

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	<b>PART II: TECHNICAL APPROACH</b>	Total Possible Points	Score	DHH Comments
		<b>Section L: Customer Service (Section §12 of RFP)</b>	<b>100</b>		
L-1	A, B, and C	<p><b>L.1</b> Provide a narrative with details regarding your member services line including:</p> <ul style="list-style-type: none"> <li>○ Training of customer service staff (both initial and ongoing);</li> <li>○ Process for routing calls to appropriate persons, including escalation;The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);</li> <li>○ Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;</li> <li>○ Monitoring process for ensuring the quality and accuracy of information provided to members;</li> <li>○ Monitoring process for ensuring adherence to performance standards;</li> <li>○ How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and</li> <li>○ After hours procedures.</li> </ul>	<b>25</b>		
L-12	A, B, and C	<p><b>L.2</b> Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.</p>	<b>25</b>		

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L-14	A, B, and C	<p><b>L.3</b> Describe the procedures a Member Services representative will follow to respond to the following situations:</p> <ul style="list-style-type: none"> <li>o A member has received a bill for payment of covered services from a network provider or out-of-network provider;</li> <li>o A member is unable to reach her PCP after normal business hours;</li> <li>o A Member is having difficulty scheduling an appointment for preventive care with her PCP; and</li> <li>o A Member becomes ill while traveling outside of the GSA.</li> </ul>	20	
L-19	A, B, and C	<p><b>L.4</b> Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.</p>	15	
L-32	A, B, and C	<p><b>L.5</b> Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.</p>	15	

Question L.1  
Member Services Line

## Section L: Customer Service

L.1 Provide a narrative with details regarding your member services line including:

### Overview

The mission of Member Services staff is “Determined to succeed, one call at a time” and we accomplish this through “high touch” personalized service. LHC’s member call center provides a critical link between members and timely, accurate information about health services. Our Member Services Representatives (MSRs) will be available from 7 a.m. to 7 p.m. Central Time, Monday-Friday, excluding State declared holidays, with after hours support provided by NurseWise®, our 24/7 nurse advice line affiliate and subcontractor. Our member call center will be located in Baton Rouge. Establishing a regional presence not only provides local jobs, it automatically builds in greater cultural compatibility between LHC staff and LHC members.

Our staff are the cornerstone of the member call center and we describe first, their specific roles. Second, to understand how LHC’s technology enables and supports call center service delivery by staff, we summarize key systems and features. In light of this background on staff and systems that applies throughout the response, we then address DHH’s eight specific questions regarding the member call center.

### Call Center Functions and Staff Responsibilities

The **Director of Member and Provider Services** will oversee all member call center functions; provide strategic planning and departmental goal-setting; provide oversight for staff training; develop all related policies, procedures, and work processes; ensure compliance with State, federal, and LHC requirements and guidelines, and will work with the management team and Workforce Analyst to ensure the call center is properly staffed to meet DHH performance standards. Placement of the member and provider call center under a single Director will provide cross-functional integration by ensuring consistency in our technologies, training programs, policies, and interface protocols. The **Supervisor of Member Services** will oversee the daily functions of the team such as floor supervision, coaching and providing guidance to call center staff as needed, and developing and monitoring adherence to department and individual performance goals and shift schedules. (There may be more than one Supervisor, depending on Contract award and enrollment.)

The **Workforce Analyst** will monitor call center activity and work with the management team to initiate necessary staffing changes to ensure sufficient coverage for all inbound call queues; analyze call volumes, call trends, and staff productivity and scheduling; and provide management with call center reports and recommendations to enhance forecasting models, staff distribution, and schedules. The Member and Provider Services **Trainer** will develop and update the training curriculum and materials and conduct in-person training. The **Quality Specialist** will evaluate MSR interaction with our members as well as the effectiveness of training programs by monitoring, via our Call Witness audit tool.

**Member Services Representatives**, the heart of our member call center, will be hired from the local community, and they will respond to telephonic inquiries from members and their representatives, educate members about appropriately accessing covered services, and serve our diverse membership in a culturally competent manner. Local staff are best prepared to recognize and respond appropriately to the rich variety of dialects represented across the State of Louisiana.

### Innovative and Integrated Technology

Our member call center will share the same call management platform as NurseWise and all internal LHC departments. The *Avaya Call Management System* delivers call routing, advanced vectoring, messaging,

and information tracking that enable seamless, efficient call answering and transfer capabilities and reporting. MSR's primary information and documentation tool is our proprietary *Member Relationship Management (MRM) System*. The MRM system is our *member services inquiry and member data management application* specifically designed for member related data and workflow processing in Medicaid and CHIP Program administration, while supporting customization needed or appropriate for DHH requirements. MemberConnect (the integrated contact relationship management component of MRM) will allow call center staff to view data regarding and interact with our members in a holistic and coordinated fashion, across the breadth of our members' wellness, clinical care, and administrative and financial matters.

In addition, MRM combines, integrates, and deploys data from multiple internal systems, such as AMISYS Advance, our claims and eligibility transaction processing system, our Member Portal, and TruCare, our integrated, member-centric health services management platform, presenting a single view patterned by user type and user need. MRM presents staff with all relevant information right at their fingertips so they may quickly and accurately address inquiries without having to access multiple systems independently (such as through separate logons). MRM will provide our MSR's with information and functionality such as:

- **Member Information.** MRM includes contact and eligibility information, including preferred mailing address and phone number, other insurance coverage, PCP assignment, languages spoken, any special needs or additional assistance required, and authorized callers who may act on the member's behalf.
- **PCP Selection.** MSR's will use MRM to help members select their PCP based on location, specialty, language spoken, and gender.
- **Authorizations.** MSR's can view all authorizations and their status.
- **Care Gaps/Wellness Alerts.** Upon receipt of an inbound call, MRM will prompt MSR's that a care gap or wellness alert (such as meeting appointment or immunization periodicity) exists for a particular member so they can address it or transfer the call to a Case Manager once the member's original inquiry has been addressed.
  - In addition, if an MSR or Case Manager has been unsuccessful in reaching a member (usually after three attempts), MRM can display an alert that a particular staff person is "looking for" for the member, so that the call can be transferred if the member initiates contact with the call center.
  - Using MRM in this manner has proven highly effective with affiliate plans. For example, analysis by one affiliate health plan *prior to* MRM implementation showed that of the members for whom a Case Manager had made three unsuccessful attempts to reach them, *45% of the members had initiated an unrelated recent call to Member Services*. Thus, an MSR's ability to see in MRM that the plan is looking for the member will significantly increase effectiveness of our outreach and accuracy of member contact information.
- **Member Location Relative to Provider Location.** This feature allows MSR's to display a map highlighting the member's location in comparison to a provider's location. MSR's can advise on directions to the provider's office, including available public transportation options and routes, or to arrange non-emergency medical transportation for members.
- **Member Inquiry History.** The system displays a real time summary of historical inquiries received from members by LHC staff including MSR's and MemberConnections™ (Connections) outreach staff. All inquiries are assigned a "call type and subtype" category for inquiry tracking and monitoring purposes. When MSR's see in MRM that a member has inquired several times regarding the same or a similar issue, they can attempt to determine the underlying reason for these repeat inquiries. For example, if the MRM inquiry history notes that the member has had several inquiries categorized as PCP Change, they would attempt to problem solve with the member to identify a compatible PCP to meet their needs on an ongoing basis. In addition, MRM can generate reports such as for "frequent callers" who may have needs that could be best served through an assigned Case Manager.

- **Members Within a Family.** Our MRM allows linkage of families within our system, including their needs and services, and increases understanding about how to most effectively address members' needs. We will use MRM to identify any member issues that staff and providers should be aware of. For example, if an MSR updates the member address field during a call with a member who has another family member receiving LHC services, MRM notifies the MSR to confirm that the other family member's address should be updated as well. Our system and processes will bring together all the information available about the member and family to identify needs and issues particularly for our high-needs and high-risk members.
- **Manage Prospective Members.** MRM allows MSRs to document inquiries from non-members such as prospective members seeking information about the plan and our provider network.

The management team will use MRM to manage overall performance of the department, using tools such as MemberConnect to provide results of operational metrics, staff performance, call types, routing statistics and volumes, and Centelligence™Insight, to provide desktop reporting and Key Performance Indicator Dashboard capabilities. These tools will help management continuously evaluate our performance by quickly identifying performance issues, monitoring trends, and identifying and implementing process improvements.

#### Training of customer service staff (both initial and ongoing);

LHC's comprehensive training program will ensure that all MSRs are qualified, professional, and equipped to provide outstanding customer service to our members. To maintain this level of service, training initiatives will be continuously implemented, adjusted and improved.

#### Initial Training

The Member Services Department's six-week training program will consist of three phases including **Fundamentals**, which focuses on the common tools, techniques, and resources available to all staff members of the department; **Programs**, which provides a comprehensive review of covered services, DHH program descriptions and requirements, populations served, and Geographic Service Areas (GSAs) including the provider network; and **Job Functions**, which targets the specific roles and responsibilities of staff and introduces supervised, hands-on training. The **Trainer** conducts training in a classroom setting, supplemented by interactive, online modules described below in connection with Ongoing Training.

The first phase of training, **Fundamentals**, covers the following nine topics:

1. **Customer Service Tools.** Customer service and telephone etiquette; active listening; the Avaya Call Management System; the MRM inquiry tracking, documentation and workflow system; call routing/warm transfers to other areas such as Case Management and Prior Authorization; coordinating three-way calls with our subcontractor for language translation.
2. **Clinical.** Prior authorization process; Case and Disease Management Programs.
3. **Claims.** Reimbursement models; claims review including filing requirements and guidelines; techniques to detect other insurance; resubmission and resolution processes; AMISYS Advance Claims Processing System.
4. **Provider Processes.** Credentialing and recredentialing; the medical home; LHC's Provider Portal; provider complaints and appeals.
5. **Secure Member Portal.** Self service features for members such as how to order an ID card replacement; update demographic information; complete online health risk screenings or assessments; view the online Provider Directory; change PCP.
6. **Subcontractors.** Roles and scope of responsibility; interface protocols.

7. **Legal.** HIPAA and confidentiality of member information; detection and reporting of fraud, abuse and waste.
8. **Resources.** Internal Intranet site containing LHC’s policies and procedures, quick reference guides, information about statewide programs (such as WIC, Partners for Healthy Babies, fuel and food assistance programs), local community resources (such as homeless shelters and food banks), LHC’s Provider Manual, Member Handbook, and Emergency Management Plan.
9. **Human Resources.** LHC organization structure; Ethics and Compliance; conflict resolution; quality improvement initiatives.

The second phase, **Programs**, contains an in depth review of covered services (including limitations and exclusions, basic behavioral health services, FQHC behavioral health services, and carevout services such as specialized mental health and pharmacy services), Coordinated Care Program requirements and features, populations served, our GSAs, and the importance of the medical home and coordination of services through each member’s PCP.

After successfully completing this module, participants progress to topics such as income levels and member eligibility categories, orienting new members to services, assisting new members through transition periods (such as from fee-for-service or CommunityCare 2.0 to CCN), screening and preventive services including EPSDT, access to emergency services, indicators of possible behavioral health crisis and the process for immediately accessing a behavioral health clinician to talk with the member, coverage for urgent or emergent needs, and complex conditions and when to transfer calls to Case Managers who can provide members with clinical information and support.

LHC will require all staff to complete our **Cultural Competency Training Program** upon hire and annually thereafter. This program is based on the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards). LHC and Centene affiliates follow all 14 CLAS Standards. The training reviews daily challenges facing many members such as poverty, Limited English Proficiency (LEP), low literacy, limited mobility, behavioral health conditions, and lack of shelter, food, childcare, and social supports.

We will require MSRs to participate in *annual recertification training which is based on CLAS Standards*, and uses role-playing, presentations, and case discussions, with emphasis on developing skills to communicate appropriately and address members’ linguistic and disability related needs and cultural differences. MSRs will receive training on listening for members’ needs and anxieties, and identifying potential life stressors that may affect how they do or do not access care. We also will require biannual refresher training for staff with member contact, including MSRs.

Member Services staff will be trained on disability sensitivity, using People First Language, and DHH’s Person First Policy. In addition, our training will include a review of our member education campaigns (such as the seasonal “Fluvention” flu prevention campaign) to ensure that staff are prepared to answer member questions and provide related educational materials upon request. Further information on our Cultural Competency Training Program is in Section L.4.

