

## SECTION I – MEMBER ASSESSMENT AND CARE COORDINATION

*I.1 DHH intends to provide MCOs with two years of historic claims data for members enrolled in the MCO effective the start date of operations. Describe how you will ensure the continuation of medically necessary services for members with special health needs who are enrolled in your MCO effective February 1, 2015. The description should include:*

- *How you will identify these enrollees, and how you will use this information to identify these enrollees, including enrollees who are receiving regular ongoing services;*
- *What additional information you will request from DHH, if any, to assist you in ensuring continuation of services;*
- *How you will ensure continuation of services, including prior authorization requirements, use of non-contract providers, and transportation;*
- *What information, education, and training you will provide to your providers to ensure continuation of services; and*
- *What information you will provide your members to assist with the transition of care.*
- *Describe your approach to identifying "hot spotters" who are high utilizers and describe any innovative approaches you utilize to be able to identify the difficult to find patients.*

### Experience and Approach to Ensuring Continuation of Medically Necessary Services

Louisiana Health Care Connections (LHCC) has ensured continuity of care for members with special health care needs (SHCN) since Bayou Health program inception. We have drawn on the familiarity of LHCC's local staff with the unique characteristics and needs of the eligible Louisiana population and the providers who serve them, as well as the expertise of our Centene affiliate health plans in other states serving Medicaid and CHIP members with SHCN. During the first six months of Bayou Health implementation, we transitioned over 150,000 members to LHCC from the Fee-for-Service (FFS) Program, including those with special needs, such as high-risk pregnancy; organ transplant needs; co-morbid behavioral health conditions; and chronic and complex conditions, such as asthma, diabetes, congestive heart failure, HIV, and sickle cell disease.

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*We successfully transitioned over 150,000 members into Bayou Health during the initial six-month program implementation period.*

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Our existing provider network is an important factor in our ability to ensure continuity of care for members with SHCN under the new contract, as it includes many of the significant traditional Medicaid providers who have served Bayou Health members since before program implementation. By contracting with these providers, we not only ensure our members can access services from providers who know and understand the population, we also minimize the chance that a new member will enter LHCC receiving services from an out-of-network (OON) provider. In addition, our providers are already trained on our continuity of care policies and procedures, and are aware that they should continue providing existing care when their patient enrolls in LHCC.

The inclusion of the voluntary opt-in population in Bayou Health has resulted in additional members with SHCN enrolling in LHCC, and we are well positioned to ensure continuity of care for these members. Our Centene affiliates in nine other states provide the long term services and supports (LTSS) that the voluntary opt-in population currently receives via the FFS Program, making LHCC **part of a company** that is recognized as a **national leader in managed LTSS**. We will draw on lessons learned and successful practices of our affiliates and understand not only the importance of ensuring continuity of all services (not just LTSS) for these individuals, but also on the nuances of doing so that require a deep understanding of the interdependence of health and functional status, and a holistic approach to each individual's unique needs, circumstances, and preferences.

Consistent with 42 CFR §438.208, we ensure continuity for members with special health care needs (SHCN) and those with ongoing services through:

- Prompt identification of members with SHCN and/or ongoing services
- Prompt identification and authorization (regardless of current provider network status) of existing services
- Provision of authorization and billing information to providers to ensure prompt payment and no gaps in services
- Outreach to providers and members to educate them to continue existing services with no change until we complete an assessment and authorize a new Care Plan in collaboration with the member, PCP, and treating providers
- Offering to contract with OON providers serving new members in order to preserve existing relationships
- Continuing care with OON providers, when necessary, to prevent disruption and protect member health.

LHCC has dedicated staff who enhance our ability to quickly obtain and share information necessary for continuity of services. Our Transition Coordinators outreach to the previous Managed Care Organization (MCO) or FFS Program representatives and providers to ensure we are able to obtain complete information about each member’s needs and services, and to provide prompt authorization information to providers to ensure continuation of existing services.

### Identifying Members with Special Health Care Needs (SHCN) and Ongoing Services

Quick identification of members with SHCN and/or ongoing services is a critical step in ensuring continuous care. LHCC’s Case Management and Utilization Management staff identify members with SHCN and/or ongoing services using a wide range of information sources, such as those described below.

Sources Used to Identify Members With SHCN and/or Ongoing Services	
The two years of <b>claims data</b> provided by DHH	The pregnancy or 1915c waiver program identifier on the 834 file
<b>Enrollment and other information from DHH or another MCO</b> reflecting existing and pending authorizations or potential need for services (such as existing care plan, new Members who are inpatient)	Information indicating high risk pregnancy obtained from <b>Notification of Pregnancy (NOP)</b> forms, which we require providers to submit for all identified pregnant members regardless of trimester
<b>Pharmacy data</b> from DHH or another MCO to identify Members with prescriptions that indicate a chronic or complex condition that may require ongoing services	Provider <b>requests for authorizations and referrals</b> , and <b>notification</b> of Members with SHCN, such as those with ongoing specialty care needs or medical supplies
Our <b>Health Risk Screening</b> conducted with all new Members within 14 days of enrollment	Information from our <b>concurrent review nurses</b> onsite at 17 network hospitals
<b>Outreach to specialty Providers</b> asking them to identify any existing services they are providing that are not reflected on the DHH enrollment file	<b>Phone or in-person contact from members</b> or family/caregivers

Our staff use the DHH claims data to identify members with claims for:

- Recent hospitalization or NICU stay
- Recent ED visit for non-ambulatory, care-sensitive conditions
- Services such as enteral feedings, oxygen, wound care, ventilators, medical supplies, dialysis, and chemotherapy and/or radiation therapy
- Three or more psychotropic medications
- Multiple medications that indicate one or more chronic conditions
- Claims for the same service from different providers within 30 days.

Staff also use the claims data and other information in the table above to identify members who:

- Have or may have ongoing covered services in place
- Are inpatient at the time of enrollment
- Have a serious ongoing illness, complex and/or chronic condition, disability, or catastrophic condition
- Have an illness, condition, or disability that results (or without treatment would be expected to result) in limitation of function, activities, or social roles compared to accepted age-related milestones for physical, cognitive, emotional, and/or social growth and/or development
- Have Severe Emotional Disturbance (SED)
- Have a high-risk pregnancy
- Require regular, ongoing therapeutic intervention and evaluation by appropriately trained personnel
- Have health and/or health-related service needs at a level significantly above what is usual for their age
- Have a prior authorization for scheduled surgeries
- Require a post-discharge follow-up visit and therapies to be provided after transition, or out-of area specialty services
- Have conditions that require ongoing monitoring or screening such as elevated blood lead levels and members who were in the NICU after birth
- Need organ or tissue transplantation.

We prioritize identified members for outreach and coordination of ongoing services to ensure continuation, which we describe in detail below.

### **Additional Information LHCC Will Request to Ensure Continuation of Services**

Based on our experience serving Bayou Health members with SHCN, as well as the experience of our Centene affiliate plans in other states that serve members with SHCN, we have learned that the information we receive prior to, or upon enrollment is critical to quickly identifying and ensuring continuity for members with ongoing service needs. In addition to the two years of claims history, LHCC will request that DHH provide the following information for all new members:

- Existing FFS care plans
- Open FFS authorizations
- Claims for 1915 (c) waiver services with codes, descriptions, and providers.

