

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section H: Utilization Management (UM) (Section § 8 of RFP)	80		
H-1	A, B, and C	H.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.	30		
H-8	A, B, and C	H.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.	10		
H-11	A, B, and C	H.3 Regarding your utilization management (UM) staff: <ul style="list-style-type: none"> • Provide a detailed description of the training you provide your UM staff; • Describe any differences between your UM phone line and your provider services line; • If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls, <ul style="list-style-type: none"> ○ explain how you will track CCN calls separately; and ○ how you will ensure that applicable DHH timeframes for prior authorization decisions are met. 	20		

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
H-17	A, B, and C	<p>H.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over- utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system. Individuals who will make medical necessity determinations must be identified if the criteria are based on the medical training, qualifications, and experience of the CCN medical director or other qualified and trained professionals</p>	20		

Question H.1

Preventing Arbitrary/Inappropriate
Denial or Reduction in Amount,
Duration or Scope of Services

Section H: Utilization Management (UM)

H.1 Describe how you will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope as specified in the Louisiana Medicaid State Plan.

Overview

Louisiana Healthcare Connections (LHC) will ensure that medically necessary Covered Services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope. This begins with adopting and/or developing evidence-based, clinical support criteria for use by authorization staff. To ensure relevance to enrolled population, proposed criteria are presented to the Quality Assessment Performance Improvement Committee (QAPIC) to obtain input from local practicing physicians and providers familiar with the specific needs of members in the Coordinated Care Program. Once the Committee approves the criteria or guidelines, they are distributed to authorization staff, including Medical Directors, who attend mandatory training before the criteria are used in medical necessity (MN) appropriateness reviews. Staff use the guidelines to review prior authorization (PA) requests for inpatient hospitalizations, to conduct concurrent review (CR) and to approve outpatient and ancillary referrals. LHC uses the following techniques to ensure that all staff understand how criteria should be applied and how to document MN appropriateness decisions into Trucare, our integrated clinical documentation system. These techniques facilitate consistent application of criteria, routine oversight and evaluate the effectiveness of oversight processes.

LHC will work to maximize health outcomes by ensuring our Members receive consistent, unduplicated care that is of the best quality and in line with evidence-based clinical practice guidelines. Our experience has shown us that the best approach to cost control and quality medical care is to strictly adhere to our philosophy of the **right care, at the right time and in the right place** in order to establish a lifetime of healthy behaviors and outcomes. LHC will maintain a UM Program Description that defines the structures and processes within the department, including assignment of responsibility to appropriate individuals, in order to promote fair, impartial and consistent utilization decisions. Our UM Program meets or exceeds compliance with 42 CFR 456, 42 CFR 431, 42 CFR 438 and will be reviewed at least annually or more frequently as needed by the UM and QAPIC Committees. LHC will submit our UM Program to DHH for approval within thirty days of the effective date of the program and annually thereafter.

The **Scope** of the UM Program will be comprehensive and apply to all eligible members across all product types, age categories and range of diagnoses. LHC's UM process will incorporate all care settings, including settings for preventive, primary, specialty, acute, emergency, home care and ancillary care. The **Goals** of LHC's UM processes will be to optimize member health status, well-being, productivity, and access to quality health care, while at the same time actively managing cost trends in the least intrusive manner. We will limit authorization requirements only to those services or procedures for which the quality or efficiency of care can be favorably influenced by our management. We will accept flexible alternative means of receiving requests for authorization to accommodate the needs of individual provider offices, and recognize the support providers will need in the transition from fee-for-service to managed care.

Oversight and Authority

LHC will facilitate the quality of the UM program and its management by ensuring accountability for the program, recruiting, training and retaining highly qualified managers and staff, setting high ethical and performance standards and regularly evaluating the effectiveness of the program. The LHC **Board of Directors** (Board) will have ultimate authority and accountability for the oversight of the quality of care and services provided to members. The Board, through the QAPIC, will oversee development,

implementation and evaluation of the Quality Assessment and Performance Improvement Program, which includes the UM Program. The Board will delegate the oversight and operating authority of UM activities to the **Utilization Management Committee (UMC)**.

The UMC will ensure the effectiveness of the program and ensure that UM activities are integrated into all LHC functional areas and departments. The UMC, which will meet no less than quarterly, will be chaired by the Medical Director. The UMC will be responsible for the review and approval of medical necessity criteria; utilization management policies and procedures; 24/7 nurse advice line protocols; and monitoring and analyzing relevant data, including providers' requests and the medical appropriateness and necessity of healthcare services provided to our members, to detect and correct patterns of potential or actual inappropriate under- or over-utilization of services, coordination of care, and member and provider satisfaction with the UM process. The UMC will actively involve participating network providers in utilization review activities to the extent no conflicts of interest exist. The UMC will be comprised of network physicians representing the range of network providers across the covered GSAs and the Vice President Medical Management (VPMM). UM, QI and Care Management staff will also participate as appropriate.

Nationally Recognized Criteria

LHC will use evidence-based clinical decision support criteria, developed using or based on, recognized national criteria reflecting accepted clinical practice, along with DHH program requirements, to determine the medical necessity and appropriateness of covered services requiring authorization. Criteria will be selected to enable authorization personnel (Prior Authorization, Concurrent Review Nurses, Case Managers) to determine whether services are appropriate for the member's condition, provided in an appropriate setting and meet professionally-recognized standards of care, while considering any special circumstances that may require deviation, such as disability, acute condition, co-morbidities, life-threatening illness, or risk of institutionalization. In the case of a possible denial of coverage, in accordance with NCQA and State requirements, a Medical Director will offer to discuss the case and the medical necessity guidelines with the requesting provider prior to issuing an adverse determination.

Utilization Review Criteria. Our Utilization Management (UM) criteria will ensure **timely** access to **appropriate** services that help members achieve the highest possible levels of health, wellness, functioning and quality of life. LHC will use evidence-based clinical decision support criteria to determine medical necessity of those covered services requiring prior authorization. LHC will use McKesson's **InterQual** adult and pediatric guidelines (Acute, Home Care, Procedures, Imaging, Durable Medical Equipment (DME), Subacute and SNF, Outpatient Rehabilitation and Chiropractic, and Rehabilitation) and internal guidelines to determine medical necessity for non-emergency inpatient and outpatient services. InterQual provides a consistent, evidence-based platform for care decisions that promotes appropriate use of services and improved health outcomes. InterQual Criteria, used by over 3000 organizations and agencies, are developed by physicians and other health professionals who review medical research and incorporate the expertise of a national panel of over 700 clinicians and medical experts, representing community and academic practice settings, as well as managed care, throughout the U.S. The clinical content is a synthesis of evidence-based standards of care, current practices, and consensus from licensed specialists and primary care physicians.¹ They provide algorithms for inpatient hospitalizations, discharge screens to guide determinations about member readiness for a lower level of care, decision support for determining the medical appropriateness of surgical procedures, subacute or skilled nursing care, and home health services for members with catastrophic conditions or special health care needs. Updates to InterQual criteria are released annually and will be distributed to LHC for review by the UMC. We will provide written criteria related to specific determinations to the member or provider

¹ McKesson, InterQual Level of Care Criteria proprietary notice, copyright 2008 McKesson Corporation.

upon request as our license to use InterQual criteria will not permit distribution of all criteria to all providers.

Clinical Practice Guidelines. While clinical practice guidelines (CPG) are not used as criteria for medical necessity determinations, the LHC Medical Director and UM staff will ensure that UM decisions are consistent with guidelines distributed to network providers. Our UMC, which includes contracted providers of various specialties, will review the guidelines annually and revise them as needed for consistency with local provider practice standards and compliance with DHH requirements. The UMC sends recommended guidelines each year to the QAPIC for final approval. Whenever possible, LHC will adopt preventive and clinical practice guidelines (CPG) for the provision of acute, chronic and basic behavioral health services relevant to the populations served from recognized sources such as American Academy of Pediatrics, American Diabetes Association, American College of Obstetrics and Gynecology. Such guidelines will include, but not be limited to, Preventive Health (adult and child), Asthma, Bi-polar Disorder, Cardiac Disease, Depression, Diabetes, Hemophilia, HIV, Prenatal Care, Sickle Cell and Synagis. Clinical practice guidelines are available on the LHC website. Providers, members and potential members will be given a written copy upon request. LHC will work with other CCNs to ensure consistency of CPGs across CCNs to avoid conflicting guidelines.

New Technologies. LHC's parent company, Centene Corporation's **Clinical Policy Committee (CPC)**, which includes Medical Directors from each Centene health plan, develops MN criteria in the form of Clinical Policies for a number of services that do not have InterQual guidelines or if local practice does not align with InterQual. The CPC reviews sources including, but not limited to, scientific literature, government agencies such as Centers for Medicare and Medicaid Services (Coverage Determinations and other policies), specialty societies, and input from relevant specialists with expertise in the technology or procedure. LHC will also use **Hayes Technology Assessments** to evaluate new technology. LHC's Chief Medical Director (CMD) will participate in the CPC, and submit guideline development requests to Centene's Chief Medical Officer. The CPC will develop or revise criteria based on a new technology or procedure, a new use for existing technology, or a negative trend in length of stay or utilization. The LHC CMD will work with the CPC and DHH to ensure guidelines address Louisiana requirements and the needs of our members. LHC will also conduct a comparative review of our UM guidelines and clinical practice guidelines to ensure consistency between the guidelines.

