

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section E: Chronic Care/Disease Management (Section § 6 of RFP)	100		
E-1	A, B, and C	E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.	50		
E-18	A, B, and C	E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.	50		

Question E.1

Chronic Care/Disease Management Programs

Section E: Chronic Care/Disease Management

E.1 Describe existing (other state Medicaid or CHIP contracts) and planned Chronic Care/Disease Management programs for the Louisiana CCN Program that are designed to improve health care outcomes for members with one or more chronic illnesses. Describe how the Chronic Care/Disease Management programs' data are analyzed and the results utilized by your organization to improve member outcomes.

Organizational Overview

Louisiana Healthcare Connections (LHC) is a partnership between Centene Corporation (Centene) and Louisiana Partnership for Choice and Access (LPC&A). Centene has more than 27 years of experience managing the healthcare needs of Medicaid and CHIP populations, which requires a comprehensive understanding of each member's unique physical and behavioral health issues, as well as the social, educational, and economic challenges they face. LPC&A represents 19 of the 25 Federally Qualified Health Center (FQHC) members of the Louisiana Primary Care Association (LPCA). For more than 28 years, the LPCA has been an integral component of the health delivery system in Louisiana, providing almost 632,000 visits for nearly 203,000 patients in 2010¹. LPC&A members understand the needs and preferences of Louisiana Medicaid recipients and Medicaid providers, and how they differ across the various regions of the state. LPC&A members also have extensive experience with management of chronic conditions. Building on this combined experience, LHC's approach to chronic care and disease management will focus on the whole person, and we will ensure the integration of covered, carved out, and non-covered services. We will go beyond a purely clinical determination of needs to identify and address functional status limitations, and barriers to care and self-management such as lack of caregiver support, impaired cognitive abilities, and transportation needs. A key focus for us will be to ignite in each member the behavior changes needed to improve health status. Our approach will specifically target the three essential elements of behavior change: 1) knowledge of what to do; 2) enablement and know-how to organize and prioritize action steps to get it done; and 3) the motivation to do it.

Nurtur Health, Inc. (Nurtur)

In order to offer members access to chronic care and disease management programs with a proven track record of success, LHC will partner with our Centene affiliate, Nurtur Health, Inc. (Nurtur). Nurtur was formed at the end of 2007 from the merger of two health management industry pioneers, Cardium Health (founded 1997) and AirLogix (founded 1994). The company's clients include Medicaid and commercial health plans, unions, third party administrators, and nationally known employers covering over 2.5 million eligible lives. Nurtur has earned NCQA Accreditation for Patient and Practitioner Oriented Disease Management, the most comprehensive disease management accreditation available that offers the most automatic credit for health plans contracting for these services. The current term of this accreditation runs through November 2011, and Nurtur will be applying for recertification. Nurtur also holds full Disease Management accreditation from URAC, which was renewed in May 2009 and runs for three years. Both NCQA and URAC have accredited the following Nurtur disease management programs:

- Asthma
- Cardiovascular Disease
- Congestive Heart Failure
- COPD
- Diabetes

¹ 2010 UDS Site Summary, U.S. Department of Health and Human Services, Bureau of Primary Health Care.

Since its inception, Nurtur has implemented disease management programs in over 60 markets and currently serves approximately 1.5 million Medicaid health plan members in 11 states. They have extensive experience working with diverse Medicaid populations in both urban and rural settings. This experience extends from working with SSI/ABD (Aged, Blind and Disabled) members facing multiple co-morbid conditions, including both medical and behavioral health diagnoses, to working with pediatric members with asthma in large inner cities. With eleven unique Medicaid/CHIP managed care agreements and over 1,268,000 TANF lives, 139,500 CHIP lives, and 103,000 SSI/ABD lives under contract, Nurtur brings to LHC significant experience in applying respiratory, heart disease, and diabetes disease management principles to improve care and support to Medicaid, CHIP, and other low income populations.

Nurtur has the distinction of being the first health management organization to receive H-TAP (Healthcare Transparency Accreditation Program) Accreditation from the Population Health Impact Institute for the five chronic disease management programs listed above, demonstrating its commitment to quality and transparency in its outcomes reporting. Nurtur philosophy is built around alignment, innovation, integration, implementation and reinforcement – components common to all successful organizations – and they have been recognized by a series of awards including:

- C. Everett Koop award for Nurtur’s heart disease management program
- Top 10 Disease Management companies by Health Industry Research 2000-2006
- National Health Information Awards from the Health Information Resource Center, most recently Gold Recipient in the E-Health Care Category in 2006
- 2011 Silver Award in the Portal/Gateway Site category from the 13th Annual Web Health Awards^(SM)
- 2011 National Environmental Leadership Award in asthma management by the United States Environmental Protection Agency

Existing Chronic Care/Disease Management Programs

Centene affiliate plans and/or Nurtur currently provide best-in-class chronic care/disease management programs for coronary artery disease, congestive heart failure (CHF), diabetes, asthma, chronic obstructive pulmonary disease (COPD), chronic kidney disease, depression, low back pain, hypertension, hyperlipidemia, weight management, and tobacco dependency in Texas, Mississippi, Georgia, Florida, South Carolina, Ohio, Indiana, Illinois, Massachusetts, Wisconsin, and Arizona. Programs offered vary by state.

Planned Chronic Care Management Program

Overview. LHC will provide a Chronic Care/Disease Management Program (CCDMP) for members diagnosed with asthma, congestive heart failure, diabetes, hypertension, and low back pain. To support members at high risk for developing chronic conditions and recognizing the exacerbating effects of overweight and obesity on chronic conditions, LHC will also provide a weight management program. For tobacco cessation, we will fully support DHH’s Tobacco Control Program and will educate our members about accessing all of the resources available through the program, such as the Louisiana Tobacco Quitline and the Freedom from Smoking Clinics, where our members will be able to receive instructions about topics such as recovery symptoms, weight control, stress management/relaxation techniques and how to calm the urge to smoke, as well as supplementary materials to help them develop a quit plan. Our MemberConnections[®] Representatives (MCRs) and Member Service Representatives (MSRs) will receive training on the Program and will provide education to our members who express an interest in quitting, or who are identified as being smokers during outreach activities or inbound calls to the Member Call Center. Our Case Managers will work with members who smoke and who are enrolled in our Case Management Program to incorporate an individualized quit plan into their service plan. In addition, we

will educate our providers about the Program, the Quitline, how to become a certified Fax to Quit Provider (if they are not already), and resulting access to important tobacco cessation resources for their practice, such as the Certified Health Care Provider Toolkit.

CCMP Program Goals. The overarching goal of LHC’s CCMP will be to help members achieve the highest possible levels of wellness, functioning, and quality of life. Each member participating in the program will work with an assigned Health Coach to establish both short and long-term goals that include modifying unhealthy behaviors. In addition, each CCMP-targeted condition has condition-specific, measurable goals that will allow us to measure the effectiveness of the program and make any necessary program changes to maximize our impact on health outcomes. In general, program goals incorporate one or more of the following characteristics:

- Measurable indicators of some aspect of performance, either clinical or service delivery
- Relate to an area that is of importance to LHC and DHH
- Involve clinical quality improvement initiatives consistent with the scope of services relevant to the population served.

Specific goals for the conditions being targeted by the CCMP include:

<i>Condition</i>	<i>Program Goals</i>
Asthma	<ul style="list-style-type: none"> • Reduce the need for rescue inhalers • Reduce asthma-related emergency room visits and inpatient admissions • Increase use of long-term controller medications • Achieve improvement in control and understanding of disease • Improve quality of life • Promote member adherence to treatment guidelines and improve self-management skills to control asthma and optimize quality of life
Congestive Heart Failure	<ul style="list-style-type: none"> • Promote member adherence to treatment guidelines and improve self-management skills in order to prevent subsequent cardiac events and optimize quality of life
Diabetes	<ul style="list-style-type: none"> • Increase the percentage of members who receive at least one HbA1C, LDL, and retinal eye exam to 75th percentile. • Promote member adherence to treatment guidelines and improve self-management skills in order to minimize the development and/or progression of diabetic complications and optimize quality of life
Hypertension	<ul style="list-style-type: none"> • Blood pressure <140/90 mmHg • Tobacco cessation: abstinence • Weight management: BMI < 25 • Physical activity: ≥ 150 minutes per week
Low Back Pain	<ul style="list-style-type: none"> • Reduce healthcare utilization related to back pain • Reduce pain medication usage (for members on pain medications) • Improve body mechanics • Increase exercise tolerance (duration and frequency) • Improve functional ability (based on Oswestry low back pain disability scale) • Reduce reported levels of back pain • Address life barriers • Enhance productivity
Weight Management	<ul style="list-style-type: none"> • Weight loss of 10% of body weight • Improve Physical Activity: Duration 150+ min/week • Healthier food choices: Increased number of fruits, vegetables and whole grains • Improved self-awareness and knowledge of healthy weight loss methods

Relevant Clinical Practice Guidelines. LHC’s Quality Assessment and Performance Improvement Committee (QAPIC) will review and adopt clinical practice guidelines (CPGs) relevant to the CCN-P population and published by nationally recognized organizations or government institutions. We will adopt one or more CPGs to support each targeted condition.

