to reduce provider abrasion and improve operational efficiency. For example, we currently use Robotic Process Automation to improve the near real-time identification of duplicate claim submissions. In 2022, we will introduce the use of Artificial Intelligence (AI) to enhance our third-party liability (TPL) processing and complex claims for routing to appropriate claims staff for rapid handling. We also will be AI to automatically learn from user interactions and improve capabilities as more data is received, without the need for additional programming. We will use AI in our claims centers to perform insurance verification to efficiently assist our claims staff to verify enrollee other insurance coverage and update our claims system appropriately.

2.6.13.2 Management Information System

LHCC uses an MIS that supports physical and behavioral health administration on a unified platform and complies with all requirements in the Model Contract, Section 2.19 and the MCO Manual, as well as HIPAA, HITECH, and applicable Louisiana and other federal regulations. We support the CMS Interoperability and Patient Access Final Rule, via Fast Health Interoperability Resources Representational State Transfer (FHIR RESTful) APIs through our Clinical Data and Interoperability Gateway. Our MIS is designed ***exclusively*** for publicly funded health programs, including claims processing, clinical, service, analytics, reporting and encounter functions needed for LDH. We use HIPAA compliant controls such as facility monitoring, role-based access, audit trails, and encryption, and perform regular risk assessments to ensure our MIS is secure. See ***Attachment 2.6.13.2*** for an overview of our MIS.



Supporting our Health Equity Mission. We ensure that our use of analytics and AI (collectively "data models") a dhere to our Health Equity guidelines through governance and ongoing reviews. We test changes in our data models to ensure results are useful, accurate, fair, and avoid reproducing social, economic, and health disparities and related biases. Reviews are conducted by our data science governance

committee, comprised of data analytics and information technology leaders and technical experts, who review the appropriateness, accuracy, and freedom from bias of our data models.

2.6.13.2.1 MIS Architecture to Assure System Stability

LHCC has used our proposed MIS for Louisiana operations since 2012. Centene operates a network of data centers which includes our Leadership in Energy and Environmental Design (LEED) certified, Tier 3 primary facility, supported by additional, geographically dispersed data centers. We 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. We use a best practice Change Management approach, utilizing Agile and the Information Technology Infrastructure Library (ITIL) process framework, to ensure any system changes and enhancements maintain stability and avoid disruptions. Our resilient MIS architecture maintains high availability of critical business operations. For example, over the life of our current LDH contract, ***we have never missed a weekly claim payment for our providers***.



2.6.13.2.2 Hardware and System Architecture of Core Systems

Our MIS design is informed by CMS' Medicaid Information Technology Architecture (MITA 3.0) with a standards-based Service Oriented Architecture (SOA). We employ microservices, accessible via open APIs to service application functions. Our standards-based approach also ensures that our MIS is scalable and agile, so that we can efficiently incorporate innovative technologies like real-time analytics and artificial intelligence. Data is stored on a Storage Area Network (SAN), supported by Storage Arrays with RAID 6 configurations. Our Unix databases run on Oracle Real Application Clustering for high availability, and our Windows applications run on blade servers in virtualized environments, using VMWARE. LHCC applications run at our datacenters, and our virtual desktops connect to centralized data via a secured, full-mesh, IP Multiprotocol Layer Switching Wide Area Network (WAN) sourced from independent telecommunications companies for high availability. 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 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.

2.6.13.2.3 Core System Functions

System	Description
Enrollee Enrollment System - Unified Member View (UMV)	The UMV component of our MIS provides the single source for all informational aspects of our enrollees' relationship with LHCC, including demographics, current and historic eligibility, contact information, communication preferences, and change history. UMV employs a master data management approach to collecting, matching, 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 enrollee index, enhancing our ability to maintain historic enrollee data. See ***Attachment 2.6.13.2.3.a*** for data interface details.
Provider Enrollment System (PLS)	PLS is a single repository for LHCC's provider functions including provider prospecting, contracting, credentialing, data administration, and engagement. PLS stores and indexes multiple providers' numbers, including any LDH assigned provider ID, provider types, specialty, and sub-specialty codes, language, locations, office hours, ADA accessibility, etc. PLS maintains linkages between NPI and LDH Provider IDs, and corresponding Zip and Taxonomy codes, allowing us to track multiple service locations registered to LDH Provider IDs. PLS is integrated with our Customer Service System (CSS), enabling unified provider contact management and communications. PLS continuously sends updated provider data to our claims processing system. Our claims system flags claims from excluded providers so that our Provider Engagement staff can follow/up as needed with the provider. See ***Attachment 2.6.13.2.3.b*** for additional details.
Claims Processing System (Claims System)	We use our Claims System for physical and behavioral health claims processing for coordinated benefits administration. Our Claims System supports HIPAA EDI and EFT

System	Description
	capabilities, as well as real-time clinical edits and advanced fraud, waste, and abuse detection. See ***Attachment 2.6.13.2.3.c*** for our end-to-end process. **Inbound Claims (EDI, Paper, and Web).** Our system supports all HIPAA Electronic Data Interchange (EDI) claim formats as well as paper claim formats. **Claims Pre-Adjudication.** We validate submitted claims against common edits, including enrollee identifiers, eligibility, and provider data such as billing and rendering provider identifiers. Claim rejects trigger a 277 Unsolicited (277U) notification to the EDI clearinghouse or submitting provider. If a paper claim fails pre-adjudication, we send a letter to the submitting provider, reject the claim, and cite specific responsible edit(s). **Claim Adjudication Edits.** Once a claim passes pre-adjudication edits, it is loaded into our Claims System, which performs six adjudication steps a claim must pass in succession to reach a paid, denied, or internally pended status. These steps include: • General edits – the claim is checked for validity of CPT, ICD-10, age, gender, duplicate, and timely filing edits, and rules per LDH and Federal regulations • Enrollee edits – checks for enrollee eligibility during service date spans, coverage type, and existence of Coordination of Benefits (COB) or Third Party Liability (TPL) information • Provider data – checks for the submitting provider's eligibility during service date spans and network participation status, including National Provider Identifier (NPI) • Prior-authorization – when applicable, checks for a prior-authorization and validates the presence of criteria during the service date spans • Covered Services – checked against our benefit management rules to determine if the enrollee is eligible for the services rendered on the service date • Pricing – applies any TPL or COB, and provider specific contractual agreements **Claims Workflow Management**. If a claim pends, an electronic work item is routed to a Claim Analyst to resolve the pend issue. Claims Analysts have immediate access to paper claim images and attachments if needed. Once the pend reason is addressed, we re-adjudicate the claim real-time to pay or deny all pended claims within 60 calendar days. **Provider Payment and Remittance.** Once a claim finalizes it is marked as paid or denied for the next payment cycle. We process provider payments twice weekly. We encourage providers to use EFT and Electronic Remittance Advice (ERA) payment options. We also offer paper check and paper Explanation of Payment (EOP) 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. If a claim denies, the ERA/EOP states the reason(s) for claim denial, with instructions for correction and resubmission, if applicable. ***In 2020 we improved our denial code explanations through mapping of Claim Adjustment Reason (CARC) and Remittance Advice Reason (RARC) codes to improve transparency with providers.***
Encounter Data System (EDS)	LHCC uses an encounter workflow system specifically designed for Medicaid encounter processing. Fully integrated with our MIS, EDS is configured to meet LDH specific requirements. Our encounter data includes the same line-item detail as received on the claim, regardless of claim type and disposition (e.g., paid, denied, adjusted, voided). Our encounter data includes diagnosis and DRGs as appropriate and are inclusive of LDH standards regarding the treatment of certain data elements captured on claims such as counting methods and units. In our encounter data, we provide all rendered services, rendering provider's identification numbers, billed amounts as well as an indication of whether the claim is original, adjusted, voided, denied, a replacement, or from capitated services. Prior to submission to LDH, we test encounter data for accuracy, completeness and consistency, including for our subcontractors. Our Encounters Business Operations (EBO) Team maintains rigorous processes for tracking encounter submission, error correction, resubmission, and contract compliance, using customized reports. See ***Attachment 2.6.13.2.3.d*** for process and data flow. LHCC consistently meets or exceeds LDH requirements, and we are ***meeting the new 99% encounter submission threshold as of the July 2021 Louisiana Encounter Reconciliation report.***

System	Description
Customer Service System (CRM)	Our ***Customer Relationship Management*** platform (CRM) enables us to identify, engage, and serve our enrollees, providers, and LDH in coordinated fashion. Through its integration with our MIS, CRM affords a 360-degree view of our relationship with enrollees and providers for our Customer Service Representatives (CSRs), allowing us to resolve most call inquiries in one call. CRM also helps CSRs coordinate communication between our staff, our enrollees, and providers (including support-a-user capability between CSRs and our secure web portals) and update enrollee and provider demographic data. CRM provides an integrated approach to service management including inquiry tracking, workflow & automation capabilities, complaints, and grievances & appeals. See ***Attachment 2.6.13.2.3.e.***
Utilization Management System and Service Authorizations [LHCC Care and Utilization Management Platform (LHCC CM and UM Platform)]	LHCC's CM and UM Platform includes our collaborative health management platform to support administrative productivity and clinical quality and includes support for the utilization management (UM) process. Our LHCC CM and UM Platform assists UM staff in making appropriate medical decisions based on nationally-accepted care standards and is integrated with evidence-based decision support criteria to help manage prior authorizations, concurrent reviews, discharge planning, and transition service reviews. The LHCC CM and UM Platform integrates program-specific clinical practice guidelines to ensure practices are aligned with state standards and integrates with clinical determination platforms, such as InterQual Connect™, to enable real-time determinations of medical necessity. LHCC CM and UM Platform provides UM staff access to real-time enrollee, provider, and Admission/Discharge/Transfer (ADT) data to improve authorization speed and accuracy. **Service Authorizations for Providers.** LHCC CM and UM Platform enables quick and accurate resolution of enrollee and provider authorization requests, with a singular search experience allowing users to quickly find enrollee authorization information by name, authorization number, or enrollee ID. See ***Attachment 2.6.13.2.3.f*** for additional data interface details.
Care Management and Care Coordination System [LHCC Care and Utilization Management Platform (LHCC CM and UM Platform)]	In addition to UM support, our LHCC CM and UM Platform supports collaborative physical and behavioral health clinical operations. LHCC CM Platform offers appropriate information exchange with providers and other members of the Interdisciplinary Care Team (ICT) and enrollees to support integrated care management and coordination. LHCC CM and UM Platform provides our Case Managers with a single view of the enrollee and integrates risk analysis, care gap, and stratification tools to help care teams use data to improve enrollee health outcomes. The LHCC CM and UM Platform houses an enrollee's plan of care, which displays the enrollee's identified health issues, treatment goals and objectives, interventions, outcomes, and milestone and completion dates. The system's design supports a unique profile for each enrollee, including demographics, referrals, authorizations, enrollee case notes, and enrollee preferences such as language and communication. The LHCC CM and UM Platform's integration with our Centelligence health informatics platform (discussion below) enables access to unified data from multiple sources (e.g., enrollment, claims, enrollee services, 24/7 Nurse Advice Line, & prior authorization data) to allow our staff to individual and population level needs. LHCC CM and UM Platform capabilities include: • *Enrollee Dashboard* - includes benefits, demographics, social determinants of health, care gaps, claims information, risk scores, diagnoses, medications, critical incidents, inpatient utilization, language and communication preferences and outreach efforts. • *Screenings & Assessments* - assessment and screening information for our enrollees, including Health Needs Assessments, comprehensive assessments, functional assessments, biometric screenings, and depression screenings. The system allows Case Managers to administer assessments and offers a library of effective interventions that can be tailored to the enrollee's needs. • *Plan of Care* - enables Case Managers to work with providers, the ICT, and enrollees to develop a single, integrated plan of care unique for each enrollee. The plan of care displays the enrollee's identified health issues, treatment goals and objectives, milestone dates, and progress in an engaging, well-organized format.

System	Description
Financial Management System (PeopleSoft)	PeopleSoft records LHCC's financial data. All financial transactions are auditable per Generally Accepted Accounting Principles (GAAP) guidelines, and historical data is available via online queries and reports.
Enrollee and Provider Portals	LHCC portals contain the same real-time data that our CSRs access, allowing enrollees and providers who prefer self-service options to have the same information. Our secure ***Enrollee Portal*** is mobile-optimized, informed by human centered design, and offers enrollees access to their LHCC information and a number of "self-service" functions. Providers and other ICT members can access information via the role-based portal capabilities in our LHCC CM and UM Platform, which supports physical and behavioral health provider administrative self-service capabilities and care coordination activities, including: eligibility inquiry; authorization submission and status; claim submission; claim status; claim payment history; and a growing number of clinical applications. These clinical applications include online care gap notifications and health alerts, an enrollee health record, patient analytics, provider analytics (including cost and quality performance), care and disease management referral, and clinical practice guidelines. In addition, via the LHCC CM and UM Platform portal, providers can view and download assigned enrollee details. Providers can also submit claims, claim reconsideration and appeal requests online, and receive emails updating them on any changes in authorization request status. We have recently enhanced our claims status tracking to include a color-coded visualization of claims status (e.g., paid, denied, or pending).
Reporting and Analytics (Centelligence)	Our Centelligence system includes an Enterprise Data Warehouse (EDW) which uses our Service Oriented Architecture to integrate data from the core functional systems above. Centelligence also incorporates reporting and analytic functionality for online dashboards, standard and ad-hoc reports, predictive modeling, and other business intelligence support. See ***Attachment 2.6.13.2.3.g***.

2.6.13.2.4 Data and Process Flows for Key Business Processes

See these attachments outlining the data and process flows for our key business processes: ***Attachment 2.6.13.2; Attachment 2.6.13.2.3.a-g; and Attachment 2.6.13.3.***

2.6.13.5 Resources Dedicated to 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 Extract, Transform, and Load (ETL) tools. 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. Our MIS supports all LDH proprietary formats for provider data, reference files, and plans of care. Our Louisiana team of claims, analytics, and reporting staff are supported by Centene's 4,000 IT professionals, including our Network Operations Center, which manages and monitors our interfaces to the MMIS, our EDI Helpdesk available to LDH, providers and subcontractors for any support needs, and our Enrollment/Eligibility and Encounter Business Operations (EBO) teams that support 834 and encounter exchanges respectively.

2.6.13.3 Leveraging LHCC's Experience Maintaining Systems

LHCC has been maintaining systems for its contracts with LDH that conform with federal and State specific standards since 2012. We continually assess opportunities to enhance our MIS.

Ensuring Continuity of all Operations. LHCC's MIS is securely housed in Centene data centers, with systems and applications 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. Our data centers 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 datacenter in near-real-time. 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 Louisiana and our affiliate states. In addition, we ensure continuity through a Contingency Plan that focuses on restoring operational functions after

business disrupting events. We review, update, and test our Contingency Plan annually, and will submit it as part of readiness review. See ***Attachment 2.6.13.2.1*** for additional details. 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 the IROC identifies a systems function, data exchange availability, report distribution, or online systems access issue, our Compliance Department will promptly notify LDH via phone, fax, or email, within required timeframes. We will keep in contact with LDH providing hourly status updates.



Extending Continuity for Enrollees. We are partnering with the Association of Clinicians for the Underserved and Healthcare Ready, a non-profit organization that works to safeguard the health of all people by readying the healthcare system to recover from disruptions. Together, we are initiating a two-year project aimed at improving emergency preparedness and capacity of Louisiana clinics to respond to natural disasters, including hurricanes, flooding, and COVID-19 recovery. The project is comprised of three major initiatives:

- Strengthening clinic integration with government-managed response and relief efforts
- Increasing supply resilience for all hazards, especially in high risk/underserved communities
- Providing capacity-building, training, and technical assistance for providers and operational staff.

The program resources will be developed so that they may be tailored for use by clinics across the state.

Keeping LDH Apprised of Changes. We notify LDH of major system changes at least 90 calendar days prior to making major changes or upgrades to our core production systems. For example, in 2019 we notified LDH of a planned upgrade to our Encounter Data System, 117 days before the actual cutover date, exceeding contract requirements. In our notice to LDH, we included information on our plans for cutover, parallel testing, and backup, and result of our impact analysis on claims processing and providers. We will continue to work with LDH as we evaluate (through our Systems Refresh Planning) and consider enhancing any of our systems. 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 Centene, 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. For the past two years, we have undergone an annual external SSAE SOC 2 Type II audit related to claims processing and data center operations and effectiveness and provided a copy of the audit to LDH.

2.6.13.3.1 Enrollment Changes

In 2019, we began support for enrollee data updates for LDH via API for event-driven timeliness in lieu of batch updates. We are interested in supporting additional API exchanges with LDH, MCOs and providers (see 2.6.13.4). In terms of data capture, the flexible Big Data design of 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, and we contemplate support for the secure collection and integration of new data elements related to SDOH within UMV from a variety of new sources including external assessment data as well as from our own LHCC CM and UM Platform and Community Connect Platform. We do not have plans to subcontract any part of our enrollment system for the new Contract term.

2.6.13.2 Claims Processing Changes

Over the term of the contract, we are planning changes to our microservices operating on inbound claims to increase first pass claims submission accuracy, increase automatic adjudication, and enhance adjudication timeliness. Specifically, we will be phasing in enhancements to automated identification of claim type, and validation of newborn IDs, claim adjustments, procedure and diagnosis codes, provider match and validation. We are designing improvements in our TPL processing support, including improvements in how we integrate TPL information to increase cost avoidance, reduce data reconciliation issues, reduce the need for post-pay recovery, and increase claims processing speed. Our configurable Claims Processing System accommodates the increasing number of Value-Based Payment (VBP) arrangements that we administer with our providers and that we foresee during this contract term. We will work with LDH's chosen PBM and NEMT vendors to ensure we establish interfaces and oversight to ensure LHCC and LDH pharmacy and NEMT claims processing requirements are met and as we sunset our existing PBM and NEMT subcontractor operations, as necessary.

2.6.13.3.3 Utilization Management and Service Authorization Changes



We will be enhancing our web-based authorization capability through InterQual Connect during the term of the new contract, to support auto-determination rules that approve or pend prior authorization (PA) and provide a quick response to providers via our LHCC CM and UM Platform portal, reducing turnaround time on authorization requests.

Epic Payer Platform. Approximately 65% if Louisianans have records in the Epic EMR system. To help alleviate administrative burden for our providers using the Epic System EMR, LHCC will implement the Epic Payer Platform (see 2.6.13.4). The Epic Payer Platform will enable providers to be alerted to LHCC PA requirements for documentation while the provider considers the patient's treatment, all within the context of the provider's Epic EMR 'workflow,' including LHCC medical necessity requirements related to the proposed treatment. Once the provider decides on a plan of treatment, the Epic Payer Platform works with the Epic EMR to assemble the requisite data needed for the PA request, assembles that data into a request "template," allows the provider to complete any missing items, and submits the authorization request to LHCC. Any additional information requests and status are accommodated via the provider's Epic workflow, interactively allowing providers to submit the right information at the right time, without having to hunt for the right data in their EMR.

2.6.13.3.4 Care Management and Disease Management Changes

Enhancing ADT Processing with Machine Learning (ML). Today, through our participation in the Louisiana Health Information Network (LHIN), our LHCC CM Platform receives ADT transactions in real-time and we use Machine Learning (ML) technology to identify birth event ADTs. Please see 2.6.13.4 for details. In 2022, we are *expanding* our use of ML to identify ADTs indicating behavioral health IP admissions, as well as for ADTs that indicate patients being transferred from an inpatient setting to a step-down facility for medical rehabilitation. Our objectives in these applications of ML are for fast notification to the right UM and Case Managers to enable timely interventions leading to beneficial outcomes.

Community Connect Platform: SDOH Closed Loop Referral System. For contract go-live, LHCC will use our open standards Community Connect Platform (CCP) for closed-loop referrals and tracking. CCP is an electronic resource referral platform supporting social needs screenings (including LDH's approved Health Needs Assessment) and accessible to all authorized LHCC staff, providers, Community Based Organizations (CBOs), and enrollees. Through CCP, we will increase the social needs data we use today in our risk stratification model and care management systems to inform our population health efforts. We work with the top referral services, including 211, Unite Us and Aunt Bertha, and have the ability to engage with the referral services the state and communities prefer. CCP's SDOH database will be continuously refreshed with resources from vendor-based resources such as Aunt Bertha and with CBOs identified through our CBO Engagement Specialists to maintain a continuously refreshed referral list. CCP also allows LHCC staff to check on the closed-loop status of any enrollee referral to ensure follow-up on any additional needs. We are also engaging in EMR workflow integration to drive value-based payments and to reduce the provider's administrative burden in addressing patients' SDOH needs, by enabling providers to make CBO referrals from their EMR. Finally, to remove any lingering barriers for enrollees, providers and CBOs, we will use our Community Connections Help Line (staffed by peer specialists) to help enrollees and CBOs close the loop. Our on-the-ground community engagement team partners with CBOs to address any service gaps and support the sustainability of core community services.

Clinical Data Exchange. Since 2019, LHCC has expanded the type and volume of clinical data exchanges with our providers, including the transmission of care gap data, and receipt of quality information. During the Contract Term, we will accelerate this trend with additional clinical data connectivity. See 2.6.13.4 below for additional details.

Payer to Payer Support. Through interoperability enhancements in our Clinical Data and Interoperability Gateway, we fully comply with the CMS Interoperability Patient Access Rule and will be in full compliance for the Payer to Payer Rule on January 1, 2022. We continue to collaborate with stakeholders in formulating methods of data exchange needed for payer-to-payer interoperability. Our parent Centene is a Premier Member of the Da Vinci Project. Da Vinci is an HL7 Accelerator Project, comprised of members from the provider, payer, government, and health technology markets, which leverages the HL7 FHIR platform and uses HHS approved standards. We are currently participating in the development of the Da Vinci Payer Data Exchange (PDex) FHIR Implementation Guide, which will allow cooperating MCOs to share the United States Core Data for Interoperability (USCDI) set with other MCOs and LDH as enrollees move or transition to another MCO. We will offer PDex as one way to exchange data as Health Plan Enrollees move or transition to another MCO.

2.6.13.4 Interfacing with LDH, Providers, and Subcontractors

Our EDI subsystem supports all HIPAA transaction formats and codesets, including NCPDP for pharmacy claims, as well as LDH proprietary formats such as the LDH Weekly Provider File and all formats as specified in the Medicaid Managed Care Organizations System Companion Guide.

Interfaces with LDH. LHCC currently provides interfaces through SFTP and APIs to LDH systems, including LaMEDS, and the Enrollment Broker, and 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, LDOE and DCFS access through our LHCC CM and UM Platform 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.

Centelligence Reporting Suite for LDH. LHCC's data sets include those listed in RFP Model Contract 2.19.12.2.1, and housed in our Centelligence EDW. We will provide LDH's authorized users with secure read-only access to our Centelligence Reporting Suite, a SQL based production reporting environment, with data updated no less than weekly. Our reporting suite will allow LDH to view online dashboards and access table level data sets, with the capability to view, filter, sort, drill down, and extract to Microsoft Excel.

Integrating & Distributing ADT Data with Providers. In April, 2021, through our participation in the Louisiana Health Information Network (LHIN), we began receiving ADT transactions in real-time through LHIN's partner, Audacious Inquiry (AI), a leading provider of HIE technology. These real-time ADTs are electronically received by our LHCC CM and UM Platform, where these ADTs drive workflows such as inpatient (IP) admission authorization requests for efficient, accurate review by our Utilization Review clinicians, greatly alleviating the burden on our providers of calls and faxes related to IP admissions. We currently use Machine Learning (ML) to scan IP Admission ADTs to determine if the ADT is related to a birth event by examining data in the ADT, along with data in Centelligence. If the ADT is identified as a birth event, our system constructs the IP Authorization Request appropriately and routes that request to the appropriate UM team for efficient care management follow/up. We also securely distribute ADT events to the enrollee's PCP and other providers engaged in the enrollee's care, via our secure Provider Portal. We are rolling out this ADT functionality as LHIN participating hospitals are ready, with ten facilities completed in August, and with an accelerated pace that will have all LHIN participants online with us by the end of 2021. Based on our experience to date with automated ADT workflow, we anticipate freeing up over 5,100 hours of LHCC clinical staff time per year that can be used for other enrollee care and provider support purposes.

Bi-Directional Clinical Data Exchanges with Providers. As discussed above, we have expanded our bi-directional clinical data exchange capabilities. In 2021, we are accelerating this trend with providers using the most prevalent EMRs in the state, including Epic (discussion below), eClinicalWorks, and Athena Health. We are also working with Louisiana HIEs to extend the 'reach' of providers whom we can exchange clinical data bi-directionally. Through our investments in best-in-class EMR data integration firms Diameter Health and Apixio, we are incorporating Natural Language Processing to process EMR clinical codes and identify care gap closures to measure LDH quality metrics more accurately with the least possible burden on our network providers.

Working with Providers using Epic Systems. We continue to foster close working relationships with major EMR suppliers. Through Centene, LHCC will support Louisiana providers using Epic's EMR through the Epic Payer Platform. Through the Epic Payer Platform, we will support the transmission of clinical care gap data directly into the provider's Epic system for point-of-care alerts within the provider's clinical workflow. We will also support the receipt of EMR data from the provider for LDH quality and other supplemental data for tracking and reporting, eliminating the need for "chart chases" with the provider. We will also support a significantly enhanced prior authorization process (see 2.6.13.3.3).

Other Provider Interfaces. We support interfaces 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 support the Availity Multi-Payer Portal, used by over 18,000 Louisiana providers and offering a single entry point for provider administrative functions across multiple MCOs. We also send large data files via SFTP to providers who have the capacity to accept and process that level of data.

Interfacing with Material Subcontractors. Our affiliated subcontractors, Envolve Dental, Envolve Vision, and Envolve PeopleCare share a common voice and data network and all three subcontractors are connected with our MIS have remote access through our Citrix VPN Gateway. LHCC, Envolve Vision, and Envolve PeopleCare share a common hosting environment in our enterprise data centers. For our non-affiliated material subcontractors, we support all standard interface data exchange methods depending on the subcontractor's capabilities, including the use of APIs, as well as traditional SFTP methods. We will work with LDH's designated PBM and NEMT vendors and have experience doing this in other states.

SECTION 2.6.14

Program Integrity

"What I have found here at Louisiana Healthcare Connections is the thing my past experiences were all missing: a company that truly has values and morals and works towards the greater good for all."

- Angele Landry
LHCC Utilization Mgmt, Baton Rouge

2.6.14 Program Integrity [10-page limit]

2.6.14.1 Louisiana Healthcare Connections Comprehensive Fraud, Waste, and Abuse Program

LHCC is committed to the integrity of Louisiana's Medicaid program and has demonstrated effective management of public resources in the delivery of services to Medicaid enrollees and providers since 2012. LHCC is committed to LDH's goal of minimizing Fraud, Waste, and Abuse (FWA). Our philosophy is that all LHCC employees, providers, subcontractors, and enrollees have the responsibility for program integrity, including the identification and reporting of potential FWA. LHCC has demonstrated our commitment to the prevention, detection, reporting, and reduction of FWA since program inception. [redacted]

Quality Excellence

LHCC's FWA program has scored a perfect 100% in every MCO external quality review since 2014.

LHCC's Compliance Program, which includes all Program Integrity and FWA activities, maintains effective internal and external controls to safeguard Medicaid funds against unnecessary or inappropriate use of services and payments. Our FWA Program adheres to the requirements of the Model Contract, Section 2.20 Fraud, Waste and Abuse Prevention and federal and State requirements. LHCC leverages the resources and technology of our parent company, Centene, to support our FWA Program. Below we describe key components of our FWA Program, including accountability, staffing resources and our governance structure, as well as methods and approach to prevent, detect and correct FWA.

Accountability, Staffing Resources and Governance Structure for our FWA Program.

