August 15, 2011

Ms. Mary Fuentes
Department of Health and Hospitals
Division of Contracts and Procurement Support
628 N 4th Street, 5th Floor
Baton Rouge, LA 70802

RE: RFP # 305PUR-DHHRFP-SMO-OBH

Dear Ms. Fuentes,

On behalf of Cenpatico of Louisiana, Inc. (Cenpatico), I am pleased to submit this response for the Statewide Management Organization for the Louisiana Behavioral Health Partnership contract.

Cenpatico of Louisiana, Inc. is a Louisiana based, wholly-owned subsidiary of Cenpatico Behavioral Health, LLC. (Cenpatico) an experienced, NCQA accredited, managed behavioral health care organization, and Centene subsidiary. We bring the corporate history of over 27 years of experience implementing publicly funded medical and behavioral health care programs that improve lives. We have demonstrated success offering a flexible, member and family focused approach to a behavioral health system of care based on the principles of recovery.

Respectfully, I believe that Cenpatico is the right fit for Louisiana because of our extensive history of successfully providing complex, publicly funded behavioral health programs that are sensitive to the needs of vulnerable children, youth and adult populations. Further, Cenpatico's mission has been almost exclusively focused on helping states effectively and efficiently focus ever decreasing funding for the most vulnerable in our society. Like our parent company, Centene, we have honed our experience in the public sector because that has been our company's primary mission.

In addition, our behavioral health experience is broader than traditional managed care contracts with states and includes working agreements between stakeholder agencies such as local governments, adult corrections and juvenile corrections, Departments of Children and Families, Departments of Housing, Department of Developmental Disabilities, Departments of Long Term Care, Departments of Vocational Rehabilitation, Tribal Nations; contracting with school districts and Federally Qualified Health Centers, Rural Health Clinics; and working with local advocacy groups and community partners. We understand that funding for mental health and substance abuse services flows through a variety of entities, and we work to maximize the public dollar and improve the lives of the members we serve. Cenpatico's goals are aligned with the goals of this procurement; including:

- Foster individual, youth, and family-driven behavioral health services—just as Cenpatico has already successfully done in Arizona and other states, *we will deliver this through our regional Community Liaisons and Peer and Family supports that are dedicated to outreach and developing opportunities to engage members and families in care.*
- Increase access to a fuller array of evidence-based home- and community-based services that promote hope, recovery, and resilience—*we will deliver this through Program Specialists and Provider Coaches working every day to ensure fidelity to best practice and find new ways to deliver services in the manner that best serves the member and family. We have successfully*

worked to improve the service array by adding services like Crisis Respite for children in Indiana.

- Improve quality by establishing and measuring outcomes—*we will deliver this through our data-driven Quality Management team and committee structure that emphasizes Data Integrity, Quality Improvement and Provider Performance. Our committees across all markets include members, families and providers to provide continuous feedback opportunities.*
- Manage costs through effective utilization of State, federal, and local resources—*we will deliver on this through decreased dependence on inpatient, institutional or other out-of-home placement and working to integrate medical and behavioral health to improve overall health outcomes. Cenpatico has been very successful in other states with reducing inpatient hospitalization, especially for the foster care population in Texas. Over a three year period, Cenpatico was able to reduce psychiatric inpatient utilization by 23%.*
- Foster reliance on natural supports that sustain individuals and families in homes and communities—*we will deliver this by partnering with developed and developing Wraparound Agencies, Family Support Organizations, as well as community and advocacy organizations and other natural supports to create a Coordinated System of Care, that is holistic, integrated and will improve the lives of Louisianans. Since 2006, we have increased the percentage of children served through CFTs from a low of 44% to 99-100% in one of our Arizona service areas. In just three years, we increased the number of CFT facilitators from 83 to 216 (2006-2009) across two service areas. Arizona re-awarded Cenpatico the contract in 2010 and Cenpatico was the only managed behavioral health organization to be awarded additional service areas.*

Our Regional Care Teams (RCT) model of care management, is based on our years of experience, and designed with the unique strengths and challenges of Louisiana in mind. We recognize that the role of the SMO is to be a leader in the system transformation, a partner with the state in maximizing resources and an advocate for the vulnerable populations served by LBHP. Our RCTs bring regional flexibility to ensure that we enhance, without duplicating the good work occurring in each community. We bring information systems that support the effectiveness of our model through our enhanced clinical portals which allow safe and secure data communication with providers, DHH-OBH and authorized stakeholders.