### How LHCC Will Ensure Continuation of Services for Members with SHCN

When we identify existing services, a Transition Coordinator contacts the previous MCO (as applicable) and providers, as well as any FFS program staff or case manager we are able to identify, to obtain information about current services. Our Transition Coordinator provides authorization information to providers, including OON providers, for any existing services or course of treatment, and educates them to continue providing care with no change or disruption until a new Care Plan is completed and authorized. The Transition Coordinator also refers OON providers to our Provider Relations (PR) Department so that PR staff can contact the provider to offer them a contract, or negotiate a Single Case Agreement if they choose not to contract during the transition period, and/or if continuation with the OON provider beyond the transition period is necessary (as described below).

Our Case Managers outreach to identified members with SHCN and ongoing services to prevent any gaps and ensure continuous services through coordination activities such as those in the table below.

Examples of Coordination Activities for Members with SHCN
<b>Communication in-person or via phone</b> with the member, caregivers, and informal supports/family (with member consent) to provide education about continuing existing services and obtaining additional information about existing services and needs
<b>Conferences</b> with the previous <b>case manager</b> , current <b>PCP</b> , and <b>specialists</b> (both network and non-contract, as applicable)
<b>Conferences</b> with <b>hospital staff</b> and <b>discharge planners</b> , as well as the <b>relinquishing MCO</b> , if applicable, for inpatient members
<b>Conferences</b> with <b>ancillary providers</b> , such as home care, durable medical equipment vendors, and therapists (physical, occupational and speech therapy), and <b>verification that services continue</b> to be provided during the transition period
<b>Conferences</b> with <b>community agencies</b> supporting the member, such as housing agencies

LHCC’s Case Manager works closely with any previous FFS or MCO case manager and providers during the transition period to ensure the member’s needs are appropriately addressed and no gaps occur. In addition to discussing the member’s needs and the care and services provided under the previous MCO, our Case Manager consults with the previous case manager on our assessment results, and incorporates their input into the new Care Plan. To supplement the information obtained from the member and caregivers during our assessment and care planning process, our Case Manager also requests any information about member progress on previous goals, as well as the availability of caregivers and informal supports. If the member is receiving services from an OON provider, Case Management staff outreach to the provider to determine interest in joining our network and refer them to our PR Department for possible contracting (as described below).

In addition to providing telephonic concurrent review, LHCC locates concurrent review nurses onsite at 17 network hospitals, which is part of our evidence-based approach to transitional care. For new members who are inpatient at the time of enrollment into LHCC, our concurrent review nurses play a key role in coordinating transition services. These staff already have established relationships with hospital discharge staff and hospitalists, and are familiar with the hospital’s systems, discharge planning processes, and referral patterns. This approach allows them to quickly obtain information needed to assess transition needs, and coordinate the transition plan. They also work with the relinquishing MCO or FFS Program case manager, as applicable, to coordinate the transition plan and ensure any needed post-discharge services are in place when the member is discharged.

**Prior Authorization Requirements.** CM/UM staff authorize all ongoing covered services with current providers regardless of network status. We will authorize existing ongoing covered services for members

with SHCN for 90 days, or until the member may be reasonably transferred without disruption, whichever is less. We authorize existing prescriptions for maintenance medications for at least 60 days; continue any treatment of antidepressants and antipsychotics for at least 60 days after enrollment; and allow new members receiving a prescription drug (at the time of enrollment) that is not on LHCC's formulary to continue receiving that prescription drug, if medically necessary, for at least 60 days. LHCC will also continue the medication prescribed to a member in a state mental health treatment facility for at least 60 days after discharge, unless LHCC's Behavioral Health Medical Director, in consultation and agreement with the facility's prescribing physician, determines that the medications are not medically necessary or potentially harmful.

We also honor existing authorizations from another MCO or the FFS Program for durable medical equipment, prosthetics, orthotics, and supplies, regardless of the authorized provider's network participation status, for up to 90 calendar days or until the member may be reasonably transferred to a new provider without disruption, whichever is less.

**Out-of-Network Providers.** When we identify an OON provider serving a new member, PR staff outreach to them and attempt to contract. If the provider chooses not to contract, CM/UM staff assist the Chief Medical Director (CMD), or designee, with obtaining and reviewing information such as member condition, risks, and diagnosis; the course and estimated length of treatment; and the provider's relevant expertise. We authorize and reimburse for medically necessary covered services not available in network, until those services are available in network. For services available from a network provider, the CMD works with the member and provider to transition to a network provider when it will not interrupt or disrupt services, or place the Member's health in jeopardy. If transition would disrupt services or jeopardize health, we continue to authorize and reimburse the OON provider.

When ongoing care with a OON provider who declines to contract is necessary to ensure continuity or protect health, PR staff negotiate a Single Case Agreement (SCA). When transition to a network provider may occur without disrupting services or jeopardizing member health, a Case Manager assists the member with selecting a network provider. The Case Manager works with the member, desired supports, and current and new providers to develop a Care Transition Plan, which specifies timeframes and steps for the transition, such as joint care conferences.

**Transportation.** As part of our analysis of the two years of claims data provided by DHH, we attempt to identify regular and repeated transportation services that may indicate ongoing care, such as weekly dialysis appointments. This allows LHCC staff to quickly authorize not just the ongoing care but also the transportation necessary for the member to access the care. Case Managers working with members who have existing services also routinely inquire to determine whether the member needs transportation assistance to access care, and authorizes and arranges any transportation needed regardless of the treating provider's network status. In addition, we have an existing network of emergency transportation providers, enabling us to accommodate members with SHCN, such as those in the voluntary opt-in population, who may need transportation via ambulance.

### **LHCC in Action...**

Acadian Ambulance and LHCC have partnered to develop a Mobile Integrated Healthcare program in the New Orleans area specifically targeted to treat pediatric asthma. This mutually beneficial initiative would work towards healthier outcomes and make efforts in reducing unnecessary inpatient admissions and ER utilization.

### **Information, Education and Training for LHCC Providers**

LHCC designs all of the information, education, and training we give Providers to ensure continuation of services to proactively address and prevent common provider misperceptions. One such misperception is that MCOs will not continue existing services at all, or when provided by an OON provider. We also emphasize that the process for obtaining authorization for continuation of services is simple. Our PR staff provide initial and ongoing education about how to notify us of new or existing members with special health care needs, pregnant members, and those receiving ongoing services. We also provide this education through our Provider Manual, Provider Portal, the Provider Newsletter, as well as through other periodic targeted mailings.

When we identify a provider who is rendering ongoing services to a new LHCC member, we outreach regardless of network status to educate them about the following:

- Our policies regarding continuation of existing covered services
- Authorization requirements beyond the transition period
- Our policies and procedures for safely transitioning members to a participating provider and/or new treatment plan
- Our claim submission processes to ensure prompt payment for continued services.

### **Information LHCC Provides to Members**

To assist with the transition of care, we also educate all new members about continuity of care and our processes for transitioning services. We provide this information in the Welcome Packet we send all new members within 10 days of enrollment. Our Customer Service staff reinforce this message with new members when they contact LHCC for information and/or assistance. We also provide this education via MCRs interacting with new members, in the Member Handbook, and on our Member Portal.

When we identify a member with SHCN and/or who is receiving existing services, our Case Management staff provide information to assist with transition of care, including the information we described above, as well as how the information applies to the member's specific situation.

