

SECTION F – ORGANIZATIONAL STRUCTURE

F.1 Describe your organization's number of employees, client base, and location of offices. Submit an organizational chart (marked as Chart A of your response) showing the structure and lines of responsibility and authority in your company. Include your organization's parent organization, affiliates, and subsidiaries that will support this contract.

Number of Employees

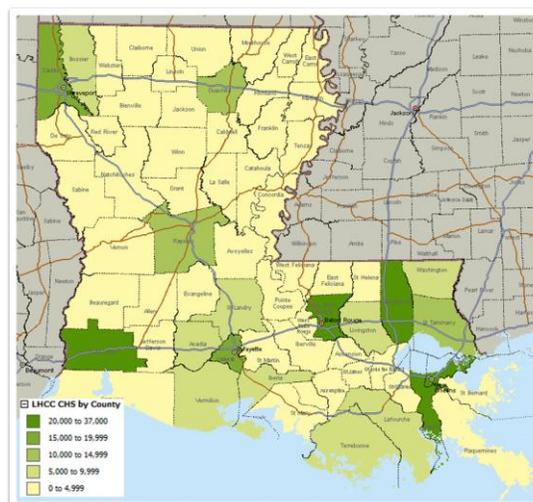
Locally Driven Accountability and Decision Making with Central Support. Louisiana Healthcare Connections (LHCC) is a Medicaid Managed Care Organization (MCO) operating statewide in Louisiana since Bayou Health's inception in 2012. LHCC currently employs over 200 experienced, highly qualified individuals dedicated to the Bayou Health program. These Louisiana-based employees serve our 360,000 Bayou Health members, including 149,000 through our prepaid plan contract and 210,000 through a shared savings contract. Under this new contract in 2015, when all of these members convert to the prepaid model, we anticipate our number of Louisiana-based employees to increase to more than 400. These employees will be fully dedicated to Bayou Health and not assigned to service other programs, populations or markets. We will continue to recruit and maintain highly qualified and experienced employees who are dedicated to managing the full scope of work outlined in the RFP and Contract.

Louisiana Healthcare Connections' Call Center is comprised of 100% Louisiana-based employees.

LHCC's parent company, Centene Corporation (Centene) empowers local decision making by locating services that directly affect health plan members, providers, and regulators in Louisiana. Member and Provider "touching" functions such as Care Management/Care Coordination, Member and Provider Call Centers, member outreach, network contracting, credentialing, utilization management (UM), disease management, compliance, quality improvement (QI), and fraud and abuse prevention are all located in Louisiana. LHCC's field staff meets its members where they are, in locations such as provider offices and homes as needed. In addition, by locating staff in Louisiana, LHCC is highly responsive and available to DHH when needs arise. This structure has proven successful for LHCC for more than three years in Louisiana.

Client Base

Louisiana Healthcare Connections has been **operating in Louisiana since 2012** and is contracted today with DHH to serve the TANF, CHIP, ABD non-dual and Foster Care populations. With the acquisition of CHS, our **Bayou Health membership is over 360,000**. Together, Louisiana Healthcare Connections and its parent company, Centene, have **over 30 years** of experience in full-risk managed care. Centene currently serves over **3.1million members** in managed care programs with **18 state** clients: Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Massachusetts, Mississippi, Missouri, New Hampshire, Ohio, South Carolina, Texas, Washington, and Wisconsin. The table below illustrates the client



base of members served by Louisiana Healthcare Connections and our affiliates’ state-sponsored programs in 20 states. (Centene programs in Minnesota and Tennessee serve the correctional medicine population and are not included in our description of managed care services above.)

HEALTHCARE COVERAGE SOLUTIONS

<i>Government Solutions</i>	AZ	AR	CA	FL	GA	IL	IN	KS	LA	MA	MI	MN	MS	MO	NH	OH	SC	TN	TX	WA	WI
Low-Income Medicaid		•	•	•	•		•	•	•	•			•	•	•	•	•		•	•	•
CHIP			•	•	•		•	•	•					•	•	•	•		•	•	•
ABD (non duals)	•		•	•		•		•	•				•		•	•	•		•	•	•
ABD (dual-eligible) or Dual Demonstrations	•		•	•		•		•			•				•	•	•		•		•
Intellectually/Developmentally Disabled						•		•							•						
Long-Term Services and Supports	•			•		•		•			•				•	•	•		•		
Foster Care			•	•				•	•				•	•	•				•		
Medicare Special Needs Plan	•			•	•											•			•		•
Health Insurance Marketplaces		•		•	•		•			•			•			•			•	•	
Correctional Healthcare										•		•						•			
<i>Specialty Health Solutions</i>																					
Pharmacy Benefits	•	•	•	•	•	•		•	•	•	•		•		•	•	•		•	•	•
Behavioral & Specialty Therapies	•	•	•	•	•	•	•	•		•	•		•	•	•	•	•		•	•	•
Life & Health Management	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Managed Vision	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•		•	•	•
Dental Benefits	•	•	•	•	•	•		•		•	•		•	•		•			•	•	•
Telehealth	•	•	•	•	•	•	•	•	•	•	•		•	•	•	•	•		•	•	•

¹ MI health plan implementation in-process and are expected to commence mid 2015

Location of Offices

LHCC serves our Bayou Health members with employees at the following office locations:

Louisiana Healthcare Connections Headquarters

Baton Rouge
8585 Archives Avenue
Suite 310
Baton Rouge, LA 70809

Satellite Offices:

Lafayette (Temporary)

901 Hugh Wallis Road South, Suite 116
Lafayette, LA 70805

Lafayette (Permanent, under construction)

Brandywine Office Complex
825 Kaliste Saloom Rd.
Lafayette, LA 70508

Northshore (Temporary)

2000 Covington Centre

Covington, LA 70433

*Permanent Northshore office is under negotiation.

New Orleans

Urban League Building

4640 Carrollton Ave.

New Orleans, LA 70118

The following Centene affiliates that will be supporting LHCC with this contract also have Louisiana-based operations:

Louisiana-based Subsidiaries:

Nurtur Health, Inc. (Nurtur)

8585 Archives Avenue

Suite 302

Baton Rouge, LA 70809

US Script, Inc. (US Script)

8585 Archives Avenue

Suite 310

Baton Rouge, LA 70809

In addition, the office locations for other Centene affiliates who will be supporting this contract are as follows:

Other Subsidiaries:

Bankers Life Insurance Company of Wisconsin (Bankers Life)

7700 Forsyth Boulevard

St. Louis, MO 63105

Cenpatico Behavioral Health, LLC (Cenpatico)

12515-8 Research Blvd., Suite #400

Austin, TX 78759

NurseWise, LP (NurseWise)

7700 Forsyth Boulevard

St. Louis, MO 63105

OptiCare Managed Vision, Inc. (OptiCare)

112 Zebulon Court
P.O. Box 7548
Rocky Mountain, NC 27804

US Medical Management, LLC (USMM)

500 Kirts Blvd.
Troy, Michigan 48084

The majority of services performed under the DHH Bayou Health Managed Care Organizations agreement will be performed in the Baton Rouge office including:

Baton Rouge

- Administration
- Behavioral Health
- Pharmacy
- Provider Relations
- Network and Development
- Member Connections
- Medical Director
- Quality Improvement
- Finance
- Medical Management – Case Management & Utilization
- Network
- Medical Home
- Facilities
- Clinical Education

The additional offices will function as satellite offices supporting the following functions:

Lafayette

- Medical Director
- Pharmacy
- Network and Development
- Medical Management – Case Management & Utilization
- Member Connections
- Provider Relations
- Clinical Education

North Shore

- Quality Improvement
- Finance
- Network
- Medical Home
- Member Connections
- Provider Relations

New Orleans

- Facilities
- Medical Director (Janifer)
- Network and Development
- Member Connections
- Provider Relations

Certain administrative services, such as Information Technology, are provided through Centene’s corporate office, located in St. Louis Missouri. Services such as Human Resources and Finance are located in Louisiana and supported by Centene. This arrangement ensures that members and providers are able to partner with trusted individuals from their communities. DHH and the State of Louisiana benefit from LHCC’s proven ability to create a customized and local presence for its members and from cost efficiencies and economies of scale, because the costs for centralized services are shared with LHCC’s affiliate health plans. Centene’s office locations are listed below:

- St. Louis office: 7700 Forsyth Boulevard, St. Louis, MO 63105
- Farmington office: 1 Centene Drive, Farmington, MO, 63640