The third phase, **Job Functions**, will review department and individual performance goals for all staff members, specific roles and responsibilities, and related policies, procedures, and workflows. To enable staff to effectively participate in cross-functional dialogue and process improvement initiatives, and ultimately to improve service delivery, our training will include an in depth review of the role of other LHC departments and their staff responsibilities, and how the departments and staff relate to one another.

MSRs will learn about the role of the Connections outreach staff, who are health outreach workers from the communities we serve and are familiar with the distinctive characteristics and needs of the local area. Connections staff receive comprehensive training and are an integral part of our Case Management teams. For example, Connections staff will make home visits to high-risk members and members we cannot reach by phone. MSRs learn how outreach in the member’s home can improve prenatal and other health

outcomes and appropriate use of Emergency Department (ED) services. MSRs also learn about the role of the Grievance and Appeal Coordinator in assisting members in State fair hearings.

Finally, we will educate staff about the unique, local community organizations that help our members with essential needs, such as WIC, fuel assistance, food banks, domestic violence shelters, and faith-based programs.

In addition to topics described above, MSRs must be proficient at helping members select a PCP; educating members about appointment timeframes for preventive, routine, urgent and emergent services; processing member identification and demographic updates; making real-time PCP changes and fulfilling ID card requests; and educating members on the availability of self-service tools on the Member Portal. MSRs also will assist new members who have not proactively selected a PCP during the CCN enrollment process or whose choice of PCP is not available. MSRs must facilitate three-way calls to assist members with making doctor appointments (including appointments within one day for urgent care), intake and document member complaints for referral to a Grievance and Appeal Coordinator, and identify members who may have special health care needs and who should be warm transferred to Case Managers for needs assessment.

Near the conclusion of the Job Functions phase, the Trainer will introduce hands-on training through involvement in real-life and real-time situations for our MSRs. Senior staff will conduct **shadowing**, during which they observe the new staff member's technique and competence and provide guidance and coaching. The duration of shadowing will depend on the skills and confidence of each new staff member, who must demonstrate proficiency prior to graduating from the program and independently performing his or her job.

During this final phase of training, the Trainer and Quality Specialist will begin **call monitoring** of MSRs via our Call Witness application, which records calls and captures screen navigation to evaluate the effectiveness of the interaction, efficiency of the MSR's system navigation to obtain and document information, and cultural appropriateness.

### **Ongoing Training**

LHC will use Centene University, a corporate wide learning management system, complete with online courses available to all affiliates, to enhance our classroom training. The tutorials provide on-demand, anytime learning, at a pace set by each individual. Examples of course content applicable to MSRs include communication skills, conflict resolution, basic problem solving skills, behavioral and interpersonal competencies, time management, computer skills, and health care reform.

The Centene University technology is flexible and intuitive and will allow LHC to develop our own course content, incorporate videos from external sources, create flexible scheduling including parameters around frequency, duration, and our own required completion dates. In addition, courses may include a real-time assessment with guided corrections as well as post-tests to evaluate MSR understanding of course content. The system provides a variety of management tools and individual employee files containing certificates of completion, all of which aid in maintaining current, individualized educational development plans for staff.

With Centene University, on an ongoing basis our Trainer will develop and deploy continuing education modules such as on cultural competency, LHC quality improvement programs and initiatives, new DHH requirements, and a variety of other topics. The Member Services management team will require ongoing training sessions regarding department wide emerging issues, trends, and program requirement changes in advance of their implementation. Centene University will issue department notifications of upcoming training to all staff, and provide management with electronic notices to confirm which staff required to participate have in fact participated in the training within the timeframe indicated, along with the results of any related test. We will use Centene University to track compliance with LHC's required annual recertification of cultural competency for our MSRs.

Process for routing calls to appropriate persons, including escalation;

### Self Service Prompts

When members call the toll-free number, they will reach our self-service automated attendant that will immediately greet and prompt them to select their preferred language of English, Spanish, or Vietnamese. For members with physical, cognitive or communication impairment, LHC will use a best practice “stay on the line” feature, which will direct callers automatically to an MSR if the caller cannot press phone keys or determine how to respond to the menu options – they will simply stay on the line for this feature to activate. After the language prompt, we also will provide certain automated options, such as for information eligibility and PCP assignment. Regardless of queue selection, all calls are answered promptly, in the order received, and by the first available MSR.

### Routing Calls

Calls normally are *not* routed among call center staff, because all MSRs have similar comprehensive training, plus information online or at their workstations, to minimize the need for routing. Whenever a transfer is necessary, all call transfers are “warm” or three-way transfers, during which the MSR stays on the line and orally introduces the member to the appropriate staff person to ensure continuity, and to remain in touch with the caller. Members need to use only one phone number and place only one call.

The following are key examples of routing calls to LHC staff *outside* the call center:

- MSRs have immediate access for urgent (below) and non-urgent matters to RN and behavioral health (BH) Case Managers when clinical expertise is needed.
- After answering a member’s questions, when an MSR sees a clinical *Care Gap Alert* in MRM for the member who has called LHC, the MSR will suggest to the member transferring the call to a Case Manager.
- Members calling about complaints or appeals are warm transferred to a Grievance and Appeal Coordinator for assistance with the complaint and appeal process.

### Escalation

**Escalation for Crisis Calls and Urgent Clinical Situations.** MSRs will be trained to quickly identify triggers indicating a medical or behavioral health crisis call or other urgent or emergency situation in which escalation is appropriate. MSRs will listen for triggers such as key emergency words and phrases, member voice volume and tone, and other indicators of stress, use instant messaging to immediately obtain RN or BH Case Manager participation in the call, and, if necessary, dial 911 for the member while keeping the member on the line. MSRs are prepared to serve all members in crisis, including members not enrolled with LHC

**Escalation for Non-Clinical Issues.** MSRs will be thoroughly trained for a wide variety of call types and have the skills and tools necessary for addressing many issues that would be escalated to supervisors in other industry settings in customer service. LHC MSRs will be prepared to deal with members with cognitive impairment or limited communication skills, LEP, financial stress, and hard-to-pin-down fears such as lack of trust of “the system.” In most cases, non-clinical issues requiring escalation to a Supervisor would relate to new program requirements such as a change in covered services, a new program or process that has not yet been fully implemented, or a member’s request to speak with a Supervisor. MSRs will escalate non-clinical questions to the Supervisor of Member Services.

**Implementation Issues Requiring Escalation.** During the CCN implementation phase, LHC will identify, track, resolve and communicate issues and risks that could impact successful implementation. For example, all LHC Key Staff will conduct daily check-in meetings with support staff and subject

matter experts. Beginning with Contract execution, key local LHC and Centene corporate leadership and staff will hold weekly meetings throughout the implementation process.

Any issues identified by our MSRs through the member call center will be documented on an Issues and Risks Log (along with issues and risks from other functional areas) that stratifies issues and problems based on timing (at what point could the problem affect the project plan), probability (what is the likelihood that the problem would affect the project plan) and impact (to what degree will the problem affect the project plan). The Issues and Risks Log also documents assignment of accountability and a high-level description of the tasks needed to mitigate any problem. Issues that require input or decisions from DHH will be tracked and communicated to DHH in a Questions and Answers Grid. This grid will include each question, the date submitted, the person from LHC requesting the clarification, a reference to a specific DHH document or contract section, the person at DHH who provides the response, the date the question was answered, and the answer provided by DHH. To ensure visibility and support, senior leadership across functional areas will be updated weekly on issues affecting progress and problems requiring escalation.

**Escalation Due to Operational or Critical Business Function Failures.** In the event of an operational emergency or crisis, LHC seeks to meet or exceed DHH guidelines for restoration of normal business operations. LHC MSRs will be trained on our Emergency Management Plan and will be able to answer member questions on emergency preparation, local Parish Office of Emergency Management contact information, and information specific to a particular declared emergency event. In the rare event the office needs to close for an emergency, LHC will immediately redirect all calls to NurseWise (which is an integrated part of our virtual call center) to ensure members do not experience a disruption in service. In the event of a failure, LHC management will immediately notify DHH, the enrollment broker, and our subcontractors, and follow up when LHC resumes handling calls directly. Our Emergency Management Plan is further described in Section M.2.

**Confidential Escalation for Waste, Abuse, and Fraud (WAF) Issues.** Centene Corporation has a comprehensive program for prevention, detection and reporting of waste, abuse, and fraud by providers, members, employees and subcontractors. LHC's WAF Program will be based on and include best practices from Centene and affiliate plans. Centene's Special Investigations Unit (SIU) in conjunction with LHC will train providers, members, employees and subcontractors regarding the SIU telephone number for *confidential* reporting of any concerns. The number will be published in the Member Handbook, Provider Manual, newsletters, and on the Member and Provider Portals. All WAF referrals are investigated and remain confidential. (If members choose to report WAF instead through the member call center, MSRs will document and report the matter to SIU.)

The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);

Virtually all information needed by MSRs will be available to them online through MRM, as described in detail at the beginning of this response and summarized in the bullets below.

- Member and provider information, including Member Handbook and interactive Provider Directory
- Information to select a PCP
- Member location relative to provider location
- Service authorizations
- Care Gaps/Wellness Alerts
- Member inquiry history
- Members within a family

Additional information that will be available online to MSRs includes GSA-specific information, covered and non-covered services information, industry coding manuals (CPT/ICD9), CMS-1500 and UB Billing

Guidelines, and process flow documents. Examples of GSA-specific information include GSA-specific Resource Directories, for example, to help refer members to community resources or adult members to substance abuse services.

Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;

From the very start of a call, members will experience the initial phone prompts in English, Spanish, and Vietnamese. If the caller chooses the Spanish or Vietnamese options, the automated attendant will route the call to a queue staffed with either a Spanish or Vietnamese speaking MSR or English speaking MSRs who access our interpretation subcontractor, which provides translators for more than 200 languages.

After hours, NurseWise provides bilingual English/Spanish staff. Approximately 40% of the NurseWise staff are fluent in English and Spanish, and they use the same interpretation subcontractor to translate other languages. Both LHC and NurseWise use the TDD line and Louisiana Relay Service for members with hearing impairment. Like our affiliate health plans, LHC will strive to hire MSRs who speak Spanish and any other languages designated by the State, including Vietnamese. For example, in Texas, 100% of MSRs are bilingual in Spanish and English and each MSR job interview is conducted half in one language and then half in the other. In Arizona, our affiliate plan includes two MSRs who speak Navajo. MSRs will arrange for face-to-face translation and American Sign Language interpretation services for health care appointments through LHC's interpretation agencies (telephone translation may be used for languages for which there are very few speakers among Louisiana residents).

MSRs will help members identify providers who speak the member's primary language via the hardcopy Provider Directory or interactive Directory on our Member Portal and provide hardcopy materials such as the ID card and Member Handbook in English, Spanish, and Vietnamese, and other languages on request.

Monitoring process for ensuring the quality and accuracy of information provided to members;

The Quality Specialist will monitor and evaluate MSR performance to ensure accuracy and appropriateness of interactions with members or their representatives, confirm accuracy, completeness, and appropriateness of call documentation, identify training opportunities, and collaborate with the Trainer on expansion and refinement of training topics. Our Quality Specialist will evaluate all MSRs' interactions with our members as well as the effectiveness of our training programs by monitoring at least 10 calls per MSR per month via our **Call Witness audit tool**. Call Witness, a software application integrated with the Avaya System, records all call center phone interactions and retains a record of any applications that staff touch or use on their computer to resolve a call. The system synchronizes the captured voice and desktop activity allowing management to observe and analyze the complete customer interaction as it actually occurred. This software also archives calls for six months, which enables the management team to review historical calls to incorporate "live" call examples into our initial and ongoing training programs as well as investigate and address a caller complaint. Based upon each MSR's audit threshold configured within Avaya, the system provides the Specialist with a system selected random sample of calls from which they conduct their review. Our call audit criteria include evaluating the accuracy and effectiveness of the interaction, accuracy of call documentation, and cultural appropriateness.

LHC will address trends indicating training needs across multiple MSRs through customized training developed by the Trainer (such as relating to specific DHH program requirements or LHC processes), or when appropriate, existing online courses through Centene University (such as for skills enhancement). The Trainer will develop the content and methods used to deliver the training curriculum, provide management personnel with reports to assess staff development and progress towards attainment of required skills, continually evaluate the appropriateness of course material, and modify current material or

develop new material when necessary.