Accountability. Our President and Chief Executive Officer (CEO) has the ultimate responsibility for all FWA activities and delegates daily oversight to the LHCC Vice President, Compliance (VP, Compliance) and Manager, Special Investigations Unit (SIU Manager). The VP, Compliance reports to LHCC's CEO and to the Board of Directors (BOD), with unrestricted access to the BOD. Our VP, Compliance oversees and directs the FWA Program and is responsible for ensuring that the Program's goals are achieved. The VP, Compliance serves as the Contract Compliance Officer; the primary point of contact for LHCC on issues related to FWA prevention; the lead for our LHCC Compliance Committee, and staff support for our Regulatory Compliance Committee. We are actively recruiting for a new Director of Program Integrity (PI Director) position, which will report to the VP, Compliance and will oversee the development and implementation of policies, procedures, and practices designed to ensure program integrity and FWA Program compliance.

Staffing and Resources. *Louisiana-Based FWA Program Staff.* Our Louisiana-based FWA Team is comprised of our Program Integrity leadership (VP, Compliance, PI Director, and SIU Manager), State Reporting Managers, six SIU Investigators, three Louisiana licensed Clinical Investigators (RN, CPC, LPCs), and an SIU Triage Analyst dedicated to assuring compliance with FWA policies in Louisiana. Our dedicated FWA Team is physically located within Louisiana, and we maintain one full-time investigator for every 50,000 enrollees. These staff collaborate across all areas of the LHCC organization and are responsible for cooperating with LDH and any State or federal agency on any investigations. They are available for interviews, grand jury proceedings, pre-trial conferences, hearings, trials, and in any other investigative or judicial processes. Every 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 Compliance team and the SIU work closely alongside numerous departments, as depicted in ***Figure 2.6.14.1.a*** these diverse teams of experienced individuals participate in our overall strategy to assure appropriate FWA compliance with the payments/services for providers and enrollees. Our FWA team, SIU, and supporting staff are trained in unconscious bias and cultural sensitivity to make sure FWA activities are equitable for providers and enrollees.

Figure 2.6.14.1.a LHCC FWA Program Supports



Special Investigations Unit (SIU). The SIU's mission is to identify, investigate and correct FWA committed by ***anyone***, including, providers, facilities, employees, and enrollees. SIU employs a multi-faceted approach to combat suspected or potential FWA as described below. Our SIU prioritizes work so that those cases that have multi-state impact, potential high dollar overpayment, patient harm, or potential for an increase in fraud or abuse are given the highest priority. The

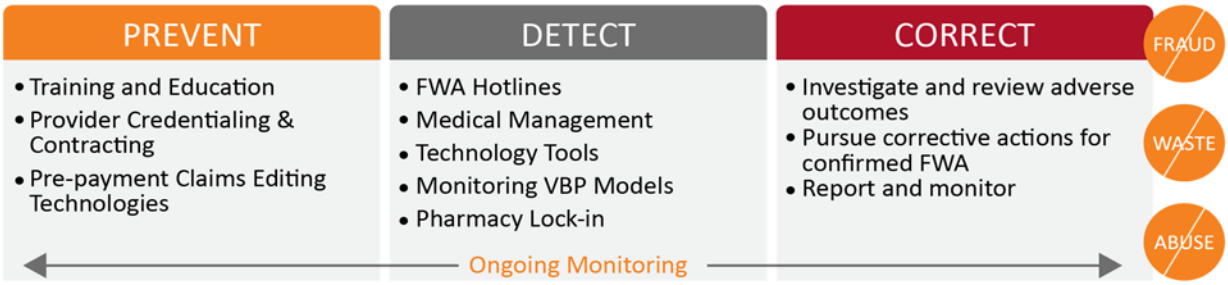
SIU Manager coordinates local SIU activities across LHCC departments, LDH, and any State or federal agency on any investigations. The SIU staff are credentialed by accredited organizations, such as the National Healthcare Anti-Fraud Association, the Association of Certified Professional Coders, and the Association of Certified Fraud Examiners.

Additional Centene Staff Supporting the FWA Program. The LHCC PI Director ensures collaboration with Centene's SIU, Payment Integrity, Claims, Provider Contracting, and IT departments providing support and analytical services from a team of over 190 staff members and Louisiana-based investigators. These support services include provider data mining, monitoring providers placed on prepayment review, and evaluating FWA referrals.

Governance Structure. *BOD Regulatory Compliance Committee***.** LHCC's Regulatory Compliance Committee is a subcommittee of the BOD and chaired by our President and CEO. The Committee is charged with overseeing the LHCC's Compliance Program and its compliance with the requirements under the Contract. *LHCC Compliance Committee.* LHCC's Compliance Committee, comprised of LHCC senior management across LHCC departments and the SIU Team, reports directly to our LHCC BOD and is responsible for overseeing LHCC's Compliance and FWA Programs. The VP, Compliance chairs the Compliance Committee, which meets quarterly to discuss standing FWA agenda topics, updates on the FWA Program, compliance training, and Model Contract compliance. The Compliance Committee serves as a resource to the VP, Compliance and to the Regulatory Compliance Committee. *Special Investigations Committee (SI Committee).* LHCC's SI Committee, a subcommittee of the LHCC's Compliance Committee, assists with our FWA prevention, detection and correction activities. The primary objective of the SI Committee is to assist LHCC's VP, Compliance and SIU by reviewing SIU activities and furnishing counsel, recommendations, and information.

Approach to Preventing, Detecting and Correcting FWA. Our comprehensive FWA Program addresses LHCC's efforts to detect, deter and prevent overpayments, abuse, and fraud regarding the provision of, and payment for, Medicaid services. LHCC's FWA Program includes policies and procedures to guide employees, providers, and subcontractors to ensure compliance with all applicable Federal and Louisiana requirements. Figure 2.6.14.1.b summarizes the key elements of our FWA Program to prevent, detect, and correct FWA in Louisiana.

Figure *2.6.14.1.b Prevent, Detect, Correct*



LHCC currently submits a copy of our FWA Plan to LDH annually and prior to implementation of any modifications, and our Plan is compliant with the 15 elements described in Model Contract 2.20.2.2. We will also submit our FWA Plan as part of Readiness Review upon contract award.

Preventing Fraud, Waste, and Abuse.

Training and Education. LHCC takes a proactive approach to prevent instances of FWA through training, education, and awareness to impede improper billing. Our FWA Program educates all employees on the processes to identify potential FWA and report issues. LHCC informs providers by posting information in our Provider Manual, Provider Portal, public website, and newsletters. We describe our provider training program below in 2.6.14.1.1 and in 2.6.14.1.2 we describe how we engage enrollees to identify and report FWA.

Provider Credentialing and Contracting Processes. Provider credentialing significantly contributes to our ability to prevent contracting with providers or entities previously found guilty of FWA. LHCC validates the credentials of network providers as part of initial contracting and re-credentials in accordance with NCQA criteria, LDH requirements, and State and federal regulations. Our provider agreements require that the provider comply with the FWA provisions as a condition of receiving Medicaid payment. LHCC screens network providers, including owners and managing employees, to determine if they have been excluded from participation in Medicaid 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. LHCC complies with the requirements set forth in 42 CFR § 438.610 regarding prohibited affiliations in Section 2.20.3 of the Model

Contract, and reports exclusion information to LDH. We maintain provider credentialing information in our core systems which can then be used by multiple departments. Working closely with LDH, we implemented a requirement that Mental Health Rehabilitation (MHR) providers obtain and submit an NPI on their claim submissions, which ***led to a marked reduction of FWA from MHR providers.*** The NPI requirement was subsequently mandated by Louisiana law and is now a policy of all Louisiana Medicaid MCOs.

Pre-Payment Claims Editing Technologies. LHCC maintains systematic controls and oversight to prevent and identify potential FWA. We use integrated pre-payment claims editing software to identify incorrect billing and potential fraud as described below in 2.6.14.1.3.

Detecting Potential Fraud, Waste, and Abuse. LHCC leverages industry-leading methods and technologies to identify potential FWA. This methodology includes a combination of mining data to spot inconsistencies; application of various levels of pre-and post-pay edits; leveraging of clinical expertise to identify and confirm unusual trends; follow-up on internal and external referrals; use of a broad set of investigative tools and skills; and the deployment of education and awareness training programs to maximize referrals.

[redacted]

Quality of Care. Our Quality Team completes medical record audits to ensure providers are properly documenting services. The Quality Team has identified a lack of assessments and other medical record requirements leading to an SIU referral. [redacted]

Utilization Management (UM) Activities. LHCC's program integrity responsibilities interface closely with our UM programs. We annually review and update, as necessary, prior authorization requirements to protect against future over-or under-utilization of services. Our UM Team monitors and identifies potential over-utilization of services by a specific enrollee through routine review of reports within the Centelligence Reporting Suite.

Referrals – FWA Hotline and Dedicated Email. Potential FWA is reported through our toll-free, confidential FWA hotline number, which can be used by providers, enrollees, employees, and subcontractors. We include the FWA hotline number in all Provider Manuals, Enrollee Handbooks, and on LHCC's publicly available website. We have a dedicated email address for reporting FWA prominently displayed on our website, which goes directly to Compliance leadership.

Data Mining. The SIU uses data mining tools (see below) to proactively identify potential FWA. The SIU employs data analysts to conduct targeted claims queries to identify enrollees and providers with suspicious activity, unusual patterns of behavior and aberrant billing patterns. For example, ***data mining identified a behavioral health (BH) provider overutilizing BH crisis intervention codes***. The subsequent investigation and onsite visit identified an overpayment of over $11,000 which was submitted to LDH resulting in payment recovery.

Artificial Intelligence (AI) and Machine Learning. LHCC and the SIU leverage industry-leading fraud detection technologies and proprietary machine learning models – commonly referred to as ***AI models***. AI models offer tremendous value over traditional rule-based fraud detection programs because they employ neural network learning to identify procedures that appear inconsistent with an enrollee's demographics, reason for visiting the provider, and final diagnoses received. For example, LHCC uses ***AI models to identify overutilization patterns for BH and pediatric services.*** Our Data Governance policies and procedures require a rigorous and ongoing review process to ensure the AI model results are useful, accurate, fair, and avoid reproducing disparities and biases.

Post-Payment Analytic Tools. Our SIU has developed analytic tools that use rules-based scenarios to identify providers whose billing violates clinical policy. We use several analytic tools to monitor and detect potential FWA by providers, subcontractors, and enrollees as described in 2.6.14.1.3.

Statistically Valid Random Samples (SVRS) and Audits. LHCC's SIU conducts SVRS and audits routinely to identify and detect inappropriate claims and potential FWA billing.

Special Investigation Resource and Intelligence System (SIRIS). As a member of the National Health Care Anti-Fraud Association® (NHCAA), LHCC's SIU has access to SIRIS, the NHCAA information-sharing website that includes regular postings of information about potential provider FWA activities by more than 100 insurance companies nationwide.

Thomson Reuters CLEAR. Thomson Reuters CLEAR is powerful online investigation software SIU investigators use throughout the different phases of an investigation. CLEAR has a vast collection of public and proprietary records that enable SIU investigators to uncover hard-to-find data.

Monitoring Providers on Value-Based Payment (VBP) Models. To support the LDH goal of ***promoting VBP methodologies***, LHCC recognizes the importance of monitoring providers on VBP models to detect potential waste and abuse. We monitor VBP providers quarterly for appropriate utilization and indicators of underutilization, such as outliers in Health Benefit Ratio (HBR) and other unusual changes in performance. We also assess the year-over-year HBR trends of VBP provider groups and provide monthly VBP reports to providers to help them identify under-utilization. Under-utilization monitoring provides us the ability to address concerns, including quality concerns related to under-utilization, with the VBP provider and make required adjustments. If we detect under-utilization, we work with our VBP providers to engage impacted enrollees.



Pharmacy Lock-in Program. LHCC's Pharmacy Lock-in Program focuses on improving safety for enrollees misusing prescription medications and obtaining excessive quantities of controlled substances through multiple visits to physicians and pharmacies. We identify enrollees potentially eligible for evaluation and enrollment in the program by monitoring frequency or number of services that exceed medical necessity and demonstrate specific patterns. For example, from ***2018 to 2020, there was a 19.37% reduction in claims for opioid prescriptions and a 43.82% increase in claims for medications for opioid use disorder.***

Correcting Fraud, Waste, and Abuse. Our comprehensive approach to correcting FWA includes a combination of analytics tools, clinical expertise, investigative knowledge, and referrals, as well as our education, training, and awareness programs.

Timely Investigation. Once we detect a potential case of FWA, LHCC's SIU investigates according to state, federal, and Contract guidelines, following the steps outlined in ***Table 2.6.14.1***. LHCC's SIU is implementing process improvements and investigative workflow revisions in Q3/Q4 of 2021 to allow the SIU to complete complex case reviews within 300 days.

Table 2.6.14.1 FWA SIU Investigative Actions

Step	Description
Intake	Tips/referrals may come from any source including the state, providers, or enrollees; our fraud hotline and website; internal FWA analytics and algorithms, and Explanation of Benefit responses.
Triage	The local SIU Triage Analyst completes a preliminary assessment which includes background checks; review of provider billing data; and evaluation of regulations, manuals, credentials, and exclusion lists. Based upon the finding, they make a recommendation to open a case for investigation, close the case, or refer to another department for follow-up. ***For example, the SIU received a tip from a Medical Director upon review of medical records of an enrollee who was hospitalized in Miami, post-cosmetic surgery.*** The case was determined to be related to eligibility and was referred to LDH.
SIU Manager Review	The SIU Manager reviews each referral prior to sending to an Investigator. Each case is entered into the SIU's case tracking software system, which automatically assigns a tracking number.
Investigation/ Onsite Visits	The Investigator pursues investigations to either corroborate the allegations or determine them unfounded. The Investigator reviews the documentation provided by the SIU Analyst and requests clinical records. They also perform additional data analysis on provider billing codes and payment records, conducts an NHCAA SIRIS and disciplinary actions search, and reviews provider and vendor contracts. The SIU may conduct an unannounced onsite visit when an allegation includes information that will require a physical inspection and notifies LDH prior to visiting the provider's office. ***For example, LHCC received a tip that a provider was seeing enrollees in a group setting and billing for individual physical exams.*** The Investigator conducted an unannounced visit to gain a front-line perspective of the enrollee experience.
Clinical Investigator Medical Records Review	We have two Louisiana-based physical health and one BH Clinical Investigators who are familiar with federal and state-specific policies, as well as LHCC policies and industry guidelines. Our Clinical Investigator conducts a detailed review of clinical records and compares them with LDH policies and industry guidelines to identify aberrant billing practices, and to ensure enrollees receive the services

Table 2.6.14.1 FWA SIU Investigative Actions	
Step	**Description**
	for which the provider billed. ***For example, a Clinical Investigator identified a BH provider driving an enrollee to school and billing transportation as therapy.***
Determination	Based on the findings of the review, the Investigator determines whether the target party engaged in FWA and creates a Final Investigation Report.
LDH Referral and Approval	We report all credible allegations of fraud or abuse to LDH and MFCU using the applicable Fraud Notice and Fraud Referral Forms. Only upon LDH approval, we proceed with any post-payment review and recovery efforts only upon LDH approval.
Corrective Action and Recovery	When an investigator determines that the target party engaged in FWA, the SIU pursues corrective action. The type of corrective action depends on the misconduct identified by the investigation. For example, if the FWA concerns an enrollee's drug abuse or doctor shopping/pharmacy shopping, the enrollee may be placed in our Pharmacy Lock-In Program, and the enrollee's access to narcotics will be closely regulated. For a provider who engages in fraud or abusive practices, remedial actions may include education along with overpayment recovery, termination of the provider, or referral to law enforcement for prosecution.

Reporting Provider and Enrollee FWA. 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 when 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. We report any provider if we suspect they are submitting claims that are coded incorrectly or not supported by documentation, we receive a credible allegation of FWA, or we requested recoupment not received.

LDH Referrals & Notices

From January 2021 through May 2021, LHCC submitted 91 referrals and notices to LDH, representing 30% of all cases, more than any other MCO.

Coordinating FWA Efforts with LDH. Our FWA Team has regular interaction with state staff, including ongoing collaboration, routine meetings, reporting and updating LDH, maintaining and submitting our FWA Plan, and ***recommending 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. LHCC supports the best practice systems implemented by LDH, such as the State TIPS report to track, investigate, and report on FWA allegations. We fully cooperate with LDH, law enforcement, and 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 further action pending approval from LDH. We suspend network provider payments when the State determines there is a credible allegation of fraud.

2.6.14.1.1 Training Programs for Employees, Subcontractors, and Providers



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. Our FWA Training Program includes initiatives, policies, systems, and best practices directed to prevent, detect, and report FWA, while preventing potential enrollee health risks. We educate all employees, including our Compliance Officer and senior management, on the processes for identifying and reporting issues as outlined in our FWA Program. Mandatory training occurs within 30 days 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). LHCC monitors staff, contractor, and provider training completion through our Provider Directory and e-learning platforms. The training curriculum is reviewed and revised to ensure continued compliance with federal and Louisiana state laws, regulations, and to reflect the latest trends and guidance.

Employee and Subcontractor Training and Education. Our online FWA training programs include modules on:

- Code of Conduct
- FWA Program organizational structure
- FWA identification and reporting
- FWA Program organizational structure

- False Claims Act and employee whistleblower protections
- Procedures for timely consistent exchange of information and collaboration with LDH
- HIPAA Privacy and Security; and other practices that reflect current state and federal laws

As needed, we configure timely, structured learning modules related to our FWA Program, deploy the training, and monitor views of the content. We educate our subcontractors during their initial orientation, mandatory annual training sessions, and ad hoc training as needed. For example, due to our proactive subcontractor oversight, in 2020 we received 20 FWA tips from our subcontractors.

3rd Annual FWA Week

"FWA issues are always evolving; FWA week helps me stay ahead and know new things to watch for."
– LHCC employee

SIU Staff Training. To maintain a high standard of knowledge and stay current on emerging FWA trends and schemes, all SIU staff are responsible for attending at least 40 hours of training each year and participate in FWA training provided by LDH. The SIU sends the team to training seminars that address topics such as BH trends, overutilization, emerging billing schemes, cultural sensitivity, and unconscious bias. Our SIU is a ***member of the National Health Care Anti-Fraud Association (NHCAA) and Healthcare Fraud Prevention Partnership (HFPP)***. These partnerships provide access to information sharing websites, SIRIS, trends, investigative techniques, legal issues and regulatory developments, all enabling the SIU to target and remedy FWA.

FWA and Compliance Weeks. The LHCC SIU hosts an annual ***FWA Week*** which includes a series of internal webinars with the LHCC staff. During the webinars, members of the SIU team share their team structure, definitions of FWA, causes of improper payments, real FWA stories, the newest scams, and methods to report potential FWA cases. A game and prizes at the end of the webinar "test" the participant's knowledge. During FWA Week, the SIU also hosts a webinar for providers, focused on similar topics tailored for the audience. We also launched an annual ***Compliance Week*** to further engage our employees in FWA compliance. During Compliance Week, we kick off the annual FWA training program. Employees can win Visa gift cards by completing quizzes and trivia contests. We post a message from the VP, Compliance, daily compliance videos and activities on our company intranet, FWA posters placed in high-traffic areas, and employee screen savers displaying the Ethics and Compliance Helpline and FWA Hotline numbers.

Provider Education and Training. LHCC educates providers about our FWA Plan through our Provider Manual, newsletters, new provider orientations, and provider webinars/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 appropriate coding to optimize clinical accuracy while mitigating FWA risk. 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 Clinical Investigators and Medical Directors outline billing aberrancies found in the medical record review. SIU refers providers to the applicable LHCC, LDH, CMS Medicaid policies and procedures, laws, and regulations as a resource for additional information on billing requirements.

2.6.14.1.2 Engaging and Informing Enrollees in Preventing Fraud, Waste, and Abuse

LHCC engages enrollees and informs enrollees about how to report fraud issues in our enrollee materials, such as the Enrollee Handbook, Enrollee ID cards, and other periodic communications and enrollee newsletters. Our Enrollee 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 LDH. The Enrollee ID card includes phone numbers for the LDH Medicaid fraud line and LHCC Enrollee Services. Our public website contains enrollee 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.

Enrollee Engagement through Validation of Paid Claims. As part of our efforts to prevent FWA, we partner with enrollees using a service verification process to determine if specific services were provided. We also mail an Explanation of Benefits (EOB) to a random sample of enrollees, reflective of all provider types and billed services of our enrollee population. We mail the EOB to the enrollee within 45 days from date of payment containing billed claim information specific to the enrollee. We ask the enrollee to sign and return the EOB to our Baton Rouge office. In the event an enrollee did not receive the services, we request that they contact Enrollee Services. ***In 2020, LHCC sent over 10,940 EOBs and 400 enrollees signed and returned the EOB to LHCC verifying services included in the EOB were received.*** Our call center and the SIU maintain

Louisiana-specific policies and procedures used when an enrollee responds to us on an EOB. Our resolution may be 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. We submit a quarterly report to the State detailing the number of enrollee-verified services.

2.6.14.1.3 Detection and Prevention Through Data Analysis

LHCC uses several FWA data analytic algorithms described below to prevent and detect potential fraud.



[redacted]

2.6.14.1.4 Method and Definition of High-Risk Claims

LHCC applies several criteria to define and evaluate high-risk claims indicating potential FWA. These criteria include inappropriately billed claims, claims from providers with a previous history of billing abnormalities compared to peers, claims not following National Correct Coding Initiative (NCCI) guidelines, claims for types of services that have a significant increase in utilization, 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 noncompliance. Claims found to be billed inappropriately by any of our program integrity and FWA programs are considered high-risk.

Methods and Tools to Identify High-Risk Claims. To identify the top high-risk claims areas for the Louisiana Program, we base our selection on contract requirements; LDH goals; Louisiana FWA historical trends; suspension, termination or other actions related to providers; revolving trends; lessons learned; and best practices of our FWA subject matter experts at the state and Federal CMS level.

System Tools to Identify High-Risk Claims. LHCC uses multiple system tools described in 2.6.14.1.3 to identify high-risk claims. These tools profile providers with aberrant coding practices prior to payment, detects multiple conditions including, but not limited to, billing spikes, upcoding, and excessive services, determines clinical claims coding appropriateness, and identifies inaccuracies.

FWA Investigative Leads to Identify High-Risk Claims. LHCC uses both reactive referrals and proactive leads 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.

Ad-Hoc Data Mining and Reporting. The SIU uses QueryShield™ and our Centelligence 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.

2.6.14.1.5 Experience with Provider Recovery Collection

[redacted]

LHCC's comprehensive FWA program is designed to use system capabilities and ongoing provider FWA education to minimize the need to recover provider funds. We may identify providers where the most appropriate action is education on patterns of possible incorrect billing. Education enables providers to improve or correct issues identified through system edits and other cost avoidance activities. We also engage recovery partners to review paid claims data monthly and identify improper payments. These partners conduct coding/clinical validation, credit balance audits, and service billing audits.

SIU Provider Recovery Processes. Our FWA Plan and policies provide a process to oversee and effectuate provider recoveries. According to the Model Contract, for all confirmed provider and enrollee fraud and abuse, SIU submits a fraud referral to LDH and MFCU using the LDH Provider Fraud Referral Form. SIU then suspends all activities until approval is received from LDH to proceed. Once approval is received, SIU sends the provider a Proposed Action Letter and Audit "Claims" Sheet detailing the reasons for the recovery. We give the provider the option to pay the recovery, negotiate a payment arrangement, or appeal the determination. If the provider fails to respond, we offset future claims for the amount of the recovery. If the provider appeals the findings, our SIU reviews the appellate records within 30 calendar days. Depending on the result of the appellate review, we continue, modify, or stop the recovery efforts. ***Since 2019, SIU has negotiated and executed 18 payment plans with providers to recover total identified overpayments within an average of***

12 months. Our Claims Department adjusts and voids the FWA claims identified in the overpayment in our Claims Processing System. Our Encounter System extracts the adjusted claim and sends the updated encounter transactions to LDH following LDH timelines in compliance with La. R.S. 46:460.73.

Program Integrity Recovery Processes. Our FWA Team partners with recovery vendors to collect credit balances on behalf of hospitals, which are required to refund any overpayments within 60 days. To assist these hospitals, our recovery vendors review the hospital's open accounts receivable credit balances. Once identified, the vendor works with the hospital to obtain approval and forwards the refund to LHCC. Our FWA Team oversees the billing and collection of other liability when benefits in addition to Medicaid are detected. Our vendor partner assists in identifying coordination of benefits (COB) by reviewing weekly claims information. The vendor requests a recoupment when Medicaid is incorrectly paid as primary.

2.6.14.2 Capability to Produce Required Reports

Our Management Information System supports LDH and federal reporting requirements by providing integrated, large scale, and secure data management capabilities for timely/accurate data collection, analysis, reporting, and quality improvement. Our FWA team has access to our large scale Centelligence data warehousing, analytics, and reporting platform which provides resources and capabilities for standard and ad hoc reporting. Our report tracking application allows us to identify approved reports ready for submission to LDH and those that have not met internal deadlines. This allows us to early identify potentially late reports and resolve delays.

LHCC has developed and maintained streamlined reporting processes and consistently submits the required monthly, quarterly and annual reports to LDH in the required timeframes and formats. We currently provide all FWA reports included in the LDH Managed Care Reporting Deliverables schedule, we report on exclusions database checks; service verification forms received from enrollees provider medical record audits, onsite visits, number of complaints of suspected FWA; actions that could result in exclusion, debarment, or suspension; number of complaints reported to our Contract Compliance Officer; monthly audits performed, and overpayments identified and recovered; and unsolicited provider refunds.

Innovations for Reporting FWA Data. We continually enhance our FWA reporting activities based on LDH's feedback on our monthly, quarterly, and annual reports and meetings. We work with LDH to revise report templates by providing feedback from the plan perspective to ensure template revisions meet LDH's data collection goals. We recently discussed a template revision with LDH staff and provided feedback which was incorporated into the production report template. Through our ***Centelligence FWA Reporting Suite,*** we will make FWA reports available to authorized LDH staff***.*** Our Centelligence FWA Reporting Suite incorporates an integrated, interactive set of data tables, reports, and configurable dashboards, enabling LDH to view, filter, sort, as well as extract data to MS Excel for LDH's monitoring and decision support needs.

Centelligence FWA Reporting Suite

LHCC will collaborate with LDH to design online interactive FWA reports, as well as summary dashboards with drill-down capabilities.

Automation for FWA145 Reporting. In 2020, we implemented automated data retrieval from our EDW to support the FWA145 reporting to LDH. FWA case data is *systematically extracted* and sent to the LHCC SIU team, ***reducing any data entry errors from a manual process.*** The SIU Manager and Investigator validates and corroborates the information, ensuring data validity and accuracy. We continue to add data.

SECTION 2.6.15

Physical & Specialized Behavioral Health Integration Requirements

"The families feel more empowered. They know there are things they can do apart from medication. I provide them with information about community resources, or connect our more complex patients to the care management team at Louisiana Healthcare Connections.

These resources have been very beneficial for our patients and their families in improving outcomes."

- Brittney Santora LCSW
Red Stick Pediatrics PH-BH Integration Pilot Program, Baton Rouge

2.6.15 Physical and Specialized Behavioral Health Integration Requirements [10-page limit]

2.6.15.1 Meeting Whole Person Needs

Integration Overview and Approach. LHCC endorses the Substance Abuse and Mental Health Services Administration's (SAMHSA) nationally recognized definition of whole-person healthcare as systematic and bi-directional integration including the continuous communication and coordination of physical health (PH), behavioral health (BH), and/or substance use disorder (SUD) treatment services. This requires integration across the continuum, at the enrollee, provider, health plan, and system level.



Using this approach, LHCC has been able to advance PH/BH integration, impact social determinants of health (SDOH), and reduce cultural barriers to deliver whole-person care. Here we describe our fully Integrated Care Model, including current experience with integrated care management and delivery models, best practices, and innovations, followed by staff and provider training and education in compliance with mental health parity.

Fully Integrated Care Model. A cornerstone of LHCC's approach to care delivery is our Integrated Care Model. Our model facilitates information sharing, cross-system coordination and collaboration, integrated training, and seamless care delivery with one primary goal – ***meeting the whole person needs of each enrollee***. LHCC designed our model to support enrollees by matching them with services, programs, and resources and optimizing and integrating care and service at the enrollee, provider, and system level.