Corporate Ownership Structure and Lines of Responsibility

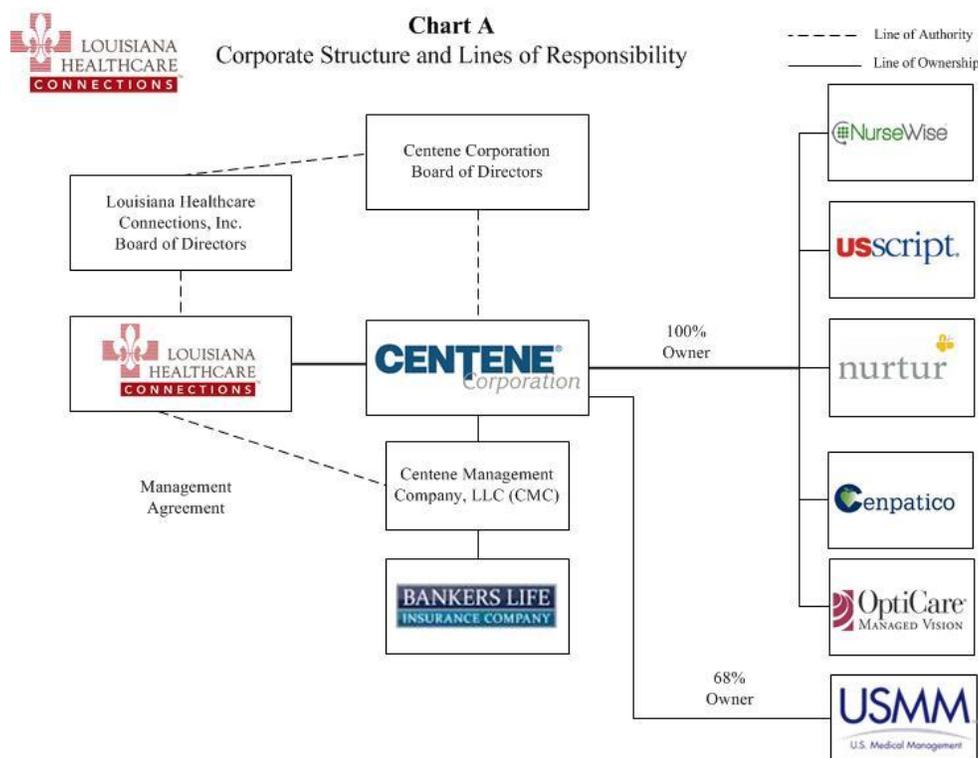


Chart A

Louisiana Healthcare Connections (LHCC) and Centene Corporation (Centene). Chart A depicts the corporate ownership structure and lines of responsibility and authority of LHCC, and the relationships between the policymaking bodies and the health plan. LHCC holds a statewide Health Maintenance Organization (HMO) license issued by the Louisiana Department of Insurance (TDI) and is the RFP Respondent. LHCC is a wholly-owned subsidiary of Centene Corporation. Centene Corporation, a Fortune 500 company, is a leading multi-line healthcare enterprise that provides programs and services to government sponsored healthcare programs, focusing on under-insured and uninsured individuals. Many receive benefits provided under Medicaid, including the State Children's Health Insurance Program (CHIP), as well as Aged, Blind or Disabled (ABD), Foster Care and Long Term Care (LTC), in addition to other state-sponsored/hybrid programs, and Medicare (Special Needs Plans). The Company operates local health plans and offers a range of health insurance solutions. It also contracts with other healthcare and commercial organizations to provide specialty services including behavioral health, care management

software, correctional systems healthcare, in-home health services, life and health management, managed vision, pharmacy benefits management, specialty pharmacy and telehealth services.

As illustrated on the chart, Centene’s Board of Directors (BOD) has oversight of LHCC’s Board of Directors. Louisiana Healthcare Connection’s Board of Directors has oversight over Louisiana Healthcare Connections, Inc. LHCC’s Board is its governing body and has legal and fiduciary responsibility for LHCC operations. The Centene and Louisiana Healthcare Connection’s Boards conduct business in accordance with U.S. Securities and Exchange Commission regulations and applicable Sarbanes Oxley requirements. The LHCC Board also operates in accordance with Louisiana law and regulations.

Centene, Centene Management Company (CMC). CMC is a wholly-owned subsidiary of Centene, and an affiliate company to LHCC. CMC provides administrative services to Louisiana Healthcare Connections through a Management Agreement.

Subsidiaries. Chart A demonstrates LHCC’s relationship to Centene Corporation, CMC and Bankers Life Insurance Company but in addition, Louisiana Healthcare Connections maintains Delegated Agreements with U.S. Medical Management, LLC (USMM), a provider of in-home health services for high acuity populations; NCQA accredited Cenpatco, which provides outpatient therapy and basic behavioral health management services; URAC accredited US Script, Inc., which manages pharmacy benefits; NurseWise, LP, to provide a URAC accredited 24/7 nurse advice line and health assessment services; Nurtur Health, Inc. to provide NCQA and URAC accredited disease management programs; and NCQA accredited and SSAE certified OptiCare Managed Vision, Inc, which provides vision services.

F.2 Provide an organization chart for this contract (marked as Chart B) including but not limited to positions in 4.2 and 4.3 of the RFP. Indicate what is the FTE for each dedicated to this contract and whether or not the position is located in Louisiana.

As a current Pre-paid health plan serving Bayou Health members, LHCC will be able to build upon our existing best practices to ensure a seamless implementation and successful ongoing operations that meet and/or exceed DHH expectations and contract requirements. Hiring from within the community we serve provides us with unique insights into how we achieve DHH’s “Big Bets” and goals for the program. Our staff, primarily comprised of Louisiana residents, is familiar with the local culture, geography and health care delivery system, which contributes to an unparalleled understanding of the needs of our members. By employing Louisianans, LHCC is also able to make a positive impact on the local economy and bring much-needed employment opportunities to the communities in which we live and work.

LHCC is fortunate to continue to build upon its experienced staff with the addition of talent from Community Health Solutions of American (CHS). LHCC Senior Management has been working collaboratively with Dr. Stewart Gordon, the first person formally hired from CHS, to continue developing relationships within the provider community and share best practices for collaborating with providers to better serve our members. In addition to Dr. Gordon, LHCC will benefit from CHS staff in important areas including provider relations, case management, compliance, quality, and the call center. LHCC’s regional approach to healthcare allows us to attentively serve the needs of our populations by not only having operations in Baton Rouge that serve our members statewide, but also additional satellite locations in Lafayette, the North Shore, and New Orleans. Our parent company, Centene, affords LHCC the opportunity to take advantage of economies of scale by providing administrative services, such as IT, Finance and HR and access to national expertise through subsidiary health plans. By utilizing the corporate expertise for some administrative tasks, LHCC can focus on important member and provider facing positions, for example employing six behavioral health staff to promote the integration of care and numerous field case managers to provide community outreach and face-to-face visits

For ease of review, Chart B has been separated into multiple charts to represent each functional area. Please note, FTEs for executive positions that appear on both the executive chart and a functional organizational chart are only counted once, on Chart B.1.

Please see **Attachment F.2_Organizational Charts B.1-5** for the following organizational chart attachments:

- **B.1_ Executive Organizational Chart**
- **B.2_Network Contracting, Provider Services & Operations Organizational Chart**
- **B.3_Case Management and Utilization Management Organizational Chart**
- **B.4_Quality Organizational Chart**
- **B.5_Finance, Compliance and Pharmacy Organizational Chart**

F.3 Attach job descriptions (including education and experience qualifications) of employees in key staff positions as defined in Sec. 4.2. Job descriptions should not exceed 2 pages.

Administrator/Chief Executive Officer (CEO)

Required Key Personnel: Administrator/Chief Executive Officer (CEO)	LHCC Position Title: Plan President and CEO	Reports To: Sr. Vice President, Centene Health Plans
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Position Purpose

Plans and directs all aspects of the Business Unit’s operations. Responsible for the short- and long-term profitability and growth of the Business Unit.

Position Qualification Requirements

Knowledge and Experience:

- Bachelor’s degree in business, health care administration, public administration or related field.
- Master’s degree preferred.
- Extensive experience in contracting and strategic planning and development.
- At least 5-8 years of experience in a top management position in the government or healthcare industry working on contract acquisition and operations management.

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

- Principal Functions and Accountabilities
- Plans and directs all aspects of the company’s operational policies, objectives, and initiatives
- Develops polices and procedures for operational processes in order to ensure optimization and compliance with established standards and regulations
- Represents the organization in its relationships with major customers, suppliers, competitors, commercial and investment bankers, government agencies, professional societies, and similar groups
- Develops a sound short- and long-range plan for the organization
- Ensures the adequacy and soundness of the organization’s financial structure and reviews projections of working capital requirements; Negotiates and otherwise arranges for any outside financing that may be indicated

License/Certifications

None required

Medical Director/Chief Medical Officer

Required Key Personnel: Medical Director/Chief Medical Officer	LHCC Position Title: Chief Medical Director	Reports To: Plan President and CEO
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Position Purpose

Provide medical oversight, expertise and leadership to ensure the delivery of cost effective, quality healthcare services to health plan members

Position Qualification Requirements

Knowledge and Experience:

- Medical Doctor or Doctor of Osteopathy required
- Current, unencumbered license through the Louisiana State Board of Medical Examiners required
- Three of training in a medical specialty required
- Five years of clinical experience in the practice of medicine required; Management experience, Utilization Management experience, and knowledge of quality accreditation standards preferred

Principal Functions and Accountabilities

Leadership/Supervision:

- Provide expertise and vision with respect to planning and establishing goals and policies to improve quality and cost-effectiveness of care and service for health plan members
- Provide expertise to all areas of the operation to ensure timely medical decisions, including after-hours consultations
- Oversee and administer all medical management and quality management functions of the health plan to ensure the continuous assessment and improvement of the quality of care provided to members
- Develop, implement, and interpret medical policies and procedures to ensure clinical integrity in the provision of medical care to members including, but not limited to, service authorization, claims review, discharge planning, credentialing and referral management, and medical review portions of LHCC's Grievance System
- Act as a resource for staff members throughout the operation, including involvement in provider education, in-service training, and orientation
- Review all network provider applications and submit recommendations regarding credentialing and reappointment of providers prior to contracting to the health plan's provider contracting staff

Compliance:

- Perform medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services
- Review all network provider applications and submit recommendations regarding credentialing and reappointment of providers prior to contracting to the health plan's provider contracting staff

Analysis and Quality Improvement:

- Serve as director of the Utilization Management Committee and chairman of the Quality Assessment and Performance Improvement Committee
- Serve as member of and participate in all Medicaid Quality Committee quarterly and phone meetings, or assign designated attendee as applicable and appropriate

- Conduct physician reviews and oversight of all potential adverse determinations including pre-certifications/prior authorizations, concurrent review, and appeals/retrospective review

Licenses/Certifications

Active, unencumbered medical license through the Louisiana State Board of Medical Examiners

Behavioral Health Medical Director

Required Key Personnel: Behavioral Health Medical Director	LHCC Position Title: Behavioral Health Medical Director	Reports To: Chief Medical Director
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Position Purpose:

Assist the Chief Medical Officer (CMO) to direct and coordinate the medical management, quality improvement and credentialing functions for the business unit. Oversee and be responsible for all Behavioral Health activities within LHCC and take an active role in LHCC’s medical management team and in clinical and policy decisions.

Knowledge/Experience:

Requires a Medical Doctor or Doctor of Osteopathy, board certified in Psychiatry in the State of Louisiana. At least five years of combined experienced in mental health and substance abuse services required. Previous experience within a managed care organization is preferred. Course work in the areas of Health Administration, Health Financing, Insurance, and/or Personnel Management is preferred. Familiarity with medical information systems, medical terminology, National Committee for Quality Assurance (NCQA) and URAC accreditation processes and standards required.

Competencies:

Manager: Integrity, Flexibility, Communication, Critical Thinking, Building a Successful Team, Decision Making, Planning and Organizing, Building Strategic Working Relationships, Technical and Professional Knowledge

Position Responsibilities:

- Provides medical leadership of all for utilization management, cost containment, and medical quality improvement activities. Performs medical review activities pertaining to utilization review, quality assurance, and medical review of complex, controversial, or experimental medical services. Supports effective implementation of performance improvement initiatives for capitated providers.
- Assists the CMO in planning and establishing goals and policies to improve quality and cost-effectiveness of care and service for members. Provides medical expertise in the operation of approved quality improvement and utilization management programs in accordance with regulatory, state, corporate, and accreditation requirements.
- Assists the CMO in the functioning of the physician committees including committee structure, processes, and membership. Oversees the activities of physician advisors. Utilizes the services of medical and pharmacy consultants for reviewing complex cases and medical necessity appeals. Participates in provider network development and new market expansion as appropriate. Assists in the development and implementation of physician education with respect to clinical issues and policies.
- Oversees, monitors, and assists with the management of psychopharmacology pharmacy benefit manager (PBM) activities, including the establishment of prior authorization clinical appropriateness of use, and step therapy requirements for the use of stimulants and antipsychotics for all enrolled members under age 18
- Provides clinical case management consultations and clinical guidance for contracted primary care physicians (PCPs) treating behavior health-related concerns not requiring referral to behavior health specialists

- Develops comprehensive care programs for the management of youth and adult behavioral health concerns typically treated by PCP's, such as ADHD and depression
- Develops targeted education and training for Bayou Health Plan PCPs related to commonly encountered behavior health issues frequently treated by PCPs
- Identifies utilization review studies and evaluates adverse trends in utilization of medical services, unusual provider practice patterns, and adequacy of benefit/payment components. Identifies clinical quality improvement studies to assist in reducing unwarranted variation in clinical practice in order to improve the quality and cost of care. Interfaces with physicians and other providers in order to facilitate implementation of recommendations to providers that would improve utilization and health care quality. Reviews claims involving complex, controversial, or unusual or new services in order to determine medical necessity and appropriate payment.
- Develops alliances with the provider community through the development and implementation of the medical management programs. As needed, may represent the business unit before various publics both locally and nationally on medical philosophy, policies, and related issues. Represents the business unit at appropriate state committees and other ad hoc committees

License/Certifications: Board certification by the American Board of Psychiatry and Neurology

Chief Operating Officer (COO)

Required Key Personnel: Chief Operating Officer (COO)	LHCC Position Title: Chief Operating Officer	Reports To: Plan President & CEO
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Position Purpose

Accountability for the day-to-day operations, profitability and growth. Ensure that the customers' needs are well served. Develop relationships with network providers, area employers, and contractors; ensure successful development and implementation of business plans.

Position Qualification Requirements

Knowledge and Experience:

- Bachelor's degree required; graduate degree preferred.
- 7-10 years of senior level MCO experience, preferably as a plan operating officer and/or executive director
- Experience in managing an MCO that offers government services products
- Experience with a joint venture MCO is desirable

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Principal Functions and Accountabilities

- Develop and implement strategic and tactical plans to ensure further growth and development of the business unit and ensure positive financial results
- Oversee development and execution of operating plans, including employee development, organization goals, and member and provider relations goals
- Establish criteria for measuring and assessing the success/performance of each component of operation
- Ensure appropriate provider network is developed and maintained
- Develop effective relationships with key stakeholders to educate providers and consumers on necessary topics
- Develop and establish operational mission statements, philosophy, policies, goals, objectives and strategy
- Provide management all necessary contractual requirement information regarding state and federal regulatory agencies

License/Certifications

None required

Chief Financial Officer/CFO

Required Key Personnel: Chief Financial Officer (CFO)	LHCC Position Title: Vice President of Finance	Reports To: Plan President & CEO
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Position Purpose

Provide leadership and oversight of all aspects of finance for the Business Unit, including budget, accounting systems, financial reporting, and all financial auditing activities

Position Qualification Requirements

Knowledge and Experience:

- Bachelor's degree in Finance, Accounting, Economics, Business Administration or equivalent; Master's degree preferred
- 8+ years in a high level finance role in the healthcare or insurance industry required

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Principal Functions and Accountabilities

- Oversee all finance related activities for business unit including developing and monitoring progress against Annual Operating Plan
- Responsible for financial analysis, identification of month end financial drivers, and forecasting including headcount planning to ensure compliance with state requirements
- Responsible for identifying medical cost trends and leadership of medical cost improvement initiatives
- Perform financial impact analysis for new contracts and support negotiations
- Review monthly performance and financial results of the business unit and provide recommendations to senior management
- Responsible for the business unit's contribution to corporate
- Perform duties as Chief liaison between Corporate Finance and the Business Unit
- Establish financial strategic vision, objectives, policies and procedures in support of the overall strategic plan
- Oversee and validate pricing models and lead initiatives to identify inefficiencies and areas of development and improvement
- Direct health plan analytical needs and coordinate reporting strategy
- May lead rate setting activity and coordinate corporate and state actuaries

License/Certifications

CPA preferred

Program Integrity Officer

Required Key Personnel: Program Integrity Officer	LHCC Position Title: Vice President of Compliance	Reports To: Plan President & CEO
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Position Purpose

Oversee the compliance program, including HIPAA oversight and fraud, waste and abuse investigation; develop and implement appropriate compliance policies, procedures and training; and assess progress and report key results and the status of initiatives to senior management

Position Qualification Requirements

Knowledge and Experience:

- Bachelor's degree in Public Policy, Government Affairs, Business Administration or equivalent
- At least five years of relevant experience in healthcare or risk management
- Extensive knowledge of state administrative code and regulations, Medicare, Medicaid and state insurance laws and regulations including managed care regulations
- Experience with state and federal government agencies, accreditation bodies, participating provider agreements, HIPAA and Third Party Administration (TPA) laws, credentialing regulations and prompt pay laws
- Master's or Law degree preferred

Principal Functions and Accountabilities

Leadership/Supervision:

- Act as primary point of contact for all health plan operational issues, to include fielding and coordinating responses to DHH inquires and referring suspected member fraud, provider fraud, and member abuse cases to DHH
- Develop and maintain records of contracts, contract amendments, compliance measures and improvements, policy, procedure and process documentation, including those related to fraud, waste and abuse
- Develop policies, procedures and processes to comply with state law, federal law and state contract requirements, including those related to fraud, waste and abuse
- Train LHCC staff of new policies, procedures and processes to comply with new state law, federal law and state contract requirements, including those related to fraud, waste and abuse
- Oversee the Billing Errors, Abuse and Fraud (BEAF) program at the health plan level pursuant to state and federal rules and regulations. Serve as the primary local contact for BEAF reports and liaison with the Corporate Special Investigations Unit (SIU).
- Oversee the LHCC privacy program
- Chair, participate in, attend, and plan/coordinate, staff, departmental, committee, sub-committee, community, State and other activities, meetings and seminars. Serve on Senior Executive and management committees, as well as direct special projects or studies.