The specific clinical practice guidelines that will be used for each of the conditions being targeted by LHC include:

<i>Condition</i>	<i>Clinical Practice Guidelines*</i>
Asthma	<ul style="list-style-type: none"> National Heart, Lung and Blood Institute: Expert Panel Report 3: Guidelines for the Diagnosis and Management of Asthma- Full Report 2007 National Asthma Education and Prevention Program: New Approaches for Monitoring Asthma Control, Expanded Recommendations for Children (Published August 2007). U.S. Public Health Service: Treating Tobacco Use and Dependence, 2000 with 2008 update
Congestive heart failure	<ul style="list-style-type: none"> The American College of Cardiology and the American Heart Association: ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult, Journal of the American College of Cardiology, 2001 and the 2005 Practice Guidelines update Heart Failure Society of America: 2010 Comprehensive Heart Failure Practice Guidelines The National Heart, Lung, and Blood Institute: Third Report of the National Cholesterol Education Program Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) 2002 U.S. Public Health Service: Treating Tobacco Use and Dependence published by the U.S. Public Health Service in 2000 with 2008 update. American Heart Association: Exercise and Heart Failure, 2003
Diabetes	<ul style="list-style-type: none"> American Diabetes Association. Standards of medical care in diabetes. Diabetes Care 2011.
Hypertension	<ul style="list-style-type: none"> National Heart, Lung, and Blood Institute. National High Blood Pressure Education Program, the seventh report of the Joint National Committee on Prevention, Detection Evaluation and Treatment of High Blood Pressure NIH Publication No 03-5233 May 2003. Exercise, American Heart Association, Circulation. 2003; 103:3109.
Low Back Pain	<ul style="list-style-type: none"> Institute for Clinical Systems Improvement Healthcare Guideline: Acute Low Back Pain, 14th edition, 2010 Guide to Assessing Psychosocial Yellow Flags in Acute Low Back Pain: Risk Factors for Long-term Disability and Work Loss (1997) published by the National Health Committee in association with the Accident Rehabilitation and Compensation Insurance Corporation (ACC) of New Zealand
Weight Management	<ul style="list-style-type: none"> National Heart, Lung, and Blood Institute’s (NHLBI): The Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults (NIH Publication Number 00-4-84 October 2000) American Dietetic Association Evidence Based Guidelines for Adult Weight Management (2006 ADA Evidence Analysis Library) American College of Sports Medicine Position Stand Appropriate Physical Activity Intervention: Strategies for Weight Loss and Prevention of Weight Regain for Adults (2009 Medicine and Science in Sports and Exercise)

* Guidelines are current at the time of submission, but will be updated as the publishing organizations provide updated versions.

We will follow a collaborative approach to CPG development, recognizing that provider involvement enhances the credibility of and encourages compliance with the guidelines. Our QM staff will identify guidelines for development by monitoring program-specific member attributes and utilization data, feedback from medical management and disease management staff and providers, and opportunities for improvement identified as part of the QAPI Program. Our Medical Directors will research valid and reliable evidence-based guidelines and collations published by governmental bodies and professional organizations. Examples of such sources include the Agency for Healthcare Research and Quality – National Guideline Clearinghouse, National Heart, Lung and Blood Institute, and the American College of Cardiology. We will coordinate the development of CPGs with other willing DHH CCNs, in an effort to present providers with consistent CPGs.

The QAPIC will include primary care and specialty providers who will provide input on current community clinical practices and how to maximize acceptance of evidence-based guidelines. CPGs involving a specialty not represented on the Committee will be referred to a community specialist. Before approval and distribution to network providers, CPGs for the CCMP will be reviewed for consistency with our authorization criteria and member educational and benefit materials. LHC will update our guidelines as soon as practicable when source guidelines or recommendations change. No less than biennially, the QAPIC will review all current CPGs and consider new guidelines. To do so, QI staff and the Medical Directors will review relevant new research findings, clinical trials and published best practices. We will identify any relevant changes in Centers for Medicare & Medicaid Services, National Committee for Quality Assurance or DHH requirements. We also will assess claims data to identify changes in member needs or provider practice pattern variation, and analyze member complaint and quality review tracked data for new trends related to specific clinical conditions.

LHC will disseminate newly approved or revised CPGs to all providers through provider orientations and other group sessions, the Provider Manual, Provider Newsletters, our Provider Portal, and targeted mailings. Examples of targeted mailings include distribution to providers along with lists of members in need of services, and to members enrolled in the CCMP and their providers. Guidelines will be available to all members, potential members, and providers upon request.

Integrated Care Team. Experience in other states with populations similar to those served by the CCN-P has shown us that multiple co-morbidities often exist in members with chronic conditions and that the level of support required by these individuals is likely to change over time. In addition to chronic conditions, many of these members face social and economic barriers to access and wellness behaviors. We have found that the most effective way to address these factors is by having case and disease management and other staff work side-by-side in multidisciplinary Integrated Care Teams (ICTs). Our ICTs use a person-centered approach and frequent, ongoing collaboration to ensure that the entire member's medical, behavioral, and social needs are addressed, and that care for one condition does not undermine care for or exacerbate another. The ICT allows for collaboration and clinical input from team members with different areas of expertise and performs both case management and disease management functions. ICT staff will include registered nurse and behavioral health clinician Case Managers, social workers, disease management Health Coaches, MemberConnections® outreach representatives and other non-clinical support staff. Because our affiliate health plans have found that locally delivered services achieve the best outcomes, LHC will hire staff who are from and familiar with the communities they serve. We will locate ICT staff members in our Baton Rouge and other local offices, and embed team members in key high-volume FQHCs and other provider offices.

For CCMP programs, a Health Coach who has experience with the member's primary condition will act as the team lead with support from other ICT staff as needed. All Health Coaches will be licensed clinical staff, such as respiratory therapists, certified diabetes educators, registered dietitians, and exercise physiologists, with a minimum of one year of experience in a clinical setting. They will promote a coordinated, proactive, condition-specific approach to chronic care management that will improve the

member's self-management of their condition, improve clinical outcomes, and control high costs associated with chronic conditions.

A recent analysis of Medicaid members with disabilities under age 65 reinforced the significance of behavioral health co-morbidities. For example, behavioral health co-morbidity was found in 69% of individuals with coronary artery disease and 65% of individuals with diabetes. In each case, behavioral health conditions were also the highest priority co-morbidity based on percent of total cost for the individuals.² Recognizing the impact of mental health and substance use on other chronic conditions and vice versa, LHC will include behavioral health clinicians in our ICTs to support other ICT staff, as well as to coordinate primary and specialty mental health services within the member's service plan.

Our Medical Directors, with support from the Corporate Pharmacy Director, will support the ICTs. A Medical Director will be available to ICT staff to answer questions about the clinical needs of complex members. If a member's condition is outside their areas of expertise, LHC Medical Directors will consult network specialists for recommendations. The Pharmacy Director will review weekly drug utilization reports to identify under-utilization, over-utilization, and noncompliance, and will work with the ICT to address these needs in the service plan and share suggested changes with the member's PCP. The Medical Director also will work with Health Coaches and Case Managers to ensure that appropriate prescribing, utilization, and compliance are achieved.

ICT staff will document all program interactions in TruCare, our member-centric integrated care management and utilization management platform. Clinical staff will use TruCare to proactively manage members with integrated workflow tools, report data to track outcomes, and identify program/quality improvement initiatives. TruCare offers InterQual evidence-based clinical appropriateness tools, customized assessments and service plans for members, stratification of risk, and tracking/reporting/improvement data. It also will allow us to identify all members participating in our CCMP programs and differentiate between members receiving different levels of services. Our ICTs will use TruCare to capture all of their outreach activities and contact information, including mailings, outbound call attempts and telephonic contacts with members and providers, and to document the category of interventions and specific interventions provided.

Integrated Care Approach. LHC's integrated care approach is structured to maximize the impact of care management resources for the population as a whole, while providing the most appropriate level of services for individual members, ranging from those with poorly controlled or multiple co-morbid chronic conditions to those with the best health status or no chronic condition. For example:

High risk: Members with high predicted risk for hospitalization, higher than expected utilization, poor outcomes, multiple co-morbidities (medical or behavioral health), or special health care needs will receive case management services from the ICT. An RN or BH clinician (depending on primary diagnosis) will be responsible for overall direction and coordination of the member's case and disease management services, to ensure appropriate clinical oversight of ICT staff activities. This will include coordination with the Health Coach for needed disease management services.