#### ***Continuity of Care Information Provided To Members***

- The importance of continuing to access their existing services and supplies with no change, regardless of the provider, and whether that provider is contracted with LHCC
- The importance of contacting LHCC if they are receiving or need services, and how to do so
- Assistance available through our Case Management Program
- How we determine whether, how, and when care can safely be transitioned to participating providers

### **Approach to Identifying “Hot Spotters”**

Case and Utilization Management staff identify members with high utilization by analyzing all available data at enrollment for indicators (described below) that the member may not be receiving appropriate care. They then attempt to enroll the member in Case Management so the member's needs can be properly addressed, and they provide education on appropriate access and effective self-management. These staff analyze information received at enrollment including, but not limited to historic claims data, and using our Centelligence™ proprietary predictive modeling and care gap/health risk identification solution. Staff review these data/reports to identify members with indicators of high utilization such as those in the table below.

Selected Indicators of High Utilization
3+ inpatient admissions within the last 90 days for same/similar diagnosis
3+ emergency department (ED) visits within the last 90 days
Polypharmacy including, but not limited to 3+ psychotropic prescriptions
Prescriptions for narcotics filled at 3+ pharmacies
Same service from multiple providers within the same 30 day period

Even when these members do not have existing authorizations for ongoing services, Case Managers outreach within seven days of identification to coordinate any existing services, offer to enroll the member in Case Management, complete an assessment and develop a Care Plan. For example, we may enroll a member with high pharmacy utilization into our Pharmacy Lock-In Program to ensure the member continues to receive necessary medications in a safe, appropriate manner by limiting the number of pharmacies and possibly providers from whom the member may obtain and fill prescriptions.

We describe our approach to ongoing identification of high utilization as well as detail on our approach to addressing identified overutilization in our response to Question N.3.

**Identifying Difficult-To-Find Members.** LHCC staff make multiple attempts to contact identified members. After making three unsuccessful phone attempts, on different days and at different times, we send a letter to the member asking them to call our toll-free number to discuss their health care. If we do not receive a response within seven days, we send a MemberConnections™ Representative (MCR) to the member’s address. If the member is home, the MCR attempts to put the member on the phone with Case or Utilization Management staff to discuss their services. If the member is not at home, the MCR leaves a door hanger asking the member to call our toll-free number to discuss their health care.

If we still do not receive a response, or if we determine that the member no longer lives at that address, we use a variety of methods to locate them. These methods may include, but not be limited to:

- Tracking pharmacy prescriptions to identify approximate refill dates, and requesting that the pharmacy notify us when the member is there
- Identifying providers who have recently submitted a claim for providing services to the member, and asking them for current contact information. If the information is not available or correct, we ask them to contact us when the member is there. We also request that they ask the member to call our toll-free number if they receive a call from the member
- Identifying approximate location of the member and interviewing local community service staff, homeless shelters, and area residents
- Conducting onsite visits when members are admitted to the ED or hospital.

If we identify that the member may have specialty behavioral health needs (such as through notification of a BH admission or a prescription for psychotropic medication), we outreach to the SMO for current contact information and assistance in outreaching to the member. If the member is a voluntary opt-in member, we will outreach to the FFS Program in which the member may participate to ask for current contact information and assistance reaching the member.

If we continue to be unsuccessful reaching the member, Case Management staff track the member’s utilization to identify additional opportunities for outreach, such as when/if the member is admitted to the hospital.

*I.2 For members who need home health and/or other services upon discharge from an acute care hospital, explain how you will coordinate service planning and delivery among the hospital's discharge planner(s), your case manager(s), your disease management staff member(s), and the home health agency. Further, explain how you will monitor the post discharge care of enrollees receiving home health services in remote areas.*

## Overview

Louisiana Health Care Connections (LHCC) has maintained and operated a formalized discharge planning program since Bayou Health program inception. Using a data-driven approach, we have worked continuously to improve this program and reduce readmissions. For example, in 2013, we implemented our Transition of Care Program (described below), and are currently adding a number of enhancements to the Program to take our readmission reduction efforts to the next level.

These enhancements resulted from our Q1 2014 review of existing Medical Management Department policies and procedures related to discharge planning and transitional care. We undertook this review based on the analysis of readmissions and other data indicating an opportunity for improvement in reducing readmissions. A cross-functional team of Medical and Quality Improvement (QI) Department staff conducted the review examining workflows, Case Management and concurrent review case audit data, and other information to identify policy, process, and training needs. Staff identified the need for process and other changes such as enhanced post-discharge follow-up by clinical staff as well as non-clinical MemberConnections™ staff, development and implementation of guidelines for staff to use in identifying root causes of admissions, and the addition of Program Specialists (social workers) to the Transitional Care Team.

Of members in rural parishes discharged from the hospital, LHCC provided post-discharge home health services for 36% in Q1 2014 and 39% in Q2 2014. Fewer than 1% of these members who received home health had a readmission within 30 days for the same diagnosis.

LHCC understands and will comply with all DHH requirements relating to coordination of service planning and delivery of and monitoring post-discharge services including, but not limited to, Sections 6.19 Medical Services for Special Populations and 6.37 Case Management, and all other relevant contractual and regulatory requirements.

## Improving Early Notification of Inpatient Stays

LHCC requires hospitals to notify us when members are admitted for an inpatient stay. LHCC also has worked to improve notification of admissions to ensure we are able to participate in discharge planning as soon as possible during the inpatient stay. Because of LHCC's strong, collaborative relationships with network facilities we have successfully placed Concurrent Review Nurses (CRNs) onsite at 17 network hospitals to assist in identifying members upon admission, and then to coordinate and share information with hospital staff. We are currently working with five additional hospitals to expand the number of CRNs located onsite.

**Health Information Exchange.** In addition to expanding our onsite concurrent program, we share DHH's interest in furthering the meaningful use of clinical data, such as by ensuring hospitals provide data feeds to MCOs to facilitate early involvement in discharge planning. Further, we agree with DHH's and LaHIE's approach to creating widespread health information exchange by focusing on an initial project, such as LaHIE's *ED Visit Registry*. We also know that building a critical mass of ADT-submitting hospitals is a logistical challenge.

LHCC proposes to replicate the early and rapid success of our affiliate health plan in Florida in implementing secure, yet quickly established direct transfers of admission, discharge, and transfer (ADT)

data from network hospitals. Over a period of one year, our affiliate has implemented direct ADT submission capabilities with over 20 hospitals, while the state continues to build health information exchange (HIE) capabilities.

LHCC will require our hospitals and their Emergency Departments (EDs) to submit ADT data to LaHIE, but we also will offer these providers the option of a free, direct, and secure connection to LHCC for receipt of ADT transactions. LHCC will serve as a collection point of ADT data for LaHIE and, subject to the execution of a HIPAA Business Associate Agreement with LaHIE, we will batch and forward collected ADT data to LaHIE for populating the ED Visit Registry.

In our view, it is critical that hospitals and EDs see a near term benefit of ADT transaction submissions. For this reason, we also will incent our providers by waiving the need for inpatient admission notices to LHCC for any providers sending us ADT data. This represents a significant opportunity for LHCC to remove a substantive administrative burden from our network hospitals and EDs.