Our commitment to Louisiana begins with locally based regional care teams, which are supported by best-in-class technology and member and family focused clinical care management programs. *Additionally, Cenpatico has proposed a financial package that includes an at-risk cost proposal for the Adult populations which assumes savings through our care management programs of approximately 17% over the current utilization and trends, a savings guarantee on the administrative services component, and shared-savings model for the provider community and DHH-OBH*

We look forward to partnering with DHH-OBH to improve the delivery of health care services and the lives of those served through the Louisiana Behavioral Health Partnership.

Sincerely,

Sam Donaldson, Ph.D.
President and CEO
Cenpatico of Louisiana, Inc.

Cenpatico of Louisiana, Inc.

Technical Proposal

Request for Proposals for the Statewide Management Organization for the Louisiana Behavioral Health Partnership with the Department of Health and Hospitals and the Office of Behavioral Health

RFP # 305PUR-DHHRFP-SMO-OBH

Issued by the Department of Health and Hospitals
And the Office of Behavioral Health

August 15, 2011

The data contained in pages 19, 22, 26, 77, 129, 154, 212-215, 395-426, Appendix 2.d, and Appendix 2.i of the proposal have been submitted in confidence and contain trade secrets and/or privileged information and such data shall only be for evaluation purposes, provide that if a contract is awarded to this Proposer as a result of or in connection with the submission of this proposal, the State of Louisiana shall have the right to use to disclose the data therein to the extent provided in the contract. This restriction does not limit the Sate of Louisiana's right to use or disclose data obtained from any source, including the Proposer, without restrictions.

TECHNICAL RESPONSE

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1.a. Introduction/Administrative Data

The introductory section should contain summary information about the Proposer's organization. This section should state Proposer's knowledge and understanding of the needs and objectives of the Louisiana BH services program for children and adults and the CSoC for children, as related to the scope of this RFP. It should further cite its ability to satisfy provisions of the RFP. This section should discuss how the Proposer will define success at the end of years 1 and 2 of the contract by describing milestones it expects to achieve, specifically addressing milestones for network development. The Proposer should address separately milestones for (1) the CSoC, (2) management of services for other children not eligible for the CSoC, and (3) adults with SMI and/or addictive disorders.

Cenpatico of Louisiana, Inc. (Cenpatico) is a subsidiary of Centene Corporation (Centene). Today we are working to improve lives through behavioral health management for more than 1.7 million members in 11 states. *For Louisiana, Cenpatico brings:*

1. **System Transformation Implementation Experience** (Arizona, Georgia, Texas Foster Care program, Schools based programs).
2. **Recovery-driven approach to population management** that introduces trauma-informed care, community and family supports, and a holistic infrastructure improvement plan based on physical health integration, inter-agency cooperation, and overall transparency.
3. **Structured, specific growth plan** supporting LGEs, WAAs and provider network development.
4. **Technical assistance and mentoring** to ensure providers successfully transition from traditional fee-for-service models to a comprehensive system of care effectively utilizing appropriate funding streams.
5. **Results** delivered across the continuum and in administrative, functional, and meaningful way that produces quality outcomes (described later) for the LBHP program and impacts medical expense.

Organizational Summary

Cenpatico's mission has always been grounded in population-focused care. As such, we bring considerable experience with managing high-risk populations serving adults and children with chronic medical conditions, developmental and physical disabilities and serious mental illness since 1994, as well as members on SSI and dually-eligible Medicare/ Medicaid since 2002. We currently also have programs for low income adults and legal immigrants. Cenpatico is a fully NCQA accredited managed behavioral health organization (MBHO or BH-MCO).

Cenpatico is the **only** BH-MCO that has operated a full continuum of school-based services (K-12) providing school districts Special Education services to assist students with learning, emotional, or behavioral challenges since 1995.

We offer speech therapy and evaluation services in innovative, culturally sensitive Day Treatment programs onsite in public school districts and charter schools or in our own facilities (See Figure 1a.1).

Figure 1a.1 Gilbert, AZ Campus

Our strengths-based model of care is a *behavioral health best practice* with demonstrated ability to exceed state and federal requirements because we work with the communities to build services across the behavioral health spectrum. Our goal is to foster natural supports within the communities and families which are ultimately also far more cost effective and highly satisfy districts, teachers, children and their parents.