Moderate risk: Members with a single chronic condition (asthma, congestive heart failure, diabetes, hypertension, obesity, and low back pain) will be referred to a disease management Health Coach for motivational interviewing, health education, training in self-management skills, and coordination of care and services. Health Coaches will coordinate with other ICT staff to ensure that these members receive the most appropriate mix of services to support their adherence to their treatment plan and optimize health status.

² *Clarifying Multimorbidity to Improve Targeting and Delivery of Clinical Services for the Medicaid Population*, Faces of Medicaid Report, Center for Health Care Strategies, December 2010

Low risk: Members with no chronic condition or with a well managed condition will receive general education through our health education programs and assistance as needed through our MCRs or MSRs through our local Member Services Call Center.

While this framework may be helpful in determining the appropriate level of intervention, LHC’s integrated care approach is flexible in providing the most appropriate mix of services for each member. Members receiving one level of management may be moved to a more or less intense level of management based on changes in the acuity of their condition. ICT staff will re-assess members at each contact to determine appropriate contact intervals based on clinical acuity, risk factors and readiness to change. MemberConnections and Member Services staff may refer members to the ICT for assessment or re-assessment at any time. LHC may also re-stratify members following our bi-weekly Centelligence™ Foresight predictive modeling analysis of member risk. For example, a member currently categorized as low risk may be moved to case management if condition-related utilization of acute care services suddenly increases or a new co-morbid condition is identified. Our approach also offers flexibility for members to choose to receive assistance in a way that best meets their preferences. For example, a member whose condition is well controlled may still prefer frequent contact from the Health Coach to maintain that control.

Identification of Eligible Members. LHC will identify members who might benefit from participation in the CCMP by administering and analyzing New Member Health Risk Screening and predictive modeling analysis of eligibility, medical, behavioral and pharmacy claims (as available from DHH), and demographic data, and lab test results, as well as ER utilization, nurse advice line logs, pharmacy utilization patterns, and referrals from LHC staff, providers and others. Please see Question E.2 for a more detailed description of the identification process.

Outreach. Once eligible members are identified, effective outreach and engagement of members and providers will be a key success factor for the CCMP. LHC’s relationship with our LPC&A owner-partner FQHCs, known and trusted organizations and Medicaid/CHIP providers throughout Louisiana, will provide immediate credibility for and confidence in our CCMP. There is a high likelihood that members eligible for the CCMP may already be in treatment, have previously sought care from, or be familiar with one of the LPC&A FQHCs. Since these FQHCs are woven into the fabric of the communities they serve, LHC’s efforts to identify, outreach to, and engage members with chronic conditions will benefit from their established relationships with social service and community-based organizations that may have existing relationships with these members.

Assessment. All potentially eligible members identified with a CCMP condition will receive an introductory mailing with information about the program. Unlike many other disease management programs, an LHC Health Coach will contact the member by phone following the introductory mailing to complete an Initial Health Assessment (IHA). The Health Coach will attempt to contact the member three or more times to complete the IHA, calling on different days of the week, including weekends, and at different times of day to maximize the likelihood of successful contact.

All Health Coaches will be trained to employ Motivational Interviewing and other advanced engagement and behavior modification techniques to establish rapport, set goals, and achieve success. On a case-by-case basis for members that have difficulty communicating by phone, initial outreach to complete the IHA may occur in person by a Health Coach, either in a member’s home or at a provider’s office. All members with asthma considered to be high-risk based on claims and pharmacy data will be offered an in-home Baseline Assessment to allow assessment of environmental risk factors. If the member cannot be reached by phone, the Health Coach will mail a postcard asking them to call a toll-free number to discuss their

“This is an excellent service. I thought I knew a lot, but this program made me realize how much I did not know. We even passed the information on to our son’s day care center so they could be prepared. Thank you!”

*Parent of an Asthma
Program participant*

health care. In 2010, almost 94% of Medicaid members contacted by a Nurtur Health Coach agreed to participate in disease management.

Through the IHA, the Health Coach gathers information about primary and co-morbid conditions and any socioeconomic barriers impacting health. For members considered to be at moderate or high risk based on the IHA, the Health Coach does a Baseline Call Assessment (BCA), which is condition-specific and includes questions about symptom severity, medications, hospital and ER use, activities of daily living, pain, medical or behavioral health co-morbidities, use of medical equipment or supplies, health literacy, unmet social needs (such as housing or food supply), family and other support, medical home, and willingness to participate. This holistic assessment features open-ended questions that foster an understanding of both the individual's clinical co-morbidities, including behavioral health conditions, and general psychosocial status. We also assess the member's current readiness for self-management in the following areas of health care:

- Daily monitoring of health indicators for the member's chronic health condition for self-triage
- Consistent self-management of acute clinical symptoms in the home/community setting
- Correct use of all prescribed medications and medication adherence over time
- Appropriate lifestyle decisions based on the member's chronic health condition and physician recommendations
- Management of depression and other mental health correlates of chronic disease
- Access to support for self-management (such as family, friends, and community services).

The assessments will be used to further stratify members to determine frequency and intensity of contact, and to establish a baseline for clinical outcome measurement. The IHA information is then documented in TruCare so that it is available to all LHC staff for future interactions. Each subsequent contact with the member will involve re-assessment and re-stratification, and evaluation of improvement in risk and health status. Between contacts, all members have access to NurseWise, our 24/7 nurse advice line, as well as their assigned Health Coach and supporting ICT staff via a toll free number.

During initial conversations with members, we will determine which methods and style of communication the member prefers. Because different people prefer different methods of communication, LHS' program employs multiple communication strategies, including written materials, telephonic outreach, web-based information, in person outreach through our MemberConnections™ Program and ICT staff, and participation in community events.

Stratification and Interventions. LHC's CCDMP stratification methodology includes specific risk factors for each diagnosis being managed. For example, left ventricular dysfunction based on ejection fraction, evidence of dysrhythmia, and recent hospitalizations will impact stratification for members with congestive heart failure. Starting with estimated future risk for members from Centelligence Foresight, our predictive modeling suite (see Question E.2) and the IHA, the Health Coach will also use BCA information to determine the member's stratification. Examples of information collected through the BCA that may affect stratification include lack of physical activity, tobacco use, high body mass index, member-reported non-compliance, access barriers, lack of social supports, engagement in behavioral health treatment, and level of understanding of condition. The BCA also provides the member's assessed readiness to change, using Prochaska's Stages of Change model³, a reliable tool to match patients with the most effective interventions to promote changes in their behavior.

As discussed above, we will stratify members as high, moderate or low risk. The ICT will provide comprehensive case management for higher risk members, and care coordination for lower risk members when needed. We will provide high intensity interventions to members with uncontrolled or disabling disease or who are at risk for ED or inpatient admission, and those who need education related to their condition, have multiple or severe co-morbid conditions, and/or have high readiness to change. Contact may occur as frequently as twice a month (may be more frequent during an acute episode), with home

³ Prochaska, J O The Transtheoretical Model of Health Behavior Change, Am J Health Promot 1997 Sep-Oct;12 (1):38-48

visits, home telemonitoring (see below), and ConnectionsPlus preprogrammed cellular phones (see below) for very high risk members. We will provide moderate intensity intervention (including monthly contact) to those with poorly controlled disease who need education related to their condition, assistance accessing social support or resources such as food or housing, or have moderate readiness to change. LHC will also provide lower intensity interventions (quarterly contact and newsletter) to those whose condition is controlled or well managed; have less need for education; and/or have low readiness to change or are not interested in more frequent contact. While these categories are helpful in determining the appropriate level of intervention, LHC's programs offer the flexibility for members to choose to receive assistance in a way that best meets their needs. For example, a member whose condition is well controlled may prefer frequent Health Coach contact to maintain that control. Health Coaches re-stratify members at each contact to determine the most appropriate interval between contacts based on clinical acuity, risk factors, and readiness to change.

LHC's approach to chronic care/disease management interventions recognizes that the best way to draw difficult-to-serve members into care is by:

- Minimizing repetitiveness where possible, especially for those with multiple co-morbid conditions
- Encouraging and supporting active member involvement with an underlying emphasis on personal accountability for their own health and wellness
- Providing member-centric information in easy-to-understand formats and context through a variety of methods to meet preferred learning styles
- Providing an active, high-quality, responsive platform of intervention methods, beginning with the first member interaction, to ensure active engagement from the start.

When members who have been unmanaged receive support to make informed health care decisions and the tools to take responsibility for managing their own decisions, they show an average 51% improvement in healthy behavior.⁴ Health Coaches are highly skilled in identification and discussion of barriers to compliance, and adept in facilitating a readiness for change, obtaining true buy-in for behavioral modification, and encouraging solution-oriented problem solving.

Self-Management Plan. The Health Coach will work with the member, ICT staff and appropriate providers to develop a self-management plan that reflects the member's preferences and goals and serves as the focal point for directing future communications. A copy of the plan will be sent to both the member and the provider to ensure shared expectations. Because all member information, including assessment results and the self-management plan, will be housed within TruCare, Health Coaches and other ICT staff will be able to 'refresh the memories' of our members, reminding them of past responses or agreements to pursue behavior modifications such as quitting smoking or making dietary changes.