Our Management Information System (MIS), provided by our parent company, Centene Corporation (Centene), is ready for HIE projects. In 2013, at the request of another affiliate plan, Grant Thornton, LLP conducted a HIE Readiness Assessment of Centene's MIS, and concluded that our readiness to participate in that state's standard health exchange met standards and requirements for HIE participation. Grant Thornton awarded Centene the highest score on their assessment.

### **Transition of Care Program**

Through our Transition of Care (TOC) Program, we coordinate hospital discharge planning including post-discharge care and follow-up, using processes that reflect evidence-based and emerging best practices such as the Care Transitions Intervention developed by Dr. Eric Coleman; the Transitional Care Model developed at the University of Pennsylvania; and the vision and recommendations of the National Transitions of Care Coalition. It includes a multidisciplinary focus on the key interventions that have been proven to support a safe transition to the next setting. Our successful approach treats member social context on par with clinical needs, and provides intensive support to engage members in their own care after discharge, preventing and reducing readmission rates for high-risk members.

Our onsite CRNs and our dedicated **Transition of Care Team (TOC Team)**, consisting of RNs and social workers, collaborate to handle care transitions, including inpatient care coordination and follow-up, for high-risk members, which includes those who require home care and other post-discharge services. CRNs work with facility staff, providers, and the member to coordinate care, ensure a safe discharge, and reduce readmission risk. The TOC Team coordinates post-discharge authorizations and service initiation; follows up with the member after discharge; and monitors during the transition period to ensure the member receives needed care, adheres to medication and treatment regimens, and avoids readmission or ED visits.

To expand our TOC Program capabilities further, we are **adding BH clinicians** to our Case Management staff, which will enable our TOC Program staff to access behavioral health expertise and support. A BH Case Manager will provide clinical input to CRNs and the TOC Team, and coordinate with the Statewide Management Organization (SMO) for members with a BH admission. We also are adding **field-based Case Managers** to increase our ability to provide in-person assessment and support to members, including but not limited to accompanying high risk members to post-discharge follow-up PCP visits when appropriate. Through our **Medication Therapy Management (MTM) Program**, we can offer in-person post-discharge medication reconciliation by a pharmacist in some areas.

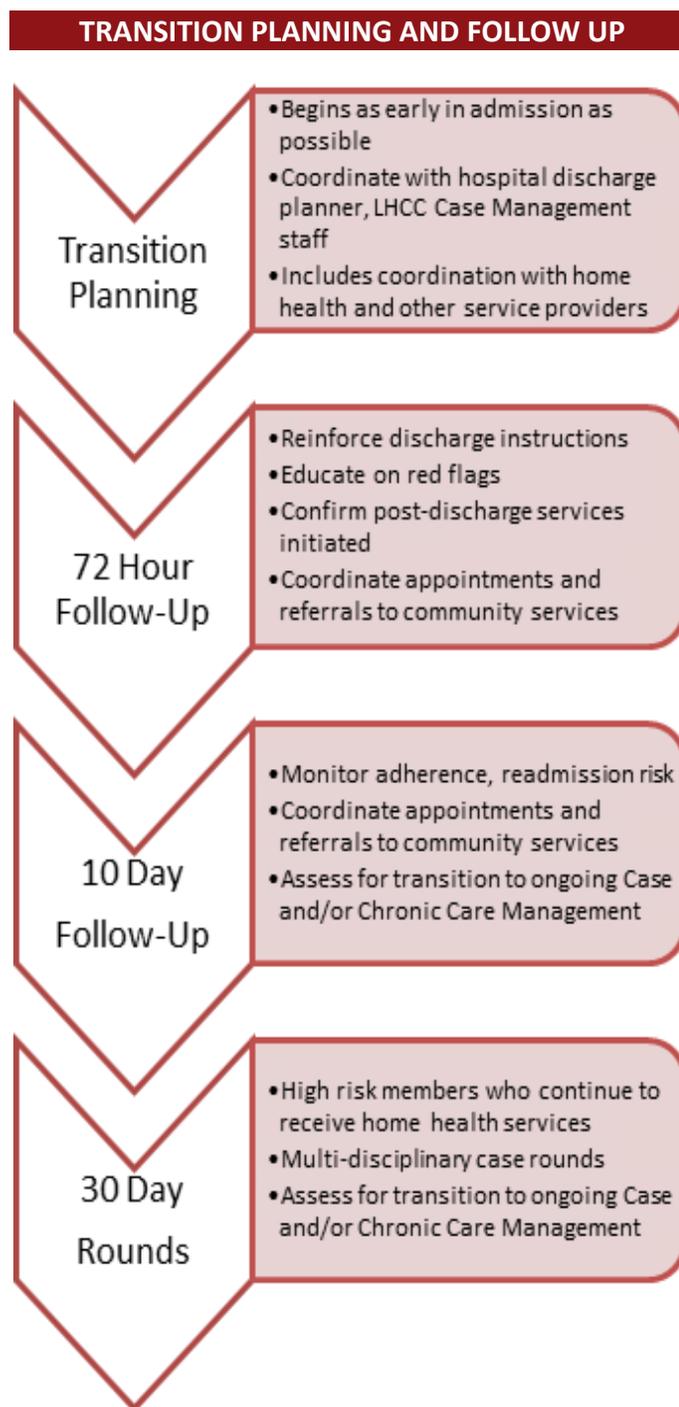
## Coordinating Service Planning and Delivery

When we identify the need for or receive notification of an inpatient stay, CRNs begin coordinating with hospital staff to assess member conditions, needs, and the potential to transition out of the facility. CRNs immediately attempt to participate in facility care conferences to identify barriers, discuss the member’s progress, and help develop and coordinate the transition plan. Having staff onsite at the hospital improves their effectiveness as they have established relationships with facility staff. If the member is receiving Case or Disease Management services, CRNs review the Care Plan in TruCare and consult with the Case Manager and/or Health Coach to obtain information needed by hospital staff, as well as recommendations for the transition plan.

### Onsite Focus on High Risk Members.

We are further enhancing our TOC Program by implementing MemberConnections™ Representative (MCR health outreach workers) visits to high risk inpatient members. The purpose of these “Get Well Visits” is to identify root causes of the admission, which will inform our transition planning efforts and follow up priorities. We are also implementing the use of “Taking Care of Myself: A Guide for When I Leave the Hospital”, a booklet developed by the Agency for Healthcare Research & Quality. Our MCRs will provide the booklet to members (or to hospital discharge planners to give to our members) prior to discharge. It contains key information about their inpatient stay, such as medications and important follow up steps, that is critical to a successful transition.

MCRs also may provide nominal gifts, such as pill boxes, that allow them the opportunity to discuss the importance of key post-discharge activities such as medication adherence. For members in the



Neonatal Intensive Care Unit, we provide our NICU Packet which contains critical information for the parent about post-NICU care and follow up, as well as the support available through LHCC.

**Coordinating the Transition Process.** CRNs send an automatic notification (through TruCare) of the pending discharge to TOC Team staff. Staff then notify and share information among the PCP and other treating providers to support clinical oversight by the medical home, ensure an integrated approach to services and transition planning, and obtain support such as physician's orders for certain home care services.

For members with a BH admission or with serious BH conditions, TOC Team staff will collaborate with a BH Case Manager to outreach to the SMO to share information and coordinate with the SMO case manager and applicable SMO network providers, as appropriate.