Compliance:

- Ensure LHCC is in compliance with federal and state Medicare Medicaid regulations, insurance regulations, regulatory requirements for business entities and state contract requirements
- Coordinate the preparation and execution of contract requirements, audits and visits and track deliverables
- Provide guidance to LHCC staff regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language

- Investigate unusual incidents and/or areas of non-compliance and implement any corrective action where necessary

License/Certifications

None required

Grievance System Manager

Required Key Personnel: Grievance System Manager	LHCC Position Title: Manager, Quality Improvement	Reports To: Sr. Director, Quality Improvement
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Position Purpose

Ensure appropriate processing of member grievance appeals, provider appeals, or request for a state fair hearing; perform duties as the point of contact with the State

Position Qualification Requirements

Knowledge and Experience:

- Three to five plus years of experience related experience in healthcare or managed care, including at least one year of management experience. Experience in healthcare law or medical grievance and appeals preferred
- Technical and professional knowledge of state grievance and appeals processes

Principal Functions and Accountabilities

Leadership/Supervision:

- Manage and adjudicate member and provider disputes that develop in the grievance system including member grievances/appeals, provider claims and disputes, and requests for state fair hearings
- Ensure that the Grievance and Appeals department processes all appeals and grievances in accordance with referred time frames and other contractual legal requirements
- Monitor appeals and grievances and provide senior management with monthly reporting on trends
- Ensure that all members and provider grievances are processed and investigated according to contract requirements
- Recommend solutions and works with department and company staff to ensure problems are corrected and departments are advised of corrective measures to prevent recurrences

Compliance:

- Ensure compliance with state and federal laws and regulations
- Ensure compliance with contract for grievance and appeals processes
- Provide training and direction to agencies in developing procedures to comply with grievance and appeals requirements

Analysis and Quality Improvement:

- Integrate federal and state law changes into company's regulatory system related to grievance and appeals
- Recommend solutions and works with department and company staff to ensure problems are corrected and departments are advised of corrective measures to prevent recurrences
- Identify trends, conduct risk assessment and identify areas for improvements in grievances and appeals
- Review and process incoming incident/accident reports

License/Certifications

None required

Business Continuity Planning and Emergency Coordinator

Required Key Personnel: Business Continuity Planning and Emergency Coordinator	LHCC Position Title: Manager, Facilities	Reports To: Vice President of Operations
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Position Purpose:

Responsible for overseeing the implementation and consistent operation of all facilities related functions for multiple sites including equipment, utilities, space utilization, safety and telecommunications systems

Knowledge/Experience:

- Bachelor's degree in related field or equivalent experience required. Four years of facilities experience.
- Previous experience as a lead in a functional area, managing cross functional teams on large scale projects or supervisory experience including hiring, training, assigning work and managing the performance of staff.
- Knowledge of telecommunication systems and software preferred.
- Multi-site management experience is a plus.

Competencies:

Manager: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Manage and oversee LHCC's emergency management plan during disasters and ensure continuity of core benefits and services for members who may need to evacuate to other areas of the State or out-of-state
- Manage the daily operations for multiple facilities, including equipment, space changes, and maintenance issues
- Plan and coordinate facilities projects related to construction, renovation, repair and maintenance, furniture, equipment relocation and physical appearance
- Review plans and proposals to determine timeframes and identify required resources
- Coordinate and oversee the work of outside vendors, business partners and contractors
- Identify areas of concern and develop plans to resolve them
- Coordinate with building management, and Corporate Facilities to ensure compliance, appropriate internal controls and adhere to policies and procedures
- Responsible for Health & Safety requirements such as fire suppression equipment, emergency evacuation plans, automated external defibrillators (AEDs), and business continuity planning

License/Certifications

None required

Contract Compliance Coordinator

Required Key Personnel: Contract Compliance Coordinator	LHCC Position Title: Vice President of Compliance	Reports To: Plan President and CEO
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Position Purpose

Oversee the compliance program, including HIPAA oversight and fraud, waste and abuse investigation; develop and implement appropriate compliance policies, procedures and training; and assess progress and report key results and the status of initiatives to senior management

Position Qualification Requirements

Knowledge and Experience:

- Bachelor's degree in Public Policy, Government Affairs, Business Administration or equivalent
- At least five years of relevant experience in healthcare or risk management
- Extensive knowledge of state administrative code and regulations, Medicare, Medicaid and state insurance laws and regulations including managed care regulations
- Experience with state and federal government agencies, accreditation bodies, participating provider agreements, HIPAA and Third Party Administration (TPA) laws, credentialing regulations and prompt pay laws
- Master's or Law degree preferred

Principal Functions and Accountabilities

Leadership/Supervision:

- Act as primary point of contact for all health plan operational issues, to include fielding and coordinating responses to DHH inquires and referring suspected member fraud, provider fraud, and member abuse cases to DHH
- Develop and maintain records of contracts, contract amendments, compliance measures and improvements, policy, procedure and process documentation, including those related to fraud, waste and abuse
- Develop policies, procedures and processes to comply with state law, federal law and state contract requirements, including those related to fraud, waste and abuse
- Train LHCC staff of new policies, procedures and processes to comply with new state law, federal law and state contract requirements, including those related to fraud, waste and abuse
- Oversee the Billing Errors, Abuse and Fraud (BEAF) program at the health plan level pursuant to state and federal rules and regulations. Serve as the primary local contact for BEAF reports and liaison with the Corporate Special Investigations Unit (SIU)
- Oversee the LHCC privacy program
- Chair participate in, attend, and plan/coordinate, staff, departmental, committee, sub-committee, community, State and other activities, meetings and seminars. Serve on Senior Executive and management committees, as well as direct special projects or studies

Compliance:

- Ensure LHCC is in compliance with federal and state Medicaid regulations, insurance regulations, regulatory requirements for business entities and state contract requirements
- Coordinate the preparation and execution of contract requirements, audits and visits and track deliverables
- Provide guidance to LHCC staff regarding compliance issues and implementation of new compliance requirements with respect to regulatory and contract language

- Investigate unusual incidents and/or areas of non-compliance and implement any corrective action where necessary

License/Certifications

None required

Quality Management Coordinator

Required Key Personnel: Quality Management Coordinator	LHCC Position Title: Senior Director, Quality Improvement	Reports To: Chief Operating Officer
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Position Purpose:

Lead and direct quality management, quality improvement, and process improvement activities that provide more efficient and streamlined workflow.

Knowledge/Experience:

Bachelor's degree in Nursing or related clinical field required. 7+ years of healthcare operations experience, including quality improvement experience required. Masters' degree and Lean Six Sigma training preferred.

License/Certificates: Current Louisiana Registered Nursing License, physician, physician's assistant, CPHQ, or CHCQM certification required. Certified Professional in Health Care Quality preferred.

Competencies:

Manager: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Responsible for National Committee for Quality Assurance (NCQA) Accreditation and/or Healthcare Effectiveness Data and Information Set (HEDIS) performance
- Ensure health plan is compliant and become/remain accredited with NCQA
- Oversee efforts to ensure individual and systemic quality of care
- Review and implement new technological tools and processes and fosters team concept with internal and external constituencies
- Present results of quality improvement efforts, performance outcomes, and ongoing performance measures to senior management
- Research and incorporate clinical quality best practices into operations
- Overall responsibility for tracking, trending, and resolving quality of care grievances
- Organize and control performance improvement projects, activities, methods, and procedures to achieve business objectives
- Analyze data to develop intervention strategies to strengthen performance outcomes
- Coordinate with Provider Relations staff to ensure a credentialed provider network
- Formulate and establish policies, operating procedures, and goals in compliance with internal and external guidelines

Performance/Quality Improvement Coordinator

Required Key Personnel: Performance/Quality Improvement Coordinator	LHCC Position Title: Senior Director, Quality Improvement	Reports To: Chief Operating Officer
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Position Purpose:

Lead and direct quality management, quality improvement, and process improvement activities that provide more efficient and streamlined workflow.

Knowledge/Experience:

Bachelor's degree in Nursing or related clinical field required. 7+ years of healthcare operations experience, including quality improvement experience required. Masters' degree and Lean Six Sigma training preferred.

License/Certificates: Current Louisiana Registered Nursing License, physician, physician's assistant, CPHQ, or CHCQM certification required. Certified Professional in Health Care Quality preferred.