Enrollee Level. LHCC offers and encourages integrated Care Management (CM) for ***all enrollees*** with co-occurring PH and BH conditions. We use a multi-disciplinary team-based structure designed to enhance access to all covered and non-covered services and meet the enrollees' holistic needs. As fully described in Section 2.6.6, CM promotes integration through:

- Dedicated Case Managers, including RNs and BH clinicians, trained in person-centered, recovery-oriented, and culturally responsive care, supported by a LHCC Collaborative Care Team that provide multidisciplinary support and consultation to the primary Case Manager for enrollees with co-occurring, complex needs
- Health Needs Assessment (HNA), comprehensive assessment, and supplemental tools including our SDOH mini-screening tool that captures PH/BH and social needs as identified by the enrollee
- Population-based predictive modeling and risk stratification that incorporates PH/BH assessment, claims, and authorizations; SDOH; and demographic data to connect enrollees to appropriate resources and services
- Development of an integrated individual plan of care (POC) with input from the enrollee's Interdisciplinary Care Team (ICT), comprised of LHCC and external partners that work together in partnership with enrollees to support their health and wellness goals that capture, support, and represent all enrollee-identified PH/BH, social, and other needs and preferences
- Health Equity Improvement model to detect, assess, and reduce health disparities
- Technology solutions that support coordination and sharing of health information

As part of CM, enrollees are wrapped with ***supportive resources*** to meet them where they are. For example:
BH Community Engagement Team. After an ED visit or inpatient stay, enrollees often need ongoing and wrap-around supports. To facilitate outreach for hard to engage enrollees, LHCC created a team of ***face-to-face, community-based BH clinicians*** to complete assessments, make follow-up appointments, and accompany enrollees to BH visits, if necessary. Clinicians assess SDOH needs and facilitate assistance from community and health plan resources and work with families, teaching them how to best support their loved ones.



LHCC Member Story: "Bill"

Mel, a BH team member, was having a hard time setting up a meeting with "Bill", a former swim instructor. Bill was battling depression and anxiety due to a knee injury that was beyond repair, preventing him from teaching kids how to swim - his biggest passion. Bill suffered from chronic pain that he "treated" with bi-weekly ED visits.

The minute Mel got in touch with Bill, she had to think quickly. He mentioned he was on his way to Walmart. This was her shot; she decided to meet him there. He liked the idea, told Mel what he was wearing and hung up the phone with, "Come find me. I'm the big guy in a motorized cart."

Mel tracked Bill down by the produce section. As they made their way around the store, Mel not only opened the dialogue about Bill's health, but also helped him shop -- grabbing items he couldn't reach and placing them in his cart. After the two finished shopping, they sat on benches outside and Bill went through his phone, showing Mel pictures of his former swim students he keeps in touch with.

Mel's persistence helped solidify their relationship and build trust. He continued engaging with her for health coaching, agreed to behavioral health care and pain management support. In the months following his Walmart visit, he did not go back to the ED once.

24/7 BH Crisis Line and Crisis Text Line. Our toll-free ***BH Crisis Hotline*** is staffed 24/7/365 days per year with immediate access to BH clinicians providing crisis assessments, de-escalations, and a warm hand-off to crisis response teams and other BH providers. CM staff follow-up with enrollees to engage in CM and assist with scheduling follow-up care and accessing needed social services. We also offer free, professional, and confidential ***24/7 crisis texting*** support from crisis counselors who can support a wide range of issues including substance use, teen pregnancy, depression, and anxiety. The texting service does not replace a medical home and enrollees are encouraged and offered resources to follow-up with a local BH provider.

Strongwell SUD/OUD Exposed Pregnancy Program (SEPP) and Substance Exposed Living Program (SELP). These specialized programs are designed to help opioid and other substance-dependent pregnant women and their families safely stabilize medications and connect with SDOH related support services before birth. Intensive case management services include certified peer specialists with diverse backgrounds and similar lived experiences as the enrollees we serve. These high-touch support services have shown success in decreasing ED utilization ***(12% reduction)***, increasing adherence with Medication-Assisted Treatment ***(greater than 80% adherence)***, and increasing rates of prenatal and postpartum visits ***(30% and 15% respectively).*** Goals are to keep families together, reduce long-term developmental issues, and provide a natural extension of the care and support throughout pregnancy, postpartum, and then continuing to support the family unit in recovery.



Provider Level. LHCC supports and implements various levels of integration appropriate to the provider and setting. We advance integration through training and technical assistance, value-based payments (VBP), enrollee referrals, and investments in evidence-based practices and infrastructure. Our comprehensive provider strategy is fully described below in 2.6.15.2.4, including moving providers along the SAMHSA-HRSA Standard Framework for Levels of Integrated Healthcare (Levels 1-6). Today, LHCC's network includes ***over 500 providers offering both PH and BH services***, based on claims history. Other ***integrated delivery models*** implemented and expanding in Louisiana to date include:

[redacted]



Plan Level. As illustrated in the examples above, LHCC's role in integrating care is convener, facilitator, and investor -- providing the tools, training, and infrastructure support needed for integration across the continuum and ***matching enrollees to those services***. Leading further efforts to advance integration in Louisiana will be our new Director of Integrated BH, facilitating and coordinating BH integration across LHCC clinical, quality, operations, and enrollee and provider departments and external provider, vendor, community, and state stakeholders. Starting with LHCC, examples of our fully integrated operations include:

Integrated BH Rounds. LHCC has twice-weekly review team meetings for enrollees with high BH needs and utilization, which includes individuals with co-occurring PH conditions. While this process developed organically, triggered by Utilization Management (UM) staff, it has developed into a formalized process with cross-system involvement. Review teams consist

of CM staff (RNs and Licensed BH clinicians), utilization managers, and LHCC PH and BH Medical Directors. Teams review current treatment setting; factors that are delaying transition to less intensive settings; history of treatment; the impact of PH conditions and care needs; SDOH needs, particularly homelessness and access to food; and current treatment team input. The LHCC team develops possible treatment plans representing clinical, social, and behavioral needs, with input from the current treatment team and the enrollee, promoting a team-based, enrollee-driven approach.



Integrated Functions and Systems. Our Population Health, CM, UM, and Network departments are fully integrated to share necessary clinical, treatment and social needs information. ***LHCC's CM Platform*** is an enrollee-centric health management platform for collaborative care and our health informatics and reporting Customer Relationship Management software is integrated with all core information technology components.

System Coordination. Enrollees with PH and BH needs are often involved with multiple system partners, requiring coordination and collaboration across systems and entities. We leverage our Integrated Care Model to help eliminate silos between disciplines and programs. For example, for our child welfare population, we provide agency-specific dedicated CM Teams and a liaison as a single point of contact between LHCC and agency case managers. CM Teams regularly communicate with Department of Child and Family Services (DCFS) case managers, involving them in the assessment and care planning process with enrollee consent. CM Teams also participate in state agency assessment and care planning activities, coordinating with Magellan for enrollees receiving services through the Coordinated System of Care. Other State liaison positions include Department of Justice, Permanent Supportive Housing, and Office of Behavioral Health, all reporting directly to the Director of Integrated BH.

PH and BH Integration Training and Education. Our comprehensive strategy for training and education for employees and BH providers builds from our staff and provider clinical training programs. Training curriculum are developed and designed to meet contract and regulatory requirements; NCQA, SAMHSA, and other national standards; and local enrollee and provider needs. Trainings include a combination of in-person trainings, webinars, and e-learning via our e-learning management system, Centene University. LHCC monitors staff and provider training completion through Human Resources, Provider Engagement, and e-learning platforms.

Staff Training. Formal staff training on the delivery and management of integrated services is incorporated into all staff training (model, framework, and contract requirements) with more detail included in our role-based clinical training program (policies, procedures, and processes). Staff training is provided upon hire, at any change in process or requirement, and no less than annually.

Provider Training. Again, as a convener, LHCC offers trainings and facilitates interactive learning environments that can lead to active workgroups to drive integration and change. Every LHCC provider, regardless of specialty, has access to our clinical provider training program. Our goals are to support continuing education units (CEUs) for providers, enhance integrated care, and expand the use of clinical and evidence-based practices. LHCC trains BH providers to screen and manage primary care and chronic conditions, in collaboration with primary care colleagues. Training includes processes necessary to provide collaborative care (huddles, open access, etc.), and specialty training on how to communicate effectively with primary care staff, including protocol on receiving a warm handoff and roles for PCPs in BH care. In addition, LHCC employs PH/BH Integration coaches under Provider Network to offer coaching and technical assistance for BH and PH providers to move along the integration continuum, as described in 2.6.15.2.4.

Clinical Training Topics. Training topics available to all staff and providers include Motivational Interviewing; Trauma-Informed Care; Adverse Childhood Experiences (ACEs); Cultural Sensitivity; Unconscious Bias; our Substance-Related and Addictive Disorders and BH 101 series'; Screening, Brief Intervention, and Referral to Treatment (SBIRT); Co-management of Chronic PH and BH Conditions; and Integrated Care. In 2020 and 2021 to date, we trained over 4,310 attendees and awarded 6,790 hours of CEUs for BH and RN licenses. Based on the 2019-2020 LDH Provider Satisfaction Survey, approximately 86% of all BH providers surveyed were satisfied with LHCC's performance and LHCC ranked 1st compared to all MCOs.

Ensuring Mental Health Parity. All LHCC staff and provider training are consistent with the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA). We educate staff and providers to understand the significance of non-quantitative treatment limitations and the importance of compliant UM, authorization, and access practices. LHCC requires staff and network providers to complete training on topics such as UM criteria and MHPAEA as part of initial onboarding and at least annually or upon any change in program or requirement.

2.6.15.2.1 Enhancing Detection and Treatment of BH Disorders in Primary Care Settings

Supporting BH Detection and Treatment through Education and Provider Outreach. Part of building provider capacity and proficiency, particularly in primary care, is ensuring providers can effectively identify and screen for potential BH disorders and risk of SUD and Opioid Use Disorder (OUD). This includes educating providers about resources to treat, manage, and refer to the right level of care. For instance, LHCC's BH Medical Director trained OB/GYN providers who provide care for enrollees at potential risk for SUD and OUD on the use of appropriate tools for identifying prenatal and postpartum depression and how to refer for services based on a positive screen. Additionally, LHCC offers SBIRT training to all providers and is expanding reimbursement for SBIRT screenings to include OB/GYN providers and PCPs. Other standardized tools we refer to and train on include the Columbia Suicide Severity Rating Scale (CSSRS), Patient Health Questionnaire (PHQ-9), Drug Abuse Screen Test (DAST-10), and Alcohol Use Disorders Identification Test (AUDIT-C). ***LHCC recently collaborated with other MCOs*** to make the American Academy of Pediatrics (AAP) ADHD Tool Kit available to all PCPs free of charge and collaborated with the Louisiana AAP to provide the Bright Futures Pocket Guide to pediatric practices.

Once identified, we train PCPs on how to refer enrollees for specialized BH services and provide resources to support PCP management of mild to moderate conditions such as depression and anxiety. For example, PCPs have access to psychiatrists for ***physician-to-physician e-consults via ConferMed***. Our contract with Quartet can assist providers in finding and connecting with BH providers, including access to tele-psych services. We also offer virtual case review with our Medical Directors and conduct peer-to-peer outreach when we identify aberrant prescribing.



We will target provider outreach based on historical outcomes and disparities. For example, the HEDIS rate for Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET) for Black enrollees is notably lower than White enrollees. We will target providers serving higher concentrations of Black enrollees and wrap those providers with additional training, ***process mapping to understand disparities in their clinic***, and specialized VBP.

Enhancing Provider Skills Training. Our ***Institute for Advanced Health Education***, jointly accredited by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education, and the American Nurses Credentialing Center, offers free, interprofessional continuing education research-informed educational activities. Providers can link to a professional peer network of national providers to share best practices and consult on the latest therapies. Provider survey outcomes include:

- 41% of providers increased their knowledge of Pain Management and Opioids
- 58% of providers increased their knowledge of Evolving Care of the Prenatally Opioid Exposed Neonate
- 47% of providers increased their knowledge of Treating Pregnant Women with Addiction

Increasing BH Disorder Detection and Treatment of Opioid Dependence. OpiEnd is our multidisciplinary, evidence-based approach to putting an end to opioid misuse. OpiEnd leverages machine learning to identify and intervene for enrollees at risk for the development of opioid misuse or OUD. OpiEnd incorporates early identification, provider and community collaboration and support, and best practices through our Opioid Risk Classification Algorithm (ORCA), specialized CM, provider education and outreach, and pharmacy interventions. For example, through systematic monitoring of PCP prescribers, we identify aberrant prescribing patterns and outreach with information and education on our pain management value-added benefits and opioid management resources, including physician-to-physician case consultation. Through early identification of at-risk enrollees, ORCA enables timelier interventions to prevent opioid misuse [redacted]



2.6.15.2.2 Coordination of Care for Enrollees with Integrated Care and Transitional Care Need

LHCC's CM structure supports enrollees with BH needs and those with PH co-morbidities. This includes a shared, integrated POC overseen by the enrollee's ICT. As described in 2.6.15.1, LHCC offers all enrollees with co-occurring PH and BH disorders care coordination and CM support as part of our Integrated Care Model. Leading this effort is a Case Manager with BH expertise, with access to PH and BH resources through our BH Rounds and LHCC Collaborative Care Team. LHCC structures CM activities to support enrollees in community-based care, institutions, or residential care, and enrollees transitioning between levels of care. Our Transitions of Care (TOC) team leads TOC activities to ensure continuity of care.

TOC/Discharge Planning. TOC staff collaborates with treating providers and facility discharge planning staff to assess and share information about enrollee PH/BH conditions, enrollee discharge needs, and potential to discharge. This includes identifying barriers affecting a safe transition to the next setting and developing the transition plan. Discharge planning starts upon admission. Our predictive modeling tools include a readmission risk score that can quickly identify enrollees with co-occurring conditions to effectively target and deploy resources. For enrollees at High or Moderate Risk, TOC staff conduct a face-to-face visit, as appropriate, to assess status and needs and provide education. TOC staff, including the Case Manager (if the enrollee is in CM), communicate with the enrollee, caregivers, attending physicians, PCP, and outpatient providers. Specific hospital discharge and transitional support activities include:

- Evaluation of PH, BH and social needs, coordination of services, and appropriate follow-up after discharge, documented in an enrollee-driven transition plan, as described below
- Support referrals and scheduling assistance for follow-up, including a 7-day follow-up appointment, specialty care, medications, supplies and equipment, transportation, housing, and other social support needs.
- Verifying medications prior to discharge and confirmation of no barriers
- Transferring of HIPAA compliant medical records to the enrollee's PCP and other PH and BH providers
- Engaging the enrollee within 72 hours of discharge to assess status, confirm services, and update the transition plan

For enrollees at Low Risk of readmission, Concurrent Review (CCR) Nurses coordinate the discharge planning by working with hospital staff and attending providers to identify network providers to deliver post-discharge services. Prior to discharge, TOC staff assist with setting up post-discharge appointments (including 7-day follow-up appointment) and review discharge orders with the enrollee to ensure they understand priorities and walk them through next steps including providing a discharge packet of information to share with the ICT and caregivers. They also review all medications with name, dosage, frequency and prescriber; and assist with filling new prescriptions including arranging for delivery of medications if needed.

Alternative Level of Care (ALOC). For enrollees identified as needing an ALOC to achieve improved outcomes, we leverage our LHCC BH Rounds, described in 2.6.15.1 above and 2.6.15.2.5 below. Currently, this process serves enrollees with high use of BH inpatient and ED services. It is an effective, high-touch approach to ensuring appropriate community-based services and care transitions.

Transition Plan. Developing a transition plan specific to the transition timeframe is a best practice in reducing readmissions. The transition plan reflects enrollee strengths, preferences, and post-transition goals, remaining in place for no less than 30 days or until all post-discharge needs and barriers are addressed.

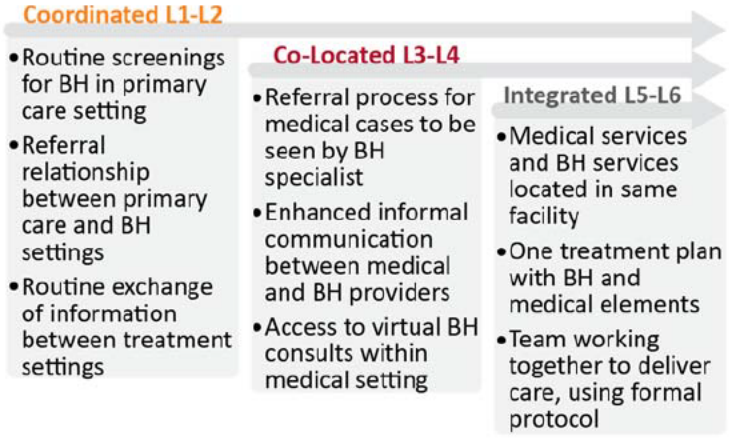
Regional Model. LHCC CM is structured on a regional basis, including our TOC team. This affords our CM and TOC staff deeper knowledge and awareness of provider and community-based organizations (CBOs) within a geographic area, as well as better relationships for effective coordination. This also improves our ability to address SDOH, such as housing or food insecurity through stronger relationships with CBOs.

Appropriate Use of BH Services. Underutilization of appropriate BH services, such as outpatient therapy and medication adherence, can result in relapse, ineffective treatment, and unnecessary care. Linking enrollees with appropriate PH and BH services at the appropriate level is a key function of our CM program. Our team-based approach and Case Managers trained in Motivational Interviewing and Person-Centered, Strength-Based, Recovery-Oriented Care, promote a POC that reflects the enrollee's goals and engages them in integrated care to ensure the right complement of services for the enrollee's health, treatment, and recovery. After ***any hospital admission or ED visit with a BH diagnosis***, enrollees receive outreach from a Case Manager or CHW to assist in scheduling follow-up care, followed by an automated call, text, or email reminder about their appointment and information on the importance of engaging in needed care. We also systematically monitor utilization to ensure enrollees on psychotropic medications are engaged with their PCP and BH providers.

2.6.15.2.3 Building Greater Care Coordination, Transparency, and Communication Across Providers

Coordination, transparency, and communication are core components of any level of integration. The methods and role of LHCC in promoting this bi-directional collaboration vary by level, including incentives and tracking (see below). In this Section 2.6.15.2.3, we will describe these processes from the front end of the Standard Framework for Levels of Integrated Healthcare (Level 1-2 Coordinated), depicted in ***Figure 2.6.15.2.3*** below. In Section 2.6.15.2.4 below, we describe how the levels of integration and our support evolve as providers advance through this practice transformation.

Figure 2.6.15.2.3 Standard Framework for Levels of Integrated Healthcare



Coordination and Communication. A secure method of communication and information sharing, including clear expectations for the information to be shared, is a critical aspect of ***coordinated integration***. Sharing of information helps facilitate integration and coordination across all services, systems, and provider types. Our strategy for information sharing is twofold. First, we will educate providers about information sharing, set expectations with requirements for sharing clinical documents and treatment plans, and participating in service planning activities, and POCs. Second, we will leverage technology to promote coordinated and integrated care planning, including electronic transfer of information and accessibility of enrollee care documents, such as assessments and POCs through our LHCC Care Management Platform.

Provider to Provider Information Sharing. To advance integration and support the information sharing required for integration, LHCC will encourage communication between PH and BH providers through education and access to data sharing tools, available through our Provider Portal and public website. With provider input, we will follow-up this educational effort with added provisions to our network contracts to support information sharing. This will include requirements for bi-directional data sharing between PCPs and BH providers with the appropriate enrollee consents. Information on coordination of PH/BH care among all treating providers will be included in LHCC Provider Orientation beginning in 2022.

Plan to Provider Information Sharing. LHCC works with our network to promote integrated care for every enrollee. Our CM model facilitates the reciprocal exchange of information between PH and BH providers, to the extent permitted by law and based on enrollee consent, in multiple ways:

- LHCC notifies the enrollee's PCP and BH provider (if applicable) of an inpatient admission or ED visit via our Provider Portal. Providers have access to the Provider Portal, which includes BH and PH information, including service utilization and medications. LHCC will monitor provider access to the portal.
- Our CM team sends the discharge summary to the PCP and treating BH providers to facilitate the provider's ability to conduct medication reconciliation and to encourage follow-up/ongoing treatment. This information is available through the Provider Portal and as part of the ICT, to develop an integrated POC that addresses the enrollee's needs. Our pharmacy team, as part of the ICT, can perform medication reconciliation and collaborate with the PCP or treating provider for any updates as needed. Our Case Manager communicates changes to the enrollee through their preferred method.
- Our LHCC Clinical Team (CM, Medical Director, and UM) conducts quarterly enrollee case conferences with several CMHCs to exchange enrollee information including PH and BH data, LHCC process changes, and educates about LHCC

services. These formal case conferences are in addition to routine outreach by the Case Manager, held in-person or virtually.

- Case Managers outreach to enrollees discharged from an inpatient facility to determine if the enrollee has scheduled or attended a follow-up visit with a BH provider. We also encourage an appointment with their PCP to facilitate medication review and needed modifications to the enrollee's medical treatment plan.
- LHCC integrates incentives for collaboration and coordination into standard VBP models

Technology Solutions. LHCC's technology solutions promote system-wide collaboration. LHCC Case Managers use LHCC's CM Platform, including our integrated, secure, external-facing Enrollee, Provider, and Community Portals, ensuring everyone has access to the same information. Our integrated care planning is supported by Centelligence enterprise platform, integrating data from multiple sources and producing actionable information for use system-wide to monitor and improve outcomes. This includes Care Gap Alerts, Provider Clinical Profiling analyses, population-level health risk stratifications, and standard and ad-hoc desktop reports. We support all providers using a single, integrated POC with direct access to assessment data, including SDOH information that may be affecting patient compliance and positive health outcomes.

Offering Incentives. LHCC designs VBP models and offers incentives to support integration along the continuum. To promote integration in primary care, our PCP VBP models incorporate incentives for BH HEDIS measures such as Follow-Up After Hospitalization for Mental Illness, Follow-Up After Emergency Department Visit for Mental Illness, and Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence.

Tracking and Monitoring. Tracking and monitoring will be managed through CM and quality activities, including evaluating HEDIS outcomes, Case Manager oversight, and care planning, including reinforcement and support through reminders and education about available tools for bi-directional sharing, and annual cross-functional provider audits of both PCP and BH records.

2.6.15.2.4 Provider Tools, Guidance, and Financial Incentives to Improve Integration

To support providers in developing the skills and infrastructure needed to schedule joint appointments, develop a shared POC, conduct effective brief assessments, integrate records, make/follow-up on referrals, collocate services, and track outcomes, LHCC will leverage lessons learned and best practices from our affiliates by meeting providers where they are on the integration continuum. LHCC utilizes LDH administered ***SAMHSA's Integrated Practice Assessment Tool (IPAT)*** results to assess and track provider readiness for integrated care today. From 2019-2020, IPAT results showed 38% of LHCC providers are at Level 5 or 6 (integrated), 24% at a Level 3 or 4 (co-located), and 38% at a Level 1 or 2 Coordinated (or pre-coordination). LHCC will focus on supporting providers to increase their IPAT completions and work directly with providers to enhance integration within their practice settings. LHCC will also work with LDH and other MCOs to develop systemic practice transformation across payers**.**

State Level Support. LHCC is committed to working with LDH and provider associations, such as the Louisiana State Medical Society (LSMS), the Louisiana Chapters of The American Academy of Pediatrics, the American Academy of Family Physicians, and the Psychiatric Medical Association to align standards, coordinate incentives, and support new functions to facilitate transformation toward fully integrated care. [redacted]

Provider Level Guidance. Providers vary considerably in their stage and capacity for integration. Successfully building and sustaining integrated care at the provider level requires full information about available models and approaches, workforce assessment, health information technology needs, practice transformation goals, and business projections to sustain new activities and identify new partners and/or staff to meet evolving needs. Leveraging our highly trained ***PH/BH Integration Coaches***, LHCC will support providers at the individual level to undertake a planning process, informed by the IPAT and their capacity for integration, and supported by our technical assistance, training, and VBP programs. This support will include:

- Meeting providers where they are, and offering practice transformation and technical assistance to move along with continuum based on an assessment of practice needs and competencies, leveraging the IPAT
- Matching providers with available funding and resources to expand staffing and infrastructure
- Supporting providers in establishing data sharing capabilities to support bi-directional data linkages, outcomes tracking, and other joint activities
- Offering training on available LHCC tools that can be leveraged by providers to support data sharing and joint care planning, including our Provider Portal
- Facilitating provider and community-based training, including practice coaching modules to complement existing efforts in the region and coordination with other MCOs

- Ensuring the provision of culturally sensitive care, addressing unconscious bias, stigma, and other barriers to equitable healthcare services in the PH, BH or PH/BH integrated environment
- Supporting provider success under new VBP models designed to advance integration

Data Analytic Tools. Our Centelligence analytics and reporting platform is based on a comprehensive data set that includes PH and BH data. The platform has practice profiling tools that support our PCP VBP models. This platform will be used to develop additional reports and practice profiles for providers at all levels of integration. We are also working with each of the integrated practices to understand the capability of their electronic health record (EHR) system to process data files into and out of their EHRs using inter-operability technology to drive performance improvement, improved care coordination, and care gap closure.

Fostering Value-Based Care. The resources and solutions we offer are tailored to the infrastructure and identified strengths and gaps of each provider. Below are examples of how ***Training/Support and compounding VBP strategies*** can be tailored to support and incentivize various levels of integration:

Level	Training and Support	Incentives, VBP Strategies
Coordinated	• Education on benefits of integrated care • Education of allowable information sharing, HIPAA, Confidentiality • EMR needs and electronic information exchange • Training on screenings and assessments and Joint care plans	• Incentivize providers who share enrollee diagnostic and active course of treatment across disciplines in a timely manner • Additional payments for providers who meet established benchmarks related to PH providers who utilize BH screenings and assessments and BH providers who utilize PH screenings and assessments as a routine part of care, as well as referrals for SDOH support, and make appropriate referrals with follow-up, select HEDIS measures • Infrastructure support – staffing, EMR, training
Co-Located	• Training on practice operations for integrated models • Support for integrating EMR and creating an integrated plan of plan	• Infrastructure support • Enhanced fee schedule to support added BH or PH staffing and services • HEDIS based incentives
Integrated	• Tailored training on advanced practices for integrated care	• Outcomes-based incentives • Value based payments, total cost of care • Upside and downside risk

2.6.15.2.5 Post-ED Outreach to Promote Follow-Up Care

Enrollee Identification. LHCC leverages real-time hospital admissions, discharge, and transfer (ADT) data to aid in the timely identification and assessment of enrollees presenting in the ED. For example, we partner with the Louisiana Hospital Association to use LHIN-ENS, which provides current ED notifications. Through our participation with Audacious Inquiry, a leading provider of HIE technology, we receive ADT transactions in real-time. When our Clinical Data Gateway receives an ADT event notification, it is automatically and electronically loaded into our CM platform which creates a task for appropriate CM follow-up and a flag in the Provider Portal for PCP action.

ED Outreach. Upon identification of any enrollee presenting to the ED with a BH diagnosis, our Case Manager or CHW outreach, in person, virtually, or by phone to assist in scheduling follow-up care, which is followed by an automated call, text or email reminder about their visit and value of care. As part of this call, we do a root cause analysis to understand why the enrollee went to the ED, assess for SDOH needs or barriers, provide education on appropriate ED use, and make a referral to CM for further screening and assessment. If the enrollee is already in CM, they receive a call from their Case Manager who will conduct a re-assessment and update the POC as indicated. For enrollee sub-populations, such as those with complex social needs, as part of our Population Health Management (PHM) program, we will deploy a Rapid ED Intervention (REDI) Team to the ED to engage an enrollee in-person. Regional teams will include multi-disciplinary BH and PH professionals, CHWs, and peers to address both clinical and social needs through follow-up visits and service coordination.