For members receiving 1915 (c) waiver services or non-covered Personal Care Services (PCS), TOC Team staff will outreach to the appropriate program to facilitate timely notice to providers to discontinue services during the inpatient stay, and program staff assessment of any changed service needs upon discharge. TOC staff will also outreach if applicable to the member's Targeted Case Management (TCM) provider to share information on the transition plan as well as information obtained during TOC Team follow-up contacts with the member after discharge. We are also implementing Complex Discharge Rounds for challenging discharge situations, such as for a homeless member with wound care needs. These Rounds will be staffed by a CRN, TOC Team, and other clinical staff such as Case Managers, Pharmacy staff, and our Medical Director.

**Covering all the Bases.** LHCC CRNs request a copy of the hospital's discharge plan and coordinate with our Prior Authorization (PA) staff on authorizations for necessary post-discharge services (such as medical equipment and supplies, home health services, or skilled short-term rehabilitation). CRNs ensure that PA for needed prescriptions is addressed and or initiated prior to discharge, so that members have continuous post-discharge access to medications prescribed while inpatient. TOC staff assist, as needed, to arrange for transportation home from the hospital. TOC Team staff coordinate with the home health agency and other applicable providers to share information about the discharge plan and provide authorization information including types and amounts of necessary services, the discharge date, the date services must be initiated, and the length of the authorization period. TOC Team staff also arrange necessary follow up with the PCP or specialists, share discharge plan information, and inform them of the necessary post-discharge services authorized to facilitate medical home oversight and appropriate coordination. We also share this information with appropriate Personal Care Services agency and waiver service program staff and/or providers (if identified to us). In addition, TOC staff identify critical community linkages, such as notifying the utility company when a member discharges with equipment such as a ventilator which requires consistent electricity, and requesting the utility company notify LHCC prior to cutting off power due to lack of bill payment.

TOC staff document all information in the member's TruCare record so that all LHCC staff with member contact or coordinating care for the member have a holistic view of the member's post-discharge and other needs and care. This central repository of member information also facilitates a smooth transition from TOC Team staff to ongoing Case and/or Disease Management staff when appropriate.

In addition to notifying TOC Team staff of the pending discharge, CRNs also enter the discharge date into TruCare, which automatically populates a daily discharge report showing all discharges for that day. TOC Team staff review this report daily to double-check the information against real-time notification from CRNs to ensure follow-up for all members after discharge.

### **Monitoring Post-Discharge Home Health Care in Remote Areas**

**Monitoring Process.** For high risk members (including but not limited to those receiving post-discharge home health and other services in remote areas), TOC Team staff conduct a post-discharge follow-up call, within 72 hours of discharge, to:

- Review and reinforce discharge instructions, and provide additional education to ensure the member understands their condition, needed follow up care, the importance of adherence to their discharge plan, and timely follow up. Discharge instructions typically provide limited information, and the member’s literacy or health literacy level may limit their understanding. Additionally, the member may not retain any education received in the hospital due to issues such as stress, pain, or medications.
- Discuss medications prescribed while inpatient, identify any barriers to the member’s compliance in taking the medications, and provide education on why the medication is needed and the appropriate way to take it. Through our MTM program, we can provide telephonic or in-person medication reconciliation for those at the highest risk for readmission with a diagnosis of asthma, CHF, diabetes, and hypertension.
- Ensure follow-up appointments are scheduled, and assist, as needed, with scheduling, arranging transportation, and addressing any other barriers to timely access. For members with a BH admission that is communicated to us, TOC Team staff and/or a BH Case Manager coordinate with the SMO to ensure the required seven day follow up visit occurs, and will assist with arranging transportation if needed.
- Confirm initiation of home care (and that any 1915 (c) waiver services or Personal Care Services have been initiated) and the delivery of medical equipment/supplies. For members receiving waiver services who indicate problems with service initiation, TOC Team staff will contact the appropriate program to report the issue.
- Coordinate referrals for needed post-discharge covered and non-covered services, including those provided by community agencies.
- Assess whether the member understands what symptoms they should look for, what to do when they have those symptoms, and how to contact their provider in order to reduce avoidable ED visits and readmissions. If needed, TOC Team staff obtain provider input on the symptom response plan, share that information with the member, and provide feedback to the PCP and treating providers, as needed.

Frequency of follow up contact with the member to monitor their condition, care, and adherence is dictated by member needs, and may be as often as daily. If the TOC Team is unable to locate a high risk member, an MCR attempts to visit the member at home. We are further expanding our field-based case management resources to facilitate our ability to conduct in-person follow up by a clinician when appropriate to the member’s needs. For members who are high risk for readmission but require less than daily contact frequency, TOC staff contact the member at 10 days post-discharge to evaluate readmission risk, including adherence and needs for ongoing Case Management.

During the transition period, which may extend up to 30 days depending on the member’s needs and conditions, TOC Team staff also follow the member’s progress through communication with the home care provider, as needed, to discuss member needs and barriers. We also will educate home care providers to notify us when they discharge the member from care so that we are better able to evaluate the effectiveness of the services at reducing readmission risk. When indicated, our field-based case management staff may accompany the member to the follow-up PCP or specialist visit to ensure provider understanding of needed follow up, and interpret provider instructions for the member. In addition, our MCRs are available to assist, via phone or in-person, any member identified as needing more intensive

education and support following discharge to ensure they understand the importance of, and are appropriately accessing, follow-up care and adhering to medication regimens. TOC staff will coordinate with our Chronic Care and Case Management staff to determine the appropriateness of telemonitoring for high risk members with heart failure to allow for close post-discharge monitoring of the member's condition.

TOC Team staff communicate with appropriate personnel, including the PCP, treating providers, the SMO, and non-covered services providers, to keep them informed of the member's treatment needs, changes, progress or problems. Staff also request and share provider and other party monitoring information among the entire team involved with the member's care. We work with the member, caregivers/family, PCP, treating providers, and others involved in the member's care to address any changes or problems identified during monitoring. We do this by revising the transition plan to address the changes or problems, such as adding physical therapy sessions and home instruction on exercise, bathing, and dressing to the Care Plan if deconditioning is delaying recovery.

Throughout the transition period, TOC Team staff assess the member for ongoing case management needs. If ongoing needs exist, TOC Team staff coordinate with the Case Manager to transfer management of the member's care going forward. This may involve case conferences to discuss progress and care plan recommendations, and joint discussions with the member and/or providers regarding the transfer. The Case Manager coordinates with a Health Coach, when applicable, to initiate and coordinate any needed disease management services. For high risk members in rural areas who still need post-discharge services 30 days post-discharge (such as members with wounds or discharged from the NICU with a ventilator), TOC and Case Management staff will conduct rounds on the member to discuss and address ongoing care needs. We also will trend by home health provider to identify potential quality of care issues.

**Innovative Approaches for Monitoring in Rural Areas.** LHCC has developed several innovative methods to monitor post-discharge home health and other care to prevent readmissions:

***Electronic Visit Verification.*** LHCC proposes to use electronic visit verification (EVV) as part of our monitoring of home health, hospice, and Personal Care Services. By enabling TOC and Case Management staff to compare actual visits to the established scheduled, EVV will allow us to ensure that post-discharge home health services are delivered according to the timeframe and frequency specified on the transition plan. In the absence of a State mandate for home health providers to use a specific DHH-designated EVV system for Bayou Health services, we propose to offer home care providers access to, and use of, our Home Health Agency Management System, which incorporates integrated EVV functionality (AMS/EVV), and will be supplied by LHCC at no cost to the provider.