Additionally, Cenpatico has managed the behavioral health care for all 30,000 youth in foster care in the state of Texas through the Health and Human Services Commission (HHSC) since April 2008. Here we have systematically worked with the Department of Family and Protective Services (DFPS), judges, case workers, foster parents and a host of child services organizations to train more than 7000 providers, foster and biological parents, case workers, and other stakeholders on Trauma Informed Care. Cenpatico also tackled the issues of over-medication by introducing a Psychotropic Medication Utilization Review (PMUR) program (details below) that has reduced inappropriate polypharmacy use by more than 80 percent. This *unique* expertise along with our specialized Schools programs for state/local departments of education combine to make Cenpatico a best practice partner for serving Louisiana's children – in both the CSoC and non-CSoC programs.

Cenpatico understands the complexities of treating the populations who will participate in the LBHP, particularly adults and children with serious mental illness (SMI) and issues these individuals face when attempting to access appropriate medical as well as behavioral care. To help break down those barriers to care and assist these members by developing a model of care that fits their specialized needs, we have met with several providers to discuss these issues. We do not want to change aspects of the health care system that are currently working well; instead, we will build upon the existing health care delivery system. There are, for example, innovative programs already in place within the mental health centers that provide inpatient diversion for patients visiting the emergency room with a behavioral health condition or addiction.

We have launched successful strategies to manage the needs of adults with SMI and/or addictive behaviors by focusing holistically on improving their lives:

- Our philosophy is to engage members and advocates in the way services are provided and how we communicate. We do this through advisory councils and believe ongoing engagement ensures outcomes are achieved.
- We embrace a holistic functionally based approach supported by care coordination which relies on a sound economic model of care rather than a diagnosis driven approach. Each member participates in an individual plan of care that facilitates access to services ranging from health to employment, housing, social activities and/or relationship development for support.
- Utilize best practices for addictive disorders such as motivational interviewing, a matrix model for care, and peer supports.
- Our unique integrated approach to serving people with cognitive impairment, including developmental disability and mental illness means partnering physical health and behavioral health specialists as a norm. Recovery and resilience outcomes are achieved by focusing on behavioral and functional status services that support physical health status improvements.
- We support the physician community through an "any willing provider" approach that maintains consumer continuity of care. In addition, we reduce the historical "hassle" of managed care by asking for the lowest level of required authorizations possible, accepting out of network care episodes, reducing no-shows by facilitating transportation, arranging specialist appointments, offering electronic interfaces, and identifying needs related to disabilities prior to the treatment visit.

Cenpatico offers several unique program features that set us apart from other Medicaid health plans and provide exceptional value both to DHH-OBH and to the residents of Louisiana.

Additionally Cenpatico places a very high value on recipients' right to direct their recovery. We recognize that members must guide their relationships with our providers; therefore, we will create supports across service domains and our management strategies reflect the value we place on recovery principles. We offer:

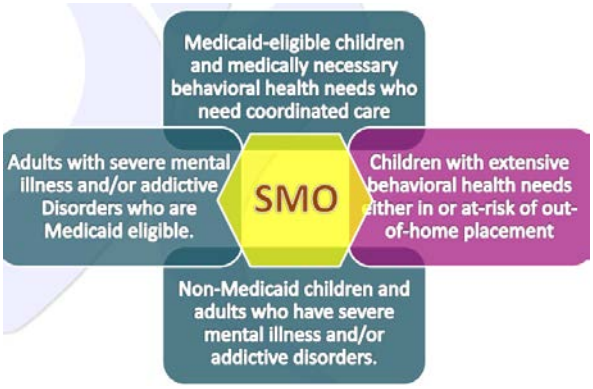
- Care Management staff to guide our recovery focused approach and engage the community in awareness of recovery issues
- Peer support services to enhance recovery options for substance abuse and mental health

Understanding LBHP Scope, Needs & Objectives

The Louisiana Health Care Reform Act of 2007 began to mandate change. The Department of Health and Hospitals (DHH) was directed to establish a ―medical home system of care with the goal of improving patient outcomes and increasing cost-effectiveness as well as budget predictability—transforming how Medicaid beneficiaries and low-income uninsured people received their health care services. As envisioned, Act 243 would ensure preventive, primary and coordinated care services were delivered.