Provider Information Exchanges and Support. LHCC shares ADT information, including ED visits, with PCPs through the Provider Portal for appropriate follow-up and BH referral. For providers with multiple linked enrollees with high ED use, we offer technical assistance and training through our Provider Engagement Team. This team addresses provider performance such as care gaps, ED use, and primary care utilization in comparison with peers, appointment availability, ADA or cultural competency barriers, and follow-up care. We provide self-service tools and reports on our Provider Portal to help providers analyze and address performance to reduce avoidable ED utilization, including enrollees with low primary care utilization and medication adherence and other drill-down capabilities.

Alternative Level of Care (ALOC) Enrollees. LHCC defines ALOC as enrollees with complex PH, BH, and social needs who would benefit from an ALOC. LHCC's ALOC programs are founded on the evidence-based best practices of the Camden

Coalition of Healthcare and Project BOOST. This model uses hot-spotting (data to allocate resources to a small subset of high-needs, high-cost enrollees) and a collaborative approach to help enrollees better manage their PH and BH needs and address SDOH such as housing, food, and transportation. Project BOOST involves discharge planning, medication reconciliation, patient and family, community, and primary care provider communication before discharge and post-discharge telephonic follow-up.

[redacted]

2.6.15.2.6 Continuity, Coordination, Referral, and Follow-Up for Enrollees with BH Needs

We use a combination of tools to identify enrollees that may benefit from CM services, including results from the HNA, provider and plan-delivered screening and assessments, and claims and referral data, including the presence of a new BH diagnosis. Once identified, we engage in CM and follow closely to ensure care is received in the right setting, by the right provider, at the right time. Providers are also educated on use of and payment for screening tools, such as SBIRT, CSSRS, and PHQ-9, and trained on how to refer positive screens for appropriate follow-up, including referral to LHCC to engage in CM.

Enrollee Referral and Follow-Up. Providers can refer any enrollee who needs BH services and enrollees may self-refer for CM. Once enrollees are engaged in CM, LHCC Case Managers provide routine in-person and/or telephonic follow-up. Our Case Managers tailor the frequency of follow-up to the enrollee's unique needs. For example, if an enrollee is High Risk, our Case Managers may engage enrollees weekly or more if needed [redacted]

Enrollee Outreach. CM staff use evidence-based practices such as Motivational Interviewing, Trauma-Informed Care, Person-Centered Care Planning, and the Strengths-Based Model to engage with enrollees who may benefit from CM and care coordination services. This is particularly important when engaging enrollees identified with co-morbid PH and specialized BH needs. Equipped with these and other evidence-based interventions, CM staff ***meet enrollees and families where they are*** by embedding staff in the community and targeting information and interventions to the enrollee's willingness to engage, level of health literacy, degree of trauma, disparities endured, and cultural preferences. Our community-based staff are accountable for outreach and engagement activities such as case finding, education, case management/care coordination, health and wellness activities, and health coaching. We collaborate with providers through care planning activities and joint outreach.

Incentives Supporting Continuity and Coordination of Care. LHCC's BH P4P Program encourages BH provider engagement of enrollees who are Moderate to High-Risk for appropriate outpatient treatment and measurement-based care by linking bonus payments to care initiation and avoiding inpatient or ED use for an enrollee's primary BH condition (or timely follow-up afterward). Referred enrollees receive BH/SUD screening and increased engagement focused on the initiation of treatment and medication adherence. Quartet, our analytics partner, supports this program by aggregating health/assessment data from multiple sources to support program reporting and lessen provider administrative burden.

Systematic Monitoring. To support Case Managers in following enrollees and ensuring the provision of needed care based on screenings, assessments, inpatient/ED utilization, and referrals, and following their POC and treatment goals, CM and other LHCC staff monitor daily, weekly, monthly, and quarterly reports. Systematic reports help identify enrollees for outreach and follow-up, as well as oversee the appropriateness of BH care.

2.6 TECHNICAL PROPOSAL



ATTACHMENTS

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.2.1.3

Non-Compliance Events

CONFIDENTIAL





[redacted]







[redacted]



[redacted]



[redacted]

















[redacted]					



louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.2.2.2.a-g

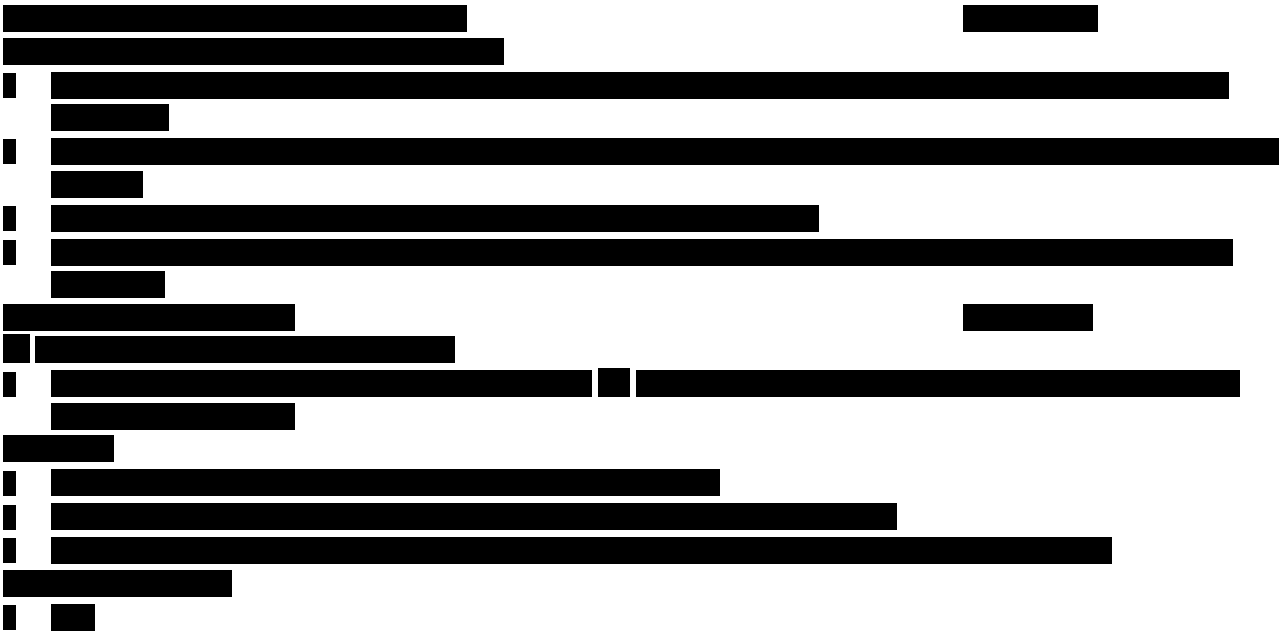
LHCC Key Personnel Resumes

CONFIDENTIAL

[redacted]

[redacted]

[redacted]















[redacted]













[redacted]

- [redacted]

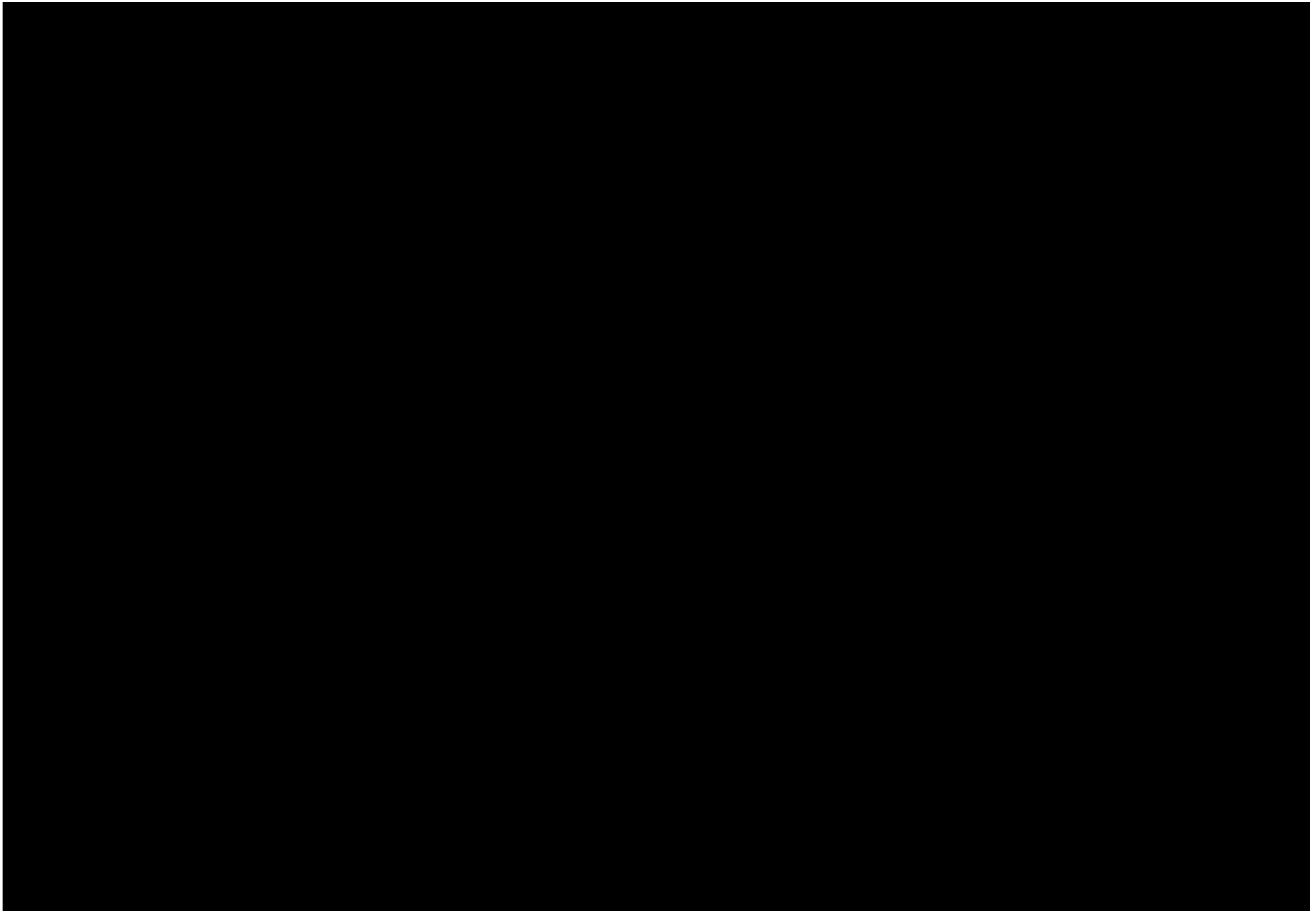
louisiana healthcare connections™

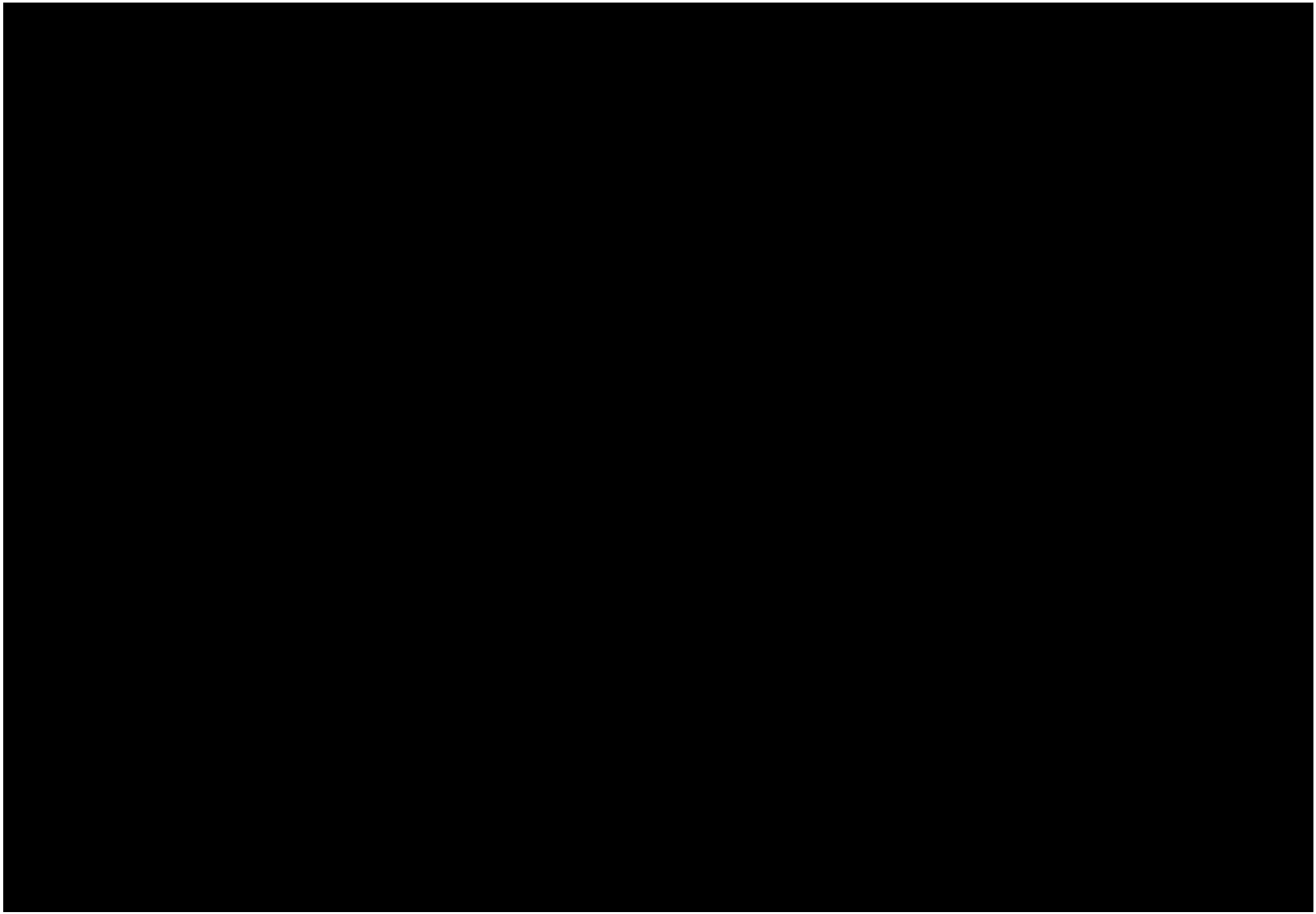
For the health of all.