Utilization Management Personnel

LHC's utilization management goal is to facilitate the provision of medically-necessary covered services that are appropriate for the member's condition, provided in the appropriate setting, and meet professionally-recognized standards of care. To reduce administrative burden on providers, and to facilitate the timely delivery of services, LHC will annually review which services require prior authorization (PA), and ensure they are specific and relevant to the LHC population. The authorization personnel entrusted with the responsibility of conducting Utilization Management activities for LHC members are listed below along with the required credentials for each position and description of responsibilities:

- **Medical Director/Chief Medical Director (CMD)** will be physicians with a current, unencumbered license through the Louisiana State Board of Medical Examiners. Medical Directors must have no history of disciplinary action or sanctions; including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical peer reviewer's physical, mental, or professional or moral character. The Medical Director must have at least three (3) years of training in a medical specialty. The Medical Director will devote full time (minimum 32 hours weekly) to the LHC operations to ensure timely medical decisions, including after-hours consultation as needed. During periods when the Medical Director is not

available, LHC will have physician staff to provide competent medical direction. The Medical Director shall be actively involved in all major clinical and quality management components of LHC. The Medical Director shall be responsible for:

- Development, implementation and medical interpretation of medical policies and procedures including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review included in the Grievance System;
 - Administration of all medical management activities; and
 - Serve as director of the Utilization Management Committee and chairman or co-chairman of the QAPIC Committee.
- **Medical Management Coordinator/ Vice President Medical Management (VPMM)** will be a Louisiana-licensed registered nurse, physician or physician's assistant if required to make medical necessity determinations; or have a Master's degree in health services, health care administration, or business administration if not required to make medical necessity determinations, to manage all required Medicaid management requirements under DHH policies, rules and the contract. The primary functions of the VPMM are:
 - Ensuring adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria;
 - Ensuring that appropriate concurrent review and discharge planning of inpatient stays is conducted;
 - Developing, implementing and monitoring the provision of care coordination, disease management and case management functions
 - Monitoring, analyzing and implementing appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services; and
 - Monitoring prior authorization functions and assuring that decisions are made in a consistent manner
 - **Manager, Utilization Management** will be a Louisiana-licensed registered nurse, physicians or physician's assistants with a minimum of three years of clinical experience. Oversee operations of the referral management, telephonic utilization review, prior authorization and concurrent review functions. Ensure compliance with government and contractual guidelines and the mission, philosophy and objectives of the health plan and corporate.
 - **Prior Authorization Staff** will be Louisiana licensed registered nurses, physicians or physician's assistants with a minimum of three years of clinical experience who will be trained in application of Interqual, nationally recognized clinical support criteria to ensure that services provided are a covered benefit, medically necessary, appropriate to the member's condition, and rendered in the most appropriate setting. Prior Authorization staff will communicate closely with Integrated Care Teams to ensure coordination between UM and Care Management functions.
 - **Concurrent Review Staff** will be Louisiana licensed nurses, physicians, or physician's assistants with at least 3 years recent clinical nursing experience in an acute care setting particularly in medical/surgical who will conduct inpatient and telephonic concurrent review. This staff will be trained in application of Interqual to ensure that services provided are a covered benefit, medically necessary, appropriate to the enrollee's condition, and rendered in the most appropriate setting. In addition, Concurrent Review staff will seek to facilitate the use of alternative settings when the above circumstances are not met, or when a quality of care question arises. The Concurrent Review staff will be able to access an extensive network of alternate care facilities and services. The Concurrent Review staff's comprehensive knowledge of these services enhances their ability to provide services at a most clinically appropriate level. These Concurrent Review staff will be onsite in the hospitals as well as telephonically for timely concurrent review and discharge planning.

- **Clerical Support Staff/ Referral Specialist** will have three or more years experience working in a medical related setting and will support the operations of the UM department.

In accordance with 42 CFR §438.6(h), 42 CFR §422.208, and 43 CFR §422.210, UM staff receive no incentives to deny, limit, or discontinue medically necessary covered services to any member. UM employee compensation includes hourly fees and salaried positions. Compensation or incentives to staff or agents based on the amount or volume of adverse determinations; reductions or limitations on lengths of stay, benefits, services; or frequency of telephone calls or other contacts with health care practitioners or patients is *prohibited*. LHC and its delegated Utilization Review agents will not permit or provide compensation or anything of value to its employees, agents, or contractors based on: the percentage of the amount by which a claim is reduced for payment, or the number of claims or the cost of services for which the person has denied authorization or payment; or any other method that encourages the rendering of an adverse determination. All UM staff will be required to sign an Affirmative Statement regarding confidentiality and compensation annually. This statement represents staff understanding that LHC does not:

- employ incentives to encourage barriers to care and services; UM decisions are based only on appropriateness of care and service and existence of coverage;
- specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care;
- provide incentives for UM decision makers that result in under-utilization.

Training and Monitoring

LHC conducts interrater reliability audits on all clinical staff who make authorization decisions at least semi-annually to ensure fair, impartial and consistent decisionmaking. LHC has developed tools to ensure consistent interpretation of criteria and guidelines among Medical Directors and authorization staff. These tools measure and evaluate each reviewer's comprehension, competency and consistency.

Non-physician Reviewers. The LHC Medical Management (MM) Trainer reviews 5% or at least 30 cases per reviewer semi-annually. An initial review occurs during the three-month probationary period for each new employee. Results are discussed with each reviewer and included in the annual employee performance review. **1) Observation or Telephonic Monitoring.** The UM Manager evaluates phone authorization interactions for accuracy, completeness and appropriateness of requested information and compliance with UM protocols and customer service. **2) Clinical Decision Making Audit Process.** A random selection of reviewer activity is collected via TruCare. Hard copy information reviewed is blinded. The LHC MM Trainer uses the McKesson InterQual Inter-rater Reliability (IRR) Tool for Acute Level of Care – Adult and Pediatric, as one method for scoring audits for inpatient authorizations. LHC will also use internally-developed audit tools for review of outpatient, specialty referral, durable medical equipment, care management, skilled nursing, subacute, inpatient rehabilitation and home health authorizations. The results of the audit are evaluated according to the following benchmarks: For All Reviewers: *90-100%* - continue semi-annual audits. No action required. *80-89%* - audit five cases monthly until accuracy reaches 90%. Notify employee in writing. Corrective action will include remedial training. Employees must improve to 90% by the next quarter. **3) Fictional or Actual Care Studies.** The UM Manager and LHC Trainer prepare at least five cases for review based on previous authorization requests or fictional case studies which simulate actual situations. The review includes approved and denied cases, and may be in narrative form or a combination of narrative and blinded attachments. Cases are distributed to each non-physician reviewer for review. Each reviewer documents their review and decisions on a Case Review Form. Reviewers must describe the review process, applying appropriate guidelines and protocols. The UM Manager meets with all participants for a group discussion and review of decision-making processes and results. This allows staff to discuss different approaches and helps ensure consistency in future clinical criteria application. In addition to group discussion and re-training,

any staff receiving less than a minimum score on their secondary review will receive additional training and monitoring until performance reaches a threshold level. Summary results for all IRR audits are reported to the UMC and QAPIC. The VPMM retains all completed reviews and a group session summary.

Medical Director Case Review. At least annually the VPMM will randomly select at least three cases per Medical Director from TruCare, including approved and denied cases. The LHC Trainer compiles copies and blinds all information used to make the authorization decision and forwards the information to Centene's Corporate Chief Medical Officer (CMO). The Corporate CMO or designee forwards a cover letter requesting review, Inter-Rater Review Forms for each case and the case information to two health plan Medical Directors not involved in the initial decision. The reviewing Medical Director reviews the case, completes the Inter-Rater Review Form, and returns the information to the Corporate CMO within 30 days of receipt. When the Medical Director(s) disagree with the initial decision, results will be considered an error. The Corporate CMO individually reviews the cases with the original Medical Director and forwards the results to the LHC Trainer to log. If opportunities for improvement are identified, the Corporate CMO will develop a corrective action plan which may include additional Medical Director training.

Inter-Rater Program Evaluation. At least annually, the VPMM will assess if Inter-Rater Programs are objectively evaluating consistency and accuracy of application of criteria and protocols. The VPMM will retain all records associated with the review process according to LHC record retention policy. The VPMM will generate and analyze a wide range of reports specifically designed to evaluate the appropriateness of criteria used in making certain MN determinations. These reports will track and trend the pre and post impact of PA/MN processes. Reports include appeals and grievance reports, trended utilization reports and provider satisfaction with UM processes. Additionally, the VPMM will develop a report summarizing program impact on performance evaluations, retraining, orientation training and the IRR review process. The report will be shared with the UMC and QAPIC for review and feedback at least annually.

Prior Authorization Process

To **reduce Provider administrative burden** and ensure timely delivery of care, our annually revised prior authorization (PA) list only includes services for which review can favorably influence quality of care. This includes non-emergency inpatient admissions (except for normal newborn deliveries), all out-of-network services, and certain outpatient and ancillary services. Prior authorization will not be required for emergency services, urgent care services, or stabilization of emergency care.

LHC will accept requests for authorization for new or continuing services by phone, fax or through the Provider Portal. UM decisions will be made in a timely manner to accommodate the clinical urgency of the situation and minimize disruptions in the provision of health care. The timeframe for standard service authorization determinations is two (2) business days of obtaining appropriate clinical information but no later than 14 days following receipt of the request. Expedited service authorization determinations will be made as expeditiously as the member's health condition requires, but no later than seventy-two (72) hours after receipt of the request.

PA nurses will conduct a Level I medical necessity review using the appropriate guidelines and available information about the member's condition and circumstances. If the request meets criteria, the provider is notified of the approval and issued an authorization number. If the request does not meet criteria, the PA nurse may request additional information or refer the case to the MD who may authorize, deny, or pend requests awaiting additional information needed to apply criteria. The MD reviews the case using UM criteria as a resource, while also considering any circumstances that may require deviation, such as age, psychosocial issues, disability, co-morbidities, complications, progress of treatment, acute or life-threatening illness, or clinical practice guideline requirements. The MD will respond to a request by the

provider to discuss the request, and may consult with a board certified Clinical Consultant from an appropriate specialty prior to issuing a final determination. Members and providers are notified in writing of decisions to reduce or deny services. Appeal rights are communicated in the Member Handbook, Provider Manual and within the notice of adverse determination.

Question H.2

Development of UM Guidelines

H.2 If the UM guidelines were developed internally, describe the process by which they were developed and when they were developed or last revised.

Overview

Louisiana Healthcare Connections’ (LHC) will use McKesson’s InterQual adult and pediatric guidelines (Acute, Home Care, Procedures, Imaging, Durable Medical Equipment (DME), Subacute and SNF, Outpatient Rehabilitation and Chiropractic, and Rehabilitation) and internal guidelines to determine medical necessity for non-emergency inpatient and outpatient services. While clinical practice guidelines (CPG) are not used as criteria for medical necessity determinations, LHC Medical Director and UM staff will ensure that UM decisions are consistent with guidelines distributed to network providers. LHC will coordinate the development and adoption of CPGs with other DHH CCNs to avoid providers receiving conflicting practice guidelines from each CCN. LHC’s Utilization Management Committee (UMC) and Quality Assessment and Performance Improvement Committee (QAPIC), which include contracted providers of various specialties, will review criteria and adopted clinical practice guidelines at least annually or upon significant change.

Internally Developed Criteria

In most cases LHC will use InterQual criteria while also considering any circumstances that may require deviation, such as age, psychosocial issues, disability, co-morbidities, complications, progress of treatment, and acute or life-threatening illness when making medical necessity determinations. For services where InterQual does not have criteria, such as biopharmaceuticals, or where local practice patterns do not align with InterQual, such as therapy services, LHC will develop criteria internally. Centene Corporation’s (our parent company) Clinical Policy Committee (CPC), which includes Medical Directors from each Centene health plan, develops criteria in the form of Clinical Policies for services for which there are no appropriate guidelines. The CPC reviews sources including, but not limited to, scientific literature, government agencies such as Centers for Medicare and Medicaid Services, specialty societies, and input from relevant specialists with expertise in the technology or procedure. LHC’s Chief Medical Director (CMD) participates in the CPC, and as needed, will submit guideline development requests to Centene’s Chief Medical Officer. The CPC develops guidelines based on such requests and on new technologies and procedures identified during its quarterly review. LHC’s Medical Director works with the CPC and DHH to ensure guidelines address Louisiana requirements and the needs of our members, and LHC ensures consistency between internally developed guidelines and our clinical practice guidelines (CPGs).