The Department of Health and Hospitals has been working to make Medicaid better for its residents, providers and the state with the ultimate goal of an improved system of care for the state including the creation of a culture of personal responsibility for health, greater flexibility and financial incentives for Medicaid providers, and a more sustainable and budget-conscious solution for all Louisiana residents with particular focus on children with behavioral health challenges and multi-department involvement. This mandate was then broadened to include addiction services and adult mental health services.

"Louisiana's children and adults with behavioral health challenges deserve a system responsive to their needs. This is about IMPROVING LIVES." Kathy Kliebert, Deputy Secretary DHH presentation: The Louisiana Behavioral Health Partnership – Transforming the lives of our youth, Supporting adults in need, Keeping families together, final slide 41.



The goals are to facilitate better coordination of services to:

- Enhance the consumer experience
- Increase access to a more complete and effective array of behavioral health services and supports
- Improve quality of care and outcomes
- Reduce repeat ER visits, hospitalizations, out-of-home placements and institutionalizations

In addition to these goals, Cenpatico will also note that it is our intention and part of our staffing design and management philosophy to coordinate medical health services within a **behavioral health home model** (BH home) where appropriate. The BH home is both a philosophy and a practice Cenpatico has established for the purposes of integration where we work with our MCO partners to jointly manage or facilitate management of appropriate care management leads based on the individual's need… in cases of SMI adults, that is often the BH practitioner verses the PCP. We have found this approach ensures the most appropriate resources are leading the plan of care development fostering the opportunity for the greatest positive outcomes. In this way we have exceeded expectations for all the goals outlined above in our other state programs.

Cenpatico staff are integration experts both with our Centene health plan partners but also with all MCOs we work with nationally. This unique experience of team co-morbidity management transcends typical managed care co-location strategies or reports as a means to facilitate quality. In our design, staff work on both the mental and physical health care complex cases creating a *true medical home* from Day One which will be invaluable throughout Louisiana as it could additionally save costs beyond the Agency's mental health spend alone.

This level of physical health and behavioral health system change is revolutionary, which by definition can be frightening to most but is thrilling to us because we have seen and demonstrated its positive effect. The level of agency integration and hope for the full continuum development which is community and family focused is inherent in the role of the SMO… and something Cenpatico works to facilitate in every other state every day.

We believe it takes fanatical planning, ongoing communications with every single stakeholder, risk mitigation strategies including critical event planning efforts, and lastly a passion to do it all well to be the LBHP SMO.

Cenpatico will meet or exceed the provisions of the Louisiana Behavioral Health Partnership, RFP #305PUR-DHHRFP-SMO-OBH.

Change should result in significant, measurable improvement that ideally is moving you forward toward a greater goal. By selecting Cenpatico, Louisiana DHH will be choosing a proven organization that specializes in delivering quality services that **improves lives** for the very populations outlined in this RFP particularly children in the child welfare system; vulnerable adults and families in Medicaid; and individuals re-entering the community from the justice system. ***Serving children and vulnerable adults is our passion and sole focus*** which is why we are the national leader in behavioral health innovations particularly in foster care, trauma training, and with regard to children/teens and SMI adults including those with co-morbid substance use.

Cenpatico has provided managed behavioral healthcare services that deliver functional outcome results, high member satisfaction, intensive quality management based on Six Sigma principles for thoughtful program and product design with exceptional customer service. We have created programs, processes, and trainings based on the diversity and complexity within Medicaid and Medicare since 1994.

Our staff and our programs leverage clinical efficacy with culturally and linguistically competent, seamless wraparound services that look beyond the immediate service request alone – which is precisely what is required for LBHP. We understand the unique circumstances and subsequent needs of these populations because they are our only focus and because of our expertise with Trauma, which we believe is an underlying reality for the entire Louisiana population given its history in the last decade alone.

During our visits with LGEs and Regional staff and Administrators, we learned that many excellent evidence-based programs, such as MST and ACT, exist in a variety of communities. However, they are not part of a comprehensive continuum of care and were siloed. Our role will be to determine and then bridge gaps in the continuum with the LGEs.

Another example is that Region 6 has a crisis stabilization team but no beds available for crisis stabilization and inpatient diversion. MST is only available through a limited funding stream and the cost of maintaining fidelity to the model is prohibitive for many LGEs/Regions.