Our AMS/EVV goes beyond EVV functionality by incorporating valuable process automation for home health agency providers. Scheduling, clinical documentation, compliance management, billing functions (including HIPAA compliant submission of EVV certified claims), payroll, and reporting are all in one consolidated system, eliminating manual and paper-based steps for our home health providers. TOC and Case Management staff and our home health providers will work off the same electronic scheduling page, which will alert LHCC staff to any missed home care appointments in real time.

Our Centene affiliates have found that providers are significantly more likely to use EVV when the system offers the integrated functionality of our AMS/EVV system. In addition, we will pay a 5% per claim financial incentive for home health services (including Personal Care Services and Hospice care) for each such claim the provider files with us through our AMS/EVV system. Electronic claims filed through our EVV are essentially "stamped" with proof that billed services were delivered at a specified location, date and time.

We will also offer our 5% per EVV claim incentive if the provider is using another EVV system (if that system meets LHCC's data interface and audit transparency standards). We reserve the right to inspect and test the provider's EVV system prior to including the provider in our 5% enhanced payment program.

We will inspect to EVV system to ensure that LHCC clinical staff have appropriate online access to the EVV to monitor the home care delivered, for example, to enable our TOC or Case Management staff to determine if a direct care worker is late for an appointment to provide care. We also will review the provider's EVV in order to be reasonably assured of the integrity of claim transactions filed with us from the provider's EVV.

If DHH decides to mandate its selected LTSS EVV (resulting from DHH's *Electronic Visit Verification System* RFP issued on July 11, 2014) for the Bayou Health Program, we have the experience and expertise to fully support that strategy, having supported a number of different EVV operational models in Florida, Texas, and Kansas.

***Improving Member Ability to Communicate with TOC Staff and Providers.*** Especially in rural and remote areas, increased telephonic communication facilitates member ability to engage with LHCC staff or providers with any questions or concerns during the critical post-discharge period. It also allows TOC Team staff to conduct frequent check-ins and monitoring of member progress and condition. We link members who lack phone service to Safelink to obtain a phone. For those who do not qualify for Safelink, such as those who are homeless, we provide phones through our ConnectionPlus® Program. We preprogram our ConnectionPlus® phones with numbers for TOC Team staff, the Case Manager and or Health/Coach, the PCP and treating providers, NurseWise, and 911. This program received URAC's 2009 Best Practices in Health Care Consumer Empowerment and Protection Silver Medalist Award; a 2009 and 2010 Medicaid Health Plans of America (MHPA) Best Practices Compendium Honoree; and a 2011 MHPA Best Practice Award in the Technology Division. This program contributes to reductions in preventable or inappropriate ED use or hospital admissions through improved access to LHCC staff, health care information, and treating providers.

***Community Paramedicine Program.*** LHCC is collaborating with Acadian Ambulance on our new Community Paramedicine Pilot in the New Orleans area targeting our high risk pediatric members with asthma. If we determine that the program is successful in decreasing unnecessary ED visits and inpatient admissions/readmissions, we will evaluate the feasibility of expanding the program as part of our strategy to monitor other high risk populations experiencing exacerbations in other areas of the state.

The Community Paramedicine Pilot will provide real time support including triage, home assessment, and appropriate redirection for targeted groups of members at risk for readmission, such as those with post-discharge home health services. Members who agree to participate will receive an in-home assessment by a community paramedic to determine needs and care, including medications, safety risks, and level of support available. Acadian will provide the member with the phone number to call during business hours should they feel that they have an urgent medical need. The Acadian community paramedic will triage and assess the member, and will make a visit to the home if the member can be treated using community paramedicine protocols. If the member needs a higher level of care, but can be diverted appropriately from the ED, the paramedic will transport the member to the appropriate level of care. This could be an urgent care center, or a provider office, if that is an available option without an appointment. After the event, the paramedic will contact TOC Team staff with an update of the situation. If the member needs assistance after hours, they will be instructed to call our 24/7 nurse advice line to speak to a nurse about their concerns.

***Telemedicine.*** LHCC is working on a collaborative telemedicine solution to improve access to specialist providers in rural and underserved parts of the state. This program will allow us to ensure closer monitoring of members with post-discharge home health needs who also require specialty care, through increased member interaction with specialists from whom TOC and Case Management staff will solicit feedback on member progress.

We are actively engaged in discussions with Louisiana State University (LSU) Hospital Services Division (HCSD), LSU Health Science Center New Orleans, and LSU Health Care Network Clinics to develop a

partnership for a telemedicine program across the state. This partnership may also include LCMC Integrated Health System (including Children’s Hospital, Interim LSU Hospital [ILH], Touro, and the future University Medical Center).

Telemedicine programs traditionally consist of three components:

- The member (patient) in a remote area who travels to a clinical setting to receive the session
- The providing physician on the other end of the video feed in a different geographic location
- The technical and administrative team at both sites that facilitate the sessions.

For our proposed Telemedicine Program, LHCC will be the lead on engaging the member for the telemedicine session. LSU Health Science Center, under the leadership of Dr. Ali, Chief Medical Officer at LSU Health Clinic, will be the lead on finding willing specialist providers from different academic departments to participate as providing physicians. LSU HCSD, under the direction of Dr. Ali, will be the lead for the technical and administrative services needed to execute the program, as the current equipment and hardware belong to them.

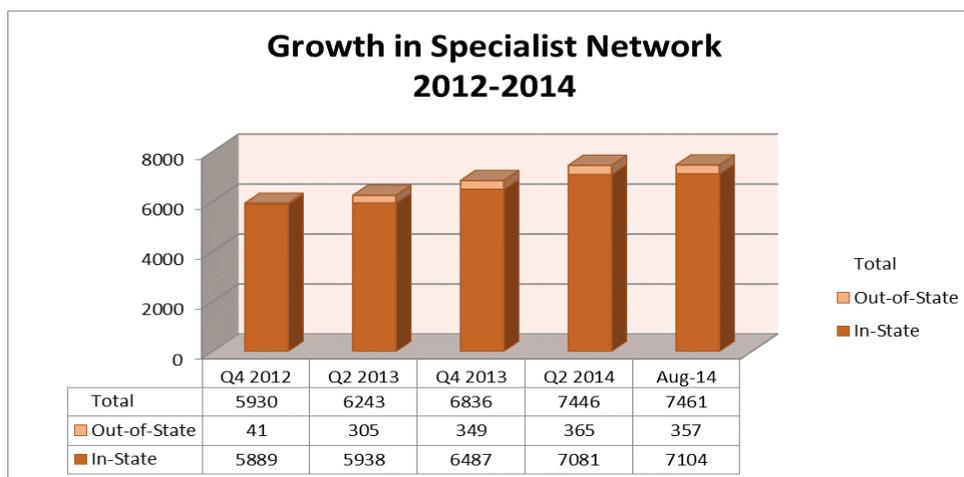
Phase I of program implementation will be traditional telemedicine. We will use existing LSU telemedicine infrastructure, with some additions by LHCC where needed. Members in certain geographic areas will access a local medical clinic or hospital for a telemedicine visit with a specialist. In Phase 2, we will be developing an innovative in-home telemedicine approach. During this phase, we will evaluate LSU’s current telemedicine platform to determine the feasibility of using it on mobile devices. If feasible, this will allow our Case Management staff to serve as the receiving end of a telemedicine visit in the member’s home. In addition, to enhancing the member’s specialty care access, this will facilitate our monitoring of the member’s post-discharge home care services, the member’s progress, and any unmet needs.