In addition to Call Witness monitoring, the Supervisor will circulate throughout the day among MSRs to observe and listen to the nature of their interaction with members, which provides immediate opportunities for coaching and performance improvement.

Monitoring process for ensuring adherence to performance standards;

### **Performance Standards**

LHC will require that 90% of callers reach a live voice within 30 seconds; an incomplete calls or abandonment rate of no more than 5%; a 99% pick up by the fourth ring; and no busy signal.

We do not impose maximum call duration times. Talk time varies among populations with different needs, but generally falls between 2 and 3.5 minutes. Our affiliate health plans have found that calls with Medicaid members in the ABD eligibility category tend to be somewhat longer than other calls, in part because members' BH conditions may impact their communication style and ability to cope with physical disabilities and chronic conditions. MSRs will spend the time that it takes to resolve a member's issues, as often as possible on their first call.

### **Monitoring and Reporting to Ensure Performance Standards Are Met**

**Ensuring Timely Response to Members.** The Workforce Analyst (Analyst) will monitor response timeliness for the member call center based in Baton Rouge via real time, on screen, call queue monitoring tools. These tools enable the Analyst to make immediate staffing adjustments to ensure coverage for all inbound calls and timely handling per DHH requirements. If the Analyst detects an increase in call volume in a particular queue, they immediately identify available MSRs and will reassign the MSRs as needed to ensure seamless coverage. The Analyst will provide immediate notice of the reassignment by instant-messaging the MSR and Supervisor of the change. (If the Workforce Analyst is temporarily absent, the Supervisor conducts the same type of on screen monitoring activities and staffing adjustments.) If call volume increases unexpectedly, the Supervisor will help handle calls and/or arrange for cross-trained staff, such as Connections staff, to assist. In the event of unusual and unexpected call volume peaks, the Avaya system can direct overflow calls to NurseWise. Our virtual call center design seamlessly integrates call center capabilities across multiple offices in an enterprise-wide Automatic Call Distribution system, allowing immediate management of geographically dispersed call center resources. Staff can log in from any office, or from home, statewide, or even nationwide under certain circumstances. One unified voice messaging system serves the entire organization so that messages can be sent or retrieved by any user at any office. If a center is experiencing extremely high call volume, or needs to close for an emergency, staff in other centers can log into those queues to answer calls. The technology proved its value when Hurricane Ike forced closure of our Corpus Christi and Houston offices in 2008. We rerouted calls to ensure prompt, uninterrupted customer service.

**Personal and Public Feedback to Promote Meeting Performance Standards.** Each MSR is required to read and sign the company's Call Monitoring Acknowledgment policy form upon hire and annually. Trends across multiple MSRs are promptly addressed at department-wide training sessions or biweekly staff meetings, and if appropriate, reminders are announced on our visual display boards. To demonstrate the importance of ongoing accuracy and link it to career advancement, the Supervisor will document Call Witness audit results in each MSR's **monthly performance report card**. This industry **best practice**, as cited by the Call Center Optimization Forum, compares individual performance to predefined performance goals, including measures for number of calls handled, quality audit results, percentage of documentation compared to calls taken, and attendance.

The Supervisor will review the performance report card monthly with each MSR, except in cases where immediate correction is warranted. In the monthly performance review, the Supervisor will discuss the

MSR's strengths, deficiencies, and specific training needs. Follow up activities may include informal coaching, retraining, or in the event of substandard performance, corrective action including termination if prompt and steady improvement does not ensue. We will provide each MSR with a **daily snapshot** of their individual performance and department wide performance, highlighting achievements and opportunities for improvement. Member Services Department performance will be summarized monthly and published in our monthly department newsletter, which will also contain helpful hints and information about CCN updates, membership, and LHC's provider network.

In addition, as part of our ongoing, real-time quality monitoring efforts, LHC will invite members to participate in automated phone surveys administered at the conclusion of their calls to the call center. Survey results will be housed in Centelligence™, our business intelligence, decision support, and reporting platform, for subsequent analysis, and will guide our continuous quality improvement efforts.

**Reporting.** LHC will provide call center performance reports to DHH within the timeframes and specifications required, including quarterly LHC call center results for number of calls received; answered; answered within 30 seconds; abandoned; and messages received after hours (the latter is not applicable, since we will provide live phone coverage after hours). In addition to the DHH reports, LHC will provide call center performance reports to LHC leadership noting operational achievements, challenges, and interdepartmental activities and initiatives.

These reports will be provided to a variety of internal constituents including our Compliance Committee and Board of Directors. We also will summarize our daily call performance reports and post daily and monthly cumulative performance within the department on our visual display boards, centrally located within the department, for all staff to view.

**Performance Standards and Subcontractors.** LHC's vision subcontractor, our affiliate OptiCare, will operate a member call center in a manner similar to LHC. The Vice President of Compliance will monitor their performance through the OptiCare Joint Operations Committee and will ensure compliance with all DHH and LHC member call center requirements.

How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g Partners for Healthy Babies, WIC, housing assistance, and homeless shelters);

### **One Call – Many Solutions**

When MSRs identify during a call member needs for services or supports not covered by CCN but that LHC has identified as being provided or accessed through State, parish, city, or other organizations, MSRs will assist members in reaching the appropriate customer service line or organization. For example, if the member identifies a lack of food or shelter for the member, their child, or family members, the MSR will offer information about WIC, a food bank, and homeless shelters in the member's local area. The MSR will also ask members if they would like the MSR to call the organization in question right then, or if they need assistance making an appointment or otherwise finding the location of the facility or organization. Call transfers to State, parish, and city organizations are always warm transfers. The MSR will stay on the line until we ensure the member reaches the appropriate party. The MSR also will evaluate the call event for possible referral opportunity to Connections outreach staff, to determine if an in-person visit may be helpful or to identify additional family, resource, or environmental issues that may indirectly be affecting members' ability to appropriately access to health care services.

And, after hours procedures.

### **After Hours Calls**

When members call LHC after hours, our automated call attendant system prompts them to select their preferred language of English, Spanish, or Vietnamese. Although DHH permits making a voice mailbox available after hours for callers to leave messages, LHC will provide NurseWise, our toll-free, 24/7 nurse

advice line that ensures members can speak directly to a live person about their benefits, accessing covered services, and their health care needs, including for seeking urgent and emergent health advice.

Like LHC MSRs, NurseWise staff will have on screen and online LHC-specific information and resources for answering member questions, as they do for other Centene affiliated plans. For each call, NurseWise staff see immediately on screen to which health plan the member belongs, based on the toll free number the member dialed. NurseWise call center staff and RNs will receive the same training as LHC MSRs; RNs also receive medical and BH training. The RNs have after hours immediate access, when needed, to LHC Medical Management staff, including a Medical Director, who maintain an after hours on-call assignment roster. At the conclusion of their shift, NurseWise staff will send an Activity Report to LHC's Member Services and Medical Management staff that includes inquiries requiring follow up; follow up must occur no later than the next business day. For example, Medical Management staff would promptly contact the member's PCP in the case of an inpatient admission.

### **Example of Success**

NurseWise has successfully lowered inappropriate Emergency Department (ED) utilization. For example, for our Texas affiliate health plan, in the year between Q3 2009 and Q3 2010, NurseWise identified 3,320 ED diversion opportunities for members seeking ED services and demonstrated a corresponding savings of \$863,847 in potential ED utilization.

### **24/7 Member Portal**

Members may contact us after hours via LHC's Member Portal to update their demographic information, change PCPs, and to access a number of other self-service features. Members also may submit inquiries online via secure messaging with responses provided within one business day of receipt.

*In summary*, LHC's call center will ensure sufficient local and toll free lines, and a call distribution and monitoring system to meet member needs 24 hours per day for consultation or referral from trained, knowledgeable staff.

## Question L.2

### Member Hotline Telephone Reports

L.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the abandonment rate.

LHC's affiliated health plan in Texas has the largest enrollment as of January 1, 2011, in a Medicaid/CHIP managed care contract. The membership includes Medicaid TANF and CHIP members (primarily children and pregnant women) and Medicaid foster care children served through the El Paso, Texas call center, and Medicaid Aged, Blind, and Disabled members (primarily adults, including dually eligible members) served through the San Antonio, Texas, call center.

The Texas Health and Human Services Commission (HHSC) measures call center performance on a quarterly basis. Our Texas affiliate surpassed the state's performance requirements in all four quarters. HHSC standards provide that at least 80% of calls must be answered by call center staff within 30 seconds, measured from the time the call is placed in queue after selecting an option, and the call abandonment rate is 7% or less. The Texas data for call volume, average speed of answer, and abandonment rate is provided on the following page.

As in Louisiana, our Massachusetts affiliate has a performance requirement that 90% of calls be answered by call center staff within 30 seconds, which is measured from the time the call is placed in queue after the caller selects an option. In the last calendar year, the health plan met or surpassed the state's standard with no less than a 90% rate for all 4 quarters.

If for any reason we do not meet our performance standards during a given month, we will immediately identify the root cause and address the issue with the appropriate staff or through process or technology enhancements.

Reporting Period	Monthly Call Volume	Average speed of answer	Abandonment Rate
<b>Overall Totals</b>	<b>309,241</b>	<b>:00:24</b>	<b>1.8%</b>
4/1/2010	23,173	:00:22	1.8%
5/1/2010	22,081	:00:27	2.4%
6/1/2010	23,320	:00:32	2.3%
<b>Second Quarter 2010</b>	<b>68,574</b>	<b>:00:27</b>	<b>2.1%</b>
7/1/2010	23,083	:00:34	2.5%
8/1/2010	25,423	:00:22	1.6%
9/1/2010	25,435	:00:26	1.9%
<b>Third Quarter 2010</b>	<b>73,941</b>	<b>:00:27</b>	<b>2.0%</b>
10/1/2010	24,902	:00:25	1.7%
11/1/2010	25,023	:00:21	1.6%
12/1/2010	23,723	:00:18	1.4%
<b>Fourth Quarter 2010</b>	<b>73,648</b>	<b>:00:21</b>	<b>1.6%</b>
1/1/2011	27,540	:00:23	1.8%
2/1/2011	30,794	:00:27	2.0%
3/1/2011	34,744	:00:18	1.3%
<b>First Quarter 2011</b>	<b>93,078</b>	<b>:00:23</b>	<b>1.7%</b>

**Question L.3**  
**Member Services Scenarios**

L.3 Describe the procedures a Member Services representative will follow to respond to the following situations:

- A member has received a bill for payment of covered services from a network provider or out-of-network provider;

LHC's member call center staff receive comprehensive training that emphasizes that all Medicaid enrolled providers serving Medicaid members through LHC may not bill members for *Core Benefits and Services*, which are those Medicaid benefits and services provided through a Coordinated Care Network, such as LHC.

The procedures a Member Services Representative (MSR) will follow when a member receives a bill for payment of *covered services* from a network or out-of-network provider follow.

1. To help members understand all their benefits, MSRs will be familiar with the Member Handbook section that tells members how and where to access *certain Medicaid Covered Services that are not provided through LHC* (including pharmacy cost sharing for certain adults), versus *Core Benefits and Services that are provided through LHC*. If members call about a bill for **Covered Services that are not provided through LHC**, MSRs will direct members to the Handbook or (for example, if low literacy may be a concern), review the Handbook section with the member, or warm transfer them through a three-way call to the appropriate customer service line for the type of Covered Services at issue.
2. When a member contacts LHC's call center about receiving a bill for **Core Benefits and Services that are provided through LHC**, the MSR will ask the member to provide a copy of the bill, instruct the member to not pay the bill, and explain that the MSR will follow up with the provider and notify the member of the results.
3. If the member does not have a copy of the bill, such as when a provider or collection agency called the member requesting payment, the MSR will obtain as much billing information from the member as possible, particularly the provider's name, type of service, date of service, and amount billed.
4. The MSR first will review the member's claim history through our Member Relationship Management system (MRM) to confirm whether the provider has submitted a claim to LHC for the services billed to the Member.
  - If the **claim was not received by LHC** and the timely filing period has not expired, the MSR will contact the provider to verify provision of services and the billing and explain that claims for Medicaid Core Benefits and Services should be sent to LHC, not to the member. The MSR will provide the member's Medicaid identification number and LHC billing address. The MSR will educate the provider's office staff or billing agent, regardless of whether the provider is in- or out-of-network, regarding any basic claims submission requirements the provider needs and will emphasize that claims, other billings, and requests for payment must not be sent to members. In most cases, our health plan affiliates have found that providers are unaware of the member's Medicaid coverage, and once made aware, providers submit the claim to the health plan. Because providers' interest is to be paid promptly, claim submission to LHC, as the correct payer, normally will conclude the matter.
  - If the **claim was received by LHC**, the MSR determines the disposition of the claim and network status of the provider. If the service provided was paid or denied appropriately, the MSR escalates the case to Provider Relations. The Provider Relations Specialist contacts the provider and informs them that billing the member is not allowed and must be discontinued. The Specialist assesses the situation to determine whether additional training for provider office staff is needed.
5. If the **MSR is unable to reach the provider**, or if the provider expresses any concerns or objects to billing LHC, the MSR will mail a letter to the provider, explaining that under applicable federal and State regulations, the provider cannot bill a Medicaid member for Core Benefits and Services. The

letter provides the member's Medicaid identification number and health plan billing address so the provider can submit a claim to LHC.