Examples of clinical policy defined by Centene’s CPC include, but are not limited to:

Topic	Sample of References	Creation	Last Update
Use of unfractionated heparin (UH) and low molecular weight heparins (LMWH) in pregnancy.	American College of Obstetricians and Gynecologists (ACOG). ACOG Practice Bulletin- Inherited Thrombophilias in Pregnancy. No.113. Washington, DC: ACOG; July 2010. Branch DW. The truth about inherited thrombophilias and pregnancy. Obstet Gynecol 2010;115:2-3.	April 2011	April 2011

Topic	Sample of References	Creation	Last Update
	<p>Duhl AJ, Paidas MJ, Ural SH, et al. Antithrombotic therapy and pregnancy: consensus report and recommendations for prevention and treatment of venous thromboembolism and adverse pregnancy outcome. <i>Am J Obstet Gynecol</i> 2007;197:457.e1-457.e.21.</p>		
<p>Treatment of macular degeneration with ophthalmic injection.</p>	<p>American Academy of Ophthalmology (AAO). Age-related macular degeneration. Preferred practice pattern. Accessed February, 2010 Facts & Comparisons®, The Formulary Monograph Service™</p>	<p>March 2010</p>	<p>April 2011</p>
<p>Osteochondral grafts for articular cartilage repair (autografts, allografts, and synthetic grafts).</p>	<p>American Academy of Orthopaedic Surgeons. 2009 Annual Meeting Podium Presentations. Surgical efficacy of mosaicplasty for capitellar osteoarthrosis.</p> <p>HAYES. Mosaicplasty.</p> <p>National Institute for Health and Clinical Excellence. Mosaicplasty for knee cartilage defects. March 2006.</p>	<p>Oct 2008</p>	<p>Sept 2010</p>
<p>Multiple sleep latency testing (MSLT) in children.</p>	<p>American Academy of Pediatrics Section on Pediatric Pulmonology, Subcommittee on Obstructive Sleep Apnea Syndrome. Clinical Practice Guideline: Diagnosis and Management of Childhood Obstructive Sleep Apnea Syndrome. <i>Pediatrics</i> Vol. 109 No. 4 April 2002.</p> <p>Freedman N. Quantifying sleepiness. Mahowald MW, Sanders MH (Ed). In: <i>UpToDate</i>, Waltham, MA, 2010.</p> <p>Paruthi S. Evaluation of suspected obstructive sleep apnea in children. In: <i>UpToDate</i>, Chervin</p>	<p>Oct 2008</p>	<p>March 2011</p>

Topic	Sample of References	Creation	Last Update
	RD (Ed), UpToDate, Waltham, MA, 2010.		

Clinical Practice Guideline Development

Clinical practice guidelines will be the basis for LHC’s prevention, education and intervention activities including utilization management, disease management and case management programs. LHC’s programs will be based on guidelines disseminated by the leading academic and national clinical organizations such as the American Academy of Pediatrics (AAP), American Diabetes Association (ADA), National Heart, Lung and Blood Institute (NHLBI), National Institute of Health (NIH) or as otherwise defined by the Department of Health and Hospitals (DHH). LHC will coordinate the adoption and development of clinical practice guidelines with other DHH CCN’s to avoid providers receiving conflicting practice guidelines from difference CCN’s. Our Utilization Management Committee (UMC), which includes providers, reviews all UM guidelines annually and revises them as needed for consistency with provider practice standards and compliance with DHH requirements. The UMC sends recommended guidelines to the Quality Assessment Performance Improvement Committee (QAPIC) for final approval. Centene has not created any internally developed clinical practices guidelines to date.

Question H.3

Training of UM Staff / Call Center

H.3 Regarding your utilization management (UM) staff:

- Provide a detailed description of the training you provide your UM staff;
- Describe any differences between your UM phone line and your provider services line
- If your UM phone line will handle both Louisiana CCN and non-Louisiana CCN calls,
 - explain how you will track CCN calls separately; and
 - how you will ensure that applicable DHH timeframes for prior authorization decisions are met.

Overview

Louisiana Healthcare Connections (LHC) is supported by its parent company, Centene Corporation, and 11 affiliate health plans which have over 27 years experience in maintaining effective medical management programs across the United States for Medicaid, CHIP and Medicare populations, including those eligible for Medicaid due to qualifying for TANF, being in Foster Care, or meeting Aged, Blind and Disabled/SSI criteria; those with serious and persistent mental illness and other behavioral health conditions; those with needs for long term care services; and those dually eligible for Medicaid and Medicare. Centene health plans have managed utilization of primary, preventive, acute, behavioral health, long term care, pharmacy, dental and other Medicaid services, including Medicaid wrap-around services for dual eligibles, as well as Medicare services provided through our Medicare Special Needs Plans.

LHC will facilitate the quality of the UM program and its management by recruiting and training highly qualified managers and staff from Louisiana; setting high ethical and performance standards for UM staff; and monitoring UM staff performance regularly and providing feedback on identified trends and individual issues. LHC staff will be required to successfully complete a robust training curriculum to ensure their ability to serve members effectively. As a Centene subsidiary, LHC has well established, well defined, and targeted training plans and curricula for our UM staff. We will implement and evaluate training for all staff, using curricula and processes refined by existing Centene health plans that serve similar populations in other states. We will adapt the curricula and processes to reflect the unique characteristics of the LHC population and local area.

LHC will ensure that all LHC UM staff and subcontractors will be fully trained and prepared by the CCN-P operational start dates to provide UM services to LHC members and providers in order to ensure optimal care and achieve improved health outcomes. LHC will delegate utilization management functions to National Imaging Associates (NIA) for medical necessity review of high dollar radiology including, but not limited to, MRI, CT and PET scans. All other utilization management functions will be performed locally at the LHC office in Baton Rouge. Before any delegation occurs, LHC will evaluate the delegate's ability to perform the activities to be delegated. Outcomes of this review will be presented to the QAPIC for review. Additionally, LHC QM staff will conduct a formal review at least annually to evaluate compliance with the agreement and to established policies and standards including applicable NCQA, State and federal regulations.

LHC will assure consistent interpretation and application of UM criteria through a comprehensive staff training program. Our local full-time Medical Management (MM) Trainer, who reports directly to the Vice President of Medical Management (VPMM), will be responsible for maintaining and implementing a robust and comprehensive training program. This program will encompass UM staff new employee training, monthly staff in-service of Medicaid, DHH, and LHC policy updates, comprehensive training reviews, clinical education lunch-and-learn sessions, and seminar opportunities. We will reinforce this training with monthly case audits and face-to-face education from supervisor to staff member.

UM Training Programs

Our local VPMM and MM Trainer, along with Centene's Human Resources and Director of Medical Management Education, will be responsible for adapting and approval of the curriculum and materials.

Training will be conducted by our MM Trainer and Centene's Medical Management Systems and Staff Development trainers. Documentation of training dates and staff attendance as well as copies of materials used will be maintained by our VPMM. Initial orientation and training of all LHC staff will be completed prior to implementation. Based on our work plan, LHC departmental leadership will develop comprehensive training and materials for each operational area of LHC, including job-specific training on job requirements and roles in readiness preparation for LHC operational start dates. The Compliance staff will provide oversight and support to trainers and are responsible for ensuring that the departmental training is delivered on schedule.

Understanding the Culture. As part of the Centene family, LHC will use employee training as an opportunity to emphasize a corporate culture strongly committed to understanding and prioritizing each member's unique and varied needs, goals, preferences and culture, including members who are elderly and those with disabilities. LHC believes that an understanding of how different cultural beliefs and norms may impact a person's health and decisions about treatment, will aid our utilization management staff, particularly those performing discharge planning, will improve our ability to communicate with members with disabilities and their caregivers and create discharge action plans that are in line with member wants and needs. Locating LHC headquarters in Louisiana and hiring staff from the communities where they live enables staff to better relate to, and embrace the cultural differences within, the State of Louisiana that set them apart from other States including the differences between each GSA, Region and Parish. For example, our employees will know that in most rural parishes transportation is a significant issue. We will ensure our members have access to transportation in our discharge action plan and if not we will arrange for transportation. We also may need to arrange for interpreter services in certain parishes such as East Baton Rouge and Jefferson where they have seen an increase in Hispanic populations and Orleans Parish with the Vietnamese population. A central component of staff training for all employees is Centene's own Disability Sensitivity Training, which includes such topics as People-First language, issues in health care utilization, types of disabilities, types of needs, using the TDD line, SSI eligibility determination, the Americans with Disabilities Act, communicating with people with disabilities, and common misconceptions about people with disabilities.

Training also covers cultural competency, which includes but is not limited to:

- Centene values and philosophy (diversity, cultural competence, how values and philosophy drive operations, how the cultural competence of operations influences health care utilization and outcomes, how the organization is structured to promote these values/philosophy, how staff are supported and held accountable for cultural competence)
- Community cultural characteristics and access patterns
- Ethnicity and culture (what they are and how they influence utilization of health care)
- Primary and secondary languages (languages our members speak, languages staff speak, accessing interpreters, using the Language Line, the unique skills needed to interpret in a health care environment)
- Alternative family forms
- Dealing with victims of mental/physical trauma
- Professional and respectful phone etiquette
- Working with providers to assist members such as languages offered, how to help members and providers communicate effectively

Job-Specific Training. UM positions within LHC require specialized skills and expertise such as clinical review, negotiation skills for network development, clinical coding for billing or auditing support, and clinical analysis for case management. Each LHC department provides supplemental training that is specific to the requirements of a particular type of job. This includes position-specific coursework, which is delivered using a combination of computer-based training (CBT) and traditional classroom learning,

with testing to ensure understanding. Below are further specifics on our functional area trainings for UM staff. Upon hire, all UM staff will receive training from LHC's dedicated MM Trainer in these areas:

- What managed care is and how it works; history of managed care; managed care products and government health programs—how they differ from commercial health care plans and how reimbursement works;
- Organization structure, ethics, compliance, professionalism;
- Customer service and telephone etiquette; call routing/warm transfers to other areas such as to a case manager and member services staff;
- Briefing on other LHC departments and functions;
- Covered services, prior authorization requirements, reimbursement models; techniques to detect other insurance;
- HIPAA and confidentiality of medical records;
- Detection and reporting of fraud, abuse, and waste;
- Systems training, including for use of TruCare, clinical management software and Avaya Call Management System;
- InterQual Guidelines including severity of illness, intensity of service, and discharge criteria;
- Prior Authorization timelines, when to send to the MD, adverse determinations and medical necessity appeals;
- Concurrent review and discharge planning;
- Case and disease management, including referral triggers and regional issues;
- Quality Improvement, including quality of care concerns and current initiatives;
- Complaints and grievances; and
- Performance standards, productivity goals, inter-rater reliability testing and quality monitoring.