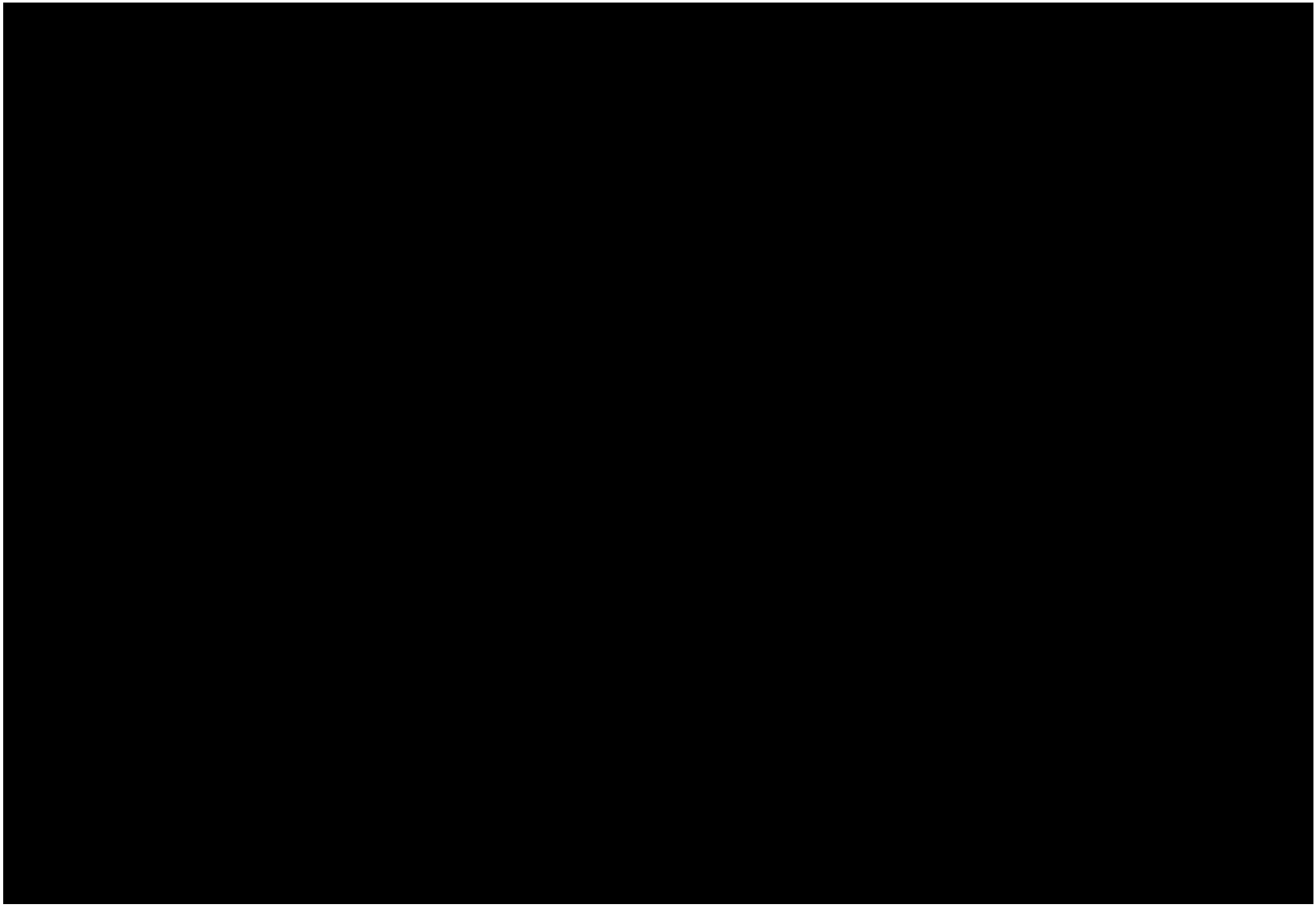
ATTACHMENT 2.6.2.2.3.a-m

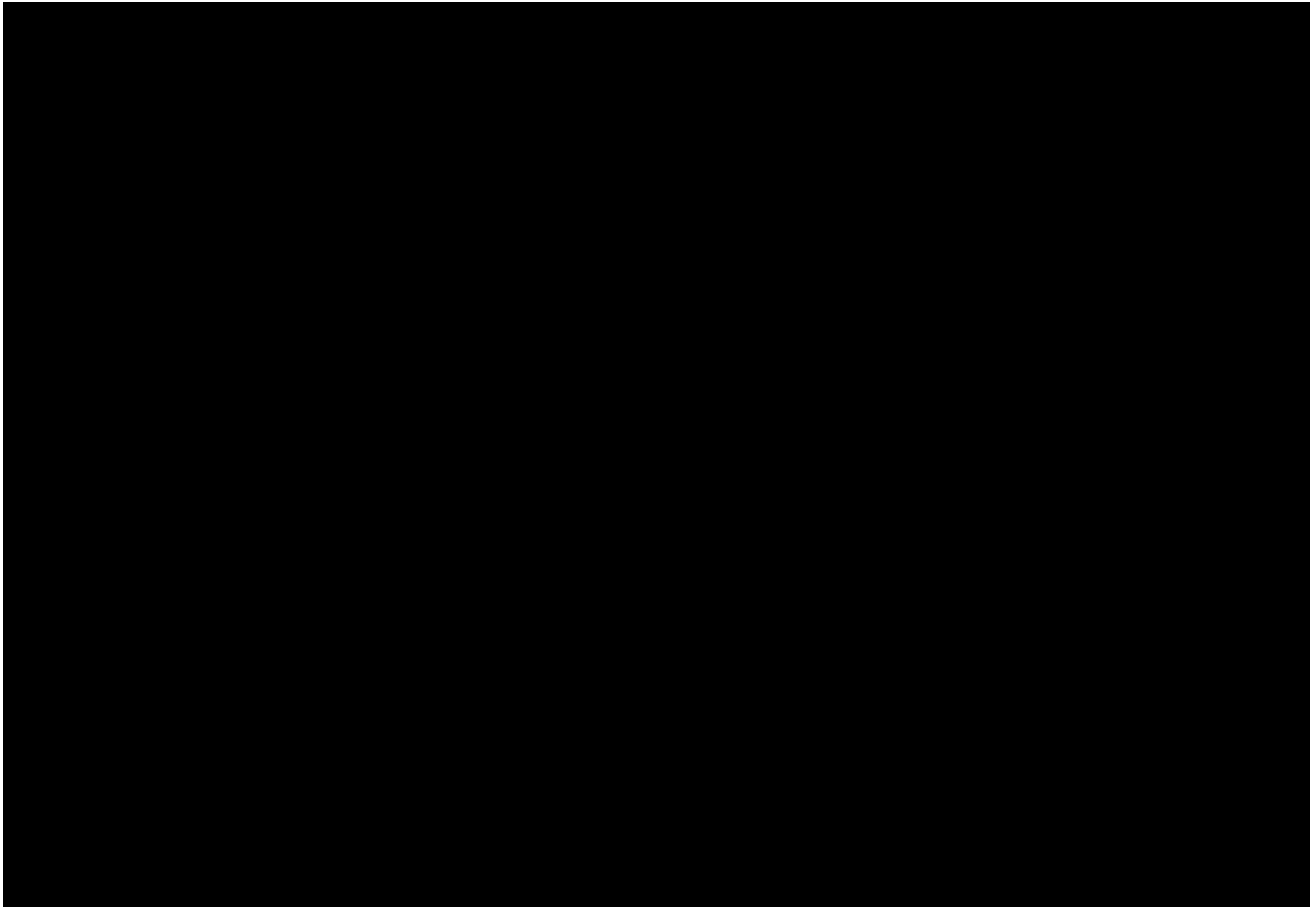
LHCC Organizational Charts

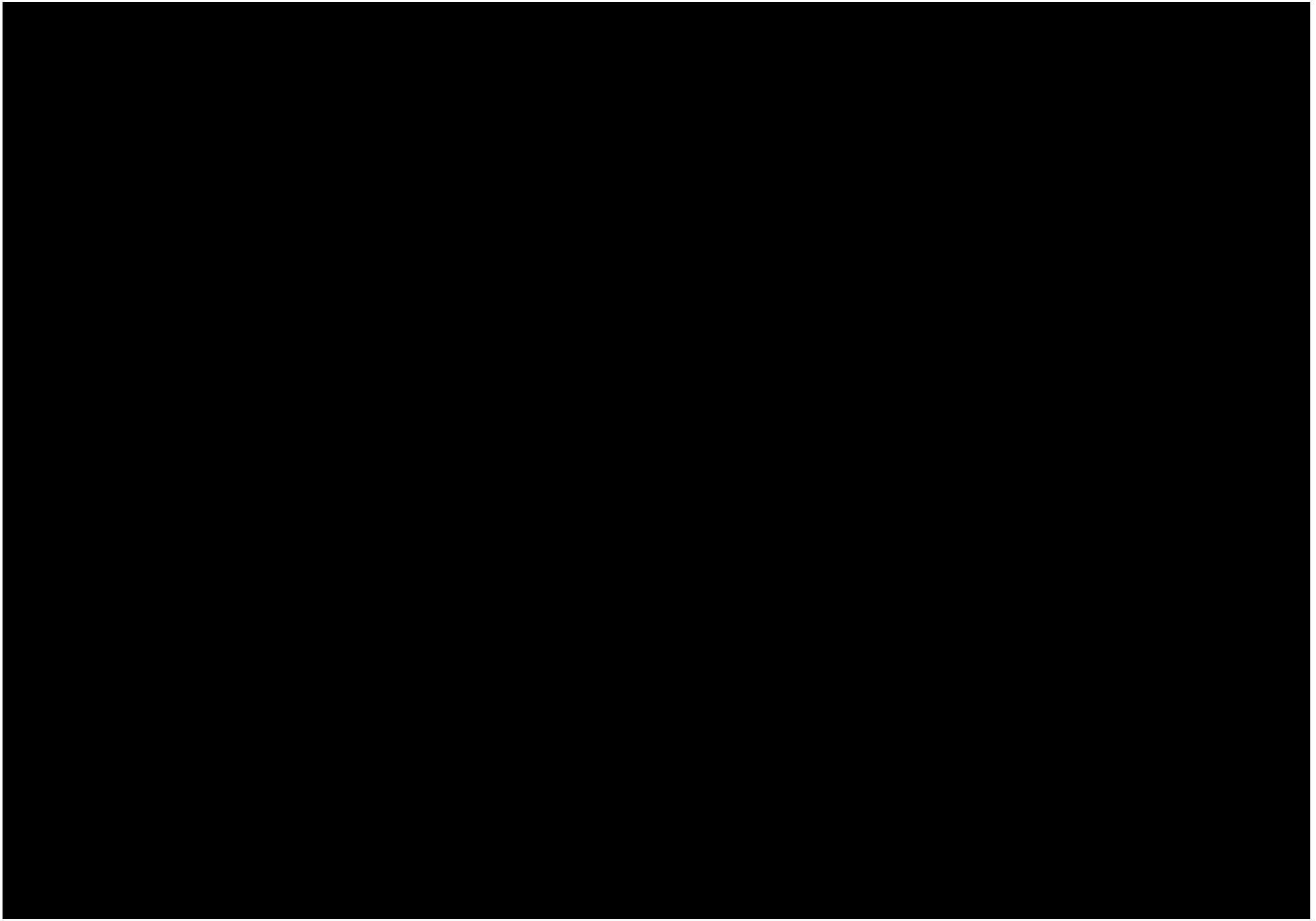
CONFIDENTIAL

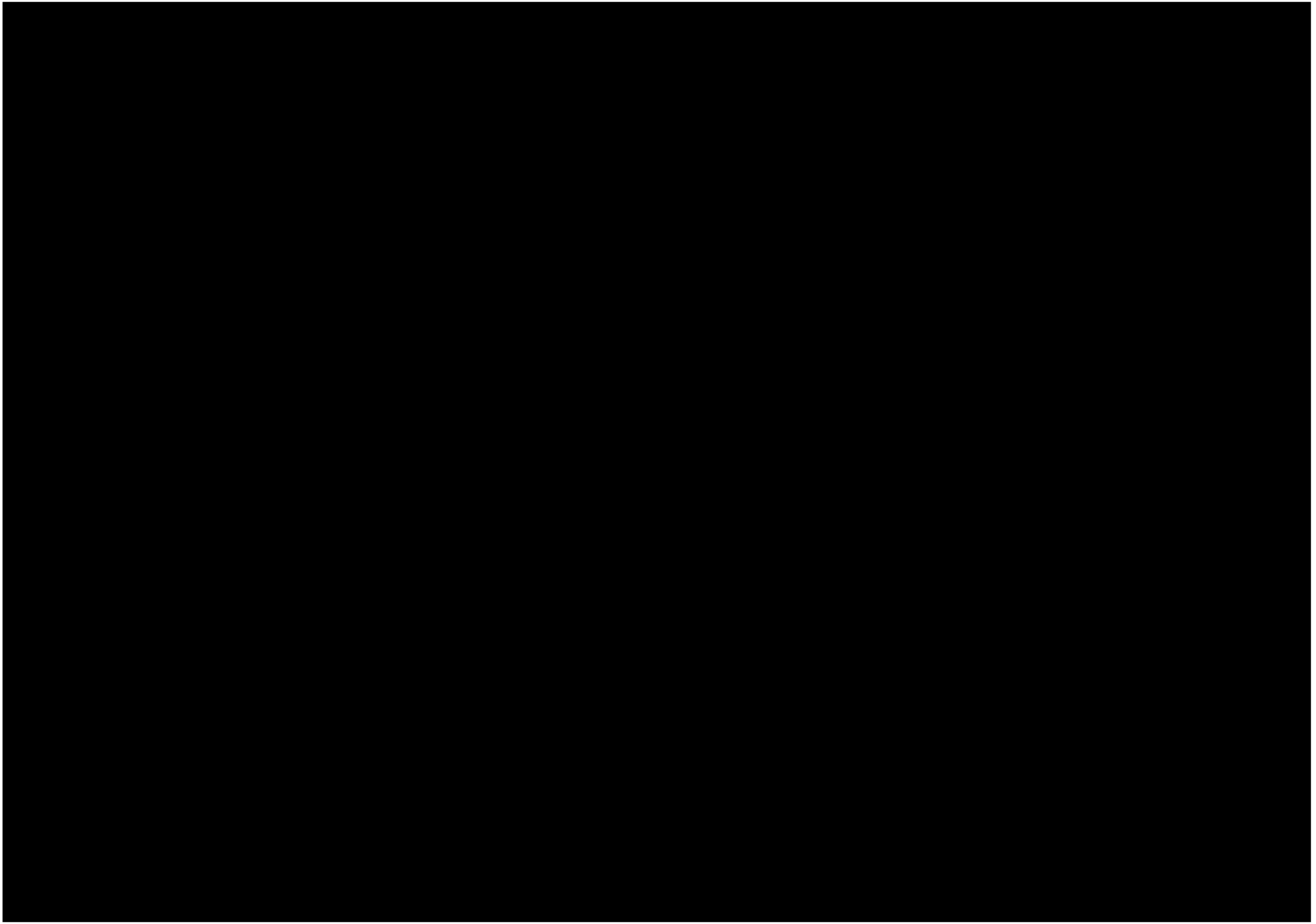


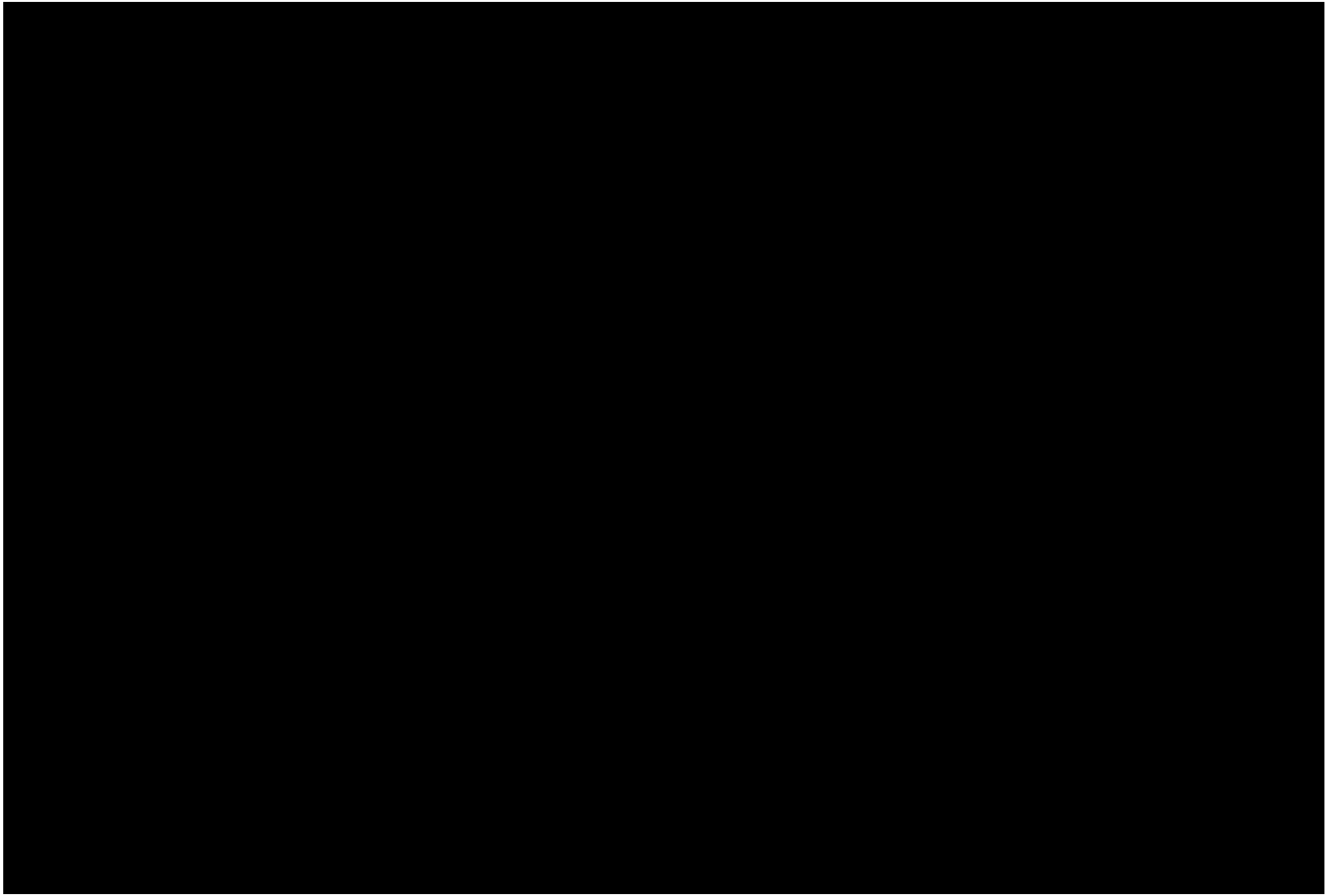


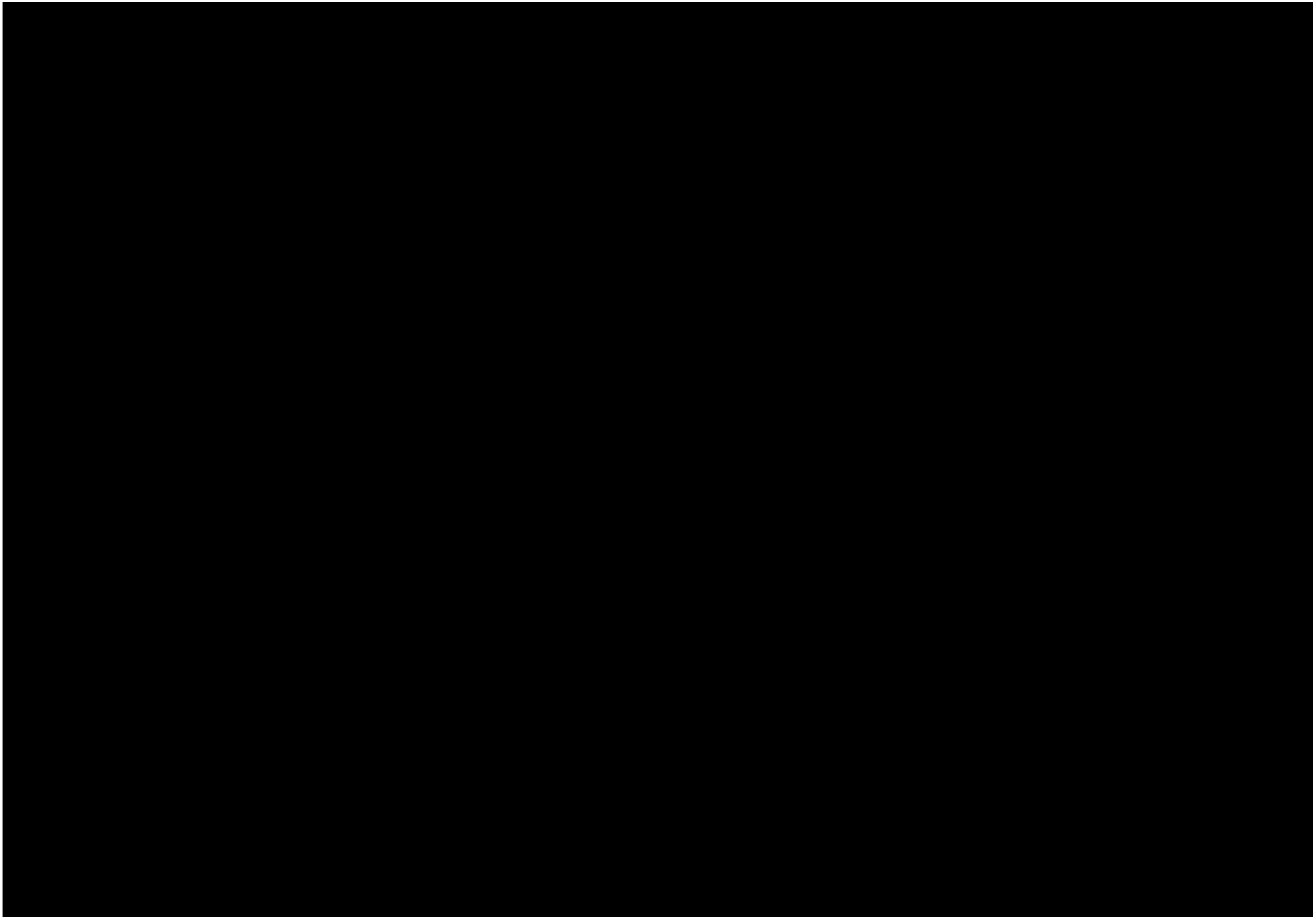


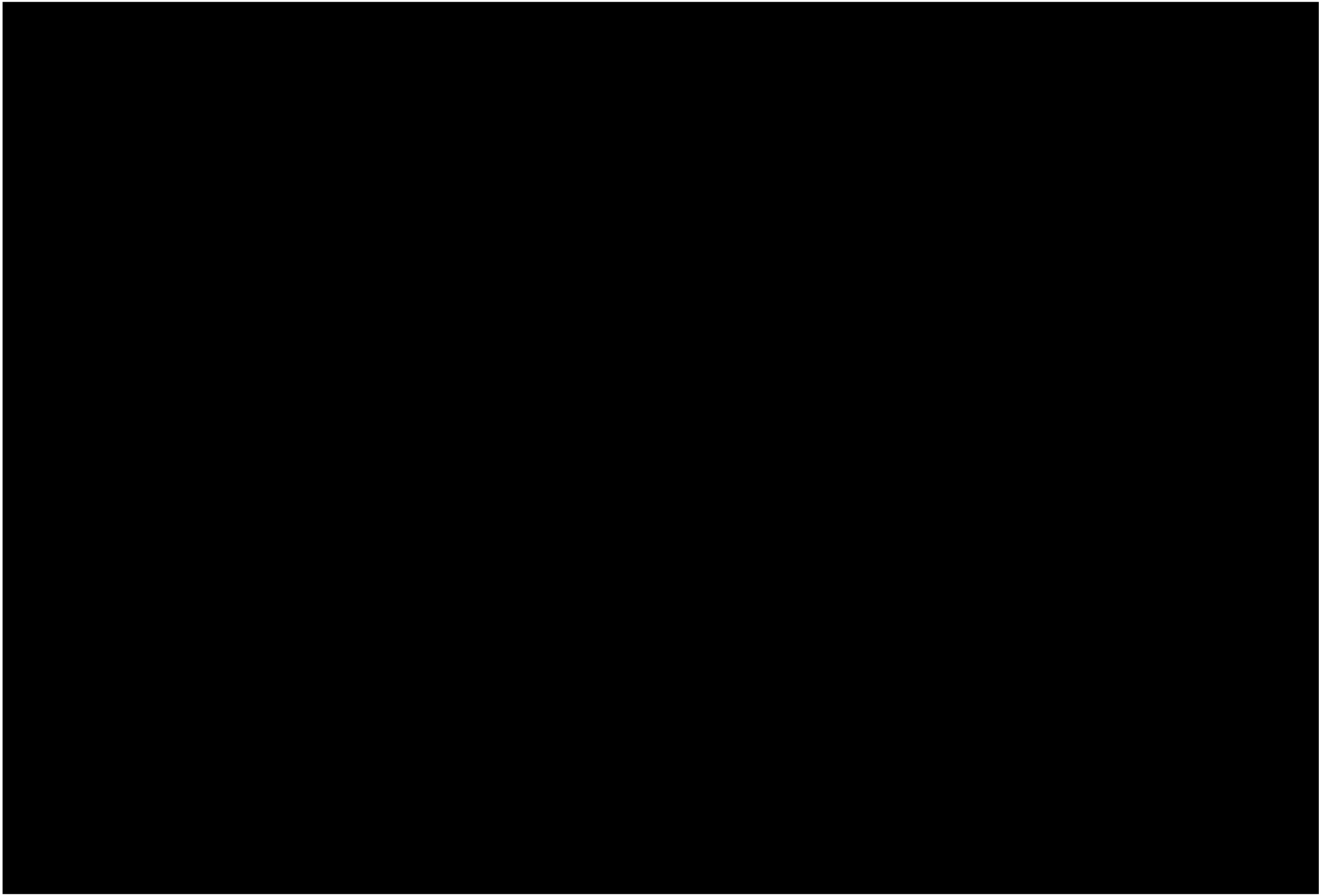


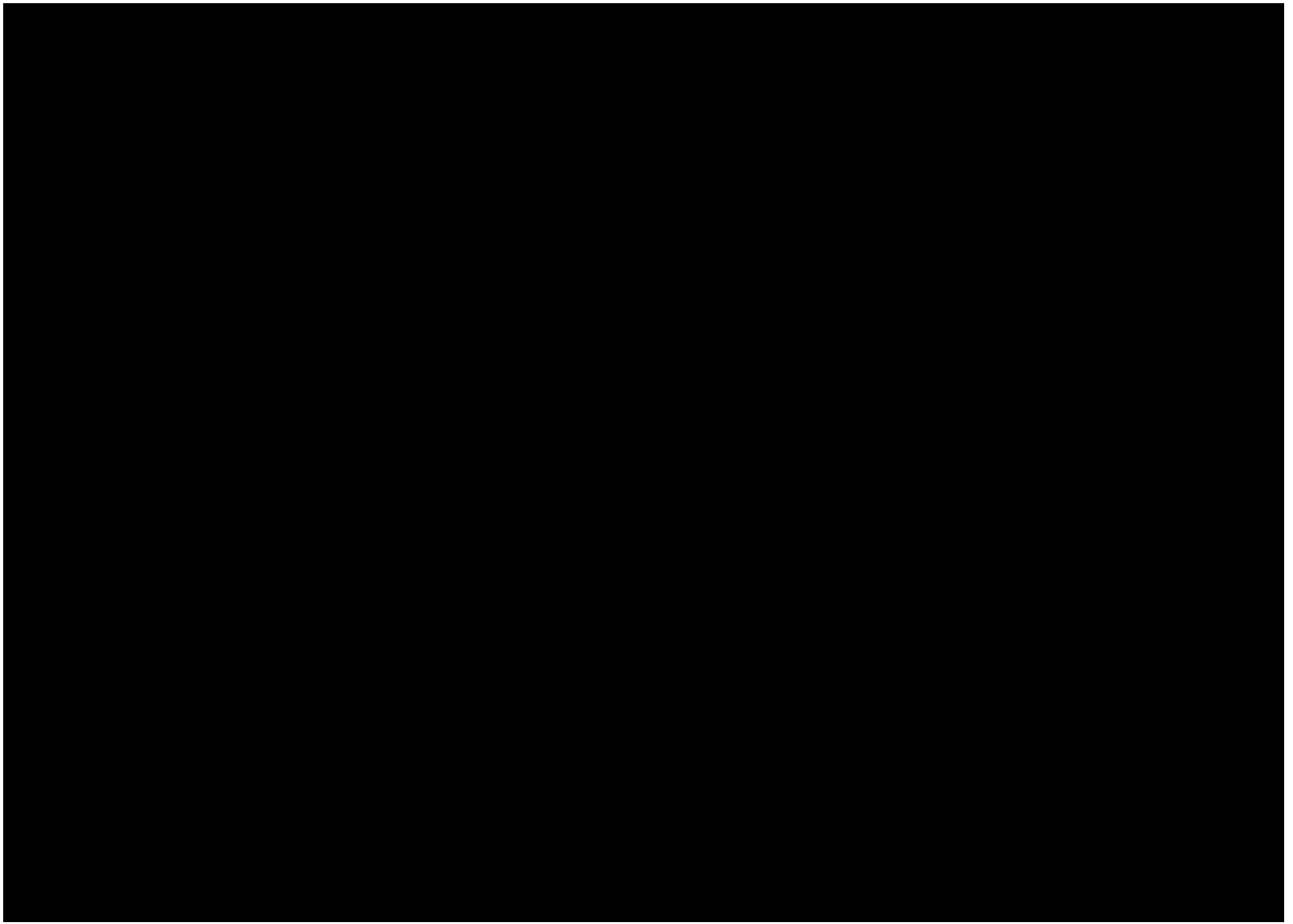


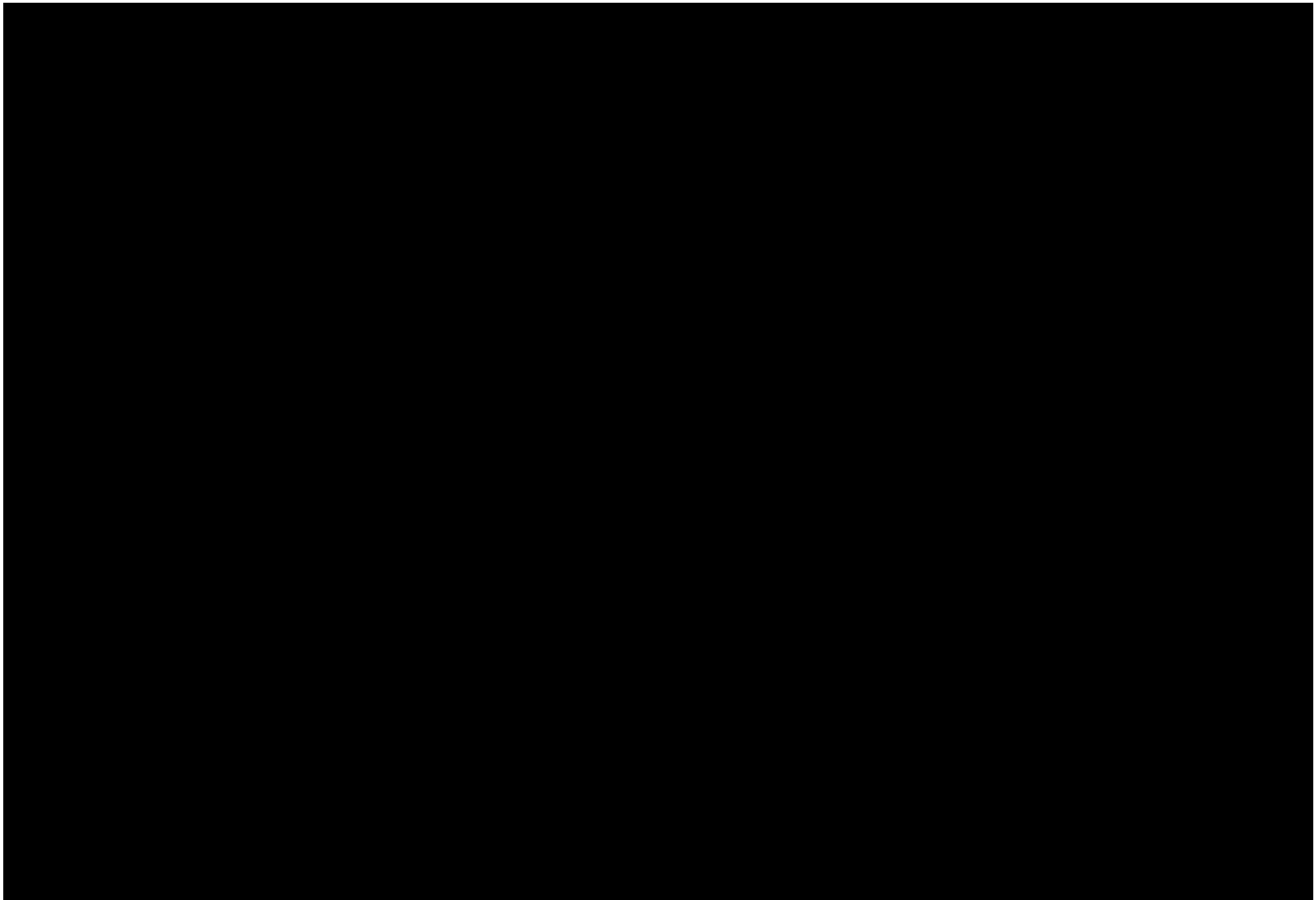


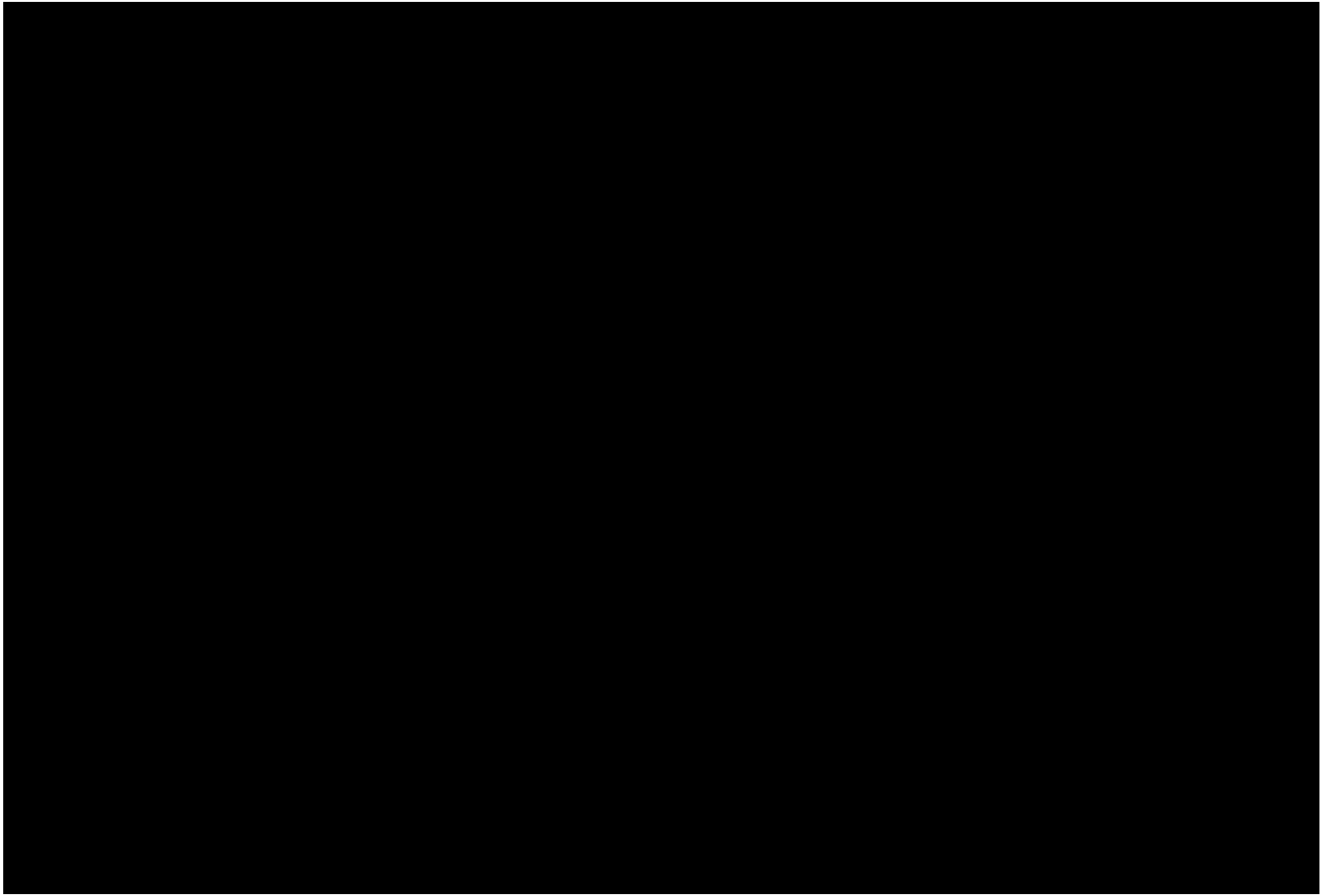


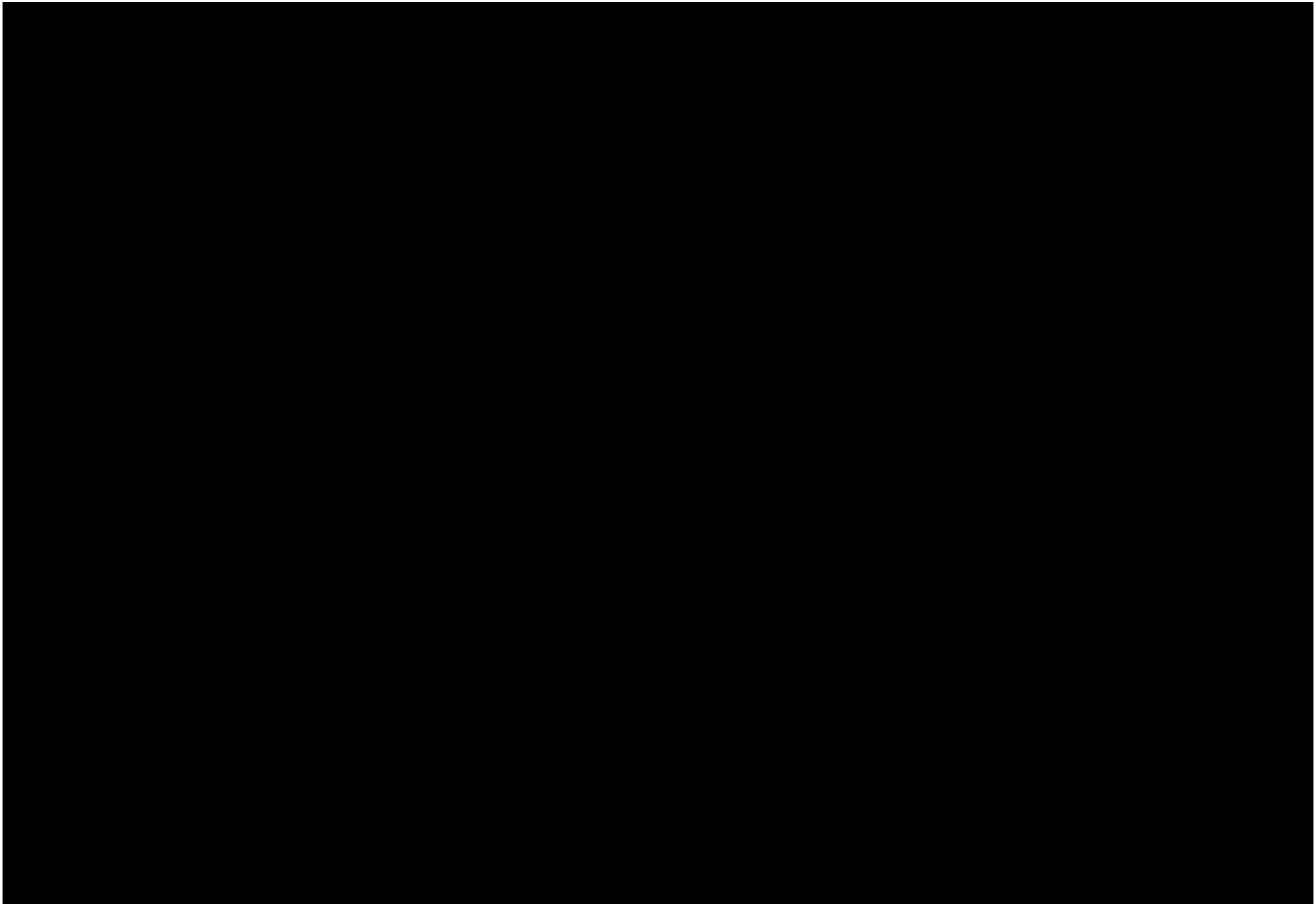












louisiana healthcare connections™

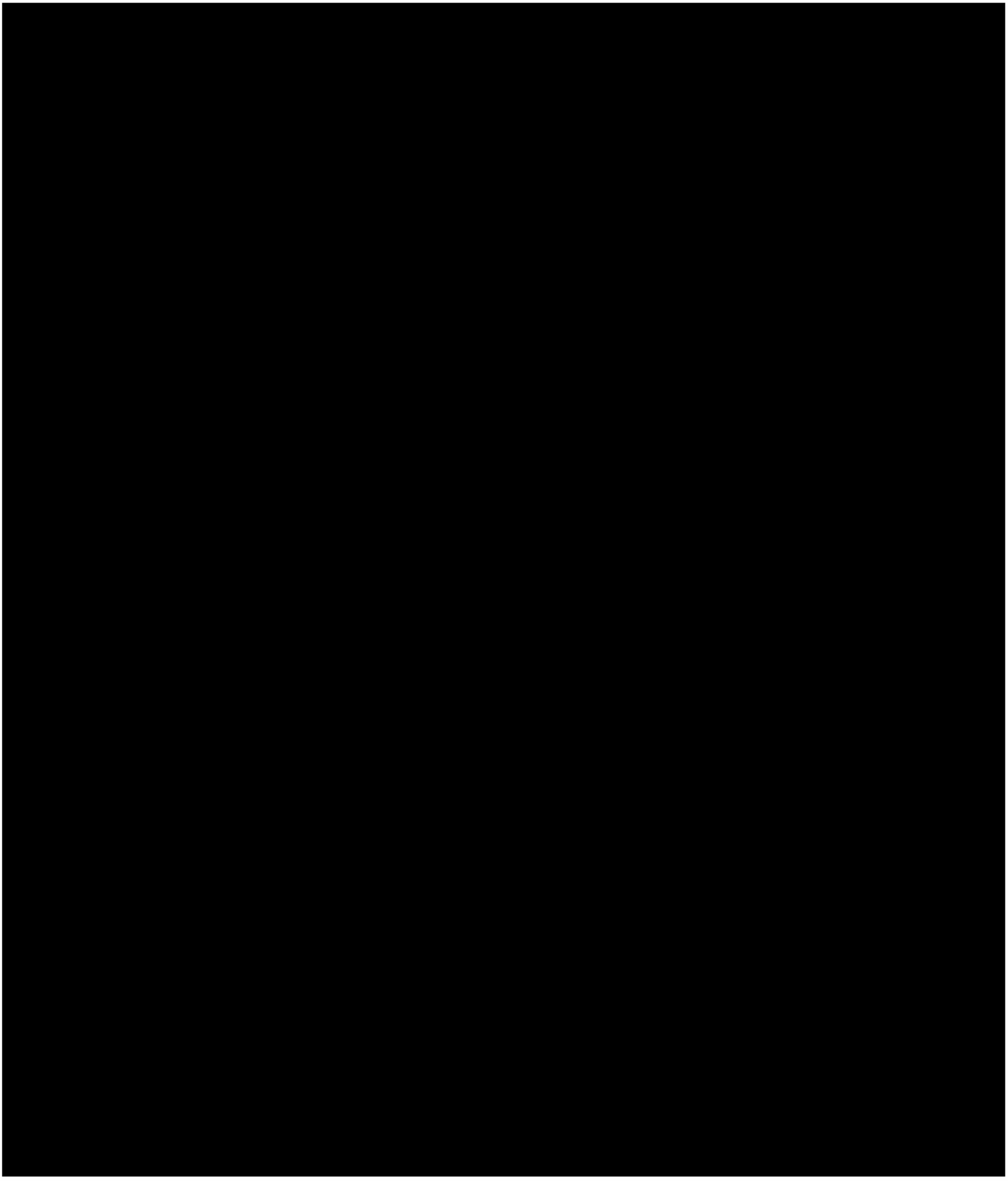
For the health of all.