6. The MSR will **conclude by calling to inform the member** how the matter was resolved, that the member should not receive further bills or requests for payment for Medicaid Core Benefits and Services, but that if a bill is received, the member should not pay it and should re-contact the member call center.
7. The MSR will **document all inbound and outbound calls and any related actions in MRM** during or immediately after each call or action, as appropriate. MSRs will document all attempts to contact members (and providers) in MRM, along with follow up dates that automatically trigger alerts that remind the MSRs, at regular intervals, to repeat their attempts to contact the member. (Reminder alerts are used for provider call follow up as well when needed, but members often are more difficult to reach than providers.)
8. In MRM, MSRs also assign all inquiries a "call type and subtype" category for inquiry tracking and monitoring purposes. "Provider billing a member" is a significant issue and a trackable call type/subtype in MRM, therefore we will produce a **monthly report** that includes identifying providers that have billed members more than once. Using the report, Provider Relations staff will identify any providers that have billed members more than once and provide education by phone or schedule a visit at the provider's office. Onsite, Provider Relations Specialists will conduct education with providers and their office staff on not billing members and will attempt to determine the cause of any member billing, to ensure that it does not continue. Provider Relations staff also will identify out-of-network providers that have billed members, for potential recruitment to the LHC network.
9. If a **member contacts us in writing** and additional information is needed to address the billing issue, the MSR will call the member, and if the MSR does not reach the member after repeated attempts, will follow up with written correspondence. The subsequent steps are the same as described above.
10. If the **billing issue is not resolved to the satisfaction of the member**, the MSR advises the member of their right to file a complaint.
11. For vision claims, the MSR will warm transfer the member to our vision **subcontractor**, OptiCare. OptiCare staff will address "providers billing members" in a similar manner to that described above. LHC will conduct at least quarterly Joint Operations Committee meetings between LHC and OptiCare staff that include reviewing information on member billing inquiries and complaints, to ensure that our subcontractor is appropriately addressing any improper billing.

- A member is unable to reach her PCP after normal business hours;

When a member calls LHC's member call center **during business hours** to report a problem with contacting the PCP after hours:

1. The MSR will determine if the situation is an **emergency**. If the matter appears emergent, the MSR will direct the member to the nearest emergency facility or assist the member in contacting 911.
2. If the matter appears **urgent**, the MSR will offer to warm transfer the member to NurseWise, our 24-hour nurse advice line. A Registered Nurse (RN) at NurseWise will discuss the member's health concerns and ensure that the member will be able to access care, if needed, within DHH timeframes for urgent care. For example, the RN will make a three-way call with the member to the PCP's office to set an appointment within 24 hours, or ask the PCP to commit to working the member into the schedule the same day or on a walk-in basis.
3. If the matter appears to be **neither emergent nor urgent**, the MSR will ask if the member still needs to reach the PCP, and if so, will place a three-way call to the PCP's office. With the member's consent, the MSR will stay on the line to assist in making an appointment. Or, for example, if the member is calling to talk with the PCP's nurse about treatment instructions or specific health care

concerns, the MSR will warm transfer the member to the nurse, introducing the member and stating the background regarding the call, and then drop off the line so the member can converse privately.

4. The MSR will document in MRM the call type that indicates a member report that a contracted PCP is not meeting after hours access standards. The entry will trigger an **electronic alert for Provider Relations staff** who will conduct telephonic or when appropriate in-person education on how to comply with DHH and LHC requirements on after hours availability. For example, if the provider's after hours voice mail message or answering service methods are noncompliant, Provider Relations staff will provide technical assistance to bring them into compliance. In the event of repeated violations, Provider Relations staff will coordinate with our Quality Management Department to determine if corrective action is necessary, or whether the provider should be presented to the Credentialing Committee for review and possible consideration for discontinued network status.

When a member calls LHC **after normal business hours** to report a problem contacting the PCP after hours, NurseWise, our 24-hour nurse advice line, receives the call:

5. A NurseWise Customer Service Representative (CSR) normally will follow Steps 1 and 2 above.
6. If a member calls during early evening hours or during the day on Saturday, the CSR or RN will check the PCP's hours in the online Provider Directory, in case on that day, the **PCP has extended business hours**. If so, and if the member still needs to reach the PCP, the CSR or RN will place a three-way call to the PCP's office. **Otherwise**, they will provide information requested by the member and advise them how LHC staff will follow up the next business day (as described above).
7. At the close of each business day, NurseWise staff will send an Activity Report to LHC's Member Services and Medical Management Departments documenting inquiries requiring **daytime follow up** action, which must be completed no later than the following business day.
8. The LHC Quality Management Department also will monitor providers regularly to determine compliance with appointment standards through methods such as **"mystery shopping" and staged scenarios** to ensure appointment availability and after hours coverage. Monitoring will include ensuring the PCP's office telephone is either answered after hours by an answering service that can contact the PCP or another designated medical practitioner, or if answered by a recording, the recording must direct the member to either a PCP, or someone who is able to contact the PCP. In either event, the member's call must be returned within 30 minutes.

- A Member is having difficulty scheduling an appointment for preventive care with her PCP; and

1. The MSR will review with the member the required **timeframe of six weeks for preventive non-urgent** appointments to ensure the member has a clear understanding of the PCP's responsibility and to ascertain whether the PCP has adhered to these requirements.
2. The MSR will place a three-way **call with the member to the PCP's office** to identify a convenient appointment time for the member.
3. If the provider is unable to schedule an appointment within the required six-week timeframe, the MSR will **request a referral to a colleague within the PCP's practice** or to another PCP that may be covering for them. The MSR will advise the member that their PCP cannot accommodate an appointment but has referred them to another PCP. If the member agrees to see an alternative PCP, the MSR will schedule an appointment with the colleague in the same practice or will place a second (three-way) call to reach the covering PCP.
4. If the member does not agree, the MSR will advise the member (with only the member on the line) of the **availability of alternative types of PCPs**, such as an FQHC or OB/GYN for annual exams, or a pharmacy for administration of a flu shot. In addition, the MSR will offer to help the member **select a different PCP** and schedule an appointment. If the member agrees, the MSR will immediately contact the selected PCP to schedule an appointment and update the PCP assignment in MRM.

5. If the member refuses all of the above options, the MSR will make a second attempt to obtain an appointment with the original provider. For each call, the MSR (with the member's permission) will coordinate a three-way call so the member can provide necessary information to the provider's office.
6. **If the MSR determines that the PCP is not complying with DHH and LHC's access and availability standards**, the MSR will remind the PCP of their contractual obligation. As described above, the MSR will assign the appropriate call type that triggers an electronic alert to Provider Relations. Provider Relations staff will promptly follow up with education for PCP office staff on appointment availability standards, and in some instances, technical assistance on scheduling practices that help PCPs improve compliance with DHH and LHC appointment standards. Provider Relations staff will coordinate with the Quality Management Department to determine if a corrective action plan is necessary, and whether to refer the PCP to the Credentialing Committee for review and possible consideration of discontinued network status.

- A Member becomes ill while traveling outside of the GSA.

The LHC Member Handbook will advise members of the process they should follow if they become ill while outside the GSA, but most members will call us for assistance (as they will not have their Member Handbook with them). The Member Handbook will state that **emergency services provided outside the GSA are covered and do not require prior authorization**, and MSRs will advise members of the same when they call us. A member with an emergency medical condition, as determined by a prudent layperson, will not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the member.

Likewise, **LHC does not require prior authorization for urgent care**. Whether the member's need appears to be for **urgent care** (24-hour standard) or **non-urgent sick care** (72 hours or sooner if medical condition deteriorates into an urgent or emergent condition), LHC will strive to ensure that the member receives care within 24 hours, because a member who is sick and outside the GSA often does not have the informal supports that are helpful during illness and that may be available near their home. When members are outside their GSA, ill, and feel they may need to see a doctor, their primary concerns usually are locating a provider who will see them right away, and knowing that the provider will not require cash or other payment from the member.

1. If the member expresses an **emergent need**, the MSR will direct the member to the nearest emergency facility or assist them in calling 911.
2. When a member who is ill calls for help, they often will select the **"Talk to a Nurse" phone menu option**, which will route their call to a NurseWise representative. NurseWise RNs answer health related questions, can triage a member's symptoms based on nationally recognized triage criteria, and may advise an emergent or urgent referral to a provider. (If by chance an ill member who is outside the GSA calls and reaches an MSR because the member did not select "Talk to a Nurse," then the MSR will warm transfer the call to a NurseWise RN.)
3. **During business hours**, the RN will follow the process below.
  - **For an ill member who is in Louisiana but outside their own GSA**, the RN will use our online Provider Directory to locate an urgent care center or walk-in clinic (collectively, Urgent Care Center), or in areas where there simply are no such services, a PCP such as an FQHC or other appropriate provider, as close as possible to the member's location.
    - The RN will provide to the member the location of and, if needed, directions to an Urgent Care Center. If directing the member to another type of provider, the RN will place a three-way call to schedule an appointment within 24 hours for urgent care, or request that the provider commit to seeing the member as soon as possible on a same-day, walk-in basis. The RN also will arrange Medicaid or coordinate other transportation to the provider's office.

- Whether the member is in Louisiana or not, the RN will encourage the member to seek any necessary follow up care with their own PCP upon returning to the GSA where the member lives.
  - **If the member is in a state with an LHC affiliate plan**, the NurseWise RN will use our affiliate health plan's online Provider Directory to locate an Urgent Care Center or appropriate PCP or other provider for the member.
    - The RN will provide directions and may place a three-way call as described in the previous bullet so the member can be seen as soon as possible. The RN can help coordinate transportation, for example, through the Urgent Care Center or FQHC, or using the state's 211 Information and Referral services.
    - The RN will provide claims filing instructions to the provider to which they direct a member, since the provider is not in LHC's own network.
  - **If the member is not in an LHC or affiliate plan area**, the RN will conduct an Internet search for Urgent Care Centers, and the RN may use tools such as local medical association resources to locate an appropriate alternative provider. Further steps are the same as in the previous bullet.
  - The RN will document the member's call and the assistance provided in MRM.
4. **After hours, on weekends, or holidays**, NurseWise answers all calls. Depending on the hour, the RN will help the member locate an Urgent Care Center or a PCP that offers extended or Saturday hours. If no providers are open when the member calls, after answering the member's questions, the RN will include details on the member's condition, needs, location, and contact information in the nightly Activity Report that is sent first thing each business day morning to LHC's Medical Management Department for any needed follow up.
5. If a member is **receiving Case Management services** and calls their assigned Case Manager, the Case Manager will help the member locate an Urgent Care Center or other appropriate provider in the manner described above. The Case Manager will follow up with the member within three business days (whether or not the member has returned home) to determine whether further assistance is needed and to update the member's service plan as appropriate.

Question L.4  
Culturally Competent Services

L.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

### **Introduction**

**Cultural Competency Experience and Expertise.** Louisiana Healthcare Connections (LHC) is a joint venture partnership between Louisiana physicians and health care providers organized as the Louisiana Partnership for Choice and Access (LPC&A) and Centene Corporation, which has 27 years experience in full-risk Medicaid coordinated care. LPC&A is a for-profit LLC composed of 19 non-profit Louisiana Federally Qualified Health Centers (FQHCs).<sup>1</sup>

One of Centene’s seven governing Core Values, which applies to all its subsidiaries including LHC, is **“Diversity of People, Cultures and Ideas.”** Centene health plans serve only Medicaid, CHIP, and low-income members. The **19 FQHCs are Significant Traditional Providers** that have provided culturally competent services to Medicaid recipients in rural and urban Louisiana for many years. **Centene health plans in Mississippi, Georgia, and South Carolina have collaborated closely with local FQHCs to successfully transition** Medicaid TANF and ABD members in rural and urban areas from fee-for-service to managed care over the past five years.