InterQual. To prepare for performing medical necessity reviews, UM staff are instructed on the correct application of InterQual (IQ) criteria to determine medical necessity (see our response to question H.1). During initial training, staff acquire a working knowledge of the criteria and system documentation. After training, staff obtain hands on experience shadowing a preceptor in actual application of the IQ criteria while performing UM medical necessity reviews. Once training and precepting is completed UM users are tested to ensure the application of the criteria is sound. Lastly, each year staff are tested using the InterQual Inter-rater Reliability Tool. LHC will have IQ trained nurses and physicians conducting medical necessity reviews. Both IQ criteria and LHC's current clinical policies are accessible through TruCare, our clinical management system.

Ongoing UM Staff Training. In addition to training on initial hire, LHC will conduct ongoing training on a quarterly basis, at a minimum and as changes to UM guidelines and policies occur. Upon hire and going forward, UM clinical review staff will receive weekly updates summarized from LHC providers updates regarding service coverage, process changes and medical necessity review guidance. Annual updates to LHC Clinical Policies are reviewed with staff during UM staff meetings and during one-on-one sessions as well as being posted on our Intranet. Clinical review staff also receive information during monthly staff in-services on DHH and LHC policy updates through clinical education lunch-and-learn sessions and seminar opportunities. We reinforce all training with monthly case audits and face-to-face education from supervisor to staff member.

Monitoring and Ongoing Evaluation. Using a combination of the following three processes, the UM Manager will review five percent, or at least 30 cases, per non-physician reviewer annually. An initial review will occur during the three-month probationary period for each new employee. Results will be discussed with each reviewer and included in the annual employee performance review. We will evaluate performance using the following mechanisms:

Observation or telephonic monitoring. The UM Manager will evaluate telephonic authorization interactions for accuracy, completeness, and appropriateness of information requested. Compliance with Medical Management department protocols, guidelines, criteria, and customer service will also be evaluated.

Clinical decision-making audit process. A random selection of reviewer activity will be collected via TruCare. Hard copy information reviewed will be blinded. The Medical Management Trainer will use the InterQual IRR tool for Acute Level of Care—Adult and Pediatric, as one method for scoring audits for inpatient authorizations. This tool is a standardized IRR version, which includes recommended actions (answers). Every six months, InterQual will send new scenarios for IRR testing. LHC will also use internally developed audit tools for review of outpatient, specialty referral, DME, case management, skilled nursing, subacute, inpatient rehabilitation, and home health authorizations. We will also score and evaluate results of the audit against the following benchmarks, and take the actions described below depending on results:

- 90–100%—We will continue semi-annual audits. No action required
- 80–89%—We will notify employee in writing and audit five cases monthly until accuracy reaches 90%. Corrective action will include remedial training. Employee must improve to 90% by the next quarter
- <80%—We will notify the employee in writing and audit cases daily until accuracy reaches 90%. Any reviewer who scores less than 80% will repeat orientation and receive intensified monitoring of all reviewer activities

For 2010, our Texas affiliate health plan's overall medical management department test results were 95% and our Indiana affiliate health plan was 94% for 2010.

Simulated or actual care review. The Medical Director and Medical Management Trainer will prepare at least five cases for review based on previous authorization requests or fictional case studies which simulate actual situations. The review will include approved and denied cases, and may be in narrative form or a combination of narrative and blinded attachments. Cases will be distributed to each non-physician reviewer for review. Each reviewer will document review and decisions on a Case Review Form. Reviewers must describe the review process, applying appropriate criteria and protocols.

The Medical Director will meet with all participants for group discussions and review of decision-making processes and results. This will allow staff to discuss various approaches and help ensure consistency in future clinical criteria application. In addition to group discussion and re-training, any staff receiving less than a minimum score (80%) on their secondary review will receive additional training and monitoring until performance reaches the 90% threshold level. Summary results for all IRR audits will be reported to the UMC and QAPIC. The Medical Director will retain all completed reviews and a group session summary.

Call Center Processes

LHC has adopted an **integrated health plan** approach by providing one toll-free number that our members and providers can call to ask questions about benefits, get help to obtain needed services, file a grievance or complaint and request prior authorization of service. Our Member and Provider Service Representatives (MSR and PSR) are hired locally from Louisiana. Our Member and Provider Service Lines are available from 7am to 7pm central time, Monday-Friday (excluding State declared holidays), with after-hours support provided by NurseWise, our URAC-accredited 24/7 nurse advice line and affiliate. NurseWise staff are located in the United States and share the same communications technology, software systems, and parallel staff training and call response protocols as LHC.

Process for Routing Calls. Our Avaya Call Management System delivers call routing, advanced vectoring, messaging, and information tracking that enable seamless, efficient call answering and transfer capabilities and reporting. We use a single telephone platform shared across LHC and its affiliates

allowing members and providers to call only one phone number and place only one call. LHC will have an Interactive Voice Recognition (IVR) system for optimal customer service. Our IVR allows both self-service options and live person assistance. When providers call our main toll-free number, they will have the option to select ‘check eligibility’, ‘medical management’ or ‘claims’. Under the medical management option they will then be able to select ‘authorizations’, ‘inpatient admissions’ or ‘case management’. The authorizations option will direct them to our prior authorization department while the inpatient admissions option will direct them to our concurrent review nurses. Our prior authorization team will work from a queue system that routes calls to the next available agent. Agents will be available Monday through Friday, excluding State declared holidays, from 8:00 am to 5:00 pm with afterhours support provided by NurseWise, our 24/7 nurse triage line.

PSR staff attempt to service *Every Call Every Time* and accomplish this through the expertise and tenure of staff from the senior management team to front line PSRs. LHC will provide staff development and training and foster an environment that encourages staff to gain a solid understanding of their coworker’s roles and responsibilities, and how they relate to one another. This enables staff to effectively participate in cross functional dialogue, process improvement initiatives, and ultimately improved service delivery. If a provider accidentally chooses the claims option instead of the medical management option when calling our primary number, PSRs have immediate access to utilization management and case management staff and will warm transfer the provider to the appropriate staff person.

After Hours Procedures. After normal business hours, LHC’s IVR call routing system will prompt the caller to choose their preferred language of English or Spanish, then offers three options: 1) leave a voice mail message, 2) speak with a representative at NurseWise, our 24/7 nurse advice line or 3) use self-service functions such as checking eligibility and claim status. If the provider chooses the option to speak to a nurse, the automated call attendant connects them to a NurseWise Customer Service Representative (CSR) who can assist the provider with eligibility and benefit questions or authorization requirements. NurseWise does not make authorization decisions but will accept notifications and requests for authorization and communicate them through TruCare for follow up by our UM staff the next business day. LHC will not require authorization for emergent, urgent or post-stabilization care services. Providers must notify LHC within two (2) business days following an inpatient admission so that we may begin discharge planning and conduct concurrent review. NurseWise has policies and procedures on staffing, hours of operation, training, performance standards, and quality and compliance monitoring that are compatible with LHC’s standards.

Monitoring Quality and Accuracy. Like our Provider Services Department, our Utilization Management Department will implement our **Call Witness** software which will be integrated within the Avaya system. Call Witness will allow LHC to better target specific types of calls; expand quality assurance by recording calls for later review (such as recording during high volume periods); and incorporate call examples in our training curricula role play library. This software records a sample of interactions that occur in the Helpline, such as phone calls, and any applications that staff touch or use on their computer to resolve a call. We will be able to evaluate accuracy of responses and etiquette of interactions with our customers as well as the effectiveness of our training programs by **silent monitoring**. Call audit criteria will include evaluating HIPAA compliance; the accuracy and effectiveness of the interaction; accuracy of call documentation; and cultural appropriateness. In addition, the systems ability to synchronize the captured voice and desktop activity allows management to observe and analyze the complete customer interaction as it actually occurred. The implementation of these quality monitoring tools will ensure our members receive superior service at all times.

Supervisors document the audit results in each agent’s **monthly performance cards**. This industry **best practice** compares individual performance to predefined performance goals, including measures for number of calls handled; average talk time; percentage of documentation compared to calls taken; and attendance. The Supervisor reviews the performance report card monthly with each telephone representative, except in cases where immediate correction is warranted. This monthly performance

review provides an opportunity to discuss strengths, deficiencies, and specific training needs. Follow up activities may include informal coaching, retraining, a Performance Improvement Plan (PIP), or corrective action initiated in an effort to correct performance. Each telephone representative is required to read and sign the company's Call Monitoring Acknowledgment and attendance policy form upon hire and annually. Trends across multiple staff are promptly addressed at department-wide training sessions or biweekly staff meetings, and if appropriate, reminders are displayed on our visual display boards.

Ensuring Adherence to Performance Standards. To ensure compliance with timeliness performance standards, Supervisors monitor call center **response timeliness** using Avaya's real time, on-screen, call queue monitoring tools that allow them to immediately adjust staffing to ensure timely handling of all calls per DHH standards. As call volume increases unexpectedly, local Supervisors will help handle calls and/or arrange for cross-trained staff, such as case managers, to assist.

LHC will provide call center performance reports to DHH within the timeframes and specifications required, including results for number of calls received; answered within 30 seconds; and abandoned and others as may be defined by DHH. The Avaya CMS system also produces historical reports so management staff can analyze trends that allow us to take action to maintain service levels. For example, we will be able to analyze and trend phone statistics in half hour increments by queue to initiate any changes in work distribution among queues.

Dedicated Prior Authorization Phone Line

Centene believes the best service is delivered locally, thus the company does not use a single or regional call center/prior authorization unit for multiple affiliate health plans. LHC will hire staff locally in Louisiana to support our utilization management call center. As part of our Emergency Management Plan, LHC will designate resources from our Centene affiliates which are able to offer staffing to ensure compliance with authorization decision timeframes and call answer timeliness. Alternatively, LHC may be called upon to support an affiliate health plan should a similar need arise. If cross support should be required, Avaya phone systems call routing, advanced vectoring, messaging, and information tracking will enable seamless, transfer capabilities while also providing separate reporting by health plan.

Track Calls Separately. Through the Avaya phone system, health plan calls are tied to the toll-free number of the original health plan. Call center agents will see the specific health plan identifier on their phone display screen so they can answer the phone appropriately with that health plans introduction phone script. Additionally, each call center department within a health plan is tied to a designated call routing queue. For example, Provider Services works from a different queue than the UM Prior Authorization call center. This clear delineation allows LHC to monitor and report performance standards by its designated queues regardless of the physical location of the agents supporting the queue.