***I.3 Aside from transportation, what specific measures will you take to ensure that members in rural parishes, or other areas where access is an issue, are able to access specialty care? Describe any plans for using telemedicine to expand services. Also address specifically how will you ensure members with disabilities have access?***

LHCC understands and will comply with all DHH requirements relating to specialty care, telemedicine, and disability access, including, but not limited to, Sections 6.19 Medical Services for Special Populations; 6.28. Referral System for Specialty Healthcare; 6.29 Care Coordination, Continuity of Care, and Care Transition; 6.37 Case Management; 7.3.3 Specialists; 7.8.3 Specialty Providers; and all other relevant contractual and regulatory requirements.

### **Ensuring Specialty Access for Members in Rural and Other Areas with Access Issues**

LHCC has ensured specialty access for our Bayou Health members throughout the state, including in rural parishes and other areas where access is an issue. We have consistently grown our specialist network over the course of our contract as shown in the graphic below. We offer access to some of the top specialty providers in Louisiana, such as Louisiana Children’s Medical Corporation (parent company of Children’s Hospital in New Orleans), Touro Infirmary and Medical Center of Louisiana at New Orleans, Tulane University Medical Group, Willis-Knighton Health System, Ochsner Health System, and Franciscan Missionaries of Our Lady System.



During the current contract period, we have maintained a robust network with relatively few gaps. Those gaps that do exist are sometimes due to a lack of providers in the area and not because of provider unwillingness to contract with LHCC. We go the extra mile to develop a network that ensures access to specialty care, using proven solutions to increase the number of contracted specialists. For example, in February 2014, our Contracting team began generating a report (which we revise quarterly) of all claims from out-of-network (OON) specialists. We target all providers on this report, and our Contracting staff outreach and offer a contract to those targeted. Through September 2014, we successfully contracted with 29% of the OON specialists that our Contracting team visited to offer a contract. For example, we identified Fresenius Medical Care, a dialysis provider with which we executed several Single Case Agreements (SCAs). We outreached to and contracted with this provider to enhance our network and ensure access to a provider that many of our members choose. When we identify a gap, we follow established processes to ensure timely member access to medically necessary care while we attempt to fill the gap.

**Network Development Strategies to Increase Rural Specialty Access.** LHCC prioritizes recruiting providers who have traditionally served the Medicaid and CHIP populations. While contracting with providers who serve the commercial population may make network numbers look impressive, often these providers are unfamiliar with the unique characteristics, needs, and cultural considerations of the Bayou Health population. Using DHH and our own data to identify the providers Bayou Health members historically have seen, we have built a network experienced with this population, and we will continue to prioritize for recruitment any traditional provider who is not contracted with LHCC.

Our August 2014 analysis of our current provider network indicated that we **currently contract with 89% of the specialists** (defined as non-PCP physician providers) **identified** by DHH as **Significant Traditional Providers (STPs)**. By the time LHCC submits this proposal, we expect this percentage to be even higher since we have received several signed **contracts from STPs in Regions 8 and 9** which are pending credentialing.

**Analysis and Patterns of Care.** We use historical claims data to regularly identify and outreach to high volume non-network specialty providers accessed by our membership. Our Network team routinely generates reports of those providers associated with the top 80% of our claims, and targets any OON provider on this list for recruitment to support existing patterns of care. Based on our August 2014 analysis, all of the providers associated with the top 80% of claims are already contracted with LHCC. Since patterns of care are an important consideration for determining adequate access, we consider such patterns in our provider recruitment strategy, particularly for specialty care. For example, to accommodate Bayou Health members who live in border areas and access care across the state border, LHCC contracts

with specialists affiliated with Natchez Community Hospital, River Region Health System and Southwest MS Regional Medical Center along the eastern border of the state. Similarly, we have contracted with several Texas providers to support rural residents on Louisiana’s western border. We also identify and attempt to contract with any new specialists who move into rural areas, and offer contracts, when necessary, to specialists who have not historically accepted Medicaid or CHIP patients to achieve access for members.

When we identify a specific gap, Network Development and Contracting staff (Network Team) identify and outreach to other potential specialty providers through sources such as the Louisiana State Board of Medical Examiners, the Louisiana Hospital Association, Louisiana State Medical Society and its chartered Component Parish Societies and other local associations and organizations. For example, in July 2014, we purchased provider data from the Louisiana Medicaid Licensing Board and compared this information to our network to identify providers for recruitment. Our Network team sorted the information to identify all out-of-network providers who represented gap specialties and we are in the process of outreaching to those providers to offer contracts. In addition, the Network Team analyze service gaps for the covered populations, provider and member demographics, and explore appropriate non-specialist options, such as through other physician types or mid-level practitioners, for delivery of needed services,.

**Ensuring Specialty Access When a Gap Exists.** When a member requires services from a specialty type that is not available within the required travel distance (either in person or via telemedicine as described below), our Case Management staff help members access needed care following the priority order of actions below:

- Identify appropriate providers who are outside the distance standard but represent the local pattern of care. For example, in Ouachita, Morehouse and Union Parishes, there are no pediatric endocrinologists (based on an analysis of all licensed physicians in the state). The pattern of care for the population in these parishes is to access this specialty type at LSU Health in Shreveport. In Cameron, Calcasieu, and Jeff Davis Parishes, no pediatric hematology/oncology specialists exist. The local pattern of care is to access this specialty type at Women’s and Children’s Hospital in Lafayette. Rural parishes are not the only areas for which specialty gaps exist. For example, no licensed pediatric nephrologists exist in Rapides Parish. The local pattern of care is to access these specialty types in Lafayette or Shreveport. In all such cases, we arrange transportation to ensure the member is able to access the specialty care they need.

**Snapshot:  
Ensuring Access for Specialized  
Needs...**

A child member with cerebral palsy and severe hip dysplasia required reconstruction of the pelvis. This procedure required a specialized pediatric orthopedic surgeon with experience working with individuals with cerebral palsy. We were unable to locate a network or OON provider in Louisiana with appropriate expertise. Our UM staff and Contracting team worked together to locate an appropriate provider in Mississippi, execute an SCA, and authorize the care in a timely manner.

- Identify a non-network specialist within the distance standard willing to provide care and address the member’s clinical, functional, linguistic and cultural needs. For example, if a Case Manager identified such a provider, s/he would refer the provider to our Contracting staff to offer to contract. If the provider chooses not to contract, we execute a Single Case Agreement for the member’s care. We can also leverage the networks of our affiliate health plans in bordering states (Mississippi and Texas) for members whose community patterns of accessing specialty care include crossing into those states.

- If a non-network specialist does not exist within the distance standard, or we are unable to identify a non-network specialist within the distance standard who will agree to serve the member, we identify an appropriate network specialist as close as possible to the member’s location. Our Case Manager assists the member with scheduling appointments and arranging transportation to ensure access to these needed specialty services. LHCC’s transportation network has the capacity to provide transportation via ambulance, if needed, for members with special health care needs and complex conditions that would prevent safe travel via other means.