Examples of Centene’s commitment to diversity include **designation of Centene by the Starkloff Disability Institute as a Role Model Company**, and the **2010 Corporate Achievement and Image Award from the National Black Caucus of State Legislators (NBCSL)**. Centene earned the Starkloff designation by working with the Institute to train and educate decision makers and companies regarding disability diversity in the employment setting. The Institute is dedicated to helping people with disabilities participate fully and equally in all aspects of society.

The 2010 Corporate Achievement and Image Award from NBCSL is presented to individuals and corporations working closely with African American legislators to address key issues affecting the African American community, including access to health care and health disparities. Centene was honored for assisting NBCSL in its networking activities with members and advocates. NBCSL represents more than 600 African American state legislators from 42 states, the District of Columbia and the Virgin Islands.

**Serving Louisiana Members.** The major ethnic cultures we will serve besides Caucasian are African American and Hispanic. In addition to the growing Vietnamese population, we anticipate serving members of Native American, Cajun, Chinese, and Haitian Creole heritage. As one of the most prevalent conditions among members, poverty has a profound impact on attitudes about care and often limits members’ ability to access care. Cultural competence is a critical factor in engaging members in their care and providing services that meet their individual needs. As described below, we will ensure that services are provided in a culturally competent manner by addressing cultural competence within both LHC and our provider network.

**Overview.** In this response we will address the following issues in describing how LHC will provide culturally competent services:

- CLAS Standards and LHC Cultural Competency Infrastructure
- Staff Hiring and Training
- Language Access Services
- Eliminating Ethnic and Other Disparities in Care
- Community Involvement

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<sup>1</sup> By federal law, FQHCs were designed to serve underserved communities, and a large proportion of their patients are Medicaid/CHIP enrollees. FQHCs are highly organized, as exemplified by the Louisiana Primary Care Association and the National Association of Community Health Centers.

- Culturally Competent Service Delivery By Providers
- Subcontractors

### **CLAS Standards and LHC Cultural Competency Infrastructure**

**NCQA CLAS Standards and Centene NCQA Pilot.** LHC will implement the NCQA Standards for Culturally and Linguistically Appropriate Services in Health Care (**CLAS Standards**), which operationalize the CLAS Standards issued by the U.S. Department of Health and Human Services' Office of Minority Health. We will implement and conduct continuous quality improvement for all 14 standards.

Using data from its affiliate health plans, Centene participated as a pilot site for the NCQA CLAS standards in 2009, and as a result, drafted modifications to the overarching Centene Cultural Competency Plan and policies, which LHC will use as the basis and starting point for our own Cultural Competency Plan and policies.

**CLAS Task Force and Cultural Competency Officer.** LHC will establish an internal **CLAS Task Force**, chaired by our Vice President of Compliance, who will serve as our **Cultural Competency Officer**. The CLAS Task Force will include management staff from our Member Services, Provider Services, Contracting and Network Development, Medical Management, and Quality Management Departments, as well as our Chief Medical Officer (CMO), other senior leadership staff, and a representative of LPC&A. The Task Force will meet at least quarterly. They will annually update LHC's Cultural Competency Plan (Plan), highlight related performance measurement, and evaluate the effectiveness of cultural competency strategies and initiatives. The CLAS Task Force will report to the Quality Assessment and Performance Improvement Committee (QAPIC), which will incorporate cultural competency data and information in our annual Quality Assessment and Performance Improvement (QAPI) Work Plan and subsequent QAPI Evaluation. The Cultural Competency Officer will be a member of the QAPIC.

**Stakeholder Input and Feedback Structures.** LHC will obtain input and feedback on evaluating and means for ensuring culturally competent service delivery, largely through our **Member Advisory Council** (one per GSA), **Community Advisory Committee**, and **Provider Advisory Committee**, all of which will meet quarterly. Our Member Advisory Council and Community Advisory Committee will provide input on draft member and other materials, performance statistics, proposed intervention strategies along with evaluation of their effectiveness, member satisfaction survey results, and community-based outreach and collaboration initiatives. To the extent practicable and relative to where committee members reside, LHC plans to hold some Member Advisory Committee meetings in different towns within each GSA, to increase opportunities for local input. For example, in GSA A, locations may include New Orleans, Slidell, and Franklinton; in GSA B, Baton Rouge, Lafayette, and Thibodaux, and in GSA C, Lake Charles, Alexandria, Shreveport, and Monroe.

In addition to seeking input through the Provider Advisory Committee, LHC will include providers on the QAPIC and other appropriate committees, such as the Utilization Management Committee, which will analyze ethnic and other disparities in utilization and quality of services. We also will solicit individual provider feedback during provider training sessions and field visits. All LHC committees will seek the participation of African-American, Hispanic, and Vietnamese providers.

**Cultural Competency Plan.** The LHC Cultural Competency Plan will address the 14 CLAS Standards and in particular the following elements:

- Staff and provider training
- Member access to interpreters including for persons with hearing impairment
- In-person and telephone communication standards
- Written materials in multiple languages (including Spanish and Vietnamese) and alternative formats
- Community collaboration

- Cultural competency regarding, at a minimum, ethnicity, gender, cultural background, poverty or low income status, religion, sexual orientation, member beliefs, interpersonal communication styles, and physical and behavioral health disabilities

**Monitoring LHC Cultural Competency.** The Cultural Competency Officer will be responsible for monitoring the cultural competency of LHC and our provider network services and the sufficiency of resources to address related issues, and reporting to the CLAS Task Force, Chief Medical Officer, and Compliance Committee. The Cultural Competency Officer will monitor metrics and activities such as:

- Utilization of telephonic interpretation services, including which non-English languages members request; utilization of TDD and Louisiana Relay services for members with hearing impairment
- Utilization of in-person interpreter services, including requested spoken languages and American Sign Language
- Member and provider complaints related to cultural competency
- Member and provider satisfaction surveys
- Progress on Cultural Competency Plan initiatives

**Centene Cultural Competency Committee.** Centene maintains a national Cultural Competency Committee that meets biannually and includes representatives from all Centene health plans. The Committee facilitates sharing of cultural competency strategies and best practices across plans for activities such as provider education and linguistic services. LHC’s Cultural Competency Officer will represent LHC at Centene Cultural Competency Committee meetings. A current committee initiative seeks to standardize reporting across plans and improve cross-plan performance and outcomes comparison related to member ethnicity.

### Staff Hiring and Training

**Hiring.** LHC will emulate the best practice of other Centene health plans by recruiting and hiring local staff who reflect the diversity of our member demographics. For example:

	African-American	Hispanic	Other
<b>Georgia</b> – Peach State Health Plan	71%	6%	23%
<b>Mississippi</b> – Magnolia Health Plan	64%	1%	35%
<b>South Carolina</b> – Absolute Total Care	50%	10%	40%
<b>Texas</b> – Superior HealthPlan	12%	54%	34%

Particularly for staff with member contact, hiring from the local area helps ensure that staff have a personal familiarity with the region, cultural norms, and how people access health care, which helps foster the trust needed for effective member communication and education. The experience of our affiliate health plans is that influencing member behavior and providing health education are most successful when members feel they are talking with a person with whom they have something in common. LHC Connections (member outreach) and Provider Relations staff will be regionally based, and may include home-based staff. LHC also will identify and use minority professional organizations such as Minority Professional Network to help recruit a diverse workforce.

**Staff Training and Resources.** Like other Centene health plans, LHC will require all staff, regardless of role or responsibility, to complete our **Cultural Competency Training Program upon hire, and at least annually thereafter.** We also will require **biannual refresher training for staff with member contact.** Our initial training will focus on the impact of culture on health care decisions, the employee’s own culture and potential biases, including ethnicity and gender, the impact of poverty on health, resources for members with disabilities, and linguistic barriers and resources for members with Limited English Proficiency (LEP) or low literacy.

LHC has identified regional advocacy groups to collaborate with in customizing and conducting our staff cultural competency training. For example, the Mississippi Coalition for Citizens with Disability (MCCD) and the Coalition of Texans with Disabilities have provided training or other support activities to our affiliate health plans in, respectively, Mississippi since 2008 and Texas since 2007. LHC is leveraging the experience of MCCD and Louisiana advocacy groups and convened the **first meeting of our Community Advisory Committee (CAC) on March 18, 2011. To date** our CAC includes local representatives from the **Institute of Women and Ethnic Studies, Nurse Family Partnership, Children’s Defense Fund, and Planned Parenthood Gulf Coast, and MCCD.** LHC will engage these groups and other Louisiana advocacy organizations to obtain local input and collaborate in developing, implementing and evaluating member education strategies and targeted services. This approach has worked well for our affiliates to ensure that health plan service delivery meets member needs and reflects the experience and perspective of community stakeholders.

All LHC staff will have access to **Centene’s Cultural Diversity Database**, which provides information on more than 20 different races or ethnicities. The database includes information on specific diseases or conditions for which a particular group is at higher risk and identifies cultural habits, beliefs, and traditions that may influence a person’s health care practices. For example, Case Managers will provide to members of a given minority race or ethnicity information about increased risk for certain diseases based on their race or ethnicity (and of course provide information about behaviors they can change to mitigate risk). The database helps Case Management staff in particular ensure that members who are not part of a prevalent race or ethnicity within their community receive culturally competent care.

### **Language Access Services**

**Member Materials.** LHC member materials will be written at up to grade 6.9 reading level in People First Language, and in accordance with DHH’s Person First Policy. Our Member Handbook, quarterly Member Newsletter, and other member materials will be available in English, Spanish, and Vietnamese, and upon request in other languages. The LHC Member Portal will be written in these languages and include a variety of member education materials. LHC will identify languages used by network providers, including American Sign Language, and the hardcopy and online Provider Directory will list which non-English languages are used by each provider. LHC member materials will comply with all DHH requirements; further details on member materials are provided in Sections K.1-K.3 and L.5.

**Translation.** LHC will use certified professional translators for translation of all member materials. When we use health education material produced by other entities, including subcontractors, we will review for grade level comprehension and sensitivity to the diversity of membership. The Manager of Marketing and Communications (who reports to the Vice President of Compliance) will coordinate the review process, which includes review by management staff in our Member Services and Provider Services and Quality and Medical Management Departments prior to submission to DHH for approval.

**Cultural Appropriateness.** We will customize our member educational materials to ensure that they are geared toward the ethnicities within our membership and their specific health care needs and are consistent with member cultures and local idioms. Materials with pictures will include appropriate representation of minority populations and, when applicable, will include information about race or ethnicity-related risk factors. We also will draw on examples from our affiliates such as MHS-Indiana, which distributed door cards from the Susan G. Komen Race for the Cure that provided information about breast self-awareness. They included cards created for African-American women that provide information about their increased risk for breast cancer.

**Disability Related Access to Materials on the Member Portal.** LHC’s Member Portal will be designed and maintained to be used by persons with vision or other impairment (per Section 508).

**Language Interpretation Services.** LHC will provide linguistic access for members whose primary language is not English or who have hearing impairment at no cost through the following means.

**Identifying Language and Communication Needs.** LHC will load any preferred language information from the DHH enrollment file into our Member Relationship Management (MRM) system. Then on the new member Welcome Call, staff will determine or verify members' preferred language and document it in MRM. This helps us, for example, assist members in selecting a PCP who speaks their preferred language.

**Telephonic Access to LHC.** LHC will recruit our call center, Connections outreach, and Case Management staff locally. Local staff are best prepared to recognize and respond appropriately to the rich variety of dialects represented across the State of Louisiana. We also will seek to include staff who speak Spanish and Vietnamese, to the extent possible and relative to the representation of Spanish and Vietnamese speakers within the general population. Members always will be able to converse with LHC staff by phone in members' preferred language, through professional translators with our interpretation subcontractor, which provides translators for more than 200 languages. After hours, all calls are answered by our affiliate NurseWise. Approximately 40% of NurseWise staff are bilingual in English and Spanish, with the following dialects spoken:

- Spanish – North American
- Spanish – Mexico
- Spanish – Latin America
- Spanish - Castilian
- Quiche, Quechua
- Kanjobal
- Mixteco Bajo
- Mixteco Alto
- Spiti Aerocam
- Puerto Rican
- Dominican Republic

Call center staff will have specialized training for communicating with callers in crisis and with behavioral health conditions that may affect their communication style and abilities. Call center staff also will have on-demand access to clinical staff when needed.