Coaching. Members will be assigned a personal Health Coach with expertise in their primary condition, such as an RN with cardiac experience for those with CHF. The personal Health Coach will coordinate with Health Coaches having other specialties, or with other members of the ICT, for medical or behavioral health co-morbidities, or special needs such as nutrition, exercise, or social services. Coaching will consist of an initial series of pre-scheduled outbound phone and/or in-home coaching sessions upon enrollment in the CCMP, followed by periodic continuing contact as often as necessary to respond to member questions and changes in health and functional status. The sessions may include health and medication education, motivational interviewing, psychosocial evaluation and support, tobacco cessation, nutrition, stress management and similar services. The Health Coach will educate members about their specific primary and co-morbid conditions based on their BCA and stated health goals. For example, a

⁴ Burke BI, Arkowitz H, Menchola M., The Efficacy Of Motivational Interviewing: A Meta-Analysis Of Controlled Clinical Trials, J Consult Clin Psychol. 2003 Oct;71(5):843-61

Health Coach could educate a member with diabetes about the disease and its possible progression, and the importance of annual physical, podiatry, and nephrology exams.

In addition, staff from MemberConnections[®], our intensive, grassroots education and outreach program, will assist with non-clinical coaching and support as well as connecting members to needed community resources. We will hire our MCRs from within the communities we serve so they understand our members, their needs, and the local barriers they face. MCRs will provide members with a trusted face and a personal connection to LHC, and often visit with members in their homes or encounter members at community events and health education workshops. During these events, they may identify members who need chronic care/disease management and, at that time, provide basic education about the member's condition. MCRs will maintain a stock of education materials which allows them to, for example, provide basic asthma education and refer the member to our Asthma Disease Management Program.

Member Education. Verbal communications with members will be reinforced multiple times using various written, audio-formatted, and online materials. Members will receive materials specific to their conditions and diagnoses upon enrollment into the CCMP and as needed throughout their involvement in the program. All of our CCMP materials will be available in English, Spanish and Vietnamese, and we will provide translated materials for any language that is spoken as the primary language for 200 or more LHC members in a given GSA. We will use relevant pictures to demonstrate and reinforce the written information, which will be written at or below a 6.9 grade reading level as measured by the appropriate score on the Flesch-Kincaid Grade Level test. LHC will provide members with relevant information about their identified conditions, appropriate preventive treatment, and tips for avoiding exacerbation. For example, a member with asthma will receive a Self-Management Guide that includes information about asthma –tips for avoiding lung infections, managing medications, how to use an inhaler, spacer, nebulizer, and peak flow meter, early warning signs of exacerbations, and when to seek help. Pediatric asthma members will receive our award-winning asthma guidebook, “Puffletown,” featuring Thumbs Up Johnnie. Members with a diagnosis of congestive heart failure will receive written materials such as “Heart Failure: Signs of a Flair Up,” “Cutting Back on Sodium,” and “Target Goals for Blood Pressure and Cholesterol.” The member's Health Coach will follow up with a phone call to verify the materials were received and answer any questions the member might have.

All participants will receive quarterly newsletters with such topics as condition-specific self-management, problem solving, decision-making, taking action, working with providers and disease-specific goals. The newsletter also will be available on our Member Portal.

All members in the CCMP program will receive *reminders* about preventive care and screenings for their conditions. These reminders are based on the clinical practice guideline for the particular condition. Each reminder, whether mailed to the member or communicated verbally, either telephonically or during an in-person interaction, will include information about the risks associated with progression of their disease and a reminder about any available incentives for receiving the service.

We will also collaborate with our partner LPC&A FQHCs to offer interventions to members enrolled in the CCMP Program in an environment where they are comfortable and where many of our members will already be receiving services. For example, members may be referred to the Baton Rouge Primary Care Collaborative FQHC, where diabetes, diet, exercise, and obesity management programs are offered at the Jewel Newman Community Center; the Primary Health Services Center in Monroe, where they can attend diabetes classes or asthma seminars; or the Southwest Louisiana Primary Health Care Center in Opelousas, which offers diabetes awareness classes and cardio workout groups.

Innovative Approaches. Our CentAccount[™] Member Incentive Program is widely used by Centene health plans and promotes personal healthcare responsibility and ownership by rewarding members for targeted healthy behaviors. Eligible members can earn rewards for completing annual preventive health visits and other recommended preventive health and chronic disease care screening, such as appropriate diabetes testing. The reward will be loaded onto an LHC-issued CentAccount MasterCard[®] debit card.

Members can use this card at many merchants they already use every day, such as Walgreens, CVS, Rite-Aid stores, supermarkets such as Albertson's, Winn-Dixie, Piggly Wiggly, Safeway, Kroger's, Sam's and Wal-Mart, and other stores throughout the state, to buy a wide variety of health-related items, including some over-the-counter medications, not covered by Medicaid. Goods and services qualify for card purchases if they are recognized by U.S. Internal Revenue Service as health care expenses for a Flexible Spending Account and flagged by the retailers' Inventory Information Approval System.

LHC's innovative **Connections Plus[®] Program** will provide our highest-risk members (with multiple comorbidities) who lack reliable phone access with a pre-programmed direct dial cell phone at no cost to the member. Health Coaches, in collaboration with the RN Case Manager, will evaluate the need for a phone on a member-by-member basis. Provision of the phone will facilitate the member's communication with the Health Coach, other ICT staff, and their providers and caregivers so they can ask questions, request assistance, and report medication side effects or new or changed needs. We will educate members to observe their health status and call promptly for advice rather than waiting until the next appointment. The phone will also be preprogrammed with other important phone numbers such as for NurseWise, our 24/7 nurse advice line, 911, and the domestic violence hotline. Health Coaches will also be able to more easily reach members to provide assistance such as reminder calls, and coaching targeted to changes in the member's condition. We will have several different styles of phones to accommodate members' special needs such as headsets or optimum texting keyboards for hearing impaired members, and voice recognition for members with visual impairment.

Certain high-risk members with multiple or complex co-morbid chronic conditions will be provided **in home telemonitoring** services. This wireless technology enables biometric readings, such as blood glucose level or blood pressure or weight, taken in the home and transmitted electronically to the Health Coach and provider within seconds of the reading being taken. Our telemonitoring software evaluates the data against Health Coach or physician determined member-specific or national guidelines; analyzes it for favorable or unfavorable trends; and provides actionable information to the Health Coach who may then share results with the PCP, if necessary. Most importantly, the real-time data enables Health Coaches to contact the member within minutes of an unfavorable reading and work with them immediately to associate the unfavorable trend with prior near-term behaviors (for instance a member with heart failure may have unknowingly eaten a high-sodium content food earlier in the day which resulted in an unfavorably-trending weight reading). The ability to receive real-time information and act on it immediately provides for a teachable moment, which can result in healthier behaviors and improved member self-management in the future. These alerts of, at times, potentially dangerous values can also result in timely interventions that can avoid unnecessary ER or hospital utilization.

This leading-edge health information technology platform is fully web-enabled. We will provide members with a web URL address and password information that enables physicians and family members to access the member's biometric data, trends, and alerts with their permission. Telemonitoring will facilitate member adherence to treatment plans, improve coordination between members of the care team, and remove barriers to care such as lack of mobility or social supports. A Medicaid plan in New York City implemented a pilot program with diabetics using this technology resulting in a 17.3% improvement in HbA1c, and with 69% of participants seeing sustained glycemic improvement. Interventions also will include the provision of devices necessary to monitor and manage chronic conditions. For example, all members with asthma who participate in our CCMP will receive a peak flow meter (to appropriately monitor their respiratory status) and a spacer (to ensure appropriate delivery of inhaled medications) as part of their introductory mailing.

Addressing Childhood Obesity: In-Community Video Exercise Pilot. Beginning in Q2 2012, we will pilot new ways to engage members in their care, through the carefully supported introduction of interactive technology to address childhood obesity. Through a partnership with the *Microsoft Corporation*, we will pilot an in-community video exercise pilot at two pilot locations: the Jefferson

Community Health Center, one of our partner FQHCs, and a local church, school or other community agency in Pointe Coupee Parish.

In consultation with the member's PCP, and with the member and member's family or legal guardian's permission and cooperation, we will invite select child members in case management to participate in a personalized exercise program at the Pilot location. The location will be equipped with a combination of Microsoft's Kinect intelligent video system, Xbox console, and Lync Server unified communications software. This system will also be integrated with MRM. Each Kinect/Xbox system will include carefully selected exercise program software designed to *complement* the dietary and exercise regimen for members with Childhood Obesity. All the exercise software we will install on the Xbox (customized for the specific member's exercise needs) are interactively *engaging* - with full motion "virtual reality" video scenery, avatars, and props - as well as audio cues, prompts, and music - all designed to immerse the member in a carefully orchestrated, exercise program.