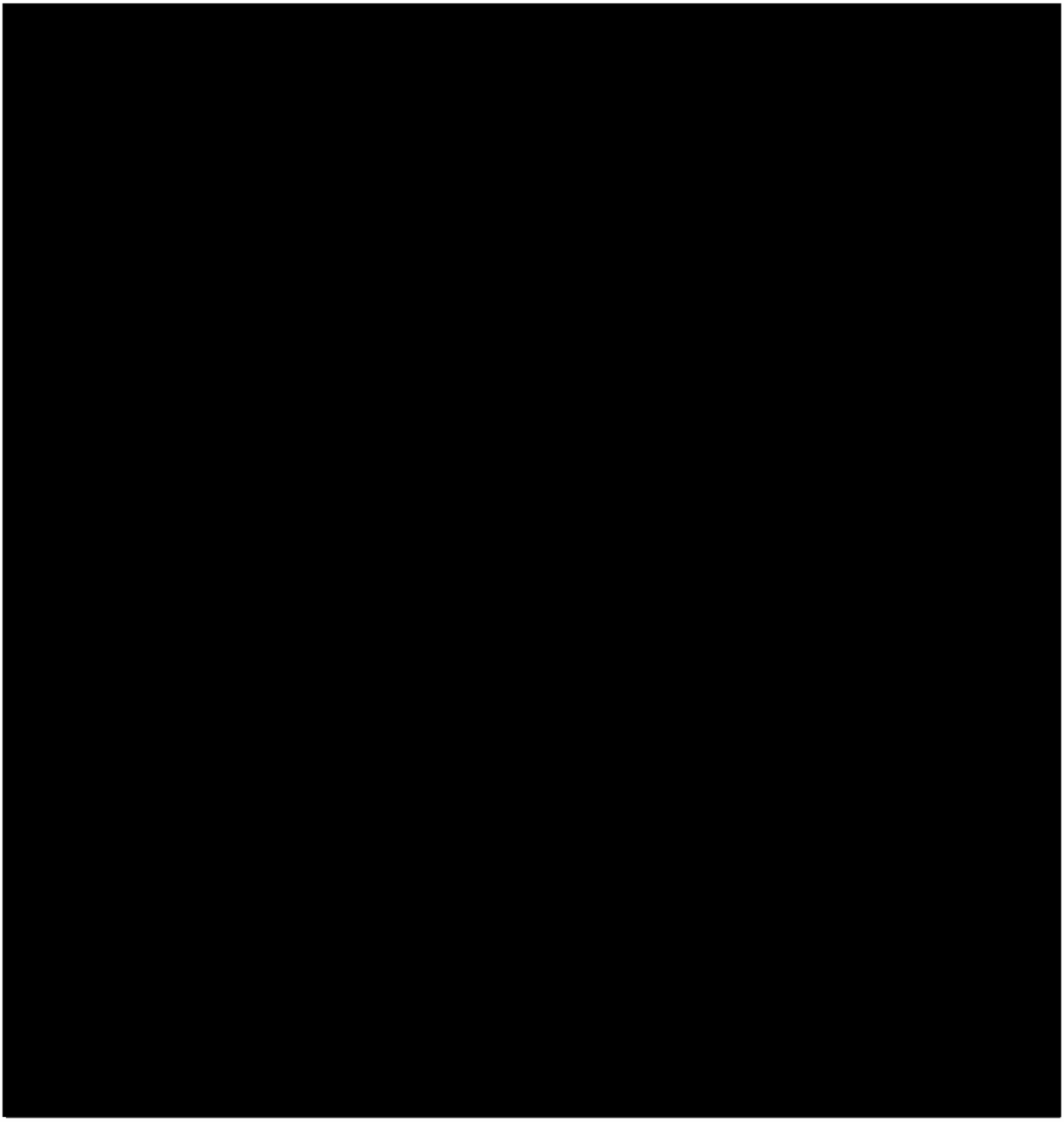
ATTACHMENT 2.6.3.4

LHCC Certification of Actuarial Values

CONFIDENTIAL

ACTUARIAL CERTIFICATION





louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.11.5

LHCC Adopted CPGs and Sample CPG

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
Adult Preventive Care	American Cancer Society Guidelines for the Early Detection of Cancer (Last Revised July 2020)	American Cancer Society (ACS)
	Morbidity and Mortality Weekly Report (MMWR)	Centers for Disease Control and Prevention (CDC)
	U.S. Preventive Services Task Force Recommendations. (Publication dates vary)	U.S. Preventive Services Task Force (USPSTF)
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)
	Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma (Full Report 2007) and 2020 Focused Updates to the Asthma Management Guidelines: A Report from the National Asthma Education and Prevention Program Coordinating Committee Expert Panel Working Group (December 2020)	U.S. Department of Health and Human Services (HHS); National Institute of Health (NIH); National Heart, Lung, and Blood Institute (NHLBI)
	2020 GINA Report, Global Strategy For Asthma Management and Prevention.	Global Initiative for Asthma (GINA)
Back Pain	Clinical Practice Guideline for Diagnosis and Treatment of Low Back Pain. (2017).	Department of Veterans Affairs and the Department of Defense (VA/DoD)
	Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society (February 5, 2008)	American College of Physicians; American Pain Society
	Low Back Pain, Adult Acute and Subacute (Updated March 2018)	Institute for Clinical Systems Improvement (ICSI)
	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
Cancer	ASCO Guidelines by Clinical Area	American Society of Clinical Oncology
	ASTRO Guidelines by Clinical Area	American Society for Radiation Oncology (ASTRO)
	NCCN Guidelines® & Clinical Resources	National Comprehensive Cancer Network (NCCN)

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
Chlamydia Screening	Final Recommendation Statement Gonorrhea and Chlamydia: Screening. (September 2014- update in progress).	U.S. Preventive Services Task Force (USPSTF)
Chronic Obstructive Pulmonary Disease	Global Strategy for the Diagnosis, Management, and Prevention of Chronic Obstructive Pulmonary Disease (2020 Report)	The Global Initiative for Chronic Obstructive Lung Disease
	Clinical Practice Guideline for the Management of Chronic Obstructive Pulmonary Disease. (2014 – update in progress).	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD)
Congenital Disorders	The Care of Children With Congenital Heart Disease in Their Primary Medical Home. (2017).	American Academy of Pediatrics (AAP) and the American College of Cardiology (ACC)
	Guideline for the Management of Adults With Congenital Heart Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. (2018)	American Heart Association (AHA) and the American College of Cardiology Foundation. (ACC)
Coronavirus Disease 2019 (Covid-19)	Overview of Testing for SARS-CoV-2 (COVID-19) (Updated March 2021)	Centers for Disease Control and Prevention (CDC)
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)
	ACC/AHA Prevention Guideline: 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk. (Circulation. 2014; 129:S49-S73) (Published online Nov. 2013)	American College of Cardiology (ACC) and American Heart Association (AHA) Task Force
	Routine Assessment and Promotion of Physical Activity in Healthcare Settings; A scientific statement from the American heart association (Circulation. 2018; 137:e495–e522)	American Heart Association (AHA)
	AHA Scientific Statement: Secondary Prevention of Atherosclerotic Cardiovascular Disease in Older Adults. (Circulation. 2013; 128:2422-2446)	American Heart Association (AHA)

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
	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
	AHA/ACCF Guideline: Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease, 2011 Update (Circulation. 2011; 124: 2458-2473) and (Correction 2015; 131: e048)	American Heart Association (AHA) and American College of Cardiology Foundation (ACC)
	2019 AHA/ACCF Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. (Correction 2019; 140:e649-e650, Correction 2020; 141:e60, Correction 2020; 141:e774)	American Heart Association (AHA) and American College of Cardiology Foundation (ACC)
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.
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-2020 Executive Summary (Endocrine Practice 2020; Volume 26, No.1)	American Association of Clinical Endocrinologists and American College of Endocrinology
	Standards of Medical Care in Diabetes-2021 (Diabetes Care 2021, Volume 44, Supplement 1)	American Diabetes Association (ADA)
Epilepsy	Guidelines by Topic: Epilepsy	American Academy of Neurology and American Epilepsy Society
Frailty and Special Populations	American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults.	American Geriatrics Society (AGS)
	Managing Medicines for Adults Receiving Social Care in the Community. (2017)	National Institute for Health and Care Excellence (NICE)
General Evidence Based Medicine	Choosing Wisely	Choosing Wisely; American Board of Internal Medicine Foundation

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
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)
Hemophilia	NHF-McMaster Guideline on Care Models for Hemophilia Management. (2017).	National Hemophilia Foundation (NHF)
HIV/AIDS	Human Immunodeficiency Virus (HIV) Infection: Screening. (2019).	United States Preventive Services Task Force (USPSTF)
	Prevention of Human Immunodeficiency Virus (HIV) Infection: Preexposure Prophylaxis. (2019).	United States Preventive Services Task Force (USPSTF)
	Routine Human Immunodeficiency Virus Screening. (2014).	American College of Obstetricians and Gynecologists (ACOG)
	Recommendations for the Use of Antiretroviral Drugs in Pregnant Women with HIV Infection and Interventions to Reduce Perinatal HIV Transmission in the United States. (2021).	National Institutes of Health (NIH)
	Diagnosis and Management of Acute HIV Infection. (2018).	AIDS Institute
Hyperlipidemia	Lipid Management in Adults (February 2017)	Institute for Clinical Systems Improvement (ICSI)
	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, Circulation 2014; 129:S46-S48, Circulation 2015; 132:e396,)	American College of Cardiology (ACC), American Heart Association (AHA) Task Force on Practice Guidelines
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 (ACC)
Immunizations	Recommended adult immunization schedule for ages 19 years and older, United States 2021	Advisory Committee on Immunization Practices (ACIP)

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
	Recommended child and adolescent Immunization Schedule for ages 18 years or younger, United States, 2021	Advisory Committee on Immunization Practices (ACIP)
	Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the ACIP — United States, 2019–20 Influenza Season	Advisory Committee on Immunization Practices (ACIP)
Lead Poisoning	CDC's Childhood Lead Poisoning Prevention Program	Advisory Committee On Childhood Lead Poisoning Prevention (ACCLPP)
	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
Long-Term Care	Transitions of Care in the Long-Term Care Continuum Clinical Practice Guidelines 2010	American Medical Directors Association
Opioids for Chronic Pain	CDC Guideline for Prescribing Opioids for Chronic Pain	Centers for Disease Control and Prevention (CDC)
Osteoporosis	Clinical Practice Guidelines for the Diagnosis and Treatment of Postmenopausal Osteoporosis. (2020 Update).	American Association of Clinical Endocrinologists (AACE)
	ACOG Practice Bulletin N. 129. Osteoporosis. (2012).	American College of Obstetricians and Gynecologists (ACOG)
Palliative Care	Palliative Care for Adults. (Revised: January 2020/Sixth edition).	Institute for Clinical Systems Improvement (ICSI)
Pediatric Preventive Care	Guidelines on Periodicity of Examination, Preventive Dental Services, Anticipatory Guidance/Counseling, and Oral Treatment for Infants, Children, and Adolescents (Revised 2018)	American Academy of Pediatric Dentistry
	Periodicity Schedule: Recommendations for Preventive Pediatric Health Care (2021)	American Academy of Pediatrics
Perinatal Care	AFP by Topic: Prenatal (Publication dates vary) AFP by Topic: Labor, Delivery, and Post-Partum Issues (Publication dates vary)	American Academy of Family Physicians (AAFP)
	Guidelines for Perinatal Care, Eighth Edition (2017)	American College of Obstetricians and Gynecologists (ACOG)

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
Pneumonia	Management of Adults With Hospital-acquired and Ventilator-associated Pneumonia: 2016 Clinical Practice Guidelines by the Infectious Diseases Society of America and the American Thoracic Society. (2016).	Infectious Diseases Society of America (IDSA)
	The Management of Community-Acquired Pneumonia in Infants and Children Older Than 3 Months of Age: Clinical Practice Guidelines by the Pediatric Infectious Diseases Society and the Infectious Diseases Society of America. (2011).	Pediatric Infectious Diseases Society (PIDS) and the Infectious Diseases Society of America (IDSA)
Respiratory Illness	Adult and Pediatric treatment recommendations. (Adult reviewed Oct. 2017, Pediatric Feb. 2017).	Centers for Disease Control and Prevention (CDC)
	AFP by Topic: Respiratory Tract Infections (Publication dates vary)	American Academy of Family Physicians (AAFP)
	Diagnosis and Treatment of Respiratory Illness in Children and Adults. (Updated September 2017)	Institute for Clinical Systems Improvement (ICSI)
Rheumatoid Arthritis	American College of Rheumatology Guideline for the Treatment of Rheumatoid Arthritis. (2021- Update in progress).	American College of Rheumatology (ACR)
Sickle Cell	Sickle Cell Disease, Recommendations (Last reviewed December 16, 2020)	Centers for Disease Control and Prevention (CDC)
	Evidence-Based Management of Sickle Cell Disease: Expert Panel report, 2014	National Institutes of Health Heart, Lung, and Blood Institute
Special Health Care Needs of Adolescents	Standards for Systems of Care for Children and Youth with Special Health Care Needs	Association Of Maternal And Child Health Programs and the National Academy For State Health Policy
Tobacco Cessation	Tobacco and Nicotine Cessation During Pregnancy (May 2020)	American College of Obstetricians and Gynecologists (ACOG)
	Smoking and Tobacco Use Cessation	Centers for Disease Control and Prevention (CDC)

Physical Health Conditions/ Diseases	Guideline Title	Recognized Source
	Interventions for Tobacco Smoking Cessation in Adults, Including Pregnant Persons (2021).	United Preventive Services Task Force (USPSTF)
	Prevention and Cessation of Tobacco Use in Children and Adolescents: Primary Care Interventions (April 2020)	United Preventive Services Task Force (USPSTF)
Traumatic Brain Injury (TBI)	Management of Concussion-mild Traumatic Brain Injury (mTBI). (2016- update in progress)	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD)
Weight management	Adult Weight Management (AWM) Guideline (2014)	Academy of Nutrition and Dietetics
	Clinical Report: Preventing Obesity and Eating Disorders in Adolescents. (Pediatrics Vol. 138 Iss.3 Sept. 2016 pp.1834-1842)	American Academy of Pediatrics (AAP)
	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
	Final Recommendation Statement Obesity in Children and Adolescents: Screening, June 2017	U.S. Preventive Services Task Force (USPSTF)
	Clinical practice guideline for multicomponent behavioral treatment of obesity and overweight in children and adolescents (March 2018)	American Psychological Association (APA)
Zika Virus	For Healthcare Providers: New Zika and Dengue Testing Guidance (November 2019)	Centers for Disease Control and Prevention (CDC)

Behavioral Health Conditions/ Diseases	Guideline Title	Recognized Source
Attention–Deficit / Hyperactivity Disorder in Children and Adolescents	Clinical Practice Guideline for the Diagnosis, Evaluation, and Treatment of Attention-Deficit/Hyperactivity Disorder in Children and Adolescents (Correction March 1, 2020)	American Academy of Pediatrics
Anxiety Disorders	Generalized Anxiety Disorder And Panic Disorder In Adults: Management (July 2019)	National Institute for Health and Care Excellence (NICE)
Autism	Practice Parameter for the Assessment and Treatment of Children and Adolescents With Autism Spectrum Disorder (2014)	American Academy of Child and Adolescent Psychiatry (AACAP)
Depressive Disorder	Management of Major Depressive Disorder (2016)	United States Department of Veteran Affairs (VA) and the Department of Defense (DoD)
Gender Reassignment and Transgender Issues	Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (2015)	American Psychiatric Association (APA)
Obsessive Compulsive Disorder (OCD)	Obsessive Compulsive Disorder. (Published 2007, Updated 2013)	American Psychiatric Association (APA)
	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Obsessive-Compulsive Disorder (2012)	American Academy of Child and Adolescent Psychiatry (AACAP)
Opioid Use Disorder and Treatment	National Practice Guideline For the Treatment of Opioid Use Disorder (2020)	American Society of Addiction Medicine (ASAM)
	Federal Guidelines for Opioid Treatment Programs (March 2015)	Substance Abuse and Mental Health Services Administration (SAMHSA)
	Clinical Guidance for Treating Pregnant and Parenting Women With Opioid Use Disorder and Their Infants (January 2018)	Substance Abuse and Mental Health Services Administration (SAMHSA)
	VA/DoD Clinical Practice Guideline for Opioid Therapy for Chronic Pain (2017)	United States Department of Veteran Affairs (VA) and the Department of Defense (DOD)

Behavioral Health Conditions/ Diseases	Guideline Title	Recognized Source
Posttraumatic Stress Disorder and Acute Stress Disorder	Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder	United States Department of Veteran Affairs (VA) and the Department of Defense (DOD)
Schizophrenia	Practice Guideline for the Treatment of Patients with Schizophrenia	The American Psychiatric Association American Academy Of Child And Adolescent Psychiatry (AACAP)
	Practice Parameter for the Assessment and Treatment of Children and Adolescents with Schizophrenia (2013)	American Academy Of Child And Adolescent Psychiatry (AACAP)
Substance Use Disorders Management	Clinical Practice Guideline for the Management of Substance Use Disorders (2015- update in progress)	Department of Veterans Affairs
Suicidal Behavior	Assessment and Management of Patients at Risk for Suicide (2019)	Department of Veterans Affairs and the Department of Defense (VA/DoD)

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger

UNITED STATES 2021

Vaccines in the Child and Adolescent Immunization Schedule*

Vaccines	Abbreviations	Trade names
Diphtheria, tetanus, and acellular pertussis vaccine	**DTaP**	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	**DT**	No trade name
Haemophilus influenzae type b vaccine	**Hib (PRP-T)**	ActHIB® Hiberix®
	Hib (PRP-OMP)	PedvaxHIB®
Hepatitis A vaccine	**HepA**	Havrix® Vaqta®
Hepatitis B vaccine	**HepB**	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	**HPV**	Gardasil 9®
Influenza vaccine (inactivated)	**IIV**	Multiple
Influenza vaccine (live, attenuated)	**LAIV4**	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	**MMR**	M-M-R II®
Meningococcal serogroups A, C, W, Y vaccine	**MenACWY-D**	Menactra®
	MenACWY-CRM	Menveo®
	MenACWY-TT	MenQuadfi®
Meningococcal serogroup B vaccine	**MenB-4C**	Bexsero®
	MenB-FHbp	Trumenba®
Pneumococcal 13-valent conjugate vaccine	**PCV13**	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	**PPSV23**	Pneumovax 23®
Poliovirus vaccine (inactivated)	**IPV**	IPOL®
Rotavirus vaccine	**RV1**	Rotarix®
	RV5	RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	**Tdap**	Adacel® Boostrix®
Tetanus and diphtheria vaccine	**Td**	Tenivac® Tdvax™
Varicella vaccine	**VAR**	Varivax®
Combination vaccines *(use combination vaccines instead of separate injections when appropriate)*		
DTaP, hepatitis B, and inactivated poliovirus vaccine	**DTaP-HepB-IPV**	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type b vaccine	**DTaP-IPV/Hib**	Pentacel®
DTaP and inactivated poliovirus vaccine	**DTaP-IPV**	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	**DTaP-IPV-Hib-HepB**	Vaxelis®
Measles, mumps, rubella, and varicella vaccine	**MMRV**	ProQuad®

*Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

How to use the child/adolescent immunization schedule

1 Determine recommended vaccine by age **(Table 1)**

2 Determine recommended interval for catch-up vaccination **(Table 2)**

3 Assess need for additional recommended vaccines by medical condition and other indications **(Table 3)**

4 Review vaccine types, frequencies, intervals, and considerations for special situations **(Notes)**

Recommended by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/acip) and approved by the Centers for Disease Control and Prevention (www.cdc.gov), American Academy of Pediatrics (www.aap.org), American Academy of Family Physicians (www.aafp.org), American College of Obstetricians and Gynecologists (www.acog.org), American College of Nurse-Midwives (www.midwife.org), American Academy of Physician Assistants (www.aapa.org), and National Association of Pediatric Nurse Practitioners (www.napnap.org).

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department
- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or 800-822-7967

Download the CDC Vaccine Schedules App for providers at www.cdc.gov/vaccines/schedules/hcp/schedule-app.html.

Helpful information

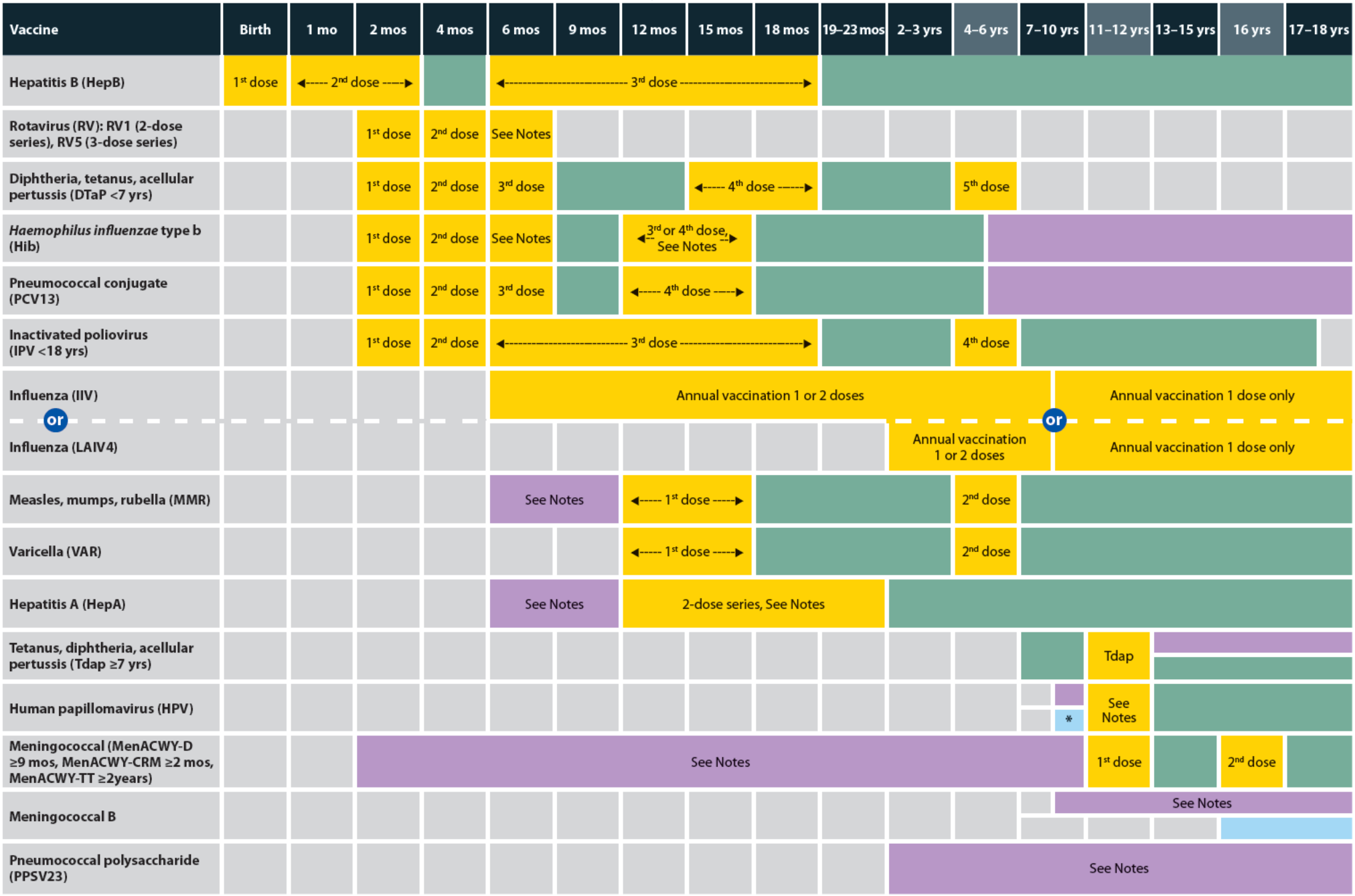
- Complete ACIP recommendations: www.cdc.gov/vaccines/hcp/acip-recs/index.html
- *General Best Practice Guidelines for Immunization*: www.cdc.gov/vaccines/hcp/acip-recs/general-recs/index.html
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases: www.cdc.gov/vaccines/pubs/surv-manual
- ACIP Shared Clinical Decision-Making Recommendations www.cdc.gov/vaccines/acip/acip-scdm-faqs.html

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

- EXEMPT FROM PAGE LIMITS -

Table 1 Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

These recommendations must be read with the notes that follow. For those who fall behind or start late, provide catch-up vaccination at the earliest opportunity as indicated by the green bars. To determine minimum intervals between doses, see the catch-up schedule (Table 2). School entry and adolescent vaccine age groups are shaded in gray.