Ensure Compliance with Decision Timeliness. All Centene health plan and affiliate medical management departments use a centralized clinical documentation system, TruCare. Similar to the phone system linkage to health plan toll-free phone lines, TruCare allows separation by health plan, through a designated plan code. With this capability we are able to monitor and report LHC specific performance standards regardless of the physical location of the call center agent. As previously stated it is not Centene practice to support multiple health plans from a single call center, however; if the need arose, supporting staff would be educated on the decision and notification timelines required by our contract with DHH. LHC supervisory staff will monitor decision timeliness through TruCare on a daily and aggregate level using their normal processes.

Question H.4

Gathering, Analyzing, and Reporting
Utilization Data

H.4 Describe how utilization data is gathered, analyzed, and reported. Include the process for monitoring and evaluating the utilization of services when a variance has been identified (both under- and over-utilization) in the utilization pattern of a provider and a member. Provide an example of how your analysis of data resulted in successful interventions to alter unfavorable utilization patterns in the system.

Identifying and Gathering Utilization Management Data

Louisiana Healthcare Connections (LHC) Utilization Management (UM) Program is data-driven and closely **integrated** with our quality management, case management and disease management functions in the shared process of improving our members' health outcomes. Utilization data is gathered, analyzed, and reported through our Quality Assessment and Performance Improvement Program. UM data is used to identify under- or over-utilization of services, aberrant practice patterns, and quality of service concerns, many of which can be corrected with education, outreach or other corrective action.

The LHC Board of Directors (Board) **oversees** the development, implementation, and evaluation of the UM Program, and approves the Annual UM Program Evaluation. The Board delegates the oversight and operating authority for the program through the Quality Assessment Performance Improvement Committee (QAPIC) to the Utilization Management Committee (UMC). The UMC oversees an integrated management system that is responsible for the assessment, planning, implementation, and evaluation of all UM activities, including, but not limited to: prospective, concurrent and retrospective review; referral management; second opinions; clinical criteria and practice guidelines; medical technology (new and existing); coordination of care and monitoring for under-or over-utilization. The Chief Medical Director (CMD) has oversight of the UM Program, including data reporting and the administration of all UM activities, and chairs the UMC. Utilization Management Committee members include the Vice President of Medical Management and network providers. Executive leadership and other staff attend as non-voting members. The UMC reports to the QAPIC on all UM activities including review of utilization data. The QAPIC is chaired by the Chief Medical Director and includes the LHC Chief Executive Officer, Executive Leadership representing all plan departments, and network providers representing a variety of specialties and provider types.

UM staff report UM data analysis, and its accuracy, completeness and consistency, to the UMC with particular attention to identification of potential over-and under-utilization. All utilization data is reported to the UMC quarterly unless significant variances are identified as needing immediate interventions. In such cases, the Medical Director and the Vice President Medical Management assess the variance and recommend an appropriate action plan. Routine reports include a comprehensive analysis of data, including identification of variances or trends, review of outcomes, and recommended interventions based on the findings. The UMC makes recommendations that may include additional data analysis, continued monitoring of the process or provider, and/or corrective action. Recommended actions, which may be multi-departmental, may include new or revised disease management programs, revisions to prior authorization requirements, new or revised clinical practice guidelines or medical necessity criteria, additional network development activities, improvements in the utilization monitoring process, or addressing the utilization trends of a particular provider or member.

Centene Corporation (Centene), LHCs parent company, supports the UM Program by providing sophisticated **data management capabilities** for data collection, indicator measurement, analysis, and improvement activities. Information Technology and Health Economics staff provide standard and ad hoc reporting and analysis support to UM staff. LHC captures and analyzes data from internal, subcontractor (vision) and external sources, including State immunization registry or clinical laboratory results or behavioral health vendor data. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, **integration**, and reporting of clinical claim/encounter data; financial information; medical management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group,

demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the UM Program. This data is refreshed nightly. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository, using our Centelligence® suite of reporting systems to build and tabulate key performance indicators and provide drill-down capability to the individual provider or member level for investigation of suspected under- or over-utilization. Medical and behavioral health data are integrated within the same systems facilitating effective integration of utilization management and case management activities. Centelligence Foresight (our predictive modeling application) enables us to not only assess appropriateness of delivered services against evidence-based guidelines, but also against the average risk of members or subgroups of members receiving the services. The software assesses whether the members receiving specific programs or services are the ones who can receive the most value from them.

This information technology infrastructure allows LHC to generate an array of regular, **consistent** utilization reports as well as ad hoc and member and provider level reports. Regular reports that UM staff and the UM Committee review includes inpatient measures such as:

- days and admissions per 1,000 members,
- proportion of unplanned readmissions, and
- average length of stay, overall and by diagnosis;

Routine outpatient measures include, but are not limited to:

- emergency department (ED) visits per 1,000 members;
- recommended preventive care exams and screenings;
- specialty referrals, laboratory, radiology and other ancillary services, and certain selected procedures (such as hysterectomies); and
- utilization related to ambulatory care sensitive conditions

In collaboration with the DHH Pharmacy Benefit Manager (PBM) and Mental Health Benefit Manager (MBHO) our analysis will also include behavioral health and pharmacy utilization data.

We also review quality of service indicators such as:

- the rate of out-of-network care;
- the rate of notices of actions to reduce or deny authorization of service and the types of services impacted;
- member and provider satisfaction, including grievances and appeals related to services delivered or denied, timeliness of authorization review, and telephone responsiveness data

Monitoring for Under- and Over-Utilization

In order to fully understand the utilization **trends** of our members and our providers, as well as the underlying causes, LHC will analyze a variety of different ‘snapshots’ of our utilization data. The UMC monitors and analyzes data at aggregate and detail levels including by member, by individual provider or facility, by provider specialty, by type of service, by diagnosis, by place of service, and by comparing services authorized to services received. Routine monthly trend reports monitor key utilization measures such as inpatient admissions and days, ED visits, and specific preventive care services. Each report includes a drill down capability to more specific areas of interest. For example, when analyzing ED visit or inpatient utilization, we can look not only at total number of visits or days, but also at the utilization in relationship to readmissions, frequent ED utilization, or presence or absence of physician office visits. We can look for patterns of under- or over-utilization by provider, by member, or by Region and Parish. The UMC will establish benchmarks using industry standards, national Medicaid HEDIS averages, or DHH mandated thresholds. Particularly when dealing with utilization data, internal benchmarks are developed based on historical data that reflect variances in population demographics, seasonal variations, cultural disparities and regional characteristics of our members.

Monitoring and Evaluating Utilization when a Variance has been Identified in a Provider's Utilization Pattern

Under-utilization by Providers. LHC Quality Management(QM) staff may identify a pattern of under-utilization by a specific provider by reviewing the provider's performance on profile measures for primary and secondary preventive services such as preventive health visits or diabetes care testing. Performance is compared to national benchmarks, when available, and average network performance. Once the provider has been identified, QM or Network Management staff, or the Medical Director, meet one-on-one with the provider to discuss performance, provide education and establish an action plan for improvement. QM staff monitor performance monthly or quarterly, depending on the measure, and report both to the UMC and the provider. We continue the higher level monitoring until performance has been corrected and maintained for at least six months. The provider will have direct access to profile performance reports on the Provider Portal.

Over-utilization by Providers. QM or UM staff may identify a pattern of over-utilization by a specific provider by reviewing quarterly profile reports of providers' utilization of inpatient, ED and other services, or of inpatient referral rates by nursing and assisted living facilities and homes. The Concurrent Review staff may note a trend of unplanned readmissions for a specific hospital. In each case, performance is compared to average network performance or national benchmarks. Network Management staff or the Medical Director meet one-on-one with the provider to discuss performance, provide education and establish an action plan for improvement. UM staff monitor performance monthly and report both to the UM Committee and the provider. We continue the higher level monitoring until performance has been corrected and maintained for at least six months. In certain cases, UM staff refer providers with patterns of over-utilization to Centene's Special Investigation Unit for investigation of possible fraud, waste or abuse. A screening process within our claims processing operations can also generate such referrals. These investigations, which can include review of clinical records, time sheets and other original documentation, are managed jointly with LHC staff and are discussed in detail in our response to Section O of the RFP.

Monitoring and Evaluating Utilization when a Variance has been Identified in a Member's Utilization Pattern.

Under-utilization by Members. LHC QM staff may identify a pattern of under-utilization by a specific member by reviewing routine reports from Centelligence Foresight of members in need of recommended preventive services. For example, adult/child preventive care services including EPSDT and annual cervical cancer screening and routine screenings for chronic conditions including hemoglobin A1c and cholesterol screenings for adults with diabetes. We may also identify members who are under-utilizing treatment services such as low use of controller medications in members with asthma. Also, members who are identified with a pattern of over-utilization of acute care services may be under-utilizing lower levels of care, preventive services or behavioral health services. For members not in case management our QM staff will initiate targeted reminders through postcard mailings, automated telephonic reminders, or direct outreach from one of our MemberConnections Representatives, depending on the service and level of non-use. For members identified who are in case management, the assigned Case Manager reviews the member's care plan, including a partial or full reassessment of the member's needs, barriers and planned services, and monitors the member more frequently with personal contact, including with caregivers or guardian (for foster care members). Case Managers continue to monitor the monthly Centelligence Foresight reports to identify members persistently listed as having gaps in recommended care, and to identify those members with the highest risk for future acute care utilization, and therefore the highest priority for preventive services. In collaboration with the DHH PBM, we may identify members under-utilizing secondary preventive medication, such as asthma controller medications, from routine reports. The LHC Medical Director will contact the prescribing provider with recommendations for appropriate use.

Over-utilization by Members. LHC staff may identify a pattern of over-utilization by a specific member by reviewing routine Centelligence Foresight reports, such as members with more than three ED visits in the previous 12 months or by reviewing daily call center reports of members referred to the ED for those members with recent previous visits. Concurrent Review staff may also identify a member with repeated unplanned inpatient readmissions. Once a member is identified, the member is enrolled in case management if not already enrolled. The identified member's Case Manager reviews the member's care plan, including a partial or full reassessment of the member's needs, barriers and planned services, including behavioral health services. The Case Manager also reconciles the member's current medications with those on the care plan, and monitors the member frequently with personal contact, including with caregivers. Patterns of ED or other utilization may suggest member abuse or neglect. In such cases, Case Managers initiate an evaluation of the member in cooperation with Adult or Child Protective Services to ensure the member is in a safe environment. In coordination with the Louisiana PBM we may identify members with polypharmacy involving therapeutic duplication, or members with high use of controlled drugs from routine pharmacy utilization reports. Our UM Committee reviews identified members and may make recommendations such as discussion with the prescribing physician(s). For example, in 2010 our Arizona affiliate, Bridgeway Health Solutions (Bridgeway), reviewed a member who was on two antipsychotic medications (Geodon and Seroquel) and recommended that our psychiatric consultant contact the member's primary practitioner. The provider was unaware of the polypharmacy. The consultant is currently working with the provider to wean the member off the Seroquel. Bridgeway's Pharmacy staff continue to monitor the identified members' drug utilization monthly until the adverse pattern is resolved.

Sample Utilization Reports when a Variance has been Identified.