In all cases, the Case Manager works with our UM staff to authorize the care, and with the PCP and specialist to share information and coordinate care planning and monitoring. Community Connections, our expanded community resource guide, will enable Customer Service, Case Management, and MemberConnections™ staff to link members to social and other non-covered services in their area. We also will include specialty gaps by area in the Community Connections, so that Case Managers working with members are aware of gaps and the steps they need to take to meet the member’s needs for specialty care, following the steps above.

When necessary, LHCC authorizes specialty services with out-of-state providers that possess special expertise not available within the state, such as St Jude’s Children’s Hospital, Texas Children’s Hospital, and Boston Children’s Hospital. When a member requires specific expertise not available in Louisiana, we work with the member/family and treating providers to identify and coordinate with the out-of-state provider. We also authorize transportation and may assist with coordination of needs such as lodging for the parents when a child must travel to receive treatment.

### Using Telemedicine to Expand Specialty Services

LHCC is working on a collaborative telemedicine solution to improve access to specialist providers in rural and underserved parts of the state. We are actively engaged in discussions with Louisiana State University (LSU) Hospital Services Division (HCSO), LSU Health Science Center New Orleans, and LSU Health Care Network Clinics to develop a partnership for a telemedicine program across the state.

This partnership may also include LCMC Integrated Health System (including Children’s Hospital, Interim LSU Hospital [ILH], Touro, and the future University Medical Center). *For ease of reading, this response refers to these providers collectively as LSU.*

Our Chief Operating Officer and Chief Medical Director have held phone and in-person discussions with Chief Medical Officer Juzar Ali of LSU Health Science Center, as well as Paolo Zambito, Senior Vice President of Operations for ILH. Dr. Ali is the designated faculty and officer in charge of the existing telemedicine program for all components of the LSU system, and has given a firm commitment to LHCC to work jointly on this project, which we will implement in phases beginning Q1 2015.

Telemedicine programs traditionally consist of three components:

- The member (patient) in a remote area who travels to a clinical setting to receive the session
- The providing physician on the other end of the video feed in a different geographic location

#### LHCC/LSU Telemedicine Program

##### Phase I: Traditional Telemedicine

Use of the existing LSU telemedicine infrastructure, with some additions by LHCC where needed, to allow members in certain geographic areas to travel to a local medical clinic or hospital for a telemedicine visit with a specialist.

##### Phase II: Innovative In-Home Telemedicine

Evaluation of LSU’s current telemedicine platform to determine feasibility of use on mobile devices so that LHCC’s Case Management staff can serve as the receiving end of a telemedicine visit in the member’s home.

- The technical and administrative team at both sites that facilitate the sessions.

For our proposed Telemedicine Program, LHCC will be the lead on engaging the member for the telemedicine session. LSU Health Science Center, under the leadership of Dr. Ali will be the lead on finding willing specialist providers from different academic departments to participate as providing physicians. LSU HCSD, under the direction of Dr. Ali, will be the lead for the technical and administrative services needed to execute the program, as the current equipment and hardware belong to them.

LSU began its telemedicine program 12 years ago, with installation of video equipment in its hospitals and their associated clinics. We will evaluate capacity and locations of these facilities to determine how we can provide additional hardware and equipment to establish a facility base for telemedicine visits in geographic areas with a shortage of one or more specialist provider types needed by our members. LSU has already spent time evaluating the specialties that are ‘telemedicine friendly’, meaning, that the positive member experience and outcomes are achieved at an acceptable level through a video visit instead of a more hands-on, in-person encounter.

LHCC will rely on the expertise of the LSU physicians and staff in determining which specialties are telemedicine friendly, and work within that scope to develop the program. However, we have already discussed the possibility of adding neurology, pediatric allergy, and hematology, and plan to discuss other key specialty types for which there are shortages, such as those in the box below.

As we evaluate specialty types to include and where to locate additional facility bases, we will prioritize program expansion to areas in which we have both identified opportunities as well as heavy concentrations of membership. For example:

- Region 8 (Monroe and northeast corner) has the highest need in the state, as the region has network opportunities in all specialty types listed in the box, left. In this region, the highest concentration of our membership is in Ouachita Parish. Therefore, this Parish will be a priority.
- Region 5 has network opportunities in eight of the nine specialties shown in the box. This is one of the areas in the state in which we have the heaviest population of members, with the largest concentration of our membership in Calcasieu Parish. This Parish will be a priority.
- Region 6 (Alexandria and the central part of the state) also has network opportunities in eight of the nine specialties mentioned. In this area, the concentration of our membership is in Rapides Parish, so this Parish will be a priority.

#### Key Specialty Types with Shortages

- Geriatric Medicine Providers
- Adolescent Medicine Providers
- Pediatric Endocrinology
- Pediatric Gastroenterology
- Pediatric Hematology and Oncology
- Pediatric Infectious Disease
- Pediatric Nephrology
- Pediatric Pulmonology
- Pediatric Rheumatology

In addition to these regions and Parishes, we will evaluate other rural areas based on membership concentration as well as need for specialist coverage.

### Ensuring Members with Disabilities Have Specialty Access

In addition to the strategies described above, LHCC ensures specialty access for members with disabilities and special health care needs (SHCN) using the following strategies.

**Monitoring and Soliciting Member Feedback.** We monitor member feedback provided to Case and Chronic Care Management staff during care plan development, implementation, and monitoring. In addition, our Quality Improvement (QI) staff continuously monitor member complaints to identify potential issues with access related to disability. When we identify a potential issue, QI staff investigate and work with the provider on corrective action, such as ensuring ADA compliance. We also solicit feedback from our Member Advisory Committee on how well we are ensuring access for members with disabilities, and how we can work with providers to improve that access, such as by identifying training needs or particular providers with expertise in specific subpopulations.

**Utilization Management Policies and Procedures That Promote Specialty Access.** LHCC ensures members with disabilities and SHCN have direct access to specialists by only requiring prior authorization of specialty services provided by OON providers. We also allow members with SHCN, family/caregivers and providers to request a specialist as a PCP at any time. Within three days of receiving such a request, a Case Manager schedules an assessment to confirm that the member has a special need. Our Medical Director reviews assessment results and approves requests after determining the member meets criteria and the specialist agrees to execute and fulfill requirements of a PCP Agreement.

**Ensuring Provider Capacity to Serve Members with Disabilities.** Our approach to ensuring appropriate access goes beyond accommodation of disability. We identify providers who also display a true interest and expertise in providing care to people with disabilities. We request information about the provider's expertise and special accommodations during the initial provider site visit after contracting. At this time, we collect information about any special accommodations the provider offers, such as adjusting exam tables or the option for certain exams or procedures to be performed while the member is in a wheelchair versus on an exam table. We provide this information to Customer Service and Case Management staff to assist members in locating providers who can meet their unique needs. We also provide certified medical language interpreters, including those experienced serving people with disabilities who may have communication challenges.

LHCC educates providers on topics related to serving individuals with disabilities, such as Disability Sensitivity and People First Language, via initial and ongoing training, the Provider Manual and website, and quarterly newsletters. We also educate them to expect that some people with disabilities may require additional time to understand health care concerns, ask questions, or prepare for examinations. We encourage providers to be flexible with appointment times and help coordinate home visits where possible. In addition, our Clinical Provider Trainers offer focused training to providers and their office staff to further develop their capacity to meet the needs of members with disabilities. Training sessions cover the social and personal barriers people with disabilities face, and offer solutions to help accommodate their needs.