Competencies:

Manager: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Responsible for National Committee for Quality Assurance (NCQA) Accreditation and/or Healthcare Effectiveness Data and Information Set (HEDIS) performance
- Ensure health plan is compliant and become/remain accredited with NCQA
- Oversee efforts to ensure individual and systemic quality of care
- Review and implement new technological tools and processes and fosters team concept with internal and external constituencies
- Present results of quality improvement efforts, performance outcomes, and ongoing performance measures to senior management
- Research and incorporate clinical quality best practices into operations
- Overall responsibility for tracking, trending, and resolving quality of care grievances
- Organize and control performance improvement projects, activities, methods, and procedures to achieve business objectives
- Analyze data to develop intervention strategies to strengthen performance outcomes
- Coordinate with Provider Relations staff to ensure a credentialed provider network
- Formulate and establish policies, operating procedures, and goals in compliance with internal and external guidelines

Maternal Child Health/EPSDT Coordinator

Required Key Personnel: Maternal Child Health/EPSDT Coordinator	LHCC Position Title: Director, Case Management	Reports To: Vice President of Medical Management
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Position Purpose

Oversee coordination of Integrated Care Teams and other case management services to provide optimal, cost-effective care for high-needs Medicaid population while ensuring compliance with State guidelines and managed care case management policies

Position Qualification Requirements

Knowledge and Experience:

- Current Louisiana Registered Nursing License, physician, or physician’s assistant certification; or Master’s degree in health services field required. CPHQ or CHCQM certification preferred.
- Minimum of five years of management/supervisory experience in the health care field
- Technical and professional knowledge of state guidelines and case management practices

Principal Functions and Accountabilities

Leadership/Supervision:

- Oversee and direct the Case Management functions to ensure timely, appropriate Integrated Care Program Services and Supports
- Oversee and direct coordination of EPSDT service provision to members, including receipt of maternal and postpartum care, family planning service education, and preventive health strategy promotion
- Assist in the development and implementation of work processes and operational systems
- Provide oversight of the delivery of comprehensive community-based member education, including improving member understanding of LHCC’s Integrated Care Program
- Coordinate promotion of LHCC’s Integrated Care Program among community partners
- Participate in the integration of specialty products, such as Disease Management, into LHCC’s Case Management operations
- Develop staff skills and competencies through education, training, and experience to promote culturally competent, timely and appropriate care for members
- Provide on-call duties as assigned for potential interventions and follow up on urgent calls
- Create effective organizational structure, roles and jobs

Budget/Financial Management:

- Compile and review multiple reports on work function activities for statistical and financial tracking purposes and for process improvements to identify trends, assist in financial forecasting and make recommendations to management.
- Effectively manage all resources to balance both short and long-term needs

Compliance:

- Ensure compliance with state laws and regulations
- Ensure compliance with contract for case management
- Participate in NCQA, State, and/or other accreditation reviews of the health plan

Analysis and Quality Improvement:

- Identify trends and root causes of problems; provide recommendations for improvements, documentation, and training
- Review analyses of activities, costs, operations and forecast data to determine and project progress toward stated goals and objectives
- Identify clinical trends, conduct risk assessment and identify areas for improvements in case management

Licenses/Certifications:

Current Registered Nursing License or Social Worker License preferred

Medical Management Coordinator

Required Key Personnel: Medical Management Coordinator	LHCC Position Title: Vice President of Medical Management	Reports To: Chief Operating Officer
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Position Purpose

Perform duties to direct and coordinate the medical management, quality improvement and credentialing functions for the assigned health plan based on, and in support of the company's strategic plan; establishing the strategic vision and attendant policies and procedures

Position Qualifications Requirements

Knowledge and Experience:

- Louisiana Registered Nursing, Physician, or Physician's Assistant licensure required
- Master's degree in health services, health care administration or business administration preferred
- Experience in Medicaid, CHIP, managed care, and culturally diverse and/or medically needy populations preferred
- Advanced education in nursing, health care, business or public administration preferred
- Thorough knowledge of a specialized or technical field such as clinical nursing, managed care, case management practices, and healthcare administration
- Thorough skills knowledge of quality improvement practices
- Familiarity of medical information systems, medical claims payment process, medical terminology and coding, and of National Committee on Quality Assurance (NCQA) accreditation process and standards

Principal Functions and Accountabilities

Leadership/Supervision:

- Make medical necessity determinations as needed
- Ensure adoption and consistent application of appropriate inpatient and outpatient medical necessity criteria
- Ensure that appropriate concurrent review and discharge planning of inpatient stays
- Develop, implement and monitor the provision of care coordination and case management functions for the health plan
- Monitor the provision of disease management functions, developed and implemented by Nurtur Health, for the health plan
- Monitor prior authorization functions to ensure that decisions and medical necessity determinations are made in a timely and consistent manner based on clinical criteria
- Direct and coordinate activities of department and aid the Plan President and CEO of the health plan and appropriate corporate staff in formulating and administering organizational and departmental policies
- Participate in provider education and contracting as necessary

Quality Improvement and Analysis:

- Monitor, analyze, and implement appropriate interventions based on utilization data, including identifying and correcting over or under utilization of services
- Direct development, implementation, coordination, monitoring, and analysis of continuous quality improvement projects and initiatives related to care coordination, disease management and case management functions

- Review analyses of activities, costs, operations and forecast data to determine department progress toward stated goals and objectives
- Administer and ensure compliance with National Committee on Quality Assurance (NCQA) and/or Joint Commission on Accreditation of Healthcare Organization (JACHO) standards as determined for accreditation of the health plan

Licenses/Certifications

Current Louisiana Registered Nursing, Physician, or Physicians' Assistant License required.

Provider Services Manager

Required Key Personnel: Provider Services Manager	LHCC Position Title: Vice President of Network Development and Contracting	Reports To: Chief Operating Officer
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Position Purpose:

Direct the provider network and contracting activities. Lead all aspects of provider network strategy including access analysis, network operations and support decision makers with analysis related to reimbursement and unit cost management. Oversee the coordination and negotiation for the contracting department.

Knowledge/Experience:

Bachelor's degree or equivalent experience in Business Administration, Healthcare Administration or related field required. At least 10 years of experience in managed care network development and provider relations/contracting management in a health care and/or managed care environment. Current or recent experience managing and developing staff and/or teams required. MBA or MHA degree preferred.

License/Certificates: Current state driver's license.

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Establish the department's strategic vision, objectives, and policies and procedures
- Oversee coordination of communication efforts between LHCC and provider network
- Develop, implement and maintain production and quality standards for the Contracting department
- Oversee network development staff and external consultants in the development of provider networks across expansion markets
- Perform periodic analyses of the provider network from a cost, coverage, and growth perspective
- Provide leadership in evaluating opportunities to expand or change the network to meet Company goals
- Manage budgeting and forecasting initiatives for product lines to networks costs and provider contracts
- Oversee analysis of claim trend data and/or market information to derive conclusions to support contract negotiations
- Conduct periodic review of provider contracting rates to ensure strategic focus is on target with overall Company strategy
- Support market expansion and M&A activities by leading provider contract analysis related to due diligence
- Assist health plan CEO and/or COO vendors in key provider relations and strategy.
- Ability to travel

Member Services Manager

Required Key Personnel: Member Services Manager	LHCC Position Title: Director, Customer Service	Reports To: Vice President of Operations
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Position Purpose:

Direct and oversee the planning, development, and operation of assigned customer service function(s) and aid in formulating and administering organizational policies and procedures

Knowledge/Experience:

Bachelor's degree in healthcare, business or related field required. 7+ years of diverse planning and management experience, preferably in a healthcare or insurance environment required. Knowledge of applicable technologies, laws, regulations and industry practices required.

Competencies:

Manager: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Direct department and staff through effective planning, hiring, performance management, coaching and career development to meet goals and objectives
- Oversee coordination of all communication efforts between LHCC and its members
- Assist in the formulation and development of strategies and oversee the planning and implementation of major projects, processes and technologies
- Develop and implement performance standards for customer service function(s) and audit outcomes
- Prepare annual budgets/forecasts for all areas of responsibility (or significantly assist in the process), analyze results, and ensure that all areas of responsibility meet budgeted expectations; identify and report significant variances to management as appropriate
- Ensure compliance with applicable policies, procedures, processes, outcomes, contractual agreements and State and federal regulations
- Establish and implement best practices and standard operating procedures
- Manage relationships with key vendors and/or internal and external constituencies in support of LHCC's strategic goals and objectives

License/Certifications

None required

Claims Administrator

Required Key Personnel: Claims Administrator	LHCC Position Title: Sr. Vice President, Business Operations	Reports To: Chief Information Officer
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Position Purpose:

Develop and implement the business processes required to deliver high-quality service to various State organizations. Plan and direct all aspects of the Claims and Configuration departments.

Knowledge/Experience:

Bachelor's degree in related field required. 10+ years of experience in overseeing and developing claims operations, preferably in a managed care and/or Medicaid setting.

Licenses/Certifications: None required.

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Develop the strategic vision claims operations and configuration ensuring compliance with federal, state and company guidelines
- Drive results to support the vision and initiatives
- Responsible for achievement and maintenance of all processing and expense standards relating to business operations, including minimization of claims recoupments
- Oversee efforts for meeting DHH encounter reporting requirements
- Take business action based on impact and respond to customer service issues that require management intervention ensuring expectations are met or exceeded

Provider Claims Educator

Required Key Personnel: Provider Claims Educator	LHCC Position Title: Sr. Director, Network Access	Reports To: Vice President of Network Development
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Position Purpose:

Design and implement successful development activities for the recruitment, contracting and retention of providers. May oversee other functional areas at the health plan such as operations or claims in conjunction with Corporate partnerships and guidelines. Direct facilitation of information exchange between providers and grievance, claims processing, and provider relations systems.

Knowledge/Experience:

Bachelor's degree in a business administration, healthcare administration, related field or equivalent experience. 8+ years of provider relations or contracting experience required. 5+ years of management and supervisory experience in a health care field required. Previous management experience including responsibilities for budgeting, hiring, training, assigning work and managing performance of staff required.