LHC network providers also may access NurseWise, at a low cost, to provide multi-lingual, after-hours coverage for their office lines.

**In-Person Interpretation Services.** LHC will provide oral interpreter and sign language services free of charge to members receiving covered services to ensure effective communication on treatment, medical history, and health education. For member appointments with providers, we will strive to ensure availability of certified medical interpreters. LHC will educate providers on these services and how to use interpreter agencies. We will emphasize use of professional interpreters, and not using family members, especially children, in part because impartiality is critical, such as in assessments, therapy, and treatment.

We also will educate members about interpretation services and how to obtain them, through the new member Welcome Packet, Member Portal, and Member Newsletters. We will maintain a list of certified interpreters who provide services on an as-needed basis, including for urgent and emergency care, when members or providers request services. Additional information on ensuring linguistic access to covered services for members with LEP or hearing impairment is provided in Section L.5.

**Linguistically and Culturally Appropriate Community Resources.** LHC will facilitate member access to linguistically and culturally appropriate community health and social service resources for non-covered services. For example, our Connections staff will provide referrals to such resources at community events and when interacting with members. Our Case Management staff also will provide similar resource referrals and will educate members on how to use the 211 Information and Referral line, particularly in the event of natural disasters.

### **Eliminating Ethnic and Other Disparities in Care**

**Key Disparities in Louisiana.** According to the Centers for Disease Control, African-Americans have the poorest health outcomes of any major racial or ethnic group in the United States, with higher adult and

infant mortality rates than other groups.<sup>2</sup> African-Americans have higher death rates from breast and cervical cancer, heart disease, stroke and HIV<sup>3</sup>, and this significant variation in health care quality exists even when conditions of income, age, and severity of condition are comparable.<sup>4</sup>

The 2009 DHH report entitled *Eliminating Health Disparities* notes that in 2007, African-Americans were approximately 32% of the Louisiana population, Hispanics 3%, and Asian-Americans 1%. Compared with the white population in Louisiana, African Americans were almost 1.2 times more likely to be living in poverty in 2003, Hispanics about 0.7 times, and American Indians or Alaska Natives about 0.5 times more likely to be living in poverty in 2003.<sup>5</sup> The report cites the greater impact of poverty on African American health status. Heart disease and diabetes are leading causes of death in Louisiana, with chances of death for African American Americans 1.4 (heart disease) and 1.2 (diabetes) times higher than whites<sup>6</sup> from 2000–2005.

**Louisiana Expertise and Innovation in Addressing Disparities.** We will leverage the improvements achieved by the FQHCs in the Louisiana Primary Care Association (LPCA), which formed the **Louisiana Health Disparities Collaborative** (HDC). The HDC has taken a systematic approach to health care quality improvement in which health care clinics (FQHCs, Patient Centered Medical Homes, and other specialty clinics) and practitioners implement and then measure practice-based innovations designed to meet the specific needs of their communities. The participating organizations then share their experiences in order to accelerate learning and widespread implementation of successful change concepts and practices. Clinic-based teams from across the state worked collaboratively for 12 months, focusing on providing disease management treatment and care to patients diagnosed with diabetes and/or cardiovascular (hypertension) disease. With technical assistance and training provided by DHH’s Chronic Disease Prevention and Control Unit and LPCA, the teams learned from each other about how to improve specified health outcomes. Teams supported by the HDC showed greater improvements in outcomes than those without HDC support.

Also notable, as depicted below, is the success of **Patient Centered Medical Homes** (PCMHs) in improving health outcomes. With the help of a \$50,000 grant from Centene Foundation, LPCA has provided training and technical assistance to many Louisiana FQHCs to achieve the three progressive levels of NCQA certification as a PCMH. Of the 25 Louisiana FQHCs, 5 FQHCs have achieved NCQA PCMH Level 3 certification. Fifteen FQHCs have submitted their PCMH application to NCQA. Two FQHCs will be seeking a similar medical home certification from the Joint Commission Accreditation.

The graph below depicts the improvements in care achieved by the HDC in managing hypertension and diabetes.

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<sup>2</sup> National Vital Statistics Report, Centers for Disease Control; Hsiang-Ching Kung, Ph.D.; Donna L. Hoyert, Ph.D.; Jiaquan Xu, M.D.; and Sherry L. Murphy, B.S.; Division of Vital Statistics.

[http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56\\_10.pdf](http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf).

<sup>3</sup> U.S. Department of Health & Human Services, Office of Minority Health, African American Profile;

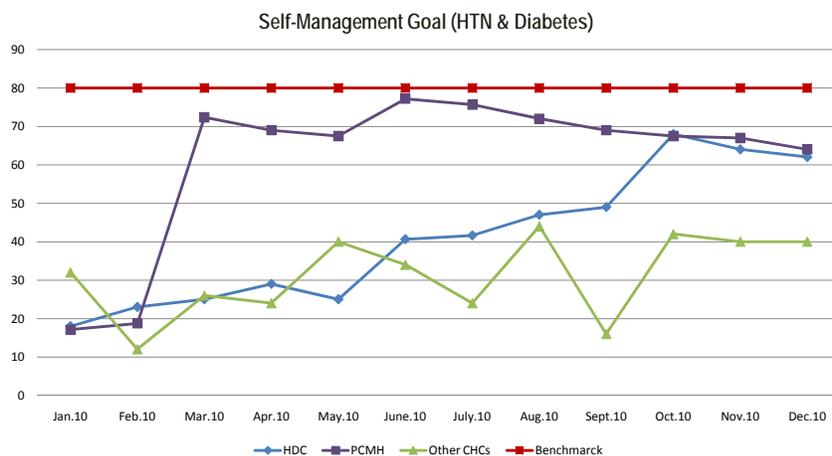
<http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlID=51>

<sup>4</sup> January Angeles and Stephen a. Somers, PhD, From Policy to Action: Addressing Racial and Ethnic Disparities at the Ground-Level, August, 2007, Center for Health Care Strategies, Inc.

<sup>5</sup> <http://www.dhh.state.la.us/offices/publications/pubs-90/Health%20Disparities%20Report2008-09.pdf>

<sup>6</sup> Ibid.

## SELF-MANAGEMENT GOAL COMPARISON CHARTS: HDC, PCMH, AND OTHER CHCs



Jun-11

Louisiana Primary Care Association

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**Clinical Initiatives Targeted at Eliminating Disparities.** Based on the above disparities data and our FQHC partners’ success in addressing heart disease and diabetes in African-Americans, we plan to focus two clinical initiatives on health disparities on these conditions. In addition, we will use Centelligence™, Centene’s comprehensive integrated decision support technology, to analyze member demographics, stratify health risks, and monitor for disparities in service delivery and outcomes. We also will conduct community needs assessments and/or use existing assessments to identify gaps in care in the parishes and GSAs that we serve and develop appropriate initiatives to address such gaps.

We will develop measures to assess quality initiatives; compliance with adopted clinical practice guidelines; access and availability of care; member and provider satisfaction; continuity and coordination of care; over and under utilization; compliance with preventive care visits, EPSDT, and prenatal care services; and disease, utilization, and case management activities. The measures we generate and analyze will comprehensively survey the quality of care and services provided to our members. We will assess the presence and degree of disparity between African-American, Hispanic, and white members for many of these measures, which will include both high-level measures, such as access to preventive health services, and more focused measures, such as an indicator within a disease-specific clinical practice guideline.

Our Texas affiliate health plan provides an example of this type of clinical initiative. The plan noted that nationally, in Texas,<sup>7</sup> and among health plan members, African-Americans have poorer birth outcomes compared to whites and Hispanics. In response, interventions in the plan’s targeted clinical initiative include collaborating with the March of Dimes and community advocates such as African-American church leaders and African-American service sororities such as Zeta Phi Beta and Delta Sigma Theta to improve prenatal care for African-American members. The collaboration encourages African-American women to seek prenatal care within the first trimester of pregnancy by offering incentives for attending appointments.

**Obesity.** Among other strategies, LHC will use Centene’s “**Thumbs Up Johnnie**” Program for children, which was developed in response to national concerns regarding obesity rates and ethnic disparities in obesity, and has been used successfully by several Centene affiliates. LHC will collaborate with schools

<sup>7</sup> The Health Disparities Task Force, 2008 Biennial Report to the Texas Legislature (2011 Report not yet available)

and School Based Clinics to implement the program in Louisiana, to address obesity concerns cited in DHH's *Eliminating Health Disparities* report.<sup>8</sup> Our campaign will include visits to local schools with "Thumbs Up Johnnie" books about healthy eating for children. Special features of the program include a visit from Thumbs Up Johnnie himself. "Thumbs Up Johnnie & the SUPER Centeam 5- Adventures Through FITROPOLIS" introduces five new characters who take Johnnie through their world of FITROPOLIS: Constance Eatrite (discusses healthy food choices), Spike Armstrong (reviews fitness), Skip Drive-Thru (assists with fast food choices), Claire Springs (encourages water intake) and Snack-King (promotes healthy snacks).

**Migrant Farm Workers and Their Children.** Ensuring continuity of EPSDT services for children of migrant farm workers throughout their temporary migration to other states is a long recognized disparities challenge for State Medicaid Programs. **Multipractice Clinic (Clinic), a bilingual FQHC in Independence,** is the only federally funded and designated Migrant Health Center in Louisiana and has provided care to migrant and seasonal farm workers and their children in five parishes for 13 years. In addition to providing primary and specialty care, the Clinic provides Migrant Education Training, a vocational training program to assist migrant farm workers in qualifying for better-paying jobs. The Clinic collaborates with the Stop Smoking Coalition, which offers smoking cessation programs for parents of children with asthma in the Area Health Education Center. The Xavier University School of Pharmacy provides a licensed pharmacist and a bilingual medication educator.

In 2010, our Texas affiliate health plan earned the highest incentive awarded by the State Medicaid Agency for improving services for children of migrant workers (17% greater than the next highest amount awarded), based on the effectiveness of their provider training and other initiatives with community groups. LHC will build on the Multipractice Clinic and our Texas affiliate's expertise and success, and collaborate with rural FQHCs and Rural Health Centers to ensure continuity of EPSDT services for children and support for migrant worker families in Louisiana.

**Rural Louisiana Parishes.** LHC is committed to serving members in rural Louisiana and will address disparities in rural access to care and health status, supported by the extensive local experience of our rural FQHC owner-partners. Our Centene affiliate health plans excel in providing health care in rural areas and unlike some plans, have embraced the opportunity to serve rural communities. In 6 of the 11 Centene health plans, at least half the counties they serve are rural as designated by the Census Bureau; in total, **58% of counties served by Centene health plans are rural.**

Our Texas affiliate's rural CHIP program illustrates the rural expertise Centene brings to LHC. In less than four years, our affiliate health plan transformed the 170-county rural CHIP program from an indemnity PPO program into a medical home primary care model, while saving the state approximately \$100 million over the previous contractor, based on the previous contractor's public data and state agency trends. For example, as a result of the plan's Disease Management Program, the asthma Emergency Department visit rate between June 2007 and 2008 was 19% lower than the preceding 12 months. The health plan also decreased potentially avoidable inpatient admissions 16% over a two-year period. LHC will build on successes such as these in improving access to care and health outcomes for members in rural Louisiana parishes.

### **Community Involvement**

LHC staff will meet our members where they are, and staff will provide outreach, education, and other services in familiar community locations that our members frequent. We will partner with community organizations that our members know and trust, to provide culturally-sensitive outreach and education. Examples of such partnerships include, but are not limited to the following.