Cenpatico will help local stakeholders develop the missing pieces, resulting in solid systems of care for adults and children.

Trauma Timeline

Further still, Cenpatico has not created commercial or employer-driven products that we've since applied to the public sector. Our programs are different and have better results because this is all we do and we are driven to do whatever it takes to connect each person with the care or services that improves their lives.

Cenpatico's Role as the SMO

Beyond the State's stated goals outlined below, to be successful, we believe the SMO will need to perform comprehensive analyses on agency capabilities for data exchange, community mental health center (CMHCs) functional analyses to determine gaps in services in conjunction with the LGEs and WAAs, successfully identify appropriate funding streams for services, and establish business process to track all aspects internally and externally. Further, we know that we need to work with the CMHCs to facilitate an ability to bill Medicaid in preparation for their needed accreditations while recruiting new providers for substance abuse and LCSWs who previously could only bill if a member was dually enrolled. Our mandate is to expand access while reducing out of home placements, recidivism for corrections, as well as decreasing hospitalization and institutionalizations, PRTF, and length of stay (LOS) by building out community based outpatient resources.

Functionally, we recognize our role is to make initial referrals once eligibility is determined to the appropriate Wraparound Agency (WAA) in the region for further assessment and planning. Prior to that, during our implementation and ongoing throughout the contract, Cenpatico will look for gaps in care and barriers to recovery so we can solve those and authorize needed services. This means we will also be working to introduce crisis respite for the foster care children as well as general improvement of the ACT teams.

We further understand that as the SMO, we will

- Foster individual, youth, and family-driven behavioral health services that are evidence-based.
- Increase access to a fuller array of evidence-based and promising home- and community-based services that promote hope, recovery, and resilience.
- Improve quality by establishing and measuring outcomes.
- Manage costs through effective utilization of State, federal, and local resources.
- Foster reliance on natural supports that sustain individuals and families in homes and communities.

Throughout our proposal response, we address each of these and have dedicated staff for each area (described in our cover letter).

Our experience and understanding will be the foundations for population specific, cross-cultural treatment protocols, training methodologies, and overall program design that will become a best-in-class model. More importantly, Cenpatico's efforts will establish the behavioral health home infrastructure that is critical for systemic inter-development with physical health MCOs ensuring

long term success of those initiatives. As the SMO, Cenpatico will provide an unbiased quality driven program that exceeds expectations for timeliness, access, appropriateness and successful functional outcomes.

By virtue of our presence and expertise, we will further ensure:

- Comprehensive integration and coordination of services, including but not limited to:
  - Physical health/mental health/substance abuse service integration through regional care coordinators working in lock-step with the LGEs, WAAs, and MCOs
  - Interagency systems coordination, including education, child welfare and homeless lead agencies, law enforcement, and other state and local agencies and resources
  - Discharge, wrap around and crisis intervention planning for high needs populations with emphasis on decreasing readmissions
  - Sub acute levels of care, such as short-term residential level 1, for step down after hospitalization or to avoid need for hospitalization
  - Staff dedicated to coordination of services for children and families focusing on preventing potential placements; but also performing discharge/treatment planning from date of admission and transitions from foster care and corrections programs
  - Crisis services, including 24/7 hotline support services with access to care assessments and services in cooperation with the WAAs
  - Unprecedented member or caregiver involvement where people can recover and have the right to be involved in their care.