Licenses/Certifications: Current state driver's license.

Competencies:

Manager: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Ensure compliance with company policies and standards, state and federal laws, regulations and contracting standards
- Direct all efforts for educating in-network and out-of-network providers regarding appropriate claims submission requirements, coding updates, electronic claims transactions, and electronic fund transfer; conduct frequent communication efforts to gain feedback regarding the extent to which providers are informed about appropriate claims submission practices
- Oversee provider education efforts related to LHCC provider resources, including fee schedules, provider manuals and provider website portals
- Coordinate with contact centers to compile, analyze, disseminate, and leverage information captured from provider calls to improve provider satisfaction
- Develop and implement strategic plans to align business goals and technologies with future needs
- Facilitate operational oversight for one or more departments.
- Effectively plan and manage budget, revenue targets and P&L, and all resources for short and long-term needs
- Prepare and analyze reports on departmental and organizational activities and recommend improvements
- Ensure timely set up, processing, auditing and distribution of network account data
- Develop, monitor and oversee the training programs and integrate programs into the organizational training plans
- Ensure positive account relationships exist with internal and external customers while maintaining adherence to Company policies and procedures.
- Create effective organizational structure and develop staff skills and competencies

Case Management Administrator/Manager

Required Key Personnel: Case Management Administrator/Manager	LHCC Position Title: Director, Case Management	Reports To: Vice President of Medical Management
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Position Purpose

Oversee coordination of Integrated Care Teams and other case management services to provide optimal, cost-effective care for high-needs Medicaid population while ensuring compliance with State guidelines and managed care case management policies

Position Qualification Requirements

Knowledge and Experience:

- Current Louisiana Registered Nursing License, physician, or physician’s assistant certification; or Master’s degree in health services field required. CPHQ or CHCQM preferred.
- Minimum of five years of management/supervisory experience in the health care field
- Technical and professional knowledge of state guidelines and case management practices

Principal Functions and Accountabilities

Leadership/Supervision:

- Oversee and direct the Case Management functions to ensure timely, appropriate Integrated Care Program Services and Supports
- Oversee and direct coordination of EPSDT service provision to members, including receipt of maternal and postpartum care, family planning service education, and preventive health strategy promotion
- Assist in the development and implementation of work processes and operational systems
- Provide oversight of the delivery of comprehensive community-based member education, including improving member understanding of LHCC’s Integrated Care Program
- Coordinate promotion of LHCC’s Integrated Care Program among community partners
- Participate in the integration of specialty products, such as Disease Management, into LHCC’s Case Management operations
- Develop staff skills and competencies through education, training, and experience to promote culturally competent, timely and appropriate care for members
- Provide on-call duties as assigned for potential interventions and follow up on urgent calls
- Create effective organizational structure, roles and jobs

Budget/Financial Management:

- Compile and review multiple reports on work function activities for statistical and financial tracking purposes and for process improvements to identify trends, assist in financial forecasting and make recommendations to management.
- Effectively manage all resources to balance both short and long-term needs

Compliance:

- Ensure compliance with state laws and regulations
- Ensure compliance with contract for case management
- Participate in NCQA, State, and/or other accreditation reviews of the health plan

Analysis and Quality Improvement:

- Identify trends and root causes of problems; provide recommendations for improvements, documentation, and training
- Review analyses of activities, costs, operations and forecast data to determine and project progress toward stated goals and objectives
- Identify clinical trends, conduct risk assessment and identify areas for improvements in case management

Licenses/Certifications:

Current Registered Nursing License or Social Worker License preferred

Information Management and Systems Director

Required Key Personnel: Information Management and Systems Director	LHCC Position Title: Vice President, Information Technology	Reports To: Chief Information Officer
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Position Purpose:

Oversee a large part of the overall organization, defining goals and accountabilities, as required to meet current and emerging business needs.

Knowledge/Experience:

Bachelor's degree in Computer Science, MIS, related field or equivalent experience required. 15+ years of related IT experience, including information systems, data processing, and data reporting required.

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Oversee department staff including hiring, performance management and career development to ensure alignment with defined goals
- Develop budgets and priorities, ensuring plans and resource allocations are consistent with those budgets and priorities
- Determine the organization's long-term systems and/or hardware needs to accomplish the organization's business objectives
- Oversee and direct connectivity maintenance with DHH information systems; coordinate the provision of necessary and timely reports to DHH
- Analyze the needs of departments and establish priorities for feasibility studies, systems design, and implementation to develop new and/or modify the company's information processing systems and policies and procedures
- Responsible for the plans and activities of the organization with senior leaders inside and outside IT, as well as strategic suppliers
- Apply process and business expertise to impact business results

Encounter Data Quality Coordinator

Required Key Personnel: Encounter Data Quality Coordinator	LHCC Position Title: Vice President of Operations	Reports To: Chief Operating Officer
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Position Purpose:

Oversee all operations for the defined region, including responsibility for Profit & Loss.

Knowledge/Experience:

Bachelor's degree in Business Administration, Healthcare Administration or equivalent experience required. 8+ years of operations, management, or administration in the Healthcare or Insurance industry required. Master's degree preferred.

Competencies:

Executive: Critical Thinking/Execution, Adaptability/Flexibility, Communication/Relationship Development, Technical and Professional Knowledge

Position Responsibilities:

- Perform duties as chief liaison between the identified region and Corporate policies & standards
- Oversee and direct efforts related to encounter data quality, including coordination with DHH for identifying, resolving, and monitoring encounter data and data validation/management issues; serving as LHCC's encounter data expert; and analyzing efforts related to encounter data processing and validation to enhance accuracy and output
- In support of the overall strategic plan, establish operational strategic vision, objectives, policies and procedures for the Plan
- Facilitate operational oversight for multiple departments and identify opportunities for maintaining the most cost efficient operation
- Identification of operational efficiencies; meet regulatory and client expectations and develop a "best practice" approach to all operations
- Meet and exceed requirements including organizational, state, compliance and contractual agreements
- Support due diligence and integration for all acquisitions
- Active accountability for budget, revenue targets and P&L
- Assess organizational strengths and weaknesses to recommend enhanced operating model
- Ensure cost effective, client and employee responsive programs are developed and maintained throughout the Plan

License/Certificates:

None required

F.4 Provide a statement of whether you intend to use major subcontractors (as defined in the RFP Glossary), and if so, the names and mailing addresses of the subcontractors and a description of the scope and portions of the work for each subcontractor with more than \$100,000 annually.

We intend to use the following Non-Affiliate and Affiliate major subcontractors:

LHCC Non-Affiliates
Subcontractor Name: Kracke Consulting (Kracke)
Mailing Address: 543 Spanish Town Road, Baton Rouge, Louisiana 70802
Description of Scope and Portions of Work: Kracke is a Louisiana-based communications consulting firm which provides LHCC with advisory services related to community outreach and relationship building.
Subcontractor Name: LogistiCare Solutions, LLC (LogistiCare)
Mailing Address: 1275 Peachtree Street NE, 6 th Floor, Atlanta, Georgia 30309
Description of Scope and Portions of Work: LogistiCare provides LHCC members with non-emergency medical transportation (NEMT) services and related administrative functions (such as call center operations, provider network access and management, and claims management). LogistiCare is a national NEMT manager currently managing programs in 35 states.
Subcontractor Name: National Imaging Associates (NIA)
Mailing Address: 6950 Columbia Gateway Drive, Columbia, Maryland 21046
Description of Scope and Portions of Work: NIA specializes in the management of high tech diagnostic imaging services and provides assistance to managed care plans in the management of utilization and cost for outpatient diagnostic imaging services. NIA performs prior authorization review for all of LHCC's outpatient, non-emergency, CT, MR and PET scans; provides and manages a network of free-standing diagnostic imaging centers for access by LHCC members; and provides management reporting to LHCC to assure that ongoing quality and safe use of the technology occurs, including the monitoring of over or under utilization.
LHCC Affiliates
Subcontractor Name: Bankers Life Insurance Company of Wisconsin (Bankers Life)
Mailing Address: 7700 Forsyth Boulevard, St. Louis, Missouri 63105
Description of Scope and Portions of Work: Bankers Life is a licensed life, health and accident insurance carrier domiciled in Wisconsin and licensed by the Louisiana Department of Insurance, which provides reinsurance, per RFP definition, to LHCC.
Subcontractor Name: Cenpatico Behavioral Health, LLC (Cenpatico)
Mailing Address: 12515-8 Research Blvd., Suite # 400 Austin, Texas 78759
Description of Scope and Portions of Work: Cenpatico, a URAC and NCQA accredited managed behavioral healthcare organization, is one of the nation's most experienced companies in managing behavioral health benefits for individuals enrolled in Medicaid, Medicare Advantage and the Children's Health Insurance Program (CHIP). The services provided to LHCC include UM and network management of basic and specialized behavioral health services, as well as physical, occupational, and speech therapy services.
Subcontractor Name: Centene Management Company, LLC (CMC)
Mailing Address: 7700 Forsyth Boulevard, St. Louis, Missouri 63105
Description of Scope and Portions of Work: CMC provides information system, claims processing, SIU/fraud and abuse, provider data management, human resources, and finance services support through a Management Agreement with LHCC.
Subcontractor Name: NurseWise, LP (NurseWise)
Mailing Address: 7700 Forsyth Boulevard, St. Louis, Missouri 63105
Description of Scope and Portions of Work: NurseWise, a leader in the telehealth community, provides LHCC with a URAC accredited 24/7 nurse advice line.