Kinect measures the "visual vitals" of the member, including height, arm span, and leg length - in order to calibrate the prompted exercise movements of the program and "set the virtual scenery" for each exercise. The software approximates and displays the calories expended during each exercise session, and can track calories "burned" against pre-set goals and challenges for the member, because Kinect recognizes *who* the member is when the member steps into Kinect's field of view. A "virtual coach" encourages the member with positive reinforcement throughout each exercise, and audio and visual messages based on the member's exercise activities. The exercises themselves mimic physical activities that encourage the member's motion; for example: using a virtual jump rope (with no possibility of tripping on a real rope); spinning a virtual hula-hoop; knocking down virtual blocks; etc.

In addition, the member (or member's caregiver/parent) can initiate or receive video conferencing requests with the member's Case Manager. We also will phase in additional functions and capabilities as we prove the logistical soundness and usability of this compelling technology. For example, in Q4 2012, we will phase in the customized use of Microsoft's Xbox Points incentive program - so that the member is automatically rewarded when appropriate exercise goals have been met. The member will be able to redeem and use their earned Xbox Points to download movies, music and/or additional Kinect/Xbox games. We are focused on Kinect - enabled games because all such games encourage *physical* activity.

One focus of our pilot will be to demonstrate the extended reach of our MRM (see Section R, Question R.7 and R.11 for information), through the on-demand video link between the member at the pilot location and LHC's staff of Case Managers and our MCRs. We will *not decrease* "in-person" contacts between our members and LHC. Rather, our Community Pilot will demonstrate the viability of on-demand video conferencing to dramatically *increase* the frequency and *augment the quality* of member contact with appropriate LHC staff.

Care Transition. Post implementation, ICT staff will work collaboratively with other CCNs or vendors to establish a process, preferably electronic, for transmitting a list of transferring members who are eligible for or already participating in a CCMP. ICT staff will contact the member's previous provider or CCMP staff, as applicable, to obtain contact information, recent clinical data, and information from the existing service plan such as treating providers, goals, assessed needs, and support systems. The Health Coach will notify the new PCP and send the member a letter and materials explaining our CCMP and the transition process. For additional detail about LHC's continuity of care processes both during and after initial program implementation, please see our response to question F1 – Service Coordination.

How CCMP Data are Analyzed and Results Utilized

LHC will continuously monitor both member-level and program-level measures. Monitoring of individual members will be an integral component of our CCMP. Through continuous, individualized assessment and evaluation, we can adjust our approach to each member's interventions to maximize effectiveness.

For example, if monitoring indicates a shift in a member’s readiness to change, the Health Coach will alter interventions. LHC will monitor the following types of metrics for each person enrolled in the CCMP:

1. Symptom improvement
2. Decreases in utilization
3. Health behavior change
4. Progression through the stages of readiness to change
5. Medication compliance
6. Proper technique in the use of medication delivery devices
7. Compliance with key measures such as smoking cessation, immunization recommendations, and condition-specific guidelines.
8. Progress toward or achievement of personal health behavior or risk reduction goal.

These measures will be evaluated using both claims and member-reported data. Member-reported data will be collected during each telephonic or face-to-face interaction. Claims-based data (both medical and pharmacy) will verify and augment the member-reported information. All information will be documented in TruCare, which will allow for comparison of past reported information as well as individual and population-based outcome analysis.

In addition, LHC will collect and analyze clinical and administrative performance measure data on a routine basis to monitor the ongoing effectiveness of the CCMP. The data will demonstrate adherence to clinical practice guidelines and improvement in patient outcomes. Performance measures will include condition-specific HEDIS or Agency for Healthcare Research and Quality Review measures. Examples (not all inclusive) of these measures include:

<i>Condition</i>	<i>Measures</i>
Asthma	<ul style="list-style-type: none"> • HEDIS: Use of Appropriate Medication for People with Asthma • Percentage of members with diagnosed asthma that were evaluated during at least one office visit during the reporting year for the frequency of daytime and nocturnal asthma symptoms.
Congestive heart failure	<ul style="list-style-type: none"> • HEDIS: Annual Monitoring for Patients on Persistent Medications - ACE Inhibitors or ARBs • Percentage of members enrolled in the program that reported using an ACE/ARB
Diabetes	<ul style="list-style-type: none"> • HEDIS: Comprehensive Diabetes Care (all sub-measures)
Hypertension	<ul style="list-style-type: none"> • HEDIS: Controlling High Blood Pressure
Low Back Pain	<ul style="list-style-type: none"> • HEDIS: Use of Imaging Studies for Low Back Pain
Weight Management	<ul style="list-style-type: none"> • HEDIS: Adult BMI Assessment and Weight Assessment and counseling for Nutrition and Physical Activity for Children and Adolescents

LHC will also monitor resource utilization (including inpatient, emergency room, home health, and PCP services), and estimated cost savings from the Program. Whenever possible, we will demonstrate improvement in claims-based performance measures by employing a methodology for which Nurtur recently received the Population Health Impact Institute’s Methods Evaluation Process (MEP™) H-TAP Accreditation for validity and transparency. Using this methodology, we will generate a comparative control group by means of propensity scoring that matches each CCMP participant with a non-participant using a logistic regression model that factors disease, presence of co-morbidities, age and gender, thus minimizing the effects of selection bias. We will calculate savings by estimating the change in medical expenses for participants between a baseline period and the participation period in the program and comparing it to the change in expenses for matched non-participants over the same interval.

We also will monitor both member and provider satisfaction with our CCMP. Upon initial program enrollment, following completion of the IHA and first follow up call, QI staff will mail participants a program satisfaction survey. The survey asks about the member’s satisfaction with our staff, educational

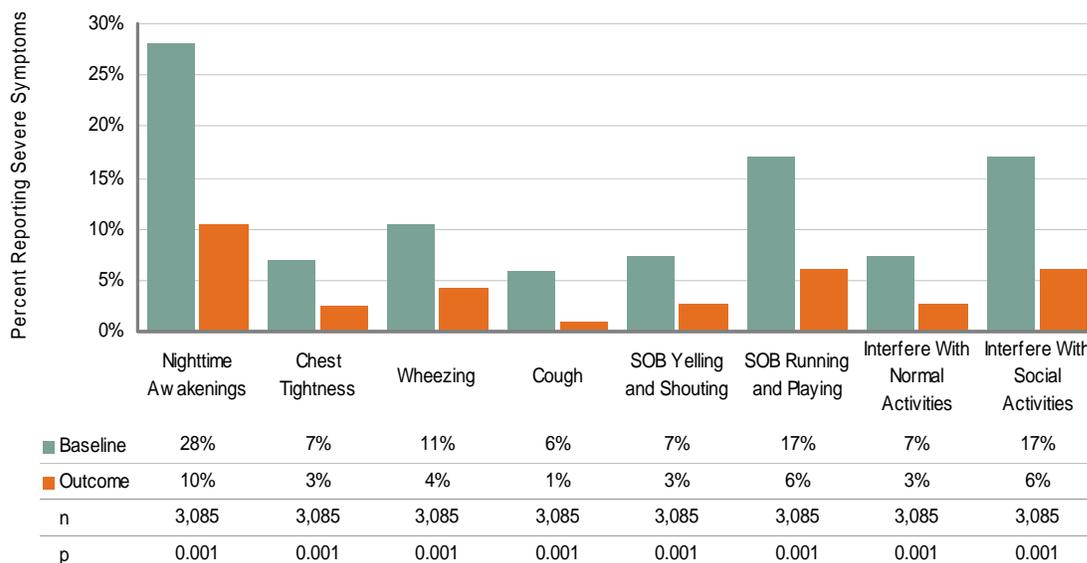
materials and the program overall. It also asks if they have kept their scheduled appointments and followed the recommendations of their providers, and asks for comments about the program. Members will also receive a survey on an annual basis based on their initial enrollment date as long as they remain in the program. In addition, LHC’s Provider Relations staff will conduct an annual comprehensive provider satisfaction survey that will include questions about the CCMP. LHC will use the information we receive through these surveys to determine improvements to our programs.

Centelligence™. Our CCMP will be supported by Centene’s state of the art reporting systems. Centelligence™ is our proprietary and comprehensive family of integrated decision support and health care informatics solutions. Our Centelligence™ enterprise platform continually integrates and analyzes an enormous amount of transactional data (e.g. claims, lab test results, authorizations) from multiple sources and produces *actionable* information. Centelligence™ Insight will produce HEDIS and utilization-based measures to assess program performance as well as provider-level compliance with clinical guidelines as part of our provider profiling program.