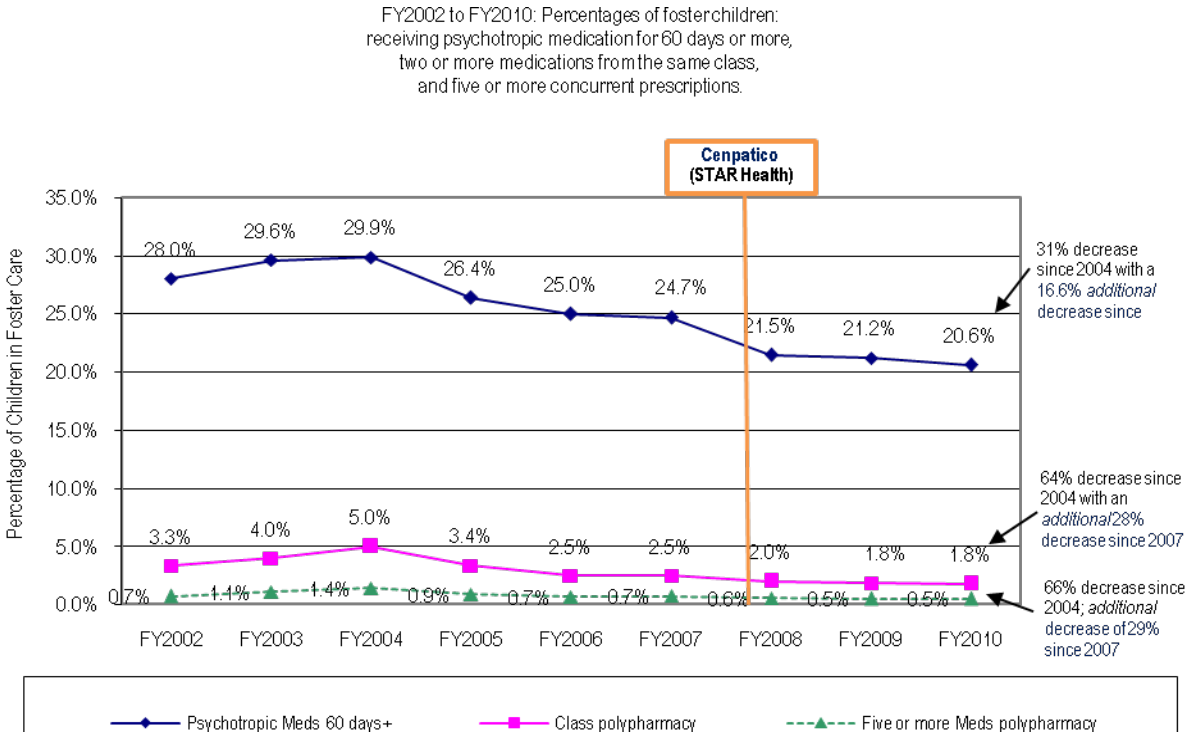
State knowledge and understanding of the needs and objectives for children and adults and the CSoC for children

As previously described, our organization places tremendous value on the sustainability of recovery and the prevention activities that may be put in place before out-of-home placements occur through the use of natural, community supports. To that end we've established a community involvement support structure – Community and Cultural Affairs team (COCCA) – which will work hand-in-hand with the Regional Care and Network teams to develop the network and all needed services (led by our COO, with community liaisons and provider coaches).

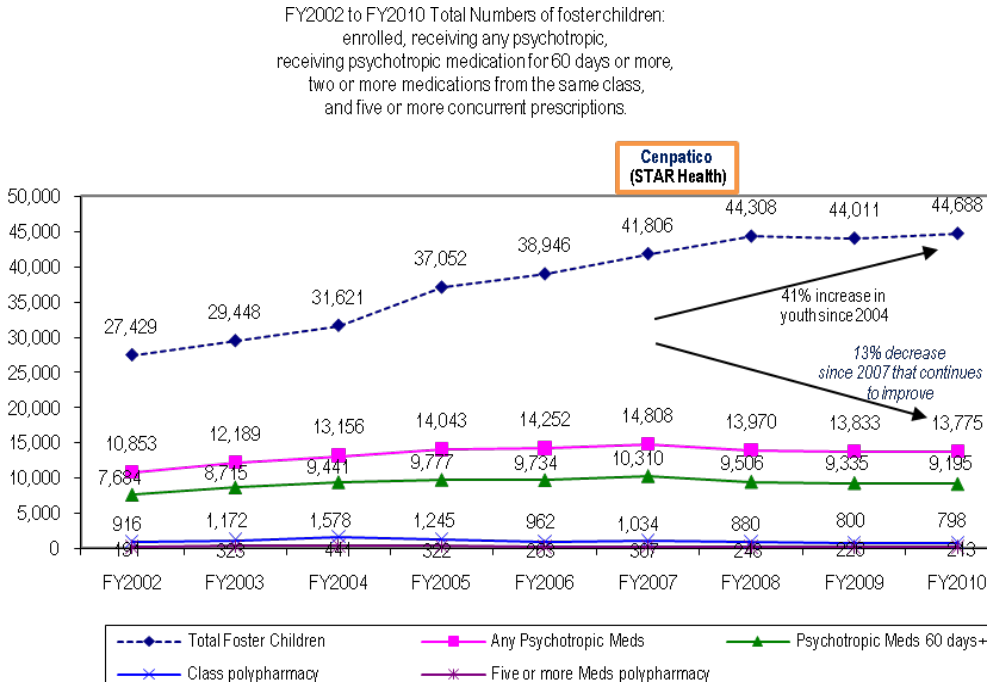
CSoC. We have participated in the implementation of managed care programs based in the System of Care principles and wraparound facilitation (AZ and TX-FC). What we have learned is that to optimize this transformation, we must start with communication and partnerships with the community (members, families, stakeholders, providers and state agencies). We do this primarily with advisory committees (both during implementation and ongoing) to ensure we are in sync with what is needed and any potential barriers. Additionally, we provide analysis of current state, and support and training to develop services or necessary infrastructure that helps improve the system, much like our CFT program launched in Arizona. We give them the tools they need to get the job done (Provider Coaches, IT support, Web Portal, ***CenTraCare Clinical Portal***, online care gaps, quick reference guides, dashboards and 24/7 access). We monitor, using chart, site and fidelity audits, Satisfaction surveys, and community feedback forums to ensure regular data feedback to providers and the state. We offer continued training and support to help the system have greater capacity, expertise and focus on the family.