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<sup>8</sup> <http://www.dhh.louisiana.gov/offices/miscdocs/docs-90/Health%20Disparities%20Report2008-09.pdf>

**Healthy Lifestyles Program.** LHC’s Healthy Lifestyles Program will identify regional community health education needs, improve outreach and communication between LHC and community-based organizations, promote healthy lifestyles and disease prevention, and help eliminate ethnic and other disparities in care and health status. Upon approval from DHH, our Healthy Lifestyles Program will include the following components:

- **Healthy Habits.** Given the rates of obesity, diabetes, and cardiac issues reported in Louisiana, LHC staff will organize and support local events and activities focused on nutrition and healthy eating, fitness and healthy habits, and safety and hygiene education. For example, on **June 10, 2011**, LHC sponsored **“Eat For Life!” a fresh foods health fair centered** around healthy foods, healthy eating habits, and nutrition. A total of 417 children, parents, and seniors from the Kingsley House Head Start, Summer Camp, and Eldercare programs participated, including volunteers and caregivers. The event included various stations featuring activities, tastings, and lessons at the Kingsley House Courtyard in New Orleans.
- **Healthy Congregations.** In another program focusing on obesity, diabetes, and cardiac health, in diverse Louisiana communities we will offer health outreach and education through faith-based organizations, such as churches and their health ministries. Healthy Congregation sessions will occur after scheduled church services, such as bible study or Sunday services, and offer attendees preventive screening services such as blood pressure checks, body mass index (BMI) measurement, and glucose or cholesterol testing. They will include health education and cooking demonstrations, such as cooking healthy on a budget. Our Healthy Congregation events are free and attendees will have the opportunity to win health-related giveaways, talk with LHC staff, and receive healthy tips and information. Some targeted regions and churches include:

#### **North/Northeast Louisiana**

- North Point Community Church, Bossier City
- North Arkansas Street Church of Christ, Springhill
- North Shreveport Baptist Church, Shreveport
- North Crossings Church, Monroe

#### **South/Southeast Louisiana**

- Star Hill Baptist Church, Baton Rouge
- Zion Travelers Baptist Church, New Roads
- Isabel Baptist Church, Bogalusa
- St. Francis Chapel, New Roads
- Grand Isle United Methodist Church, Galliano
- Our Lady of Assumption Church, Carencro
- Mary Queen of Vietnam Church; nhà thờ Maria Nữ-vương Việt-Nam, New Orleans

#### **Southwest Louisiana**

- Faith-Bible Church of Lake Charles, Lake Charles
- Morning Star Seventh-Day Adventist Church, Lafayette

- **Healthy Homes.** The Healthy Homes initiative will assist individuals who live in low-income or public housing to identify and address health hazards in the home, particularly lead. **Potential neighborhoods** that may benefit from this program include the Iberville/Trene<sup>9</sup> communities. Additional neighborhoods such as St. Thomas, Central City, St. Bernard, Desire, Dillard and the Calliope Project in the New Orleans area; East Brookstown, Melrose Place East, Scotlandville, Zion City and Monticello in Baton Rouge and Allendale, MLK, Cedar Grove and Mooretown in Shreveport may be targeted for consideration.

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<sup>9</sup> <http://portal.hud.gov/hudportal/documents/huddoc?id=CNImplementationGrantfin.pdf>

- Programs in the Greater New Orleans area such as the Neighborhood Partnership Network may be targeted for grants and sponsorships. For example, the Louisiana Public Health Institute (LPHI) **Healthy Neighborhoods-New Orleans** (HNNO) initiative gives qualifying neighborhood associations or organizations a chance to participate in a program focused on improving neighborhood health and specifically factors involved in Type 2 diabetes. Chosen neighborhoods will receive technical assistance and financial support to create community action plans that address being overweight, poor nutrition, and lack of physical activity – the risk factors of Type 2 diabetes. With funding from the Kresge Foundation, LPHI is convening a wide variety of partners including public health specialists, architectural and urban planners, neighborhood outreach organizations, civic and nonprofit organizations, and health care providers to create a one-stop resource for data, tools and guidance to support and inform neighborhood and community health improvement efforts across New Orleans. The planning and development phase of this project is currently referred to as the Orleans Neighborhood Health Implementation Plan (ONHIP), which will ultimately lead into a new program that will address an array of community health issues and indicators including built environment, nutrition, active lifestyles, health services, economic development, education and more.
- Established community resources that promote and enhance the healthy development of children are also a critical component in reducing negative long-term behavioral and physical health issues. LHC will support partnerships with organizations such as the **Boys & Girls Club of America** by sponsoring membership fees in major metropolitan areas that include New Orleans, Greater Baton Rouge, Lafayette, Lake Charles, Alexandria, Shreveport/Monroe and Ruston.

**Encouraging Staff Support of Community Organizations.** LHC will emulate a successful affiliate health plan program by sponsoring “**Jeans Days**” at our office each month. Employees who wish to wear jeans to work on Jeans Day will donate \$5. We will use money collected to support culturally diverse community organizations and projects that serve our members.

In addition, Centene sponsors and supports **Disability Mentoring Day**, an annual, nationwide job-shadow and career exploration program that links students and jobseekers who have disabilities to employers interested in hiring people with disabilities. LHC will hold a local Disability Mentoring Day in our Baton Rouge office.

### **Culturally Competent Service Delivery by Providers**

LHC will provide culturally competent care by maintaining an ethnically diverse network of providers of both genders, providing ongoing cultural competence education to network participants, and monitoring to ensure culturally competent service delivery. LHC will strive to provide a network that demographically reflects our membership. A key component of our network will be our 19 FQHC owner-partners that have provided culturally competent services at 68 sites across the State for many years.

**Strategies to Recruit a Diverse Network.** LHC prioritizes recruiting STPs because they tend to be ethnically diverse, and they already serve prospective members and understand their needs. In addition, STP demographic profiles match member demographic profiles more closely than do non-STP demographic profiles. LHC has identified minority medical societies to help in our outreach, including the **Louisiana Medical Association, New Orleans Medical Association, and Louisiana Independent Physician Association**, and our CEO, Jamie Schlottman, has met with all three associations. We will continue our outreach with minority provider association leadership and when possible their membership, regarding network development and our provider-oriented philosophy, particularly on issues such as prompt claims payment.

Once a network is operational, plans have found that network providers themselves often are the best source for identifying diverse providers and recommending to their peers that they contract with the plan.

In Indiana, for example, providers of Nigerian heritage have helped our affiliate health plan with referrals and also translated selected written materials for the benefit of members of such heritage.

Beyond including STPs in their networks, Centene health plans have included STPs in health plan governance at the highest level of the Board of Directors, as well as throughout their committees and initiatives. This STP approach is exemplified by a longtime Centene alliance with FQHCs, also called Community Health Centers (CHCs), which are STPs. For example, the long-time Board Chair of our affiliate health plan in Texas has for many years also been the Executive Director of the Texas Association of Community Health Centers, and the Board of Directors of our Georgia affiliate includes an FQHC physician CEO, FQHC physician Chief Operating Officer, and the Executive Director of the Georgia Primary Care Association. In Louisiana network development, LHC will draw on the considerable local knowledge, experience, and resources of partner FQHC executives such as **CEOs Roderick Campbell in New Iberia, Rhonda Litt in Baton Rouge, and William White in Shreveport, CFO William Brent in Franklin and Monroe, all of whom serve on the LHC Board of Directors, and Dr. Gary Wiltz, FQHC CEO in Franklin and LHC Chief Medical Officer, who will co-chair our Quality Assessment and Performance Improvement Committee along with our full-time Chief Medical Director.**

**Strategies for Retaining Diverse Providers.** LHC recognizes the importance and value of strong doctor-patient relationships. A primary LHC strategy for maintaining a culturally diverse network is supporting physicians in the coordination of their patient's care, paying them on time, and making administrative procedures as simple and provider-friendly as possible. For example, on average, Centene paid clean claims in less than 7.5 calendar days in FY 2010 (including paper as well as electronic claims). Because Medicaid rates are lower than commercial rates, prompt payment and smooth preauthorization and other procedures are especially important in helping STPs efficiently manage their practices.

We also encourage provider participation by demonstrating how our Case and Disease Management Programs can support them, especially with high needs and high risk patients. Through health education, telemonitoring for certain rural members, and other administrative supports, LHC will augment provider care in order to increase patients' ability and desire to take personal responsibility for their health.

Finally, as our affiliates do, LHC will methodically solicit and use STP input on ways to improve delivery of care and administrative processes, and we will encourage participation by ethnically diverse providers, both female and male, on committees such as the Credentialing, Utilization Management, and Quality Assurance and Performance Improvement Committees. In addition, provider (and member) satisfaction surveys will include questions relating to linguistic access and cultural issues.

**Contract Requirements and Provider Education.** LHC provider contracts require compliance with DHH and LHC non-discrimination and cultural competency requirements, such as timely use of professional interpreter services and meeting access requirements under the Americans with Disabilities Act accommodate members with disabilities.

**Training Processes, Content, and Materials.** We will provide cultural competency training to providers and their office staff during new provider orientation and at least annually, through regional group sessions and webinars free-of-charge. During new provider orientation and ongoing training, LHC will provide information on the CLAS standards and encourage providers to implement applicable CLAS standards that are not already mandatory within their own practices. We will be alert to the need for specialized training. For example, to meet the needs of their small but growing Burmese membership, our Indiana affiliate health plan developed and conducted training on Burmese culture to providers serving Burmese members.

We will provide written cultural competency materials on policies, procedures, and recommended practices during in-person and web-based trainings in our Provider Manual and Newsletters, and on our Provider Portal online. We will offer culturally appropriate health education materials, such as for our

annual “Fluvention” flu prevention campaign, to support providers in educating their patients, our members.

Provider Relations staff will reconcile in-person online training registration against network listings to validate provider completion of cultural competency training. We will outreach to providers for whom we have no documentation of training completion to facilitate their participation.

**Continuing Education Units.** Whenever possible, we will arrange for providers to receive Continuing Education Units (CEUs, encompassing both physicians and mid-level practitioners), to encourage ongoing and regular participation in training. LHC will provide a link on our Provider Portal to web training such as the Department of Health and Human Services’ Physician’s Practical Guide to Culturally Competent Care, a free, online accredited educational program<sup>10</sup>, providing up to 9 CEUs, and the America’s Health Insurance Plans program on Promoting Culturally Sensitive Health Care<sup>11</sup>, which provides 2.5 CEUs for physicians, and an additional training providing 2.5 CEUs for nurses and case managers. The trainings are all free of charge.

**Collaborative Training with Provider Organizations.** LHC will collaborate with key provider organizations and practitioners to customize, develop, and deliver provider education that meets network providers’ needs. For example, our Texas affiliate health plan facilitated a statewide training videoconference with the Texas Association of Community Health Centers in December 2010, on using managed care to improve services to diverse populations. Topics included how different races and cultures access and use care, challenges in serving members with LEP, and seasonal migration patterns of farm workers in Texas. Soon they will initiate a related statewide provider training initiative with both the same Association and our behavioral health affiliate, Cenpatico, regarding the importance of PCP screening for behavioral health conditions and integration of medical and behavioral health care. LHC’s affiliation with LPC&A positions us well to conduct similar programs in Louisiana.

**Provider Monitoring and Support.** Methods for monitoring compliance with cultural competence requirements are addressed in the first section of this response. If we identify providers who are noncompliant, we require additional training, typically in the provider’s office, develop with them a corrective action plan (CAP), and monitor for improved performance. Although failure to improve could lead to contract termination, our affiliate health plans’ experience is that providers generally recognize the benefits to them and their patients of providing linguistically and culturally competent services and most are cooperative in implementing related practices and procedures.

**Practice Support.** Through in-person visits as well as calls to our provider call center, Provider Relations staff will monitor provider satisfaction with their interaction with patients. For example, if providers express frustration with missed appointments and non-compliance with treatment plans, staff will troubleshoot and offer help, such as having Case Management staff contact members who repeatedly miss appointments to address barriers such as lack of transportation or childcare, and to provide Case or Disease Management services to increase member self-care and compliance with treatment plans. Provider Relations staff also will educate providers on how LHC Case Management and other staff can support their practice such as by linking their patients with culturally appropriate community resources.

**Quality Profiling.** LHC also will monitor HEDIS measures by GSA and ethnicity where practicable and analyze high volume provider profiles to identify practice patterns outside of evidence-based practice or inconsistent with clinical practice guidelines. Our Medical Directors and clinical staff will follow up with under-performing providers to educate them on ways to improve delivery of evidence-based, culturally competent care. Conversely, LHC will identify high volume providers with strong HEDIS performance to identify best practices in culturally competent care and share such practices with other providers.