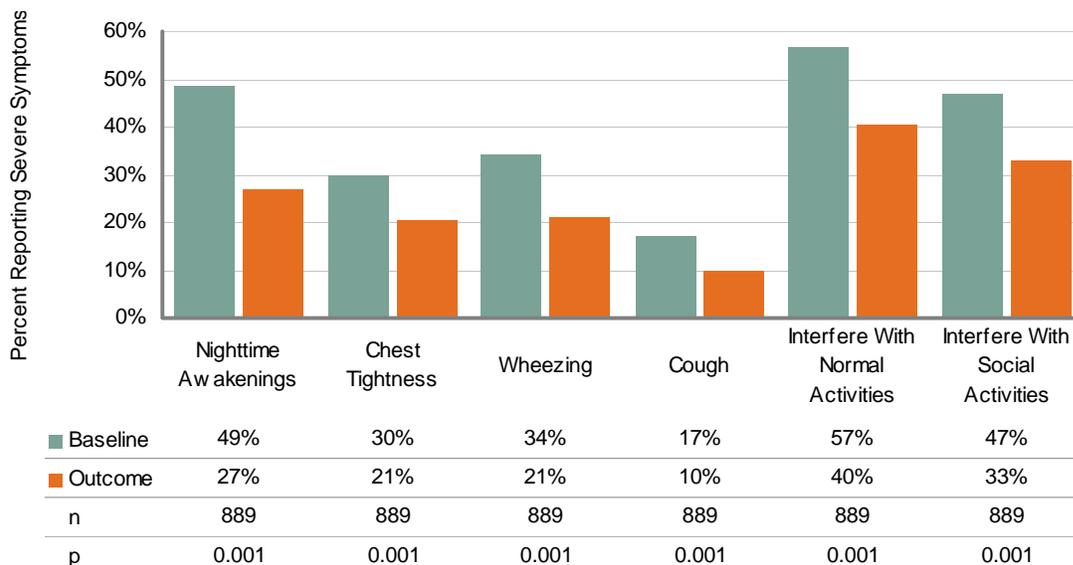
Improved Member Outcomes

Centene’s disease management programs have demonstrated significant improvements in health status and reduction in resource utilization and health care expenditures for Medicaid, CHIP, and other low-income populations. Most recently in CY2010, child and adult asthma program participants across all Centene plans significantly improved in *all* monitored symptom and functional measures. All improvements were between baseline and most recent reassessment (≥ 90 days post baseline) and were statistically significant ($p < 0.05$). For example, 28% of child program participants at baseline responded that they awoken at nighttime, “more than once a week,” “five or more times per week,” or “one to four nights per week.” At outcome, this value had decreased to 10%.

Child Asthma Symptom and Functional Outcomes – All Centene Plans CY2010



Adult Asthma Symptom and Functional Outcomes – All Centene Plans CY2010



Also in CY2010 for all Centene plans, our diabetes and hypertension programs significantly improved physiologic outcomes. For example, in the diabetes program there was a nine percentage point increase in the number of participants reporting LDL levels <100 mg/dl; a five percentage point increase in participants with controlled systolic blood pressure (< 130 mm Hg); and an increase in exercise of 150 minutes per week for 57% of members who started outside of the target goal, all between baseline and most recent reassessment. In our hypertension management program there was a nine percentage point improvement in participants reporting systolic BP < 130, an eight percentage point improvement in participants reporting diastolic BP < 80, and a 9% improvement in participants reporting exercise of more than 150 minutes per week.

Diabetes and Hypertension Physiologic Outcomes – All Centene Plans CY2010

<i>Condition-specific Physiologic Measures (# participants)</i>	<i>Baseline</i>	<i>Outcome</i>	<i>Difference</i>	<i>p – value</i>
Diabetes (412) LDL <100mg/DL	59%	68%	9	.011
Diabetes (889) Systolic BP <130mm Hg	58%	63%	5	.033
Hypertension (447) Systolic BP <130mm Hg	51%	62%	9	.001
Hypertension (444) Diastolic BP <80mm Hg	82%	90%	8	.001

Again in CY2010 for all Centene plans, our asthma, diabetes, and heart disease programs significantly reduced rates of emergency room use and inpatient admission. In the analysis of these and other claims-related measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Emergency Room Utilization Related to Asthma – All Centene Plans CY2010

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

Condition-Specific Inpatient Utilization - All Centene Plans CY2010

<i>Condition-specific related Admissions per 1,000 members (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Asthma-Related Admissions Children (49,761)	339.9	390.3	-12.9%	.001
Diabetes-Related Admissions Adults (12,472)	291.7	394.4	-26.0%	.001
All Heart-Related Admissions (1,217)	1826.1	2481.5	-26.4%	.046

Centene also demonstrated notable savings in CY2010 from its disease management programs. Savings were calculated by estimating the change in medical expenses for participants from a baseline period to the participation period in the program, compared to matched non-participants over the same interval. Total CY2010 estimated savings were \$16,173,860.

Estimated Savings from Disease Management Programs – All Centene Plans CY2010

Participant Category	Participants				Matched Non-Participants			Difference in the Difference	Estimated Savings
	n	Pre	Post	Difference	Pre	Post	Difference		
Pediatric Asthma	16,529	\$2,562	\$2,469	-\$93	\$2,263	\$2,277	\$14	\$107	\$1,768,603
Adult Asthma	4583	\$5,118	\$3,581	-\$1,537	\$3,803	\$4,167	\$364	\$1,901	\$8,712,283
Back Pain	504	\$6,422	\$6,713	\$291	\$3,902	\$5,931	\$2,029	\$1,738	\$875,952
COPD	2,321	\$12,102	\$11,999	-\$103	\$9,586	\$10,075	\$489	\$592	\$1,374,032
Adult Diabetes	6,256	\$9,666	\$10,039	\$373	\$6,418	\$7,174	\$756	\$383	\$2,396,048
Coronary Artery Disease	1,058	\$10,124	\$11,637	\$1,513	\$8,238	\$9,802	\$1,564	\$51	\$53,958
Heart Failure	830	\$15,208	\$15,785	\$577	\$11,804	\$12,947	\$1,143	\$566	\$469,780
Hypertension	2,068	\$7,470	\$9,194	\$1,724	\$4,850	\$6,827	\$1,977	\$253	\$523,204
Total Estimated Savings									\$16,173,860

Using Program Results to Improve Member Outcomes

LHC will conduct an annual CCMP Program Evaluation that will be included as part of our Annual QAPI Evaluation. The evaluation, which will be reviewed by our QAPIC and Board of Directors, will include a summary of all program activities; the impact the Program has had on member care; an analysis of the achievement of stated goals and objectives; and the need for program modifications. Program evaluation findings will be used to develop new or revised program components for the subsequent year to further improve member outcomes. The evaluation will be provided to DHH for review each year, in addition to the quarterly member activity reports required in Section 6.38.2.

LHS will monitor both CCMP-level and provider-level compliance with clinical practice guidelines used by the CCMP by generating HEDIS and other utilization measures through Centelligence Insight as part of the QAPIC oversight and provider profiling processes. Performance will be compared to DHH Performance Goals, national benchmarks and average network performance. Quality Management or Network Management staff, or the Medical Director, will meet one-on-one with non-compliant providers to provide education and establish an action plan for improvement. QM staff will then monitor performance monthly or quarterly, depending on the measure, and report both to the Utilization Management Committee and the provider. Providers also will have direct access to performance reports on the Provider Portal. CCMP-level clinical guideline compliance will be reviewed by the QAPIC as part of the annual CCMP Program Evaluation, with recommendations made for further improvement.

As an example of using data to improve the CCMP, our Arizona affiliate health plan, Bridgeway Health Solutions, found that their home telemonitoring program member participation rate remained very low after its initial pilot phase with the ABD population. After analysis, their Utilization Management Committee changed the participation criteria to include multiple recent ER or urgent care visits, in addition to multiple inpatient admissions in the previous six months. In addition, a new process was implemented for the program supervisor to review the inpatient census daily and discuss each case with the member's assigned Case Manager for possible referral for telemonitoring services. As a result, the home telemonitoring participation rate more than doubled.

Question E.2

Identifying Members/Target
Conditions for Chronic Care/Disease
Management Programs

E.2 Describe how recipients will be identified for inclusion into the Chronic Care/Disease Management program. Identify which disease states/ recipient types will be targeted for the Chronic Care/Disease Management program. Describe how the Chronic Care/Disease Management program will coordinate information and services with the PCP.

LHC will incorporate lessons learned from the experience of our affiliate health plans, Nurtur, and LPC&A FQHC members in managing Medicaid members with chronic conditions. For example, we know that members with chronic conditions, especially those with behavioral health co-morbidities, may not access timely and appropriate care. We will address this by data mining all available member information, using predictive modeling, and persistently pursuing newly enrolled members for health risk screening to achieve early identification of members with or at risk for chronic conditions or co-morbidities. Our integrated approach ensures that members with chronic conditions receive the most appropriate level or mix of care management services.

We have selected six targeted conditions - asthma, congestive heart failure, diabetes, hypertension, weight management, and low back pain – and will support each with specific program goals and clinical guidelines. Please see our response to question E.1 for details about CCMP program-specific goals and clinical practice guidelines. Guided by input from our LPC&A partners and other providers, we will implement and continuously improve processes to share program and member information and coordinate services with PCPs. We will acknowledge the key role of our providers in delivering exceptional care to members with chronic conditions with awards and other recognition for superior performance.