The following sample reports demonstrate LHC's capabilities to analyze, monitor and evaluate utilization data when we suspect under- or over-utilization. If we identify a variance in overall ED utilization, an analysis such as **Sample 1** allows UM staff to compare the utilization of ED **providers**. Further pursuing such a variance, **Sample 2** allows us to identify the primary risk categories (diagnostic groups) for **members** with two or more ED visits in the period. Should we suspect that the variance in ED utilization was driven by members with diabetes, **Sample 3** demonstrates LHC's ability to identify members with non-compliance with diabetes disease monitoring that could be a cause for increased ED utilization.

Sample Report 1. Analysis of Emergency Department Providers by Paid Claims Volume.

Navigation ...
 Claims [...]
 Top
 Top
 Top
 Top

**Georgia - All Regions CHIP Emergency Room All Sub Cost Categories
 Claims Drill Down - Top 200 Utilization
 Paid Data as of 5/31/2011 - 3 Month LAG**

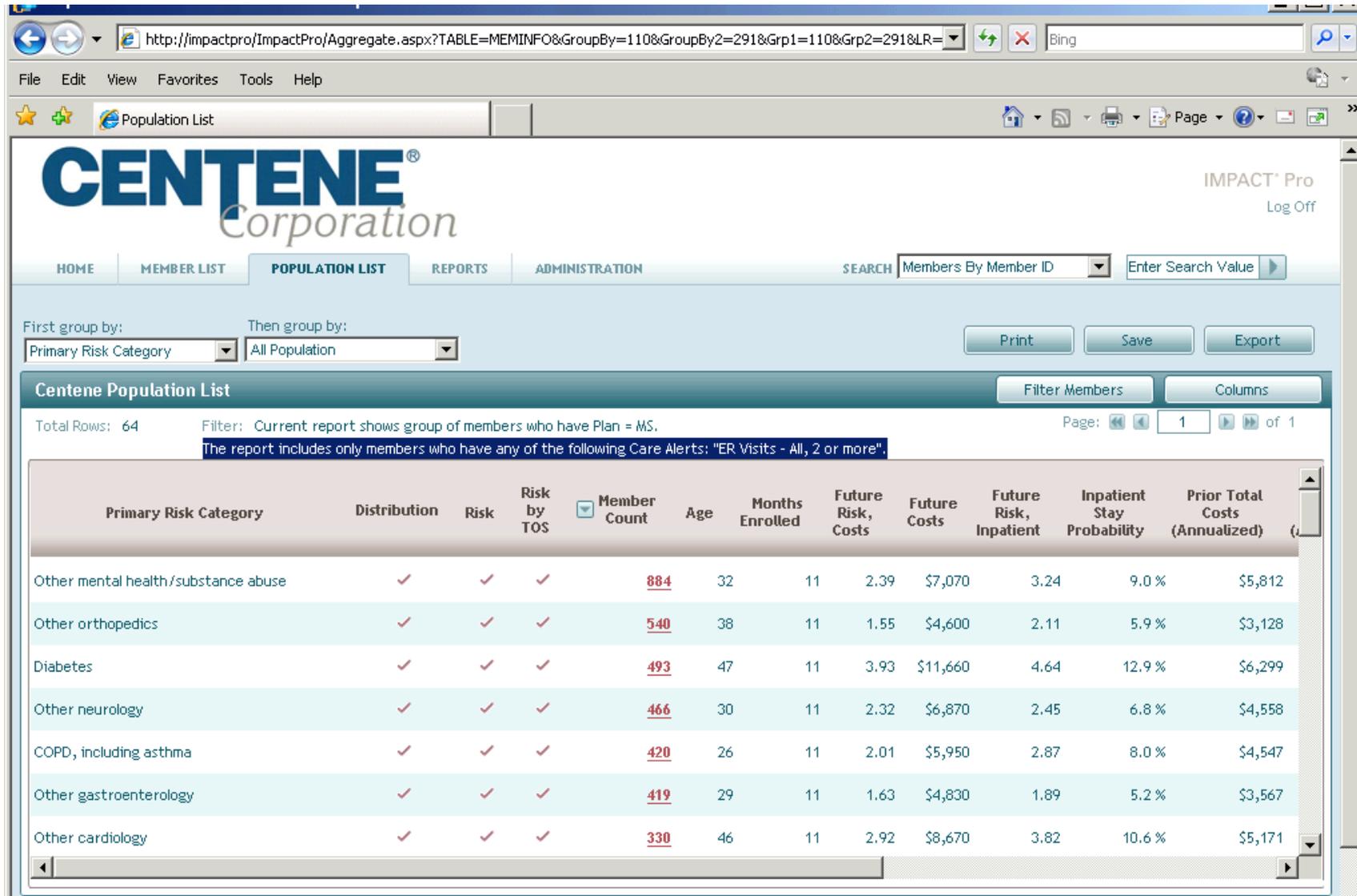
	Provider #	Utilization Rolling 3 Months									
		DEC 2009 - FEB 2010	DEC 2010 - FEB 2011	% Change	Change	Percent of Total	2010-03	2010-04	2010-05	2010-06	2010-07
CHILDRENS HLTH CARE OF ATL EGLESTON	116189	22.76	23.77	4.46%	1.02	8.72%	25.98	28.46	27.32	20.05	
SOUTH GEORGIA MEDICAL CENTER	115921	8.78	11.14	26.89%	2.36	2.44%	11.06	12.16	14.03	12.44	
ARCHBOLD MEDICAL CENTER	116040	8.05	9.23	14.67%	1.18	2.00%	6.01	5.59	9.11	6.85	
TIFT REGIONAL MEDICAL CENTER	115892	10.48	12.97	23.68%	2.48	1.48%	15.15	10.70	15.51	10.66	
COLQUITT REGIONAL HOSPITAL	115949	7.40	11.39	53.97%	3.99	1.47%	9.14	8.03	10.09	4.82	
PALMYRA MEDICAL CENTER	115958	5.93	6.57	10.68%	0.63	1.40%	6.25	8.27	10.09	7.11	
NEWTON MEDICAL CENTER	115969	3.25	4.41	35.51%	1.15	1.05%	2.89	3.65	4.18	2.28	
WEST GEORGIA MEDICAL CTR	115901	12.11	12.88	6.39%	0.77	0.98%	16.84	16.54	13.78	11.17	
SOUTHERN REGIONAL MEDICAL CENTER	115924	4.96	6.23	25.75%	1.28	0.93%	6.01	6.81	7.38	4.31	
PHOEBE WORTH HOSPITAL	115948	2.76	3.66	32.35%	0.89	0.56%	6.73	3.65	5.17	2.54	
COLISEUM NORTHSIDE HOSPITAL	115979	1.38	2.58	86.50%	1.20	0.53%	1.44	1.46	4.68	0.76	
MITCHELL COUNTY HOSPITAL	115974	2.44	4.49	84.09%	2.05	0.52%	2.41	4.38	3.94	3.05	
NORTH FULTON HOSPITAL	115966	1.38	2.08	50.40%	0.70	0.52%	1.20	1.46	0.00	2.03	
COLISEUM MEDICAL CENTER	116026	1.22	2.49	104.54%	1.27	0.51%	1.92	2.68	3.45	3.05	
NORTHSIDE HOSPITAL-FORSYTH MEDICAL CENTER INC	115914	2.93	3.91	33.52%	0.98	0.48%	3.85	4.14	5.91	4.06	
	115959	2.60	3.99	53.41%	1.39	0.46%	4.57	2.43	3.94	1.52	

Top 200 Providers

Top 200 Diagnosis | Top 200 Procedure | Top 200 Specialties | **Top 200 Providers**

Refresh Date: June 11, 2011 12:55:20 PM GMT-05:00

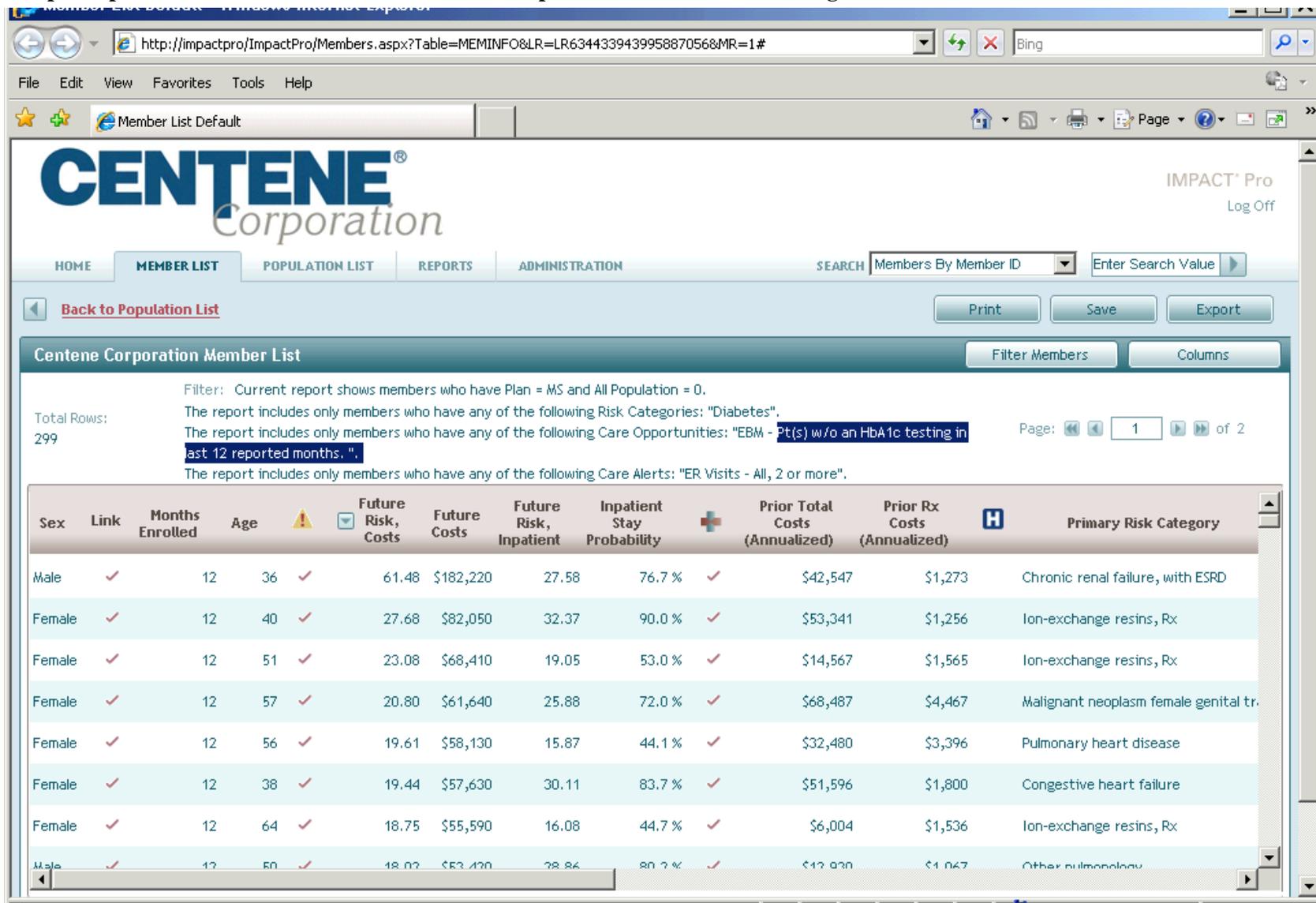
Sample Report 2. Analysis of Diagnoses (Primary Risk Categories) for Members with Two or More ED Visits.