EXEMPT FROM PAGE LIMITS

Table 2 Recommended Catch-up Immunization Schedule for Children and Adolescents Who Start Late or Who Are More than 1 month Behind, United States, 2021

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age. **Always use this table in conjunction with Table 1 and the notes that follow.**

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Children age 4 months through 6 years					
Hepatitis B	Birth	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.** Minimum age for the final dose is 24 weeks.		
Rotavirus	6 weeks Maximum age for first dose is 14 weeks, 6 days.	**4 weeks**	**4 weeks** Maximum age for final dose is 8 months, 0 days.		
Diphtheria, tetanus, and acellular pertussis	6 weeks	**4 weeks**	**4 weeks**	**6 months**	**6 months**
Haemophilus influenzae type b	6 weeks	**No further doses needed** if first dose was administered at age 15 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose)** if first dose was administered at age 12 through 14 months.	**No further doses needed** if previous dose was administered at age 15 months or older. **4 weeks** if current age is younger than 12 months ***and*** first dose was administered at younger than age 7 months ***and*** at least 1 previous dose was PRP-T (ActHib, Pentacel, Hiberix) or unknown. **8 weeks *and* age 12 through 59 months (as final dose)** if current age is younger than 12 months ***and*** first dose was administered at age 7 through 11 months; OR if current age is 12 through 59 months ***and*** first dose was administered before the 1st birthday ***and*** second dose was administered at younger than 15 months; OR if both doses were PRP-OMP (PedvaxHIB, Comvax) ***and*** were administered before the 1st birthday.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before the 1st birthday.	
Pneumococcal conjugate	6 weeks	**No further doses needed** for healthy children if first dose was administered at age 24 months or older. **4 weeks** if first dose was administered before the 1st birthday. **8 weeks (as final dose for healthy children)** if first dose was administered at the 1st birthday or after.	**No further doses needed** for healthy children if previous dose was administered at age 24 months or older. **4 weeks** if current age is younger than 12 months and previous dose was administered at <7 months old. **8 weeks (as final dose for healthy children)** if previous dose was administered between 7–11 months (wait until at least 12 months old); OR if current age is 12 months or older and at least 1 dose was administered before age 12 months.	**8 weeks (as final dose)** This dose only necessary for children age 12 through 59 months who received 3 doses before age 12 months or for children at high risk who received 3 doses at any age.	
Inactivated poliovirus	6 weeks	**4 weeks**	**4 weeks** if current age is <4 years. **6 months (as final dose)** if current age is 4 years or older.	**6 months** (minimum age 4 years for final dose).	
Measles, mumps, rubella	12 months	**4 weeks**			
Varicella	12 months	**3 months**			
Hepatitis A	12 months	**6 months**			
Meningococcal ACWY	2 months MenACWY-CRM 9 months MenACWY-D 2 years MenACWY-TT	**8 weeks**	See Notes	See Notes	
Children and adolescents age 7 through 18 years					
Meningococcal ACWY	Not applicable (N/A)	**8 weeks**			
Tetanus, diphtheria; tetanus, diphtheria, and acellular pertussis	7 years	**4 weeks**	**4 weeks** if first dose of DTaP/DT was administered before the 1st birthday. **6 months (as final dose)** if first dose of DTaP/DT or Tdap/Td was administered at or after the 1st birthday.	**6 months** if first dose of DTaP/DT was administered before the 1st birthday.	
Human papillomavirus	9 years	**Routine dosing intervals are recommended.**			
Hepatitis A	N/A	**6 months**			
Hepatitis B	N/A	**4 weeks**	**8 weeks *and* at least 16 weeks after first dose.**		
Inactivated poliovirus	N/A	**4 weeks**	**6 months** A fourth dose is not necessary if the third dose was administered at age 4 years or older and at least 6 months after the previous dose.	A fourth dose of IPV is indicated if all previous doses were administered at <4 years or if the third dose was administered <6 months after the second dose.	
Measles, mumps, rubella	N/A	**4 weeks**			
Varicella	N/A	**3 months** if younger than age 13 years. **4 weeks** if age 13 years or older.			

- EXEMPT FROM PAGE LIMITS -

Table 3 Recommended Child and Adolescent Immunization Schedule by Medical Indication, United States, 2021

Always use this table in conjunction with Table 1 and the notes that follow.

VACCINE	INDICATION										
	Pregnancy	Immunocompromised status (excluding HIV infection)	HIV infection CD4+ count[1]		Kidney failure, end-stage renal disease, or on hemodialysis	Heart disease or chronic lung disease	CSF leak or cochlear implant	Asplenia or persistent complement component deficiencies	Chronic liver disease	Diabetes
			<15% and total CD4 cell count of <200/mm³	≥15% and total CD4 cell count of ≥200/mm³						
Hepatitis B										
Rotavirus		SCID[2]								
Diphtheria, tetanus, and acellular pertussis (DTaP)										
Haemophilus influenzae type b										
Pneumococcal conjugate										
Inactivated poliovirus										
Influenza (IIV) or Influenza (LAIV4)						Asthma, wheezing: 2–4yrs[3]				
Measles, mumps, rubella	*									
Varicella	*									
Hepatitis A										
Tetanus, diphtheria, and acellular pertussis (Tdap)										
Human papillomavirus	*									
Meningococcal ACWY										
Meningococcal B										
Pneumococcal polysaccharide										

Vaccination according to the routine schedule recommended

Recommended for persons with an additional risk factor for which the vaccine would be indicated

Vaccination is recommended, and additional doses may be necessary based on medical condition. See Notes.

Not recommended/ contraindicated—vaccine should not be administered.

*Vaccinate after pregnancy.

Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction

No recommendation/not applicable

1 For additional information regarding HIV laboratory parameters and use of live vaccines, see the *General Best Practice Guidelines for Immunization*, "Altered Immunocompetence," at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html and Table 4-1 (footnote D) at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html.

2 Severe Combined Immunodeficiency

3 LAIV4 contraindicated for children 2–4 years of age with asthma or wheezing during the preceding 12 months

- EXEMPT FROM PAGE LIMITS -

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2021.

Additional information

COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines within the scope of the Emergency Use Authorization or Biologics License Application for the particular vaccine. Interim ACIP recommendations for the use of COVID-19 vaccines can be found at www.cdc.gov/vaccines/hcp/acip-recs/.

- Consult relevant ACIP statements for detailed recommendations at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html and relevant ACIP statements at www.cdc.gov/vaccines/hcp/acip-recs/index.html.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.
- Information on travel vaccination requirements and recommendations is available at www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization* at www.cdc.gov/vaccines/hcp/acip-recs/general-recs/immunocompetence.html, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 Report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics; 2018:67–111).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html.

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older and at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- Wound management in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination
- For other catch-up guidance, see Table 2.

Special situations

- **Chemotherapy or radiation treatment:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant, regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5 years or older*
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated persons age 15 months or older*
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated persons age 5–18 years*
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

**Unvaccinated* = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

- EXEMPT FROM PAGE LIMITS -

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

Hepatitis A vaccination
(minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series (minimum interval: 6 months) beginning at age 12 months

Catch-up vaccination
- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel
- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (www.cdc.gov/travel/):
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
  - **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination
(minimum age: birth)

Birth dose (monovalent HepB vaccine only)
- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants ≥2,000 grams. Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series
- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination
- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.
- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).
- For other catch-up guidance, see Table 2.

Special situations
- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Human papillomavirus vaccination
(minimum age: 9 years)

Routine and catch-up vaccination
- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9–14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination**: 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine.

Special situations
- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Influenza vaccination
(minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

Routine vaccination
- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2020, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2020
  - 1 dose for **all persons age 9 years or older**
- For the 2021–22 season, see the 2021–22 ACIP influenza vaccine recommendations.

Special situations
- **Egg allergy, hives only**: Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than Flublok or Flucelvax, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. All vaccination providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
  - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
  - Receiving aspirin or salicylate-containing medications
  - Age 2–4 years with history of asthma or wheezing
  - Immunocompromised due to any cause (including medications and HIV infection)
  - Anatomic or functional asplenia
  - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
  - Pregnancy
  - Cochlear implant
  - Cerebrospinal fluid-oropharyngeal communication
  - Children less than age 2 years
  - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours,. peramivir within the previous 5 days, or baloxavir within the previous 17 days

- EXEMPT FROM PAGE LIMITS -

Notes

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination
- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination
- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

Special situations
International travel
- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A,C,W,Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

Routine vaccination
- 2-dose series at 11–12 years, 16 years

Catch-up vaccination
- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations
Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.
- **MenQuadfi**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (www.cdc.gov/travel/)**:**
- Children less than age 24 months:
  - **Menveo (age 2–23 months)**
    - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months)**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose Menveo, Menactra, or MenQuadfi

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:
- 1 dose **Menveo, Menactra,** or **MenQuadfi**

Adolescent vaccination of children who received MenACWY prior to age 10 years:
- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk.
- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Shared clinical decision-making
- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations
Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:
- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 3-dose series at 0, 1–2, 6 months

Bexsero and **Trumenba** are not interchangeable; the same product should be used for all doses in a series.
For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13
- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13
- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations
Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit.

Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Age 6–18 years
- •No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years
- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years
- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

EXEMPT FROM PAGE LIMITS

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series See Tables 8, 9, and 11 in the ACIP pneumococcal vaccine recommendations (www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Poliovirus vaccination
(minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.
- IPV is not routinely recommended for U.S. residents age 18 years or older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm?s_%20cid=mm6601a6_w.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
  - For guidance to assess doses documented as "OPV," see www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm?s_cid=mm6606a7_w.
- For other catch-up guidance, see Table 2.

Rotavirus vaccination
(minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months
- **RotaTeq:** 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination
(minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably in early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years:**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years**:
  - **Children age 7–9 years**: DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years**: Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap.
- For detailed information, see www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

**Fully vaccinated* = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older

Varicella vaccination
(minimum age: 12 months)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years**: routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years and older**: routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

- EXEMPT FROM PAGE LIMITS -

Table 1. Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

Always make recommendations by determining needed vaccines based on age (Table 1), determining appropriate intervals for catch-up, if needed (Table 2), assessing for medical indications (Table 3), and reviewing special situations (Notes).

Get Email Updates

COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines for everyone ages 12 and older within the scope of the Emergency Use Authorization for the particular vaccine. COVID-19 vaccine and other vaccines may be administered on the same day. See the COVID-19 Vaccine Product Information page for additional information about COVID-19 vaccines authorized for use in the United States.

Table 1. By age | Table 2. Catch-up schedule | Table 3. By medical indications | Schedule Changes & Guidance | Parent-friendly schedule | Resources for health care

- 8.5"x11" print color [8 pages]
- 8.5"x11" print black and white [8 pages]
- Compliant version of this schedule

- Vaccines in the Child and Adolescent Immunization Schedule
- Learn how to display current schedules from your website.

Download Schedules App

Legend

Range of recommended ages for all children	Range of recommended ages for catch-up immunization	Range of recommended ages for certain high-risk groups	Recommended based on shared clinical decision-making or *can be used in this age group	No recommendation/Not applicable

Birth to 15 Months

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos
Hepatitis B (HepB)	1st dose	←2nd dose→			←3rd dose→			
Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)			1st dose	2nd dose	See notes			
Diphtheria, tetanus, & acellular pertussis (DTaP: <7 yrs)			1st dose	2nd dose	3rd dose			←4th dose→
Haemophilus influenzae type b (Hib)			1st dose	2nd dose	See notes		←3rd or 4th dose, See notes→	

- EXEMPT FROM PAGE LIMITS -

Vaccine	Birth	1 mo	2 mos	4 mos	6 mos	9 mos	12 mos	15 mos
Pneumococcal conjugate (PCV13)			1st dose	2nd dose	3rd dose		←4th dose→	
Inactivated poliovirus (IPV: <18 yrs)			1st dose	2nd dose	←3rd dose→			
Influenza (IIV)					Annual vaccination 1 or 2 doses			
or Influenza (LAIV4)								
Measles, mumps, rubella (MMR)					See notes		←1st dose→	
Varicella (VAR)							←1st dose→	
Hepatitis A (HepA)					See notes		←2-dose series, See notes→	
Tetanus, diphtheria, & acellular pertussis (Tdap: ≥7 yrs)								
Human papillomavirus (HPV)								
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)			See notes					
Meningococcal B (MenB)								
Pneumococcal polysaccharide (PPSV23)								

18 Months to 18 Years

Vaccines	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Hepatitis B (HepB)	←3rd dose→								
Rotavirus (RV) RV1 (2-dose series); RV5 (3-dose series)									
Diphtheria, tetanus, & acellular pertussis (DTaP: <7 yrs)	←4th dose→			5th dose					
Haemophilus influenzae type b (Hib)									

Vaccines	18 mos	19-23 mos	2-3 yrs	4-6 yrs	7-10 yrs	11-12 yrs	13-15 yrs	16 yrs	17-18 yrs
Pneumococcal conjugate (PCV13)									
Inactivated poliovirus (IPV: <18 yrs)	←3rd dose→			4th dose					
Influenza (IIV)	Annual vaccination 1 or 2 doses					Annual vaccination 1 dose only			
or Influenza (LAIV4)			Annual vaccination 1 or 2 doses		or	Annual vaccination 1 dose only			
Measles, mumps, rubella (MMR)				2nd dose					
Varicella (VAR)				2nd dose					
Hepatitis A (HepA)	← 2-dose series, See notes→								
Tetanus, diphtheria, & acellular pertussis (Tdap: ≥7 yrs)						Tdap			
Human papillomavirus (HPV)					*	See notes			
Meningococcal (MenACWY-D ≥9 mos, MenACWY-CRM ≥2 mos, MenACWY-TT ≥2years)	See notes					1st dose		2nd dose	
Meningococcal B (MenB)					See notes				
Pneumococcal polysaccharide (PPSV23)			See notes						

Administer recommended vaccines if immunization history is incomplete or unknown. Do not restart or add doses to vaccine series for extended intervals between doses. When a vaccine is not administered at the recommended age, administer at a subsequent visit. The use of trade names is for identification purposes only and does not imply endorsement by the ACIP or CDC.

Notes

Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger, United States, 2021

For vaccination recommendations for persons ages 19 years or older, see the Recommended Adult Immunization Schedule, 2021.

- EXEMPT FROM PAGE LIMITS -

Additional information

COVID-19 Vaccination

ACIP recommends use of COVID-19 vaccines for everyone ages 12 and older within the scope of the Emergency Use Authorization for the particular vaccine. COVID-19 vaccine and other vaccines may be administered on the same day. See the COVID-19 Vaccine Product Information page for additional information about COVID-19 vaccines authorized for use in the United States.

- Consult relevant ACIP statements for detailed recommendations.
- For information on contraindications and precautions for the use of a vaccine, consult the *General Best Practice Guidelines for Immunization* and relevant ACIP statements.
- For calculating intervals between doses, 4 weeks = 28 days. Intervals of ≥4 months are determined by calendar months.
- Within a number range (e.g., 12–18), a dash (–) should be read as "through."
- Vaccine doses administered ≤4 days before the minimum age or interval are considered valid. Doses of any vaccine administered ≥5 days earlier than the minimum age or minimum interval should not be counted as valid and should be repeated as age-appropriate. **The repeat dose should be spaced after the invalid dose by the recommended minimum interval.** For further details, see Table 3-1, Recommended and minimum ages and intervals between vaccine doses, in *General Best Practice Guidelines for Immunization*.
- Information on travel vaccination requirements and recommendations is available at https://www.cdc.gov/travel/.
- For vaccination of persons with immunodeficiencies, see Table 8-1, Vaccination of persons with primary and secondary immunodeficiencies, in *General Best Practice Guidelines for Immunization*, and Immunization in Special Clinical Circumstances (In: Kimberlin DW, Brady MT, Jackson MA, Long SS, eds. *Red Book: 2018 report of the Committee on Infectious Diseases*. 31st ed. Itasca, IL: American Academy of Pediatrics, 2018:67–111).
- For information about vaccination in the setting of a vaccine-preventable disease outbreak, contact your state or local health department.
- The National Vaccine Injury Compensation Program (VICP) is a no-fault alternative to the traditional legal system for resolving vaccine injury claims. All routine child and adolescent vaccines are covered by VICP except for pneumococcal polysaccharide vaccine (PPSV23). For more information, see www.hrsa.gov/vaccinecompensation/index.html .

Diphtheria, tetanus, and pertussis (DTaP) vaccination (minimum age: 6 weeks [4 years for Kinrix or Quadracel])

Routine vaccination

- 5-dose series at 2, 4, 6, 15–18 months, 4–6 years
  - **Prospectively:** Dose 4 may be administered as early as age 12 months if at least 6 months have elapsed since dose 3.
  - **Retrospectively:** A 4th dose that was inadvertently administered as early as age 12 months may be counted if at least 4 months have elapsed since dose 3.

Catch-up vaccination

- Dose 5 is not necessary if dose 4 was administered at age 4 years or older **and** at least 6 months after dose 3.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in children less than age 7 years with history of 3 or more doses of tetanus-toxoid-containing vaccine: For all wounds except clean and minor wounds, administer DTaP if more than 5 years since last dose of tetanus-toxoid-containing vaccine. For detailed information, see www.cdc.gov/mmwr/volumes/67/rr/rr6702a1.htm.

Haemophilus influenzae type b vaccination (minimum age: 6 weeks)

Routine vaccination

- **ActHIB, Hiberix, or Pentacel:** 4-dose series at 2, 4, 6, 12–15 months
- **PedvaxHIB:** 3-dose series at 2, 4, 12–15 months

Catch-up vaccination

- **Dose 1 at age 7–11 months:** Administer dose 2 at least 4 weeks later and dose 3 (final dose) at age 12–15 months or 8 weeks after dose 2 (whichever is later).
- **Dose 1 at age 12–14 months:** Administer dose 2 (final dose) at least 8 weeks after dose 1.
- **Dose 1 before age 12 months and dose 2 before age 15 months:** Administer dose 3 (final dose) 8 weeks after dose 2.
- **2 doses of PedvaxHIB before age 12 months:** Administer dose 3 (final dose) at age 12–59 months and at least 8 weeks after dose 2.
- **1 dose administered at age 15 months or older:** No further doses needed
- **Unvaccinated at age 15–59 months:** Administer 1 dose.
- **Previously unvaccinated children age 60 months or older who are not considered high risk:** Do not require catch-up vaccination
- For other catch-up guidance, see Table 2.

Special situations

- **Chemotherapy or radiation treatment:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Doses administered within 14 days of starting therapy or during therapy should be repeated at least 3 months after therapy completion.
- **Hematopoietic stem cell transplant (HSCT):**
  - 3-dose series 4 weeks apart starting 6 to 12 months after successful transplant regardless of Hib vaccination history
- **Anatomic or functional asplenia (including sickle cell disease):**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5 years or older
  - 1 dose
- **Elective splenectomy:**
  Unvaccinated* persons age 15 months or older
  - 1 dose (preferably at least 14 days before procedure)
- **HIV infection:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

  Unvaccinated* persons age 5–18 years
  - 1 dose
- **Immunoglobulin deficiency, early component complement deficiency:**
  12–59 months
  - Unvaccinated or only 1 dose before age 12 months: 2 doses, 8 weeks apart
  - 2 or more doses before age 12 months: 1 dose at least 8 weeks after previous dose

*Unvaccinated = Less than routine series (through age 14 months) OR no doses (age 15 months or older)

*Unvaccinated – Less than routine series (through age 14 months) OR no doses (age 15 months or older)

Hepatitis A vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series (minimum interval: 6 months) beginning at age 12 months

Catch-up vaccination

- Unvaccinated persons through age 18 years should complete a 2-dose series (minimum interval: 6 months).
- Persons who previously received 1 dose at age 12 months or older should receive dose 2 at least 6 months after dose 1.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix®**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).

International travel

- Persons traveling to or working in countries with high or intermediate endemic hepatitis A (http://www.cdc.gov/travel/)
  - **Infants age 6–11 months**: 1 dose before departure; revaccinate with 2 doses, separated by at least 6 months, between age 12–23 months.
  - **Unvaccinated age 12 months or older**: Administer dose 1 as soon as travel is considered.

Hepatitis B vaccination (minimum age: birth)

Birth dose (monovalent HepB vaccine only)

- **Mother is HBsAg-negative:** 1 dose within 24 hours of birth for **all** medically stable infants ≥2,000 grams. Infants <2,000 grams: Administer 1 dose at chronological age 1 month or hospital discharge (whichever is earlier and even if weight is still <2,000 grams).
- **Mother is HBsAg-positive:**
  - Administer **HepB vaccine** and **hepatitis B immune globulin (HBIG)** (in separate limbs) within 12 hours of birth, regardless of birth weight. For infants <2,000 grams, administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Test for HBsAg and anti-HBs at age 9–12 months. If HepB series is delayed, test 1–2 months after final dose.
- **Mother's HBsAg status is unknown:**
  - Administer **HepB vaccine** within 12 hours of birth, regardless of birth weight.
  - For infants <2,000 grams, administer **HBIG** in addition to HepB vaccine (in separate limbs) within 12 hours of birth. Administer 3 additional doses of vaccine (total of 4 doses) beginning at age 1 month.
  - Determine mother's HBsAg status as soon as possible. If mother is HBsAg-positive, administer **HBIG** to infants ≥2,000 grams as soon as possible, but no later than 7 days of age.

Routine series

- 3-dose series at 0, 1–2, 6–18 months (use monovalent HepB vaccine for doses administered before age 6 weeks)
- Infants who did not receive a birth dose should begin the series as soon as feasible (see Table 2).
- Administration of **4 doses** is permitted when a combination vaccine containing HepB is used after the birth dose.
- **Minimum age** for the final (3rd or 4th) dose: 24 weeks
- **Minimum intervals:** dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 8 weeks / dose 1 to dose 3: 16 weeks (when 4 doses are administered, substitute "dose 4" for "dose 3" in these calculations)

Catch-up vaccination

- Unvaccinated persons should complete a 3-dose series at 0, 1–2, 6 months.

- Adolescents age 11–15 years may use an alternative 2-dose schedule with at least 4 months between doses (adult formulation **Recombivax HB** only).
- Adolescents age 18 years or older may receive a 2-dose series of HepB **(Heplisav-B®)** at least 4 weeks apart.
- Adolescents age 18 years or older may receive the combined HepA and HepB vaccine, **Twinrix**, as a 3-dose series (0, 1, and 6 months) or 4-dose series (3 doses at 0, 7, and 21–30 days, followed by a booster dose at 12 months).
- For other catch-up guidance, see Table 2.

Special situations

- Revaccination is not generally recommended for persons with a normal immune status who were vaccinated as infants, children, adolescents, or adults.
- **Revaccination** may be recommended for certain populations, including:
  - **Infants born to HBsAg-positive mothers**
  - **Hemodialysis patients**
  - **Other immunocompromised persons**
- For detailed revaccination recommendations, see http://www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/hepb.html.

Human papillomavirus vaccination (minimum age: 9 years)

Routine and catch-up vaccination

- HPV vaccination routinely recommended at **age 11–12 years (can start at age 9 years)** and catch-up HPV vaccination recommended for all persons through age 18 years if not adequately vaccinated
- 2- or 3-dose series depending on age at initial vaccination:
  - **Age 9 –14 years at initial vaccination**: 2-dose series at 0, 6–12 months (minimum interval: 5 months; repeat dose if administered too soon)
  - **Age 15 years or older at initial vaccination:** 3-dose series at 0, 1–2 months, 6 months (minimum intervals: dose 1 to dose 2: 4 weeks / dose 2 to dose 3: 12 weeks / dose 1 to dose 3: 5 months; repeat dose if administered too soon)
- **Interrupted schedules:** If vaccination schedule is interrupted, the series does not need to be restarted.
- No additional dose recommended after completing series with recommended dosing intervals using any HPV vaccine.

Special situations

- **Immunocompromising conditions, including HIV infection:** 3-dose series as above
- **History of sexual abuse or assault:** Start at age 9 years.
- **Pregnancy:** HPV vaccination not recommended until after pregnancy; no intervention needed if vaccinated while pregnant; pregnancy testing not needed before vaccination

Influenza vaccination (minimum age: 6 months [IIV], 2 years [LAIV4], 18 years [recombinant influenza vaccine, RIV4])

Routine vaccination

- Use any influenza vaccine appropriate for age and health status annually:
  - 2 doses, separated by at least 4 weeks, for **children age 6 months–8 years** who have received fewer than 2 influenza vaccine doses before July 1, 2020, or whose influenza vaccination history is unknown (administer dose 2 even if the child turns 9 between receipt of dose 1 and dose 2)
  - 1 dose for **children age 6 months–8 years** who have received at least 2 influenza vaccine doses before July 1, 2020
  - 1 dose for **all persons age 9 years or older**
- For the 2021–22 season, see the 2021–22 ACIP influenza vaccine recommendations.

Special situations

- **Egg allergy, hives only**: Any influenza vaccine appropriate for age and health status annually
- **Egg allergy with symptoms other than hives** (e.g., angioedema, respiratory distress, need for emergency medical services or epinephrine): Any influenza vaccine appropriate for age and health status annually. If using an influenza vaccine other than Flublok or Flucelvax, administer in medical setting under supervision of health care provider who can recognize and manage severe allergic reactions.
- Severe allergic reactions to vaccines can occur even in the absence of a history of previous allergic reaction. All vaccination providers should be familiar with the office emergency plan and certified in cardiopulmonary resuscitation.
- A previous severe allergic reaction to influenza vaccine is a contraindication to future receipt of any influenza vaccine.
- **LAIV4 should not be used** in persons with the following conditions or situations:
    - History of severe allergic reaction to a previous dose of any influenza vaccine or to any vaccine component (excluding egg, see details above)
    - Receiving aspirin or salicylate-containing medications
    - Age 2–4 years with history of asthma or wheezing
    - Immunocompromised due to any cause (including medications and HIV infection)
    - Anatomic or functional asplenia
    - Close contacts or caregivers of severely immunosuppressed persons who require a protected environment
    - Pregnancy
    - Cochlear implant
    - Cerebrospinal fluid-oropharyngeal communication
    - Children less than age 2 years
    - Received influenza antiviral medications oseltamivir or zanamivir within the previous 48 hours, peramivir within the previous 5 days, or baloxavir within the previous 17 days

Measles, mumps, and rubella vaccination (minimum age: 12 months for routine vaccination)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 4 weeks after dose 1.

Catch-up vaccination

- Unvaccinated children and adolescents: 2-dose series at least 4 weeks apart
- The maximum age for use of MMRV is 12 years.