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<sup>10</sup> [cccm.thinkculturalhealth.org](http://cccm.thinkculturalhealth.org)

<sup>11</sup> <http://www.ahip.org/disparities/QIModules/>

### **Subcontractors**

LHC will contractually require subcontractors to maintain policies and programs that comply with our cultural competency requirements and ensure that services to members are linguistically and culturally competent. The staff of all Centene affiliate subcontractors must complete Centene's initial and annual cultural competency training. We also will require subcontractor participation in community outreach activities for cultural minorities. We will provide subcontractors our Cultural Competency Plan and post it together with related policies and procedures on our Provider Portal.

For each subcontractor, a Joint Operations Committee will monitor and provide oversight of subcontractors to ensure compliance with all DHH and LHC requirements. Each committee will include LHC and subcontractor managers for all functional areas applicable to each subcontractor's delegated functions. Oversight will occur through monthly or quarterly meetings of each Joint Operations Committee and annual delegation oversight audits. At meetings, committee participants will analyze standardized performance reports, member and provider complaints, and other key data and act on them to promote compliance and continuous quality improvement in LHC service delivery.

## Question L.5

Appropriate Delivery of Services to  
Members with Limited English  
Proficiency or Hearing Impairment

L.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.

### **DHH Requirements**

LHC will make real-time oral interpretation services available, free of charge, to each member and potential member for Spanish, Vietnamese, and all other non-English languages. LHC will notify members that oral interpretation is available for any language, and written information is available in Spanish and Vietnamese, and other languages on request and how to access those services. On materials with the notice regarding Spanish and Vietnamese, the notice will be written in both Spanish and Vietnamese.

LHC will ensure that translation services are provided for written marketing and member education materials for any language that is spoken as a primary language for 200 or more members of a CCN within the GSA. Within 90 calendar days of notice from DHH, LHC will translate and make available member materials in the DHH designated language. Materials will be available at no charge in that specific language to assure a reasonable chance for all members to understand how to access LHC and network providers and use services appropriately as specified in 42 CFR §438.10(c) (4) and (5).

LHC will comply with the Office of Minority Health, Department of Health and Human Services' Cultural and Linguistically Appropriate Services Guidelines, known as CLAS Standards. Standards 4-7 govern language access services.

In describing below how LHC will fulfill these requirements we address the following topics:

- LHC Staff Who Use Linguistic Services and Promote Members' Access to Them
- Language Assistance Services for Members with LEP
- Language Assistance Services for Members with Hearing Impairment
- Written Materials for Members with LEP
- Quality Monitoring, Including Subcontractors

### **LHC Staff Who Use Linguistic Access Services and Promote Members' Access to Them**

LHC staff with member contact include **call center and Case Management staff**, who communicate with members primarily by telephone, and **MemberConnections® outreach staff**, whose member contact is mainly in-person, in the community. LHC will recruit all such staff locally and strive to hire staff who are bilingual in Spanish, Vietnamese, and any other DHH designated languages. We will provide our staff extensive training on communication with members who have LEP or hearing impairment.

**Provider Relations Specialists** are field staff who conduct provider training sessions and one-on-one training to providers and their office staff. Provider Relations educate providers on LHC language access services for members with LEP and hearing impairment and how LHC supports provider/member communication through interpretation services.

### **Language Assistance Services for Members with LEP**

**LHC Call Center.** When members call LHC's toll-free number, they will reach our self-service automated attendant that will immediately greet and prompt them to select their preferred language of English, Spanish, or Vietnamese. For members with physical, cognitive or communication impairment, LHC will use a best practice "stay on the line" feature, which will direct callers automatically to a Member Services Representative (MSR) if the caller cannot press phone keys or determine how to respond to the menu options – they will simply stay on the line for this feature to activate. Members will speak either with bilingual staff or a staff member who engages a translator from our interpretation subcontractor, which provides interpretation for over 200 spoken languages.

After hours, callers will reach our 24/7 nurse advice line, NurseWise. Approximately 40% of NurseWise staff are bilingual in Spanish, and staff will use the same interpretation subcontractor as LHC to translate languages other than Spanish.

The Quality Specialist in the Member Services Department will evaluate all MSR's interactions with our members by monitoring at least 10 calls per MSR per month via our **Call Witness audit tool**. Call Witness, a software application integrated with the Avaya System, records all call center phone interactions and retains a record of any applications that staff touch or use on their computer to resolve a call. We will use Call Witness to monitor and ensure that staff using translator services are providing members the same level of service as for calls in each MSR's primary language. We will similarly monitor calls involving bilingual staff. Our call audit criteria include evaluating the accuracy and effectiveness of the interaction, accuracy of call documentation, and cultural appropriateness.

We expect that our diverse staff will be a significant resource to each other in improving linguistic access, as they have been for our Texas affiliate health plan. Recognizing the notably different dialects among Spanish speakers, Texas health plan staff identified specific differences and now train each other and new staff on distinctive accents and word usage. This approach will be helpful for serving members from neighborhoods such as Kenner, Terrytown, Mid-City, eastern New Orleans and central Metairie, where the rapidly growing Hispanic population is from a variety of Latin American countries that have different dialects.

**Statewide and In-Person Services.** LHC will contract with interpretation agencies that provide in-person translation services for member appointments with health care providers, home visits such as with LHC Connections staff, as well as telephonic services as needed. For member appointments with providers, we will strive to ensure availability of **certified medical interpreters**, such as through our subcontractor that also provides call center interpretation services. Upon contract award we will look to expand to include Louisiana based resources such as the local agency Multi-Language Solutions, Inc. We will maintain a list of certified interpreters who provide services on an as-needed basis, including for urgent and emergency care, when members or providers request services.

LHC will **educate providers** on how to schedule interpreters for member appointments. We will encourage providers to notate members' language preference in a prominent way on their medical record and to take the initiative in scheduling a translator, rather than assuming that members will arrange for a translator by contacting the LHC call center. We will emphasize to providers that members should not use family and friends, and especially children, to interpret (except on specific request by the member, after knowing that no-cost translation is available).

LHC staff who work with members also will **educate members** with LEP about the availability of and how to use of translation services, so they can take an active role in removing linguistic barriers to receiving timely health care services. On the new member Welcome Call, our staff verify each member's preferred language and enter it in the Member Relationship Manager (MRM) system. The preferred language designation, along with the MRM member inquiry history, prompts call center staff to provide the type of member education that is most important and appropriate to each individual member with whom they speak. We also will educate members about interpretation services and how to obtain them through the Welcome Packet, Member Portal, and Member Newsletters.

### **Language Assistance Services for Members with Hearing Impairment**

**Telephonic Services.** LHC will use Louisiana Relay Service (Relay), the State's portal to the nationwide 711 relay to communicate with members with hearing impairment. To use the relay service, which is considered a best practice by persons with hearing impairment, members dial 711 to reach a Communications Assistant. The member then types in LHC's toll-free call center number and the Communications Assistant connects the member and the LHC or 24/7 NurseWise staff person, and "relays" the discussion between the member and the LHC representative. Training also will include use of

Telecommunications Device for the Deaf (TDD) equipment (which is used less now with the advent of the Relay), and the Telebraille system (through Louisiana Relay), for members who are visually and hearing impaired. As with our affiliate health plans, LHC will engage a local community member who is hearing impaired to train our staff to use TDD equipment. Training by a person who is hearing impaired improves staff understanding of sign language conventions and etiquette distinctive to use of the equipment.

Louisiana Relay operates an Equipment Distribution Program to provide TDD equipment for individuals who cannot afford it. Call center and outreach staff will help members access this and other resources as needed. Currently, our affiliate plan members without TDD equipment, who do not qualify for a state equipment program, usually ask a family member or friend who can both speak and use sign language to call the health plan and interpret for the member. Our Centene affiliate health plans have found, through both Consumer Assessment of Health Plan Providers and Systems (CAHPS) results, and feedback from their Member Advisory Councils, that many members with hearing impairment do not use electronic communication due to lack of equipment and lack of confidence and experience, such as in establishing an internet account. LHC will provide information and community resource referrals to members with hearing impairment regarding equipment options and internet access, including through the LHC Member Portal. LHC Member Services staff will respond to requests received through the Portal within one business day. In addition, LHC will educate providers on options for improving communication with members with hearing impairment.

**In-Person Services.** LHC will arrange face-to-face American Sign Language interpretation services for members with hearing impairment at health care appointments in a manner similar to providing language translation for members with LEP. Provider Relations staff will educate providers on use of Louisiana Relay and encourage them to be proactive in using interpreter services for members with hearing impairment.

### **Written Materials for Members with LEP**

LHC will comply with requirements relating to all written member materials, regardless of the means of distribution, for example, printed, web, advertising, and direct mail.

**Accountability for Compliance with Language Requirements.** LHC will submit complete final drafts of all written materials to DHH for approval using the DHH Marketing and Member Education Materials Approval Form. Before submission, LHC's **Marketing and Communications Manager** (Communications Manager) **and Vice President of Compliance** will review the materials for compliance with State and federal requirements including but not limited to required content, accuracy, no more than 6.9 grade reading level, cultural sensitivity including People First Language and the DHH Person First Policy, formatting standards, and quality of materials used for printing. The Communications Manager will coordinate the review process, which includes review by management staff in our Member Services and Provider Services, Medical Management, and Quality Management Departments, as appropriate to the content and proposed use of the materials.

**Readability and Member Comprehension.** All LHC member materials will be in a style and reading level that will accommodate the reading skills of CCN members. The writing will be at no higher than a 6.9 grade level, as determined by the **Flesch Reading Ease and Flesch-Kincaid Grade Level Index**, taking into consideration the need to incorporate and explain certain technical or unfamiliar terms to assure accuracy.

When writing all member materials, we write the way a person talks: we use a friendly tone, active voice, common words, and short sentences, and we provide examples when words might be confusing. We will include appealing graphic elements and culturally relevant illustrations to reinforce narrative in member materials. In addition, we will ask participants from our Member Advisory Council and Community Advisory Committee to review proposed materials and provide feedback on issues such as readability,

clarity, and confirming that the materials convey what is intended and are culturally sensitive to local norms and expectations.

**Language Translation.** LHC will notify members that written information is available in Spanish and Vietnamese and how to request it. On materials where this information is provided, including the Member Handbook, the notation will be written in both Spanish and Vietnamese. For all member materials translation, LHC will use certified professional translator services such as Inlingua Translation Services, an international language translation and language and intercultural training organization with more than 40 years experience. Inlingua issues certifications of accuracy and completeness for each translation. LHC also may engage local translators to translate or review certain materials.

**Requests for Translation.** We anticipate that most requests for translation (Requests) will be received by Member Services Representatives in our call center or MemberConnections outreach staff who meet with members in their homes and the community. Requests entered in MRM alert Communications Department staff, who then order the specified materials, monitor timely production of them, and normally mail the materials to the member who submitted the Request. MRM is then updated to indicate the mailing, which will trigger an alert to the appropriate staff (call center or Connections staff) to contact the member to verify receipt of the materials and answer any questions.

**Content.** The Communications Manager will use checklists and related management tools to identify and assemble content requirements and guidelines for member written materials. The Manager will use such tools both early in development of new materials, and for the final review, to ensure that all required content is included. The Manager will include, at a minimum, all DHH standards, including the DHH Person First Policy and notice of the availability of real-time oral translation services. The Communications Manager also ensures the accuracy of content for member written materials.

**Written Materials for Provider Offices.** LHC will provide member education materials in English, Spanish, and Vietnamese to providers for their optional use in their waiting rooms and offices, in keeping with DHH requirements. Provider Relations Specialists will educate providers on appropriate use of these member materials and encourage providers to post their own office signage in Spanish and Vietnamese.

### **Quality Monitoring, Including Subcontractors**

LHC's Vice President of Compliance, who serves as our Cultural Competency Officer, will monitor to ensure that covered services are provided in an appropriate manner to members with LEP and members with hearing impairment. Monitoring will include provision of covered services by LHC subcontractors. The VP of Compliance will report the results of monitoring to the CLAS Task Force, Chief Medical Officer, and Compliance Committee. The VP of Compliance will monitor metrics and activities such as:

- Utilization of telephonic interpretation services, including which non-English languages members request; utilization of TDD and Louisiana Relay services for members with hearing impairment
- Utilization of in-person interpreter services, including requested spoken languages and American Sign Language
- Member and provider complaints related to linguistic access
- Member and provider satisfaction surveys

The CLAS Task Force will meet at least quarterly and will report to the Quality Assessment and Performance Improvement Committee (QAPIC). The QAPIC will include monitoring and evaluation of linguistic access in the annual Quality Assessment and Performance Improvement Workplan and Evaluation.