The screenshot displays the CENTENE Corporation IMPACT Pro web application interface. The browser address bar shows the URL: `http://impactpro/ImpactPro/Aggregate.aspx?TABLE=MEMINFO&GroupBy=110&GroupBy2=291&Grp1=110&Grp2=291&LR=`. The application header includes the CENTENE Corporation logo, the text "IMPACT Pro" with a "Log Off" link, and navigation tabs for HOME, MEMBER LIST, POPULATION LIST (selected), REPORTS, and ADMINISTRATION. A search bar is set to "Members By Member ID" with a search value field. Below the navigation, there are dropdown menus for "First group by:" (set to "Primary Risk Category") and "Then group by:" (set to "All Population"). Action buttons for "Print", "Save", and "Export" are visible. The main content area is titled "Centene Population List" and includes "Filter Members" and "Columns" buttons. It shows a total of 64 rows and a filter: "Current report shows group of members who have Plan = MS." A note states: "The report includes only members who have any of the following Care Alerts: 'ER Visits - All, 2 or more'." The data is presented in a table with the following columns: Primary Risk Category, Distribution, Risk, Risk by TOS, Member Count, Age, Months Enrolled, Future Risk, Costs, Future Costs, Future Risk, Inpatient, Inpatient Stay Probability, and Prior Total Costs (Annualized).

Primary Risk Category	Distribution	Risk	Risk by TOS	Member Count	Age	Months Enrolled	Future Risk, Costs	Future Costs	Future Risk, Inpatient	Inpatient Stay Probability	Prior Total Costs (Annualized)
Other mental health/substance abuse	✓	✓	✓	884	32	11	2.39	\$7,070	3.24	9.0 %	\$5,812
Other orthopedics	✓	✓	✓	540	38	11	1.55	\$4,600	2.11	5.9 %	\$3,128
Diabetes	✓	✓	✓	493	47	11	3.93	\$11,660	4.64	12.9 %	\$6,299
Other neurology	✓	✓	✓	466	30	11	2.32	\$6,870	2.45	6.8 %	\$4,558
COPD, including asthma	✓	✓	✓	420	26	11	2.01	\$5,950	2.87	8.0 %	\$4,547
Other gastroenterology	✓	✓	✓	419	29	11	1.63	\$4,830	1.89	5.2 %	\$3,567
Other cardiology	✓	✓	✓	330	46	11	2.92	\$8,670	3.82	10.6 %	\$5,171

Sample Report 3. Identification of Members Non-Compliant with HbA1c Monitoring.



Filter: Current report shows members who have Plan = MS and All Population = 0.
 The report includes only members who have any of the following Risk Categories: "Diabetes".
 The report includes only members who have any of the following Care Opportunities: "EBM - Pt(s) w/o an HbA1c testing in last 12 reported months."
 The report includes only members who have any of the following Care Alerts: "ER Visits - All, 2 or more".

Sex	Link	Months Enrolled	Age	Future Risk, Costs	Future Costs	Future Risk, Inpatient	Inpatient Stay Probability	Prior Total Costs (Annualized)	Prior Rx Costs (Annualized)	Primary Risk Category
Male	✓	12	36	61.48	\$182,220	27.58	76.7 %	\$42,547	\$1,273	Chronic renal failure, with ESRD
Female	✓	12	40	27.68	\$82,050	32.37	90.0 %	\$53,341	\$1,256	Ion-exchange resins, Rx
Female	✓	12	51	23.08	\$68,410	19.05	53.0 %	\$14,567	\$1,565	Ion-exchange resins, Rx
Female	✓	12	57	20.80	\$61,640	25.88	72.0 %	\$68,487	\$4,467	Malignant neoplasm female genital tr.
Female	✓	12	56	19.61	\$58,130	15.87	44.1 %	\$32,480	\$3,396	Pulmonary heart disease
Female	✓	12	38	19.44	\$57,630	30.11	83.7 %	\$51,596	\$1,800	Congestive heart failure
Female	✓	12	64	18.75	\$55,590	16.08	44.7 %	\$6,004	\$1,536	Ion-exchange resins, Rx
Male	✓	12	50	18.02	\$53,430	28.86	80.2 %	\$12,030	\$1,067	Other pulmonary

Analysis of Data Resulting in Successful Interventions

Centene health plans have over 27 years of experience in gathering, monitoring and reporting utilization data. Based on analysis of this data, we have implemented interventions that resulted in improved health outcomes. Below is an example of our process for monitoring and improving outcomes based on analysis of UM data.

Bridgeway Experience Decreasing Inpatient Readmissions

Identification of Opportunities and Selection of Project. In May 2009, Bridgeway’s Medical Management/Utilization Management (MM/UM) Committee reviewed a series of inpatient admission, readmission and emergency department (ED) utilization reports. Their analysis identified a subset of ALTCS (long-term care) members who had frequent ED visits and multiple inpatient admissions and readmissions for the same chronic condition, with a **disproportionate financial impact** on the plan. Case Managers had identified many of these members individually in the past and provided assistance, which was frequently focused on home-based services. These high-risk members often had multiple co-morbidities and a complex treatment plan. Follow-up indicated that many of them continued their high utilization of acute care services and were often moved from their natural setting to assisted living or skilled nursing facilities to attempt more consistent monitoring of their chronic conditions. Root cause analysis revealed underlying causes including limited member mobility, transportation barriers, an insufficient natural support system, and limited health literacy.

Target population. ALTCS members who have been diagnosed with diabetes, hypertension, heart failure, or chronic obstructive pulmonary disease (COPD), and who have needed inpatient or ED services recently (see below).

Objectives. Reduce utilization of acute services; improve self-management skills; improve control of the chronic condition; achieve more stability in natural setting (home or assisted living facility).

Intervention. In August 2009, Bridgeway implemented a pilot telemonitoring program designed to improve the clinical stability of high-risk members in their **natural settings**, and bypass barriers such as limited mobility and associated transportation issues (for example, no caregiver available to accompany the member). The monitoring devices available through the program are appropriate for members with diabetes, hypertension, heart failure, and COPD. This program provides in-home telemonitoring devices such as glucometers, pulse oximetry, blood pressure monitors, and weight scales that allow members’ biometric information to be tracked, trended, and managed daily via real-time data. The program used patent-pending, FDA-approved technology that is “device-agnostic”, interfacing with virtually any medical home monitoring device via wireless or wired modem using land line, cellular or VOIP communications links. Within seconds of a reading being taken in the home, the biometric value was transmitted electronically to our monitoring office and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. If the value was outside physician-defined parameters, the monitoring nurse **immediately** informed the member or caregiver, physician and Case Manager as appropriate. The technology is entirely web-enabled; all members were provided a login card that enables them, their family, or their physician to access their biometric information from anywhere in the world at anytime – as long as they have access to the Internet. This technology is **innovative** and sets Bridgeway and other Centene health plans apart as having the only device-agnostic, real-time biometric monitoring capability among its competitors.

During the initial phase of the intervention, the enrollment criterion was two or more inpatient admissions within a six-month period. Each Bridgeway ALTCS member was assigned a Case Manager, many of whom were social workers. The Social Work Case Managers, in turn, had an assigned Nurse Case Manager to provide support for clinical issues. When Social Work Case Managers noted during evaluations or reevaluations that members met enrollment criteria, they reviewed the assessment results and scheduled a joint home visit to include both the Nurse and Social Work Case Managers, the member

and family, or caregiver (and assisted living facility staff when appropriate). The meeting included discussion of the member's chronic condition and how well the member understood it, the potential for improved self-management and, if appropriate, the possible benefits of participating in the telemonitoring program. If the member met criteria and was amenable to the program, the Case Manager contacted the member's primary physician, reviewed the results of the assessment, and discussed a referral to the telemonitoring program as a part of the member's plan of care.

Once there was agreement, a technician delivered and set up the equipment; taught the member, family and caregiver how to use it; and provided a toll-free number to call in case of technical issues with the equipment. If needed, a technician was dispatched to the member's location for troubleshooting. Both Bridgeway Case Managers, and the member's provider, were able to access the member's data at any time on the telemonitoring program web portal. The Nurse Case Managers and the monitoring nurses held bi-weekly case conferences to discuss any member-specific issues, as well as updates on each member's compliance with transmissions and the results. The Nurse Case Manager updated the member's Social Work Case Manager and assisted with any recommendations. The monitoring nurse sent a report to the primary physician at least monthly, or more often if requested, with a summary of the member's data. If there were any events outside the prescribed parameters, the monitoring nurse immediately contacted the Case Manager and primary physician by phone or email with the transmission results. The Bridgeway Case Manager and monitoring nurse coordinated any interventions or change in monitoring as prescribed by the physician, including assistance with scheduling appointments and arranging transportation, if necessary. Focused coaching at these **teachable moments** improves the members' knowledge of the disease process. Focused goals for self-monitoring help motivate the members.

This telemonitoring program gave the member's team – member, caregiver, primary physician, Case Manager - actionable opportunities to detect pre-acute conditions and prevent worsening health status with early attention and self-care. The program also provided continuous meaningful information on illness progression in the members' natural setting. It empowered members (or caregivers) to take a more active role in managing their own care. It also made family members and caregivers more aware of subtle clinical changes in conditions in order to more proactively respond to members' needs.

Evaluation. The MM/UM Committee evaluated the effectiveness of the telemonitoring program, most recently in February 2011. As of February 1, 2011, there were 25 members enrolled in the program, with an average participation period of 10.4 months. These members have had a total of 17 inpatient admissions while enrolled (0.68 admissions per member). These members had a total of 98 inpatient admissions during the 12-month period prior to participation (3.92 admissions per member). The program therefore yielded an annualized **80.1%** reduction in inpatient admissions per year for participating members. As an example, in October 2010, a Case Manager identified a member with co-morbid diabetes, hypertension and cardiopulmonary disease who had 14 ED visits and inpatient admissions in the previous nine months. Previous attempts to stabilize his condition included discharge to a skilled nursing facility for more intense monitoring and subsequent transition home from the nursing facility with home health services. Recognizing that this pattern of need for acute services was persistent, the Case Manager enrolled the member, with his agreement, in the telemonitoring program for home monitoring of blood sugar, blood pressure and oxygen saturation. He has had only one inpatient admission and 0 ED visits in the four months since he enrolled in the program. The program has also demonstrated an improvement in member self-care (or care by caregiver). At members' entry to the program, their average rate of compliance with recommended self-monitoring (blood sugar, blood pressure, weight, blood oxygen saturation) was 27%. It is currently at 63%.