Identification of Eligible Members

Data Analysis. LHC will use medical and pharmacy claims, utilization, and health screening data and referrals (in addition to any state enrollment file information) to identify potentially eligible members for the CCMP. Staff from our multidisciplinary Integrated Care Teams (ICT) will review information from new member Health Risk Screenings; monthly reports from our Centelligence™ Foresight (Foresight) predictive modeling system for members identified as at risk for developing a qualifying condition; monthly claims-based reports driven by diagnosis, procedure, and pharmacy codes that indicate or are associated with qualifying conditions; monthly ED utilization reports and daily logs from NurseWise, our 24/7 nurse advice line; and assessments conducted by Case Managers to identify eligible members. We will also identify members through referrals from concurrent review of members receiving inpatient treatment, and review pharmacy data to identify members utilizing drug classes that indicate a qualifying condition. Referrals from providers, staff, community organizations, and member self-referral may also identify members eligible for the program.

New Member Health Risk Screening. Early identification of physical and behavioral health conditions as well as any psychosocial issues is one of the key factors for improving outcomes. With that in mind, the information gathered through completion of LHC's Health Risk Screening tools (HRS) for newly enrolled members will be an important resource for identifying members for participation in the CCMP. Information collected on the HRS will allow LHC to identify multiple risk factors that would qualify members for participation in the Program. The HRS data can also identify members with risk factors that indicate the need for additional services such as case management or care coordination. Examples of such risk factors include, but are not limited to:

- Members with other conditions such as cancer, a stroke, a transplant or a spinal cord injury
- Over-utilization of services, such as multiple inpatient admissions or emergency room visits within the past six months
- Under-utilization of services, such as members who can't identify a PCP or haven't visited their PCP within the past year
- Members with co-morbid medical and behavioral health conditions.

Our affiliate plans' experience with Medicaid, CHIP, and other low-income populations in other states has shown that successfully reaching new members for health screening requires repeated attempts using a variety of strategies and a strong tracking process. LHC will implement a multifaceted approach to encourage new members to complete the HRS within 90 days of enrollment. Members may choose to submit a completed hard copy; complete it via an online form on our secure Member Portal; or over the phone with assistance from NurseWise or Member Services staff. Each New Member Welcome Packet will include an HRS form and a return envelope with prepaid postage. LHC will include a brochure explaining our CCMP and case management services, and how to contact the ICT for more information or to request enrollment in the program. During the New Member Welcome Call, we will also assist members in the completion of the HRS if they have not already completed it. In addition, our MemberConnect function, which is a component of our innovative Member Relationship Management (MRM) system, will ensure that if a new member who has not completed the HRS calls our Member Services Call Center, the MSR will see a message that the HRS has not been completed and offer to assist the member in completing it while they are on the phone.

If we are unable to contact the member telephonically and there is indication that the member is at high risk, our MemberConnections Representatives (MCRs) may go to the member's home to complete the HRS, conduct an environmental assessment, or evaluate the need for enrollment in any of LHC's ICT programs. Our owner-partner FQHCs, as well as other network Patient-Centered Medical Home providers, may assist in this outreach. If we are unable to reach the member after three attempts, we will include the member on the monthly report to DHH of members who cannot be reached.

Predictive Modeling. LHC will use Centelligence™ Foresight (Foresight), Centene's innovative predictive modeling solution, to assist in identifying and risk stratifying eligible members. Foresight, which incorporates OptumInsight's Impact Pro application plus additional customized applications, is a suite of multi-dimensional, episode-based predictive modeling and care management analytics tools that will allow our ICTs to use eligibility, medical, behavioral and pharmacy claims (as available from DHH), and demographic data, and lab test results from Centene's Enterprise Data Warehouse to target health care services to our members. Foresight's flexible, modular approach and product outputs will support a wide range of options for stratification of members. This flexibility includes accounting for the lack of continuous enrollment with Medicaid members, the identification of risk relevant to Medicaid members (for example chronic conditions, mental health, probability of inpatient stay), and clinical care guidelines (for example medication adherence, chronic care patterns, ED visits, mental health, substance abuse). We will be able to add additional risk markers or adjust the risk weights to support the population being served by the CCN-P Program. For example, our affiliate plans have added risk markers and weights to stratify pregnant members. LHC will evaluate the range of risk scores and assign a range to each stratification level. Through our reporting, we will be able to identify eligible members and stratify by the risk score calculated in Foresight. The risk score will guide the program for which the member is eligible, disease or case management interventions, and the timeframe for completing a comprehensive assessment to confirm appropriate risk stratification, determine goals, and develop a customized service plan. Because a member may receive a new diagnosis or experience an exacerbation of a previously well-controlled condition after the initial assessment, we will generate reports from Foresight on a biweekly basis to frequently reassess risk levels.

Conditions Targeted for the CCMP

LHC will offer programs in our CCMP for asthma, congestive heart failure, diabetes, hypertension (as a precursor to coronary artery disease), weight management, and low back pain. We selected these conditions due to DHH priorities, their prevalence, our ability to affect outcomes, and their potential financial impact. According to the experience of our LPC&A FQHC partners with low-income Louisianans, approximately 13% of those receiving services through member FQHCs had hypertension,

5% had diabetes, 2% had asthma and 2% were overweight or obese.⁵ Our analysis of FY2010 Louisiana Medicaid claims data showed a prevalence for asthma of 8.9% (as high as 10.2% in SSI and Foster Care); 6.4% for low back pain (as high as 20.5% in Breast and Cervical Cancer and 18.6% in SSI); 2.9% for diabetes (as high as 20.3% in Breast and Cervical Cancer and 15% in SSI); 2.1% for obesity (as high as 5.6% in Breast and Cervical Cancer and 4.0% in SSI); and 0.6% for congestive heart failure (as high as 4.3% of SSI).

We will not vary eligibility for the CCMP by recipient type. All programs will be open to members with TANF, CHIP, SSI/Aged, Blind and Disabled, and other eligibility types.

Coordinating Information and Services with the PCP

Provider engagement will be an integral part of a successful CCMP. LHC has developed a comprehensive and ongoing provider outreach and education plan for the CCMP. We have already begun soliciting input from LPC&A member FQHCs regarding program design, including educational materials and preferred methods for receiving materials, and ongoing collaboration regarding member service plans. We will continue to solicit ongoing input from LPC&A members after the operational start date. In addition, we will solicit and document ongoing input no less than quarterly from other network providers through our Provider Relations staff and provider representation on our QAPIC and quality subcommittees such as the Utilization Management and Provider Advisory Committees. We will obtain DHH approval for our provider outreach plan and all materials before distribution to providers, and we will provide updates to materials on a semi-annual basis.

Initial Provider Education and Support. Through initial and ongoing provider training, we will educate providers on our CCMP and ICT model, and related LHC support services. Initial provider materials will include, but are not limited to an introductory letter, accompanied by the following additional materials, provided on a CD format to allow for easy storage and retrieval. Providers may request additional CD copies or printed versions of any materials:

- An introductory overview of the CCMP, including performance measures used to evaluate the program
- Contact information including telephone numbers and email addresses for the ICT Case Managers and Health Coaches, Provider Relations and Pharmacy staff, and our toll-free 24/7 CCMP call center for providers, which will be answered by our NurseWise nurse advice line outside of business hours (7:00 p.m. – 7:00a.m. Monday through Friday and all day Saturday and Sunday).

In addition, the ICT will provide initial support and a package of educational information and tools providers need to effectively manage members with chronic conditions. This will include:

- Educational materials such as information about evidence-based clinical practice guidelines, including quick reference guides, new or emerging technologies, best practices in the treatment of the chronic conditions and co-morbidities (including behavioral health) prevalent in the CCMP, information on best practice models such as the MacColl Institute's Chronic Care Model, and reviews and other peer-reviewed literature
- Forms that can be customized for member referral to LHC for CCMP services
- Member chart forms to track regular screenings and key metrics.

Ongoing Provider Education. LHC will use a variety of methods to provide ongoing provider training on CCMP components and goals, facilitating coordination between providers and ICT staff, improving awareness and compliance with evidence based clinical practice guidelines, and providing education on

⁵ Bureau of Primary Health Care, Health Resources and Services Administration, <http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/2009/2009LATOTsumdata.html> accessed 6/3/2011

best practices such as MacColl Institute’s Chronic Care Model. LHC Provider Relations staff will play a central role in ongoing provider outreach and training so critical to the success of the CCMP. LHC will hire local Provider Relations Specialists (PR Specialists) who are familiar with the provider community and culture. PR Specialists will provide in-person training to providers and their staff on all program components to further facilitate collaboration, communication and compliance with guideline-recommended member care. PR Specialists will establish close working relationships with providers and their staff in order to promote the CCMP, facilitate the referral process, arrange onsite member education sessions, and obtain provider feedback for program improvements. These staff will play an important role in providing ongoing education regarding changes in clinical guidelines and best practices. To further support providers, they will provide clinical tools relevant to the provider’s practice, including practice guidelines, clinical decision algorithms, desired patient outcomes, and patient counseling materials. LHC and LPC&A members will collaborate on “lunch and learn” and other onsite sessions to communicate CCMP services and referral processes and to gather feedback from FQHC member staff on improving coordination of information and services.