Special situations

International travel

- **Infants age 6–11 months:** 1 dose before departure; revaccinate with 2-dose series at age 12–15 months (12 months for children in high-risk areas) and dose 2 as early as 4 weeks later.
- **Unvaccinated children age 12 months or older:** 2-dose series at least 4 weeks apart before departure

Meningococcal serogroup A, C, W, Y vaccination (minimum age: 2 months [MenACWY-CRM, Menveo], 9 months [MenACWY-D, Menactra], 2 years [MenACWY-TT, MenQuadfi])

Routine vaccination

- 2-dose series at 11–12 years, 16 years

Catch-up vaccination

- Age 13–15 years: 1 dose now and booster at age 16–18 years (minimum interval: 8 weeks)
- Age 16–18 years: 1 dose

Special situations

Anatomic or functional asplenia (including sickle cell disease), HIV infection, persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Menveo**
  - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
  - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
  - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart
- **Menactra**
  - **Persistent complement component deficiency or complement inhibitor use:**
    - Age 9–23 months: 2-dose series at least 12 weeks apart
    - Age 24 months or older: 2-dose series at least 8 weeks apart
  - **Anatomic or functional asplenia, sickle cell disease, or HIV infection:**
    - Age 9–23 months: Not recommended
    - Age 24 months or older: 2-dose series at least 8 weeks apart
    - **Menactra** must be administered at least 4 weeks after completion of PCV13 series.
- **MenQuadfi**
  - Dose 1 at age 24 months or older: 2-dose series at least 8 weeks apart

Travel in countries with hyperendemic or epidemic meningococcal disease, including countries in the African meningitis belt or during the Hajj (http://www.cdc.gov/travel/):

- Children age less than 24 months:
  - **Menveo (age 2–23 months)**
    - Dose 1 at age 8 weeks: 4-dose series at 2, 4, 6, 12 months
    - Dose 1 at age 3–6 months: 3- or 4- dose series (dose 2 [and dose 3 if applicable] at least 8 weeks after previous dose until a dose is received at age 7 months or older, followed by an additional dose at least 12 weeks later and after age 12 months)
    - Dose 1 at age 7–23 months: 2-dose series (dose 2 at least 12 weeks after dose 1 and after age 12 months)
  - **Menactra (age 9–23 months)**
    - 2-dose series (dose 2 at least 12 weeks after dose 1; dose 2 may be administered as early as 8 weeks after dose 1 in travelers)
- Children age 2 years or older: 1 dose **Menveo**, **Menactra,** or **MenQuadfi**

First-year college students who live in residential housing (if not previously vaccinated at age 16 years or older) or military recruits:

- 1 dose **Menveo**, **Menactra,** or **MenQuadfi**

Adolescent vaccination of children who received MenACWY prior to age 10 years:

- **Children for whom boosters are recommended** because of an ongoing increased risk of meningococcal disease (e.g., those with complement deficiency, HIV, or asplenia): Follow the booster schedule for persons at increased risk**.**
- **Children for whom boosters are not recommended** (e.g., a healthy child who received a single dose for travel to a country where meningococcal disease is endemic): Administer MenACWY according to the recommended adolescent

schedule with dose 1 at age 11–12 years and dose 2 at age 16 years.

Note: Menactra should be administered either before or at the same time as DTaP. For MenACWY **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see https://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Meningococcal serogroup B vaccination (minimum age: 10 years [MenB-4C, Bexsero; MenB-FHbp, Trumenba])

Shared Clinical Decision-Making

- **Adolescents not at increased risk** age 16–23 years (preferred age 16–18 years) based on shared clinical decision-making:
  - **Bexsero:** 2-dose series at least 1 month apart
  - **Trumenba:** 2-dose series at least 6 months apart; if dose 2 is administered earlier than 6 months, administer a 3rd dose at least 4 months after dose 2.

Special situations

Anatomic or functional asplenia (including sickle cell disease), persistent complement component deficiency, complement inhibitor (e.g., eculizumab, ravulizumab) use:

- **Bexsero:** 2-dose series at least 1 month apart
- **Trumenba:** 3-dose series at 0, 1–2, 6 months

Bexsero and **Trumenba** are not interchangeable; the same product should be used for all doses in a series. For MenB **booster dose recommendations** for groups listed under "Special situations" and in an outbreak setting and additional meningococcal vaccination information, see https://www.cdc.gov/mmwr/volumes/69/rr/rr6909a1.htm.

Pneumococcal vaccination (minimum age: 6 weeks [PCV13], 2 years [PPSV23])

Routine vaccination with PCV13

- 4-dose series at 2, 4, 6, 12–15 months

Catch-up vaccination with PCV13

- 1 dose for healthy children age 24–59 months with any incomplete* PCV13 series
- For other catch-up guidance, see Table 2.

Special situations

Underlying conditions below: When both PCV13 and PPSV23 are indicated, administer PCV13 first. PCV13 and PPSV23 should not be administered during same visit. Chronic heart disease (particularly cyanotic congenital heart disease and cardiac failure); chronic lung disease (including asthma treated with high-dose, oral corticosteroids); diabetes mellitus:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after completing all recommended PCV13 doses)

Cerebrospinal fluid leak, cochlear implant:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 1 dose PPSV23 at least 8 weeks later
- Any PCV13 but no PPSV23: 1 dose PPSV23 at least 8 weeks after the most recent dose of PCV13
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent dose of PPSV23

Sickle cell disease and other hemoglobinopathies; anatomic or functional asplenia; congenital or acquired immunodeficiency; HIV infection; chronic renal failure; nephrotic syndrome; malignant neoplasms, leukemias, lymphomas, Hodgkin disease, and other diseases associated with treatment with immunosuppressive drugs or radiation therapy; solid organ transplantation; multiple myeloma:

Age 2–5 years

- Any incomplete* series with:
  - 3 PCV13 doses: 1 dose PCV13 (at least 8 weeks after any prior PCV13 dose)
  - Less than 3 PCV13 doses: 2 doses PCV13 (8 weeks after the most recent dose and administered 8 weeks apart)
- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose) and a 2nd dose of PPSV23 5 years later

Age 6–18 years

- No history of either PCV13 or PPSV23: 1 dose PCV13, 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- Any PCV13 but no PPSV23: 2 doses PPSV23 (dose 1 of PPSV23 administered 8 weeks after the most recent dose of PCV13 and dose 2 of PPSV23 administered at least 5 years after dose 1 of PPSV23)
- PPSV23 but no PCV13: 1 dose PCV13 at least 8 weeks after the most recent PPSV23 dose and a 2nd dose of PPSV23 administered 5 years after dose 1 of PPSV23 and at least 8 weeks after a dose of PCV13

Chronic liver disease, alcoholism:

Age 6–18 years

- No history of PPSV23: 1 dose PPSV23 (at least 8 weeks after any prior PCV13 dose)

**Incomplete series* = Not having received all doses in either the recommended series or an age-appropriate catch-up series. See Tables 8, 9, and 11 in the in the ACIP pneumococcal vaccine recommendations (https://www.cdc.gov/mmwr/pdf/rr/rr5911.pdf) for complete schedule details.

Poliovirus vaccination (minimum age: 6 weeks)

Routine vaccination

- 4-dose series at ages 2, 4, 6–18 months, 4–6 years; administer the final dose on or after age 4 years and at least 6 months after the previous dose.
- 4 or more doses of IPV can be administered before age 4 years when a combination vaccine containing IPV is used. However, a dose is still recommended on or after age 4 years and at least 6 months after the previous dose.

Catch-up vaccination

- In the first 6 months of life, use minimum ages and intervals only for travel to a polio-endemic region or during an outbreak.

- IPV is not routinely recommended for U.S. residents age 18 years or older.

Series containing oral polio vaccine (OPV), either mixed OPV-IPV or OPV-only series:

- Total number of doses needed to complete the series is the same as that recommended for the U.S. IPV schedule. See https://www.cdc.gov/mmwr/volumes/66/wr/mm6601a6.htm.
- Only trivalent OPV (tOPV) counts toward the U.S. vaccination requirements.
  - Doses of OPV administered before April 1, 2016, should be counted (unless specifically noted as administered during a campaign).
  - Doses of OPV administered on or after April 1, 2016, should not be counted.
    For guidance to assess doses documented as "OPV," see http://www.cdc.gov/mmwr/volumes/66/wr/mm6606a7.htm.
- For other catch-up guidance, see Table 2.

Rotavirus vaccination (minimum age: 6 weeks)

Routine vaccination

- **Rotarix:** 2-dose series at 2 and 4 months
- **RotaTeq:** 3-dose series at 2, 4, and 6 months
- If any dose in the series is either **RotaTeq** or unknown, default to 3-dose series.

Catch-up vaccination

- Do not start the series on or after age 15 weeks, 0 days.
- The maximum age for the final dose is 8 months, 0 days.
- For other catch-up guidance, see Table 2.

Tetanus, diphtheria, and pertussis (Tdap) vaccination (minimum age: 11 years for routine vaccination, 7 years for catch-up vaccination)

Routine vaccination

- **Adolescents age 11–12 years:** 1 dose Tdap
- **Pregnancy:** 1 dose Tdap during each pregnancy, preferably during the early part of gestational weeks 27–36
- Tdap may be administered regardless of the interval since the last tetanus- and diphtheria-toxoid-containing vaccine.

Catch-up vaccination

- **Adolescents age 13–18 years who have not received Tdap:** 1 dose Tdap, then Td or Tdap booster every 10 years
- **Persons age 7–18 years not fully vaccinated* with DTaP:** 1 dose Tdap as part of the catch-up series (preferably the first dose); if additional doses are needed, use Td or Tdap.
- **Tdap administered at age 7–10 years**
  - **Children age 7–9 years** who receive Tdap should receive the routine Tdap dose at age 11–12 years.
  - **Children age 10 years** who receive Tdap do not need the routine Tdap dose at age 11–12 years.
- **DTaP inadvertently administered on or after age 7 years:**
  - **Children age 7–9 years**: DTaP may count as part of catch-up series. Administer routine Tdap dose at age 11–12 years.
  - **Children age 10–18 years:** Count dose of DTaP as the adolescent Tdap booster.
- For other catch-up guidance, see Table 2.

Special situations

- **Wound management** in persons age 7 years or older with history of 3 or more doses of tetanus-toxoid-containing vaccine: For clean and minor wounds, administer Tdap or Td if more than 10 years since last dose of tetanus-toxoid-containing vaccine; for all other wounds, administer Tdap or Td if more than 5 years since last dose of tetanus-toxoid-containing vaccine. Tdap is preferred for persons age 11 years or older who have not previously received Tdap or whose Tdap history is unknown. If a tetanus-toxoid-containing vaccine is indicated for a pregnant adolescent, use Tdap. For detailed information, see https://www.cdc.gov/mmwr/volumes/69/wr/mm6903a5.htm.

*Fully vaccinated = 5 valid doses of DTaP OR 4 valid doses of DTaP if dose 4 was administered at age 4 years or older.

Varicella vaccination (minimum age: 12 months)

Routine vaccination

- 2-dose series at 12–15 months, 4–6 years
- Dose 2 may be administered as early as 3 months after dose 1 (a dose administered after a 4-week interval may be counted).

Catch-up vaccination

- Ensure persons age 7–18 years without evidence of immunity (see *MMWR* at http://www.cdc.gov/mmwr/pdf/rr/rr5604.pdf) have a 2-dose series:
  - **Age 7–12 years:** routine interval: 3 months (a dose administered after a 4-week interval may be counted)
  - **Age 13 years or older**: routine interval: 4–8 weeks (minimum interval: 4 weeks)
  - The maximum age for use of MMRV is 12 years.

Vaccines in the Child and Adolescent Immunization Schedule

Vaccines	Abbreviations	Trade Names
Diphtheria, tetanus, and acellular pertussis vaccine	DTaP	Daptacel® Infanrix®
Diphtheria, tetanus vaccine	DT	No Trade Name
***Haemophilus influenzae* type B vaccine**	Hib (PRP-T) Hib (PRP-OMP)	ActHIB® Hiberix® PedvaxHIB®
Hepatitis A vaccine	HepA	Havrix® Vaqta®
Hepatitis B vaccine	HepB	Engerix-B® Recombivax HB®
Human papillomavirus vaccine	HPV	Gardasil 9®
Influenza vaccine (inactivated)	IIV	Multiple
Influenza vaccine (live, attenuated)	LAIV4	FluMist® Quadrivalent
Measles, mumps, and rubella vaccine	MMR	M-M-R® II

Vaccines	Abbreviations	Trade Names
Meningococcal serogroups A, C, W, Y vaccine	MenACWY-D MenACWY-CRM MenACWY-TT	Menactra® Menveo® MenQuadfi®
Meningococcal serogroup B vaccine	MenB-4C MenB-FHbp	Bexsero® Trumenba®
Pneumococcal 13-valent conjugate vaccine	PCV13	Prevnar 13®
Pneumococcal 23-valent polysaccharide vaccine	PPSV23	Pneumovax® 23
Poliovirus vaccine (inactivated)	IPV	IPOL®
Rotavirus vaccine	RV1 RV5	Rotarix® RotaTeq®
Tetanus, diphtheria, and acellular pertussis vaccine	Tdap	Adacel® Boostrix®
Tetanus and diphtheria vaccine	Td	Tenivac® TDvax™
Varicella vaccine	VAR	Varivax®

Combination Vaccines

(Use combination vaccines instead of separate injections when appropriate)

Vaccines	Abbreviations	Trade Names
DTaP, hepatitis B, and inactivated poliovirus vaccine	DTaP-HepB-IPV	Pediarix®
DTaP, inactivated poliovirus, and *Haemophilus influenzae* type B vaccine	DTaP-IPV/Hib	Pentacel®
DTaP and inactivated poliovirus vaccine	DTaP-IPV	Kinrix® Quadracel®
DTaP, inactivated poliovirus, *Haemophilus influenzae* type b, and hepatitis B vaccine	DTaP-IPV-Hib-HepB	Vaxelis®
Measles, mumps, rubella, and varicella vaccines	MMRV	ProQuad®

This schedule is recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC), American Academy of Pediatrics (AAP), American Academy of Family Physicians (AAFP)), American College of Obstetricians and Gynecologists (ACOG), American College of Nurse-Midwives (ACNM), American Academy of Physician Assistants (AAPA), and National Association of Pediatric Nurse Practitioners (NAPNAP).

The comprehensive summary of the ACIP recommended changes made to the child and adolescent immunization schedule can be found in the February 12, 2021 *MMWR*.

Report

- Suspected cases of reportable vaccine-preventable diseases or outbreaks to your state or local health department

- Clinically significant adverse events to the Vaccine Adverse Event Reporting System (VAERS) at www.vaers.hhs.gov or (800-822-7967)

Helpful information

- Complete ACIP recommendations
- *General Best Practice Guidelines for Immunization*
- Outbreak information (including case identification and outbreak response), see Manual for the Surveillance of Vaccine-Preventable Diseases
- ACIP Shared Clinical Decision-Making Recommendations

Page last reviewed: February 12, 2021

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.11.7

Certificates of Accreditation

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.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

05/27/2020	05/27/2023
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

California Health & Wellness

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. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

05/09/2019	05/09/2022
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Health Net of California, 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 Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

05/09/2019	05/09/2022
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

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. Oh
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

02/08/2019
DATE GRANTED

02/08/2022
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

WellCare of Florida, 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 Chris, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Ot
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

02/04/2019	02/04/2022
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

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 Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

05/22/2020
DATE GRANTED

05/22/2023
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

WellCare Health Insurance of Arizona, Inc. dba Ohana 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.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

02/11/2021	02/11/2024
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Iowa Total Care

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 Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

03/17/2020
DATE GRANTED

09/17/2021
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Meridian Health Plan of Illinois, 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.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

02/11/2020	02/11/2023
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

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 Scott
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

10/14/2019
DATE GRANTED

10/14/2022
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

04/13/2020	04/13/2023
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

WellCare Health Insurance Company of Kentucky, 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 Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

09/18/2020	09/18/2023
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Meridian Health Plan of Michigan, 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

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

12/24/2019	12/24/2022
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 Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Kelly
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

08/03/2020	08/03/2023
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 Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oh
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

01/08/2020	01/08/2023
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. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

03/12/2019	03/12/2022
DATE GRANTED	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

WellCare Health Plans of New Jersey, 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.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

03/11/2020	03/11/2023
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Western Sky Community 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 Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret Schlak
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

03/26/2021
DATE GRANTED

03/26/2024
EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

SilverSummit 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

01/30/2020	01/30/2023
DATE GRANTED	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 Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

03/18/2019	03/18/2022
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Pennsylvania Health & Wellness

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

11/19/2019
DATE GRANTED

11/19/2022
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

ACCREDITED NCQA HEALTH PLAN COMMENDABLE

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. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

08/28/2019	08/28/2022
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

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

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

02/18/2021	02/18/2024
DATE GRANTED	EXPIRATION DATE

- EXEMPT FROM PAGE LIMITS -

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Coordinated Care of Washington, 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. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

05/06/2020
DATE GRANTED

05/06/2023
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

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

09/06/2019
DATE GRANTED

09/06/2022
EXPIRATION DATE

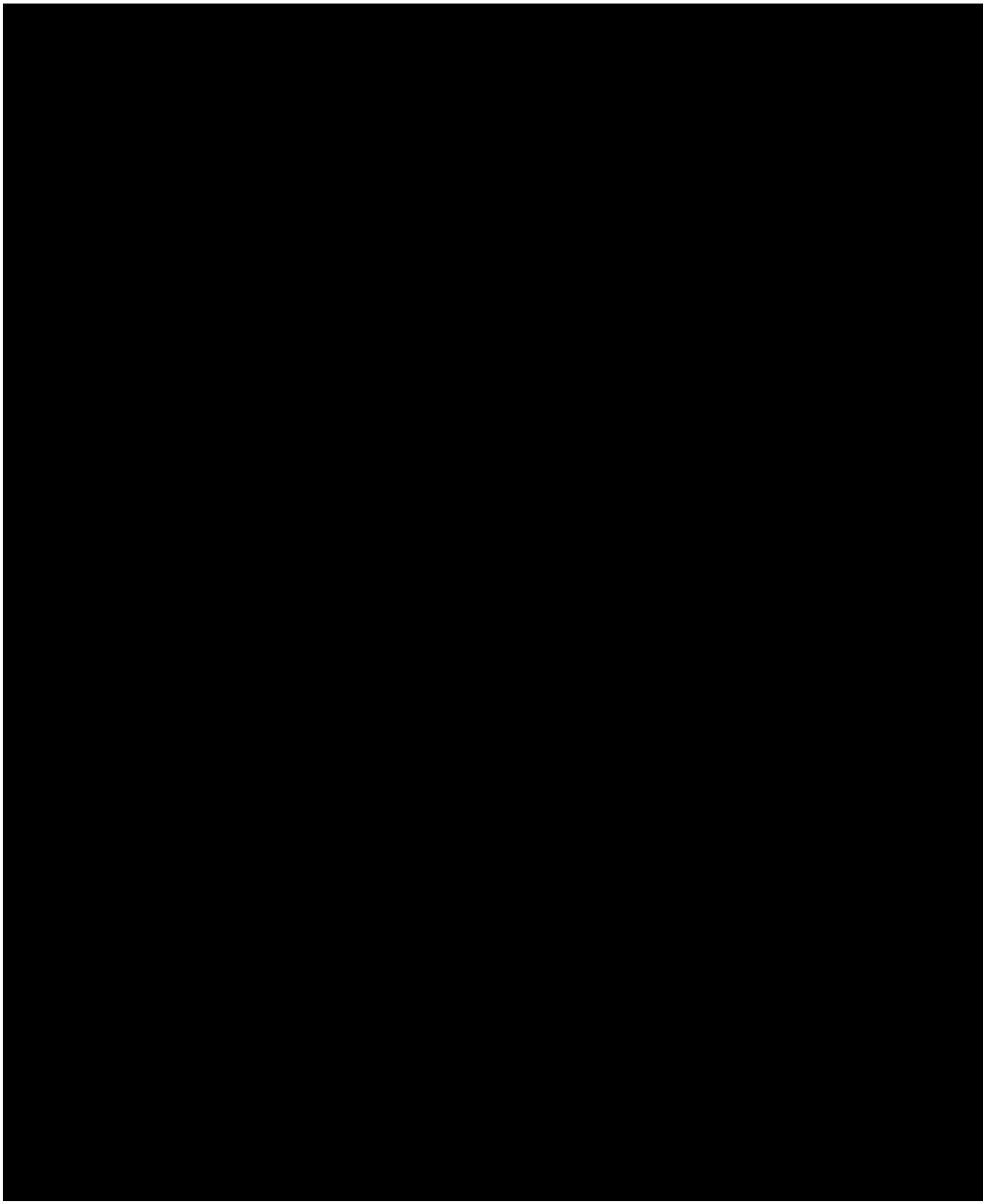
- EXEMPT FROM PAGE LIMITS -

louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.13.2

IT Systems Landscape



louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.13.2.3.a-g

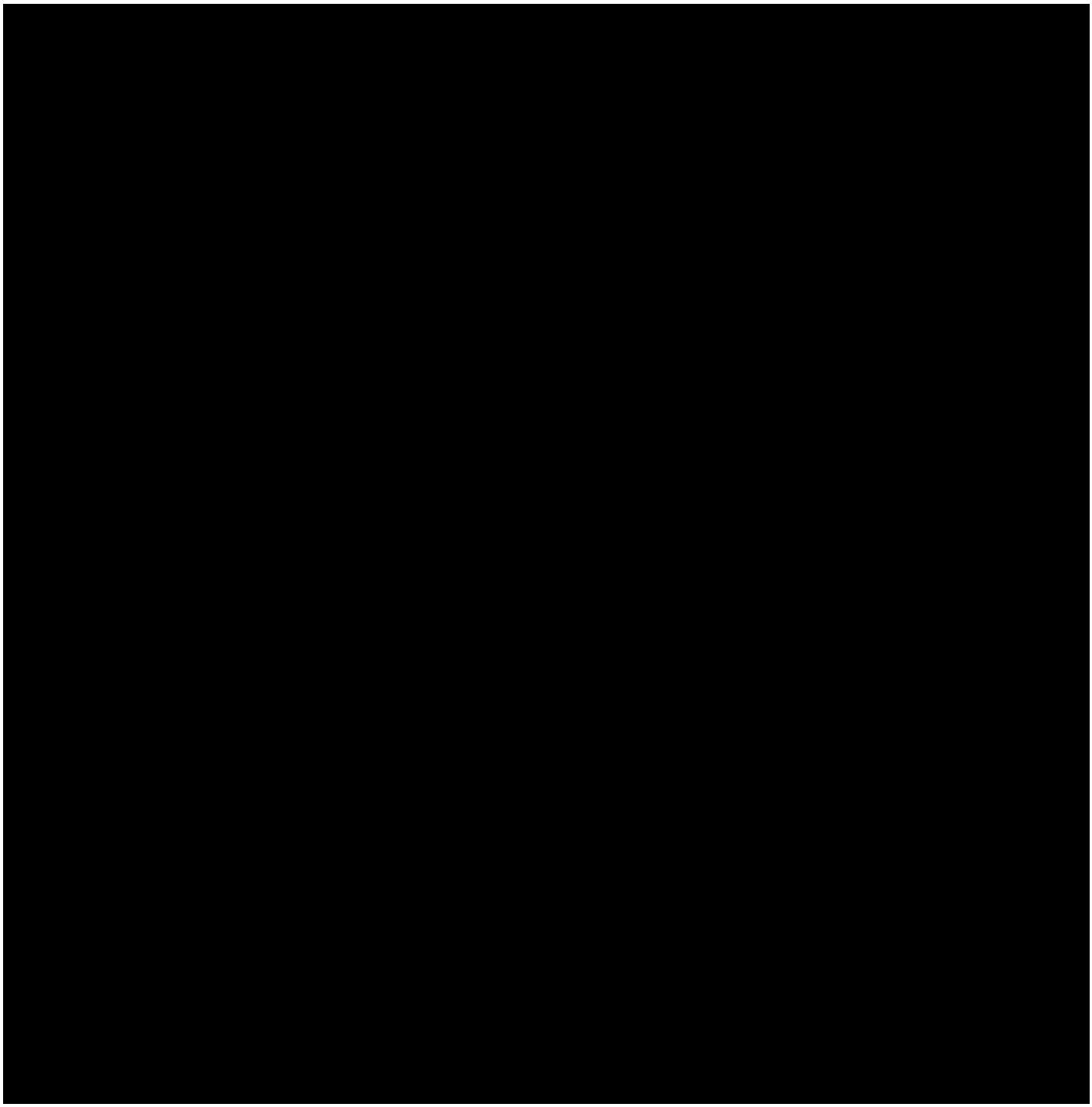
Data and Process Flows

CONFIDENTIAL



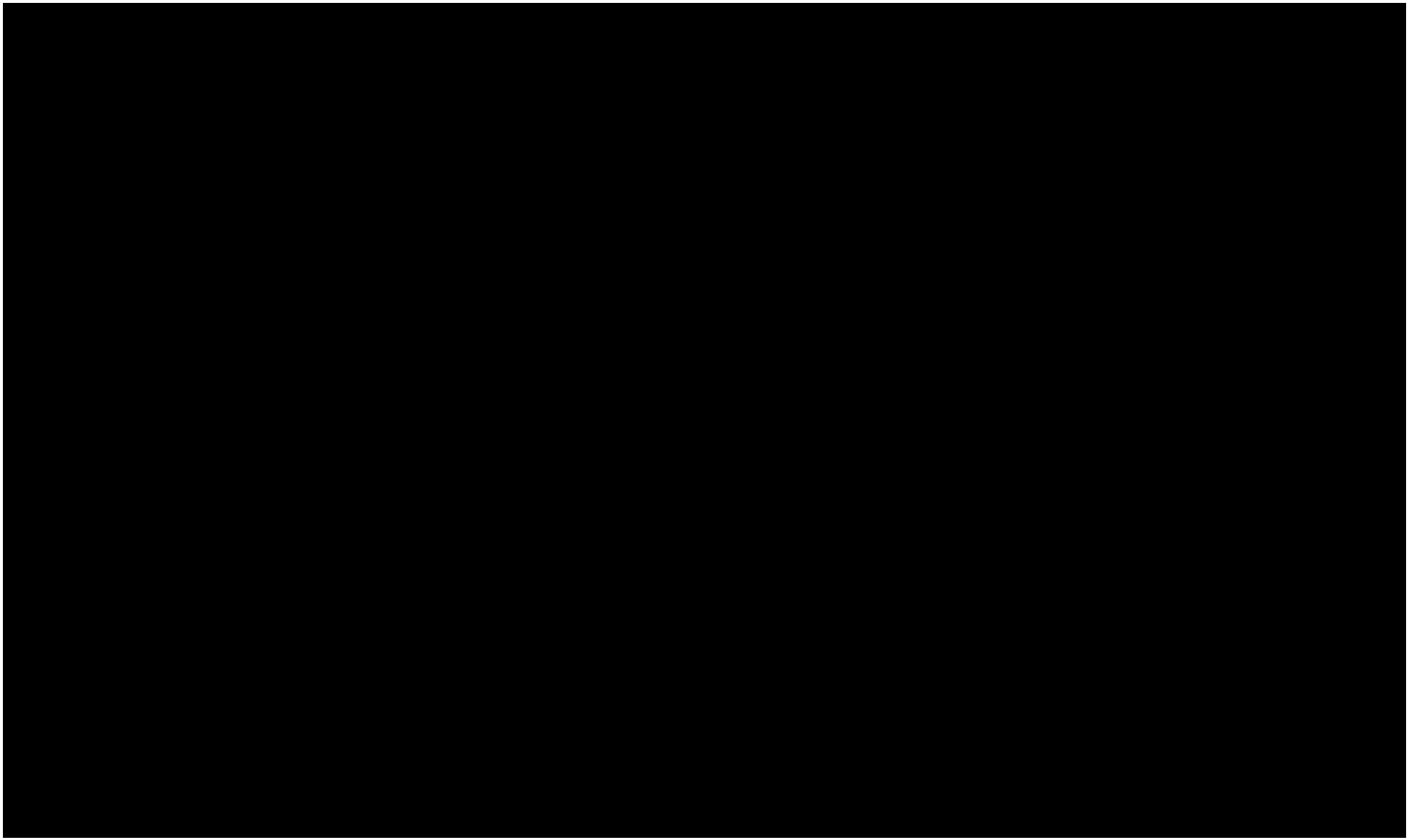














louisiana healthcare connections™

For the health of all.

ATTACHMENT 2.6.13.3

Contingency Plan

CONFIDENTIAL



SECTION 4.4

Veteran and Hudson Initiatives

"We've worked with Louisiana Healthcare Connections for almost ten years now, and they are an outstanding partner. They've invested their time and expertise to help our company meet higher healthcare privacy requirements, which lets us expand the types of projects we can take on. They didn't have to do that; they could have gone to some national company. I'm grateful Louisiana Healthcare Connections is such a true partner to local businesses."

- Kevin Bankston
President, Baton Rouge Printing Company

SECTION 4.4

Veteran and Hudson Initiatives

Per the RFP, the Proposer may submit this information as an attachment in electronic format in lieu of hard copy.

CONFIDENTIAL