Post-Measurement Activity. The MM/UM Committee completed a six-month interim assessment of the telemonitoring pilot in February 2010, and noted that only 10 members had been enrolled since its inception. They decided that the enrollment process was too restrictive and initiated two **changes** in the intervention. The enrollment criterion was changed from two or more inpatient admissions to two or more inpatient admissions, ED visits, or urgent care visits within a six-month period. Secondly, the Nurse Case

Manager Supervisor began receiving a daily census of hospitalized ALTCS members. The supervisor reviews all listed members with their assigned Case Managers for possible program eligibility, considering admitting diagnoses, patterns of past utilization, and any gaps in guideline-recommended care. An additional 15 members were added to the program after these process changes.

Buckeye Community Health Plan's Experience with Diabetes Management

Focus and Reason for Selection. Over 3% of Buckeye's member population has been identified as having diabetes. Buckeye's HEDIS Comprehensive Diabetes Care Measures were below the national Medicaid 50th percentile in CY 2006.

Barriers. Buckeye identified gaps in member and provider education, as well as providers' ability to recognize their diabetic Enrollees who were due for various screenings and eye exams. Enrollees were often faced with the challenge of trying to acquire home testing kits to monitor their blood glucose levels.

Interventions. Buckeye initiated several interventions to improve diabetic care for Enrollees in late 2007 which included member and provider education, screening reminders, and identification of non-compliant Enrollees for outreach. Buckeye piloted an innovative home test kit strategy in 4th quarter 2008 targeting those Enrollees who had not yet received their hemoglobin A1C and their nephropathy screening tests. A home test kit was mailed to the member with follow-up phone calls to ensure receipt of the mailing, answer questions, and encourage completion and return of the test kit. In addition, Buckeye provided their network practitioners with diabetic stickers for their patient's charts which indicated patients who needed their screenings and services. Buckeye expanded their member and provider education program to include information regarding diabetes as well as providing incentives to both Enrollees and Providers encouraging diabetic screenings.

Improvement Achieved. The CY 2008 HEDIS Hemoglobin A1C Testing measure *improved* 3.4 % and the Medical Attention for Nephropathy Measure *improved* 25.5% in 2008. In addition to the increase in screening scores, Buckeye identified 52% of their respondents as having elevated HgbA1c levels and was able to enroll 100% of those Enrollees into case management for care coordination and follow-up.

Sustained Improvement. Due to the robust and innovative interventions implemented in 2007, Buckeye's performance for the HEDIS Hemoglobin A1C Testing measure *improved* by 27.7% since 2006, and the HEDIS LDL-C measure *improved* by 21.2% since 2006 representing three (3) consecutive years of sustained improvement in the care for Enrollees with diabetes.

MHS-IN experience with Diabetes Management

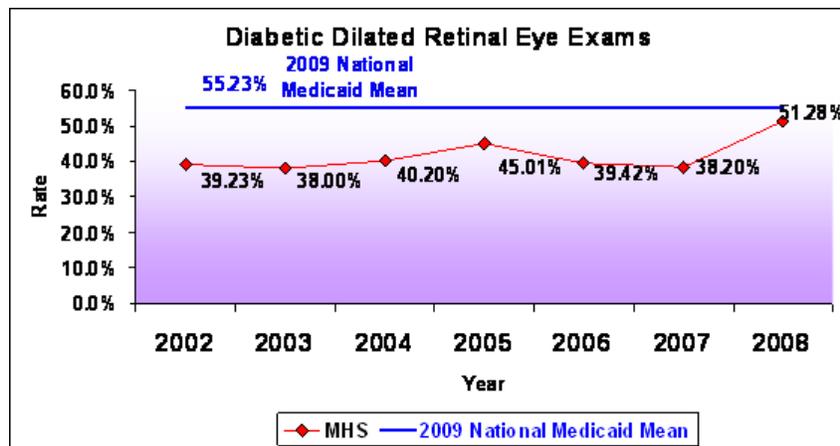
Focus and Reason for Selection. MHS-IN also noted Comprehensive Diabetes Care Measures below desired levels and were not meeting their objectives in achieving the 75th percentile on all NCQA required HEDIS measures.

Barriers. MHS-IN identified gaps in member and provider education, as well as member resources and knowledge of the importance of getting their annual diabetic eye exam.

Interventions. MHS-IN implemented a partnership with OptiCare, a Centene wholly-owned subsidiary for vision benefit management, to conduct telephonic outreach and assistance with appointment scheduling for those diabetic Enrollees who had not received an eye exam by beginning of the third quarter in 2008.

Improvement Achieved. As noted below, MHS-IN saw a 34% *improvement* in their diabetic dilated retinal eye exams between 2007 and 2008.

Improvement in Diabetic Dilated Retinal Eye Exams



MHS-IN Experience Improving Compliance with Antidepressant Medication Management

Focus and Reason for Selection. In 2007, MHS-IN identified performance on the HEDIS measure for management of antidepressant medication as an area for improvement, with a goal of meeting or surpassing the national Medicaid 50th percentile.

Barriers. Through barrier analysis, MHS-Indiana determined barriers to member and provider education, member transportation to follow-up appointments, and member understanding regarding the importance of follow up appointments while taking medication for the treatment of depression.

Interventions. MHS-Indiana initiated a new depression management education program that incorporated targeted outreach to the top 40 prescribers of antidepressant medication, including personal calls to the top 20 prescribers and presentations to local FQHCs and CMHCs by the MHS-IN Medical Director and Cenpatico Vice Presidents Medical Affairs. They also initiated reminder calls to Enrollees with new prescriptions for antidepressants, offering assistance with follow-up appointments and arranging for transportation, if necessary.

Improvement Achieved. As a result, the acute phase HEDIS measure **increased** from 43.5% in CY2007 to 47.7% in CY2008, surpassing the 50th percentile.

Peach State Health Plan (Peach State) Experience Improving Follow-Up Care for ADHD

Focus and Reason for Selection. In 2009, Peach State identified performance on the HEDIS measure for Follow-Up Care for Children Prescribed ADHD Medication as an opportunity for improvement, with a goal of meeting or surpassing the national Medicaid 75th percentile.

Barriers. Through barrier analysis, Peach State determined barriers to member and provider knowledge of the clinical practice guideline for “ADHD - Treatment of School-aged Children with Attention Deficit/Hyperactivity Disorder”, member transportation to appointments, and member understanding regarding the importance of medical home approach and follow-up appointments.

Interventions. Peach State implemented a member outreach campaigns through newsletter and web communications to encourage compliance with follow-up visits. Peach State distributed both ADHD clinical practice guidelines to the provider network through fax blast, mailings, newsletters and web communications. Peach State also partnered with Cenpatico Behavioral Health, Centene affiliated managed behavioral health organization, to educate the behavioral health provider network regarding recommended follow-up timeframes for children prescribed ADHD medications.

Improvement Achieved. As a result, Peach State noted improvement in both the Initial Phase and Continuation/Maintenance phase for follow-up care for children prescribed ADHD medications; both achieving greater than the NCQA 2009 75th Percentile for these measures.

	HEDIS 2009	HEDIS 2010	NCQA 75 th Percentile
F/U Care for Children Rx ADHD Medications (ADD): Initiation Phase	40.0	47.0	42.2
ADD: Continuation and Maintenance Phase	52.2	57.3	48.4

Superior Health Plan (Superior) Experience Improving Adult and Child Access to Care

Focus and Reason for Selection. In 2007, Superior identified performance on the HEDIS measure for Adult Access to Preventive/Ambulatory Health Services and Child and Adolescents’ Access to Primary Care Services as an opportunity for improvement, with a goal of meeting or surpassing the national Medicaid 75th percentile.

Barriers. Through barrier analysis, Superior determined barriers to member and provider education, member transportation to appointments, and member understanding regarding the importance of annual well care appointments.

Interventions. Superior implemented a telephonic and postcard member outreach campaign to encourage compliance with visits including annual Texas HealthSteps (EPSDT) visits. Superior distributed both adult and child Preventive Health Guidelines to the provider network through mailings, newsletters and web communications. Superior also piloted the CentAccount program for child members in their Bexar service area for completing a wellness exam in accordance with the Texas HealthSteps periodicity schedule. Monthly listings of STAR+PLUS members due for EPSDT exams were provide to the Service Coordination Team for outreach.

Improvement Achieved. As a result, Superior noted sustained improvement in both the Adult Access and Child Access HEDIS measures.

Access Measures:	HEDIS 2007	HEDIS 2008	HEDIS 2009	HEDIS 2010
Adult Access 20-44 years	82.36	79.03	79.3	81.8
Adult Access 45-64 years	86.18	80.75	82.6	92.2
Child Access 12-24 months	97.39	97.76	98.2	98.1
Child Access 25 months to 6 years	91.29	91.68	91.7	93.2
Child Access 7-11 years	91.64	92.70	92.9	94.3
Child Access 12-19 years	89.78	91.29	91.8	93.7

Centene Experience Reducing Emergency Utilization through Disease Management Programs

Through Nurtur, LHCs affiliated subcontractor for population-based DM services, Centene’s health plans show statistically significant reductions in the incidence of both pediatric and adult asthma-related ER visits by using life and health coaching techniques that span an array of integrated, customized and stand-alone programs. Nurtur is fully accredited by the Utilization Review Accreditation Commission and NCQA. Nurtur generated a comparative control group using propensity scoring that matched each DM participant with a non-participant using a logistic regression model that factored disease, presence of co-morbidities, age and gender. Nurtur excluded from the analysis DM participants for whom no match was available. Data analysis revealed 24.6% reduction in asthma related ER visits for children and 12.5% reduction in asthma related visits for adults. Statistically significant reductions were also evident in condition-specific related admissions for pediatric asthma (12.9%), diabetes (23.4%), and heart (26.4%). Please see table below:

Significantly Significant Reductions in Asthma Related ER Visits

<i>ER visits per 1,000 members (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Asthma-Related Children (49,761)	108.7	144.1	-24.6%	.001
Asthma-related Adults (7,473)	581.4	664.7	-12.5%	.001

Statistically Significant Reductions in Condition-Specific Related Admissions

<i>Condition-specific related Admissions per 1,000 members (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Asthma-Related Admissions Children (49,761)	339.9	390.3	-12.9	.001
Diabetes-Related Admissions Adults (12,472)	144.8	189.1	-23.4	.001
All Heart-Related Admissions (1,217)	1826.1	2481.5	-26.4	.046

Source: Nurtur, May 10, 2011, covering the CY 2010 period for Centene’s book of business.

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