LHC’s Provider Newsletter will provide refresher information about the CCMP, Program enhancements, clinical practice guideline updates, relevant new technologies, program outcome data, and success stories that highlight a member’s or provider’s success in improving health outcomes.

Provider Relations and Quality Management staff will provide targeted support to PCPs who demonstrate lagging compliance with clinical guidelines on LHC provider performance profiling or with linked members on Centelligence Foresight Care Gap reports. In such cases, a team consisting of the provider and provider office staff, and ICT and PR staff will develop a Care Improvement Plan, which includes identification of process gaps and possible causes or barriers; best practices; performance improvement targets; an action plan and timeline. This team will work together to help the provider implement the plan and evaluate the effectiveness of interventions.

Communication, Coordination and Support. LHC will notify PCPs by mail when we enroll members in the CCMP. For members stratified for the CCMP as medium- or high-risk (see Question E.1), the Health Coach will request input from the PCP on a proposed self-management plan generated from the Initial Health Assessment (IHA), listing co-morbidities and self-reported symptoms and medications, and requesting current biometrics and recommendations for the member’s service plan. The ICT also will alert the PCP to any changes in the member’s health status noted during member contacts and periodic reassessments. A Medical Alert Fax will be sent to the PCP, in addition to a call by the Health Coach, anytime a CCMP participant is in a potentially urgent situation. The ICT will also alert the PCP to any gaps between evidence-based, guideline recommended prevention and treatment and actual care received, and the member’s adherence to the self-management plan. ICT staff and our Medical Directors will communicate directly with the PCP (or other treating providers, including behavioral health) as often as required.

Innovative Coordination and Support Solutions. LHC will offer an innovative package of technology solutions to support our efforts to communicate and coordinate services with our PCPs. If the PCP or FQHC uses an electronic appointment scheduling system that supports the HL7 Scheduling Information Unsolicited (SIU) data exchange standard, we will support remote appointment scheduling from MRM. If ICT or Member Services staff are in contact with a member who requests or is in need of an appointment, they will be able to use our HL-7 SIU equipped MRM application to determine provider availability and book an appointment for the member directly into the provider's appointment scheduling software. Further, after the appointment is scheduled on the provider system, the appointment data will be captured in MRM, allowing MRM to notify the member that the appointment has been booked and the date and time of the appointment.

MRM will also have the capability of coordinating outreach through our MRM MemberConnect application. Should ICT staff be attempting to contact a member about a gap in needed care, MRM will take that information from TruCare, our integrated health management system, and present it as an alert to

an MSR, for example, when they are responding to an inbound call from the member for unrelated reasons. This feature will enable our ICT staff to more effectively intervene when care gaps are identified and facilitate the delivery of timely preventive and other needed services by the member's PCP.

Provider Portal, Clinical Portal and CenTraCare. We will support our network of PCPs, including FQHCs, with an integrated family of secure, web-based tools for clinical quality improvement, administrative productivity, and operational efficiency. Each of our three Provider Portal offerings builds on the other, to offer the right applications to the appropriate provider audience.

Our secure **Provider Portal** will allow all PCPs and other network providers to perform several self-service functions online such as checking eligibility and submitting authorization requests. See Section R, Question R.11 for more information. *All PCPs* also will have access to *Online Care Gap Alerts (Care Gaps)* which pushes alerts to any provider when they check eligibility, and to our PCPs when viewing their *online Member Panel Roster (Roster)* of linked members. These alerts are displayed if the member is due for or missing a service recommended by evidence-based guidelines. The Roster will also allow the PCP user to view, print, or export to Microsoft Excel all members under the PCP's or FQHC's care, with summary and detail information on each member. The Roster will also include information on whether the member has special healthcare needs, and information on those needs. For example, our Roster will also include information on chronic or acute disease conditions the member may have. Special health needs will be populated automatically from the HIPAA 834 eligibility information we receive from DHH's Enrollment Broker, and/or other special health needs that the member's PCP or LHC Case Manager have identified.

LHC's secure **Clinical Portal**, available to all authorized PCPs and network providers (subject to HIPAA Minimum Necessary Rules), builds on the core functionality of the Provider Portal to deliver a set of medically oriented informational tools to the provider. Our Clinical Portal will house evidence-based Clinical Practice Guidelines, and is designed to support clinical best practices as well as providers pursuing NCQA or JCAHO Medical Home recognition. Clinical Portal users can also view a member's TruCare service plan. The TruCare Service Plan displays the member's identified health problems, treatment goals and objectives, milestone dates and progress - in an engaging, well organized online format. The Clinical Portal's online summary Member Health Record (MHR) offers a well organized view of a member's care gaps as well as a cursory clinical "face sheet" for each member for which we have supporting data. Our MHR is based on current and historic medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received and processed in our Enterprise Data Warehouse (EDW). For emergency scenarios, any provider with Provider Portal or Clinical Portal access will be able to view our Emergency Care Record (ECR). The ECR contains content specifically focused on the most vital information a provider needs when treating a member with whom they are not familiar. Our Provider Portal captures all ECR access information in full compliance with §164.312 of the HIPAA Security Rule (emergency access to medical records) and associated audit trail requirements, through the use of a "Break Glass" affirmation from the provider that access is needed.

The Clinical Portal will also offer online access to Provider Overview Reports, which will be available to our providers as viewable and printable PDF documents. LHC Provider Overview Reports present individual or group practice comparative performance information against key quality and utilization indicators, which enable our providers focus in on indicators specific to CCMP effectiveness. Please refer to Section G, Question G.13 for more information.

For network PCPs and FQHCs who have achieved NCQA Patient Centered Medical Home or JCAHO Medical Home recognition (both designations abbreviated "PCMH" for purposes of this section), or that commit to attaining PCMH recognition from either NCQA or JCAHO, we will provide access to our **CenTraCare Clinical Portal (CenTraCare)** for additional clinical and care coordination capabilities beyond those provided in our Clinical Portal. Our PCMH providers will be able to access CenTraCare through a single sign on to our secure Provider Portal. CenTraCare is specifically designed with PCMH

provider information needs in mind, and offers a more "data rich" and interactive version of our online Member Health Record (MHR) described above. Providers will also have the capability to "drill-down" into panel-level data to obtain specific information such as top diagnoses and compliance with clinical guidelines. CenTraCare's MHR is a superset of the summary MHR and ECR offered in our Clinical Portal, and is based on medical and pharmacy claims information, lab test results, health risk assessments, and other information systematically received, integrated and processed in our Enterprise Data Warehouse.

CenTraCare will also offer several Clinical Quality Improvement reports including practice level HEDIS measures; other quality, cost, and utilization information at the aggregate provider practice level and by episode, and with costs broken out both as direct PCP costs and as episode-related external costs (hospitals, pharmacy, lab and specialty). Our overarching objective with CenTraCare is to give the PCMH provider a *holistic view* of the member's healthcare experience and support the concept of care accountability that is **central** to the PCMH concept. When combined with the other features of our Provider and Clinical Portals, including OCGNs, CenTraCare is a *powerful informational assist* for collaborative care coordination and ongoing clinical quality improvement for our PCMH providers and our members.

LHC also intends to participate in health information exchanges as they develop in Louisiana to facilitate our ability to share data with PCMHs and other PCPs with electronic medical record systems. For selected PCMH providers equipped with Office of National Coordinator (ONC) certified Electronic Medical Record (EMR) technology, we propose to pilot in 2012, the exchange of CCD/CCR formatted Electronic Health Records between LHC and these providers. We will work with the Louisiana Health Care Quality Forum (LHCQF) and the LaHIE project (at DHH's direction), and share results of our pilot programs with LHCQF, with the ultimate goal of being a participant (along with our providers) in LaHIE. Please see Question R.15 for more information on our approach to sharing Electronic Health Record information with PCMHs.

Provider Recognition. After the first year of operations, LHC will implement programs designed to recognize providers with superior performance, including CCMP clinical practice guideline compliance. LHC will present the Summit Award, started by Centene in 2007, to PCPs who, compared to their peers, have demonstrated exemplary care in several areas of performance, including compliance with clinical guidelines. Awardees will receive an engraved plaque and a catered lunch for their office staff and will be recognized in national and local press releases and on LHC's Provider Portal. LHC and Centene are currently developing additional awards recognizing sustained high performance for three consecutive years, significant improvement (at least a two standard deviation increase from the previous year's performance), and significant contribution to the health and well-being of their community.