Subcontractor Name: Nurtur Health, Inc. (Nurtur)
Mailing Address: 20 Batterson Park Road, 2 nd Floor Farmington, Connecticut 06032
Description of Scope and Portions of Work: Nurtur Health, Inc. (Nurtur) is a life, health and wellness company that helps people transform their lives and well-being through best in-class life and health coaching. Nurtur’s URAC and NCQA-accredited disease management programs provide LHCC with population-based disease management and telemonitoring services for high needs members. Nurtur’s Health Coaches are co-located in local Louisiana offices with LHCC Case Managers.
Subcontractor Name: OptiCare Managed Vision, Inc. (OptiCare)
Mailing Address: 112 Zebulon Court, P.O. Box 7548, Rocky Mount, North Carolina 27804
Description of Scope and Portions of Work: OptiCare, a vision benefit management company, arranges for the full administration of LHCC’s vision benefit. The services provided include contracting and maintaining a network of credentialed eye care specialists to treat members, payment of claims for services rendered, and the provision of member education and screening programs related to member’s general vision care.
Subcontractor Name: US Script, Inc. (US Script)
Mailing Address: 2425 West Shaw Avenue Fresno, California 93711
Description of Scope and Portions of Work: US Script, a URAC accredited pharmacy benefits management company, provides a network of contracted pharmacies, a mail order pharmacy service, prescription drug formularies, prescription drug utilization management, claims administration services, pharmacy provider credentialing, and member and provider services.
Subcontractor Name: U.S. Medical Management, LLC (USMM)
Mailing Address: 500 Kirts Blvd., Troy, Michigan 48084
Description of Scope and Portions of Work: USMM, of which Centene holds 68% ownership, is a management services organization and provider of in-home health services for LHCC’s high acuity members.

F.5 Describe how you intend to monitor and evaluate subcontractor performance. Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.

Monitoring and Evaluating Subcontractor Performance

Overview. LHCC maintains a time-tested subcontractor oversight program that ensures compliance with external accrediting bodies and all State, federal, and contractual requirements (including, but not limited to, provisions in RFP Sections 7.13 and 25). LHCC will subcontract certain functions as described in our response to question F.4, and will remain ultimately accountable for contract performance, whether or not subcontractors are used. No subcontract will operate to terminate LHCC’s legal responsibility to assure that all subcontractor activities conform to the DHH contract requirements.

LHCC complies, and will continue to comply, with all subcontractor-related contractual requirements which include, for the provision of services under this RFP and the subsequent contract to DHH, submitting all major subcontracts to DHH for review and approval prior to execution. LHCC will continue to provide DHH any proposed amendment or changes to any subcontract which would materially affect the DHH Contract, per Sections 7.13.5 and 25.1.

LHCC will continue to monitor subcontractor performance using a continuous quality improvement approach to ensure acceptable performance in accordance with LHCC and DHH requirements through ongoing oversight activities relevant to each subcontractor and subcontracted function. LHCC’s multi-pronged subcontractor performance monitoring approach is comprised of numerous measures, including initial and annual delegated audits; analyses of specific subcontractor-submitted reports, such as network management; approval of credentialing and re-credentialing files by the Credentialing Committee; and investigations resulting from member grievances and suspected quality of care issues. Under the direction of LHCC’s Sr. Director of Quality Improvement (QI), with support from the Vice President of Compliance, most LHCC departments will participate in subcontractor oversight to ensure compliance

with LHCC and DHH performance standards in each department's respective area. If a deficiency is identified, LHCC will require the subcontractor to implement a corrective action plan (CAP). LHCC's Sr. Director of QI or designated representative, with support from LHCC's Compliance Department as needed, will monitor CAP activities to ensure that all deficiencies are addressed, and that necessary steps are taken to prevent such deficiency from re-occurring. In accordance with Sections 17.5.5 and 25.18.1, LHCC will immediately report any suspected cases of Medicaid fraud, abuse, waste, or neglect by its subcontractors to DHH.

Monitoring Technology. For monitoring subcontractor contractual obligations required by LHCC and DHH, LHCC uses Compliance 360. This robust, innovative software solution stores contract requirements, as well as documents such as relevant policies and procedures to demonstrate subcontractor compliance. Any subcontractor identified with a contract compliance issue is tracked in Compliance 360 along with the current status and progress related to completing any assigned corrective action plan (CAP). Staff generate status reports from Compliance 360 for executive leadership and quarterly review by the Quality Assessment and Performance Improvement Committee (QAPIC) and Board of Directors.

Evaluating (Auditing). LHCC will continue to evaluate prospective subcontractors for their ability to perform delegated activities prior to contracting for services. The delegated functions audited include, but are not limited to:

- Claims Processing and Encounter Data Metrics
- Utilization Management
- Disease Management
- Member and Provider Services Helplines, and Nurse Advice Line
- Network Management
- Credentialing

LHCC evaluates prospective subcontractors for their ability to perform delegated activities prior to contracting for services. LHCC applies NCQA guidelines to determine which subcontractors we require pre-delegation and annual audits. Before entering into, renewing or amending a delegation agreement with any prospective subcontractor, Centene's Compliance Department staff or, for credentialing, Centene's Credentialing Department staff, evaluate the delegate's current and prospective ability to perform the functions to be delegated. This evaluation is accomplished through a combined desk and onsite audit using a standardized audit review tool that includes the standards for each delegated function. The review includes but is not limited to (as applicable): organizational structure review, policy and procedure review, file review, site audit, and staff interviews.

Centene's corporate Quality Improvement (QI) and Compliance Departments, in conjunction with other applicable departments as necessary, conduct pre-delegation and annual audits of subcontracted national vendors, such as NurseWise, Nurtur, and NIA. LHCC is encouraged to participate in the annual audit of national subcontracted vendors, as coordinated by Centene's Compliance Department. Conducting a single audit, with health plan participation, ensures consistent application of standards and coordination of any corrective actions across all Centene health plans who subcontract with these vendors. At the same time, this audit approach enables each health plan to ensure compliance with State-specific requirements. For non-national contracts, Centene's Compliance Department follows the same steps for pre-delegation and annual audits.

Pre-Delegation Audit Tool. The Pre-Delegation Audit Tool used to facilitate pre-delegation audits contains review categories such as: quality management, utilization management, credentialing and re-credentialing, and member's rights and responsibilities. Centene's Compliance Department tailors the core audit tool for the specific type of subcontracted activity. Examples of additional audit tool criteria include staffing thresholds, compliance with specific State and contractual requirements (such as Quality Assessment Performance Improvement (QAPI) and Utilization Management (UM)), any required

insurance, financial considerations, and accreditation. Based on the outcome of the evaluation, LHCC determines the degree to which each prospective subcontractor's delegated function is likely to be effectively implemented using "ready", "partially ready", or "not ready" designations. If a delegated function receives the "not ready" designation, the subcontractor is not allowed to implement the contract until such time as LHCC determines readiness. The QAPIC monitors and reviews subcontractors based on this pre-delegation audit as provided by Centene's Compliance Department.

Annual Audit Tool. Centene's Compliance Department also requires an annual audit of each delegate, for each delegated function, using a standardized Delegation Review Tool. The annual audit includes a comprehensive review of areas including, but not limited to, policies and procedures, member files, reports (access, utilization management, financial, etc.), marketing material, and clinical guidelines, if applicable.

Monitoring. All delegation agreements include a monitoring plan. The monitoring plan for delegated activities includes the following elements (as applicable and appropriate to the scope of functions delegated to the subcontractor):

- **Overall Compliance** – Review each subcontractor's compliance with the terms of the subcontract as well as with all applicable statutes and rules affecting the delegated functions
- **Reporting to LHCC Staff** – Review of required operational reports from each subcontractor, applicable to the delegated function. For other operational functions, LHCC subcontractors such as, but not limited to, those performing network contracting and management, utilization review functions, are contractually required to meet or exceed all performance standards established by DHH and LHCC. To ensure performance standards are met, LHCC requires subcontractors to submit monthly, quarterly and annual reports that demonstrate compliance.
- **Reporting to the Joint Operations Committees** – An important formal monitoring mechanism is conducted through Joint Operations Committees. LHCC's Sr. Director of QI or designated representative conducts, at a minimum, quarterly meetings of the Joint Operations Committees (JOC). The committee includes appropriate LHCC staff and subcontractor staff for the relevant functional areas and the committee maintains ongoing communication to ensure optimal coordination of covered services and all other subcontractor functions.
- **Reporting to the QAPIC and Performance Improvement Team (PIT)** – The LHCC JOCs report quarterly to the PIT who subsequently reports to the QAPIC on a quarterly basis. The quarterly report includes a summary of monthly reports (that is, metrics, outcomes, and barriers), any CAP or work plan progress, quality improvement (QI) evaluations, performance or QI activities and outcomes and any improvement recommendations based on data.
- **QI Program** – For subcontractors delegated certain QI functions, the QAPIC annually reviews and approves subcontractors' QI programs in the form of a QI evaluation. These evaluations become part of LHCC's QI Program and Evaluation.
- **Key Program Documents** – LHCC reviews and approves all key program documents related to the delegated functions including, for example, quality initiatives, utilization management and disease management program descriptions, and marketing plan (if any). The subcontractor submits those documents based on the required contractual frequency (such as annually) and as programs are revised.
- **Ad Hoc Data Collection** – The above mentioned committees may also collect data on an ad hoc basis to comply with LHCC and DHH requests or audits
- **Documentation and Tracking** – Updated delegation oversight documents are entered into Compliance 360 for tracking purposes and a quarterly subcontractor scorecard is generated

LHCC requires subcontractors to meet all State, federal, and DHH requirements, as well as LHCC and NCQA standards, including those for quality assessment, improvement and reporting. LHCC monitors the

subcontractor’s performance on an ongoing basis and, at least annually, LHCC performs delegation audits during which data and reports are reviewed and validated.

Throughout the year, LHCC’s inter-departmental PIT and QAPIC review performance data submitted by subcontractors (including all clinical and non-clinical quality indicators, utilization trends, focus studies and outcomes of improvement initiatives) to identify trends related to performance and data submission problems and to ensure data integrity. If performance issues related to contractual data submission requirements are identified, the subcontractor will be required to complete a CAP. Continued non-compliance by a subcontractor may result in monetary penalties and/or contract termination.

LHCC requires subcontractors that maintain NCQA or URAC accreditation, such as NurseWise (nurse advice line) and Nurtur (disease management), to fulfill all accreditation requirements related to monitoring member satisfaction and provide LHCC relevant reports. LHCC monitors service performance measures and grievance trends. To supplement the annual CAHPS survey, we perform targeted surveys of member satisfaction for specific services and seek input from our Member Advisory Council and Community Advisory Committee. The QI staff, with assistance from Centene Health Economics staff, uses our executive dashboard and other reports as well as customized queries to further assess performance data related to specific enrolled populations. For example, we may analyze utilization or quality indicators by eligibility group, racial group, geographic region (such as rural vs. urban), or disease category (for example, percentage of members with diabetes receiving eye exams through OptiCare, our vision services subcontractor). LHCC uses subcontractor monitoring to identify opportunities for proactive improvement as well as for compliance adherence purposes. For example, cross-departmental teams within LHCC meet regularly with US Script, our pharmacy benefit subcontractor, to identify and improve best-practice coordination processes between LHCC and the subcontractor.

QI and Compliance staff communicate any deficiencies identified in a subcontractor performance review, or findings that subcontractor performance is a source of member dissatisfaction, to the subcontractor and establish a CAP. Compliance, QI and staff in other departments, as applicable, monitor established CAPs and related subcontractor performance. LHCC reserves the right to issue monetary penalties or terminate the contract or specific delegated functions if the subcontractor fails to meet contract, delegation, or Subcontractor Monitoring Plan requirements. LHCC retains the ultimate responsibility for any and all functions delegated. If a subcontractor is unable to comply with applicable contract, statutes and rules or monitoring standards, LHCC will terminate delegation of any or all delegated functions and LHCC will perform the delegated activities previously performed by the subcontractor or otherwise arrange for them to be performed. LHCC complies with all requirements as outlined in Sections 7.13.7-7.13.9 regarding termination and notification as pertains to subcontractors with delegated networks.

Also specify whether the subcontractor is currently providing services for you in other states and where the subcontractor is located.

Note that, because LHCC’s business is limited to Louisiana, none of the major subcontractors listed below provide services to LHCC in other states; therefore, we have provided information for this question based on the subcontractor’s potential work in other states for LHCC’s parent organization (Centene Corporation) and our affiliates or subsidiaries.

LHCC Non-Affiliates
Subcontractor Name: Kracke Consulting (Kracke)
<i>Services Provided for Centene Corporation and Affiliates in Other States:</i> Kracke does not currently provide services to Centene or Centene affiliates in other states.
<i>Subcontractor Location(s):</i> Kracke provides all services from its Louisiana office.
Subcontractor Name: LogistiCare Solutions, LLC (LogistiCare)
<i>Services Provided for Centene Corporation and Affiliates in Other States:</i> LogistiCare provides services for

LHCC’s affiliate health plans in California, Florida, and Kansas.
Subcontractor Location(s): LogistiCare provides services from its corporate headquarters location in Atlanta, Georgia.
Subcontractor Name: National Imaging Associates (NIA)
Services Provided for Centene Corporation and Affiliates in Other States: NIA provides services for LHCC’s affiliate health plans in Texas, Georgia, Ohio, South Carolina, Illinois, Mississippi, and Florida.
Subcontractor Location(s): NIA provides services from its offices in Missouri and Maryland.
LHCC Affiliates
Subcontractor Name: Bankers Life Insurance Company of Wisconsin (Bankers Life)
Services Provided for Centene Corporation and Affiliates in Other States: Bankers Life provides services for LHCC’s affiliate health plans in Arizona, Florida, Georgia, Illinois, Indiana, Kansas, Louisiana, Mississippi, Missouri, Ohio, South Carolina, Texas, and Wisconsin.
Subcontractor Location(s): Bankers Life provides services from its office in St. Louis, Missouri.
Subcontractor Name: Cenpatico Behavioral Health, LLC (Cenpatico)
Services Provided for Centene Corporation and Affiliates in Other States: Cenpatico provides services to LHCC’s affiliate health plans in Arizona, Arkansas, California, Florida, Georgia, Illinois, Indiana, Kansas, Massachusetts, Mississippi, Missouri, New Hampshire, Ohio, South Carolina, Texas, Washington, and Wisconsin.
Subcontractor Location(s): Cenpatico provides services from its offices in Austin, Texas; and Tempe, Arizona.
Subcontractor Name: Centene Management Company, LLC (CMC)
Services Provided for Centene Corporation and Affiliates in Other States: CMC provides services to its affiliate health plans in Arkansas, California, Kansas, Michigan, Minnesota, Missouri, New Hampshire, Tennessee, Washington, Texas, Georgia, Ohio, Wisconsin, Indiana, Massachusetts, Arizona, Florida, South Carolina, Mississippi, and Illinois.
Subcontractor Location(s): CMC provides services from its offices in St. Louis, Missouri with offices for claims processing services located in Farmington, Missouri, Tyler, TX and Great Falls, Montana.
Subcontractor Name: NurseWise, LP (NurseWise)
Services Provided for Centene Corporation and Affiliates in Other States: NurseWise provides services to LHCC’s affiliate health plans in Arkansas, California, Kansas, Michigan, Missouri, New Hampshire, Washington, Texas, Georgia, Ohio, Wisconsin, Indiana, Massachusetts, Arizona, Florida, South Carolina, Mississippi, and Illinois.
Subcontractor Location(s): NurseWise provides services from its offices in St. Louis, Missouri Tempe, Arizona; El Paso and Tyler, Texas; Fort Lauderdale, Florida; and Atlanta, Georgia.
Subcontractor Name: Nurtur Health, Inc. (Nurtur)
Services Provided for Centene Corporation and Affiliates in Other States: Nurtur provides services to LHCC’s affiliate health plans in Texas, Georgia, Ohio, Wisconsin, Indiana, Massachusetts, Arizona, Florida, South Carolina, Mississippi, Kansas, Washington, California, Missouri, New Hampshire, and Illinois. Nurtur also provides services to LHCC’s correctional medicine affiliate in Tennessee.
Subcontractor Location(s): Nurtur provides services from its offices in Baton Rouge, Louisiana; Nashville, Tennessee; Farmington, Connecticut; Tempe, Arizona; and Dallas, Texas.
Subcontractor Name: OptiCare Managed Vision, Inc. (OptiCare)
Services Provided for Centene Corporation and Affiliates in Other States: OptiCare provides services to LHCC’s affiliate health plans in Arkansas, California, Kansas, Michigan, Missouri, New Hampshire, Washington, Texas, Georgia, Ohio, Wisconsin, Indiana, Massachusetts, Arizona, Florida, South Carolina, Mississippi, and Illinois.
Subcontractor Location(s): OptiCare provides services from its offices in North Carolina.
Subcontractor Name: US Script, Inc. (US Script)
Services Provided for Centene Corporation and Affiliates in Other States: US Script provides services to LHCC’s affiliate health plans in Arkansas, California, Kansas, Michigan, New Hampshire, Washington, Texas, Georgia, Ohio, Massachusetts, Arizona, Florida, South Carolina, Mississippi, and Illinois.

<i>Subcontractor Location(s):</i> US Script provides services from its offices in California, Georgia, Missouri, Texas and Arizona.
Subcontractor Name: U.S. Medical Management, LLC (USMM)
<i>Services Provided for Centene Corporation and Affiliates in Other States:</i> USMM provides services for LHCC’s affiliate health plans in Texas, Florida, Indiana, Missouri, Ohio, and Wisconsin.
<i>Subcontractor Location(s):</i> USMM provides services from its corporate headquarters location in Troy, Michigan.