In short, we are *passionate* experts at serving children and youth that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement. Our experience in Texas is one example where as a result of our focus to improve and expect more FOR our members we saw the following results:

- 16.6% decline in the number of foster children prescribed psychotropic medications overall and specifically a 29% decline in polypharmacy;
- Today only 0.5% of children in foster care are on multiple medications and those have been deemed clinically necessary.



Note: Data provided from Texas Department Health and Human Services (HHSC), which has approximately 30,000 children in the foster care system jointly managed with Department of Family and Protective Services (DFPS), 2011.



To obtain these meaningful results, Cenpatico had to go beyond basic utilization review techniques. We launched a program specifically designed to target over-utilization of psychotropic medications coupled with assertive outreach training and education campaigns to address the concerns of policymakers, judges, case workers, parents, and providers individually. Our team understood the lack of information present as children were first brought into the system and the potential hazards related to real trauma being misunderstood or misdiagnosed as long term behavioral disorders. So we worked with each stakeholder group to introduce positive change in the initial screening and overall data sharing processes.

SMI Adults. For this population and the other smaller groups, Cenpatico will work on the network development effort to ensure appropriate access. Historically, we apply the same principles we utilize effectively for children for the SMI group. Further, we will establish protocols and system flags across our platforms to check for fraud and abuse. Cenpatico will partner with the existing providers to facilitate the exchange of information, plans of care and treatment with community resources and PCPs so we can focus on forensic patients with chronic conditions. Our goal will be to prevent or divert these individuals from the judicial system (jail) and into the behavioral health delivery system decreasing the risk for restrictive settings. Having worked with this population, we also know of the strong co-morbidity with substance use, which again underscores the need for communication and infrastructure.

That same passion also produced results like:

- 43% reduction in behavioral health inpatient events as a result of our *Caring Voices* program (for transient individuals); and
- Only 13% of community re-entry program participants re-offended in our measurement period which is a significant improvement from the national average where greater than 60% re-offends within three years.

Define Success at the End of years 1 and 2

At full implementation, we expect to be able to meet DHH-OBH expectations to improve services for:

- About 2,500 of our youth who are at greatest risk and have the most complex needs (CSoC).

- About another 50,000 children and teens with behavioral health challenges.
- About 100,000 adults with serious mental illness, major mental disorder, acute stabilization needs and/or addictive disorders.

Beyond these goals, Cenpatico expects to introduce the same rigor and passion to the children of Louisiana – both in the CSoC and non – which we believe will transform the system first through use of technology to make important information available across agencies and providers. Second, through our child-focused experts who have designed our programs based on trauma-informed care best practices and aggression prevention strategies.

Further, we recognize that the children have long been a focus for Louisiana. While they are also a focus for us, a key strength of Cenpatico is centered on our practices for management of vulnerable populations, particularly SMI adults with or without substance use co-morbidity.

To that end, we are confident that our program design will result in significant improvements including **greater savings that requested** (see 1.b. Fiscal Responsibility and our Cost Proposal). Cenpatico is therefore willing to introduce the following key milestone highlights for DHH-OBH in addition to meeting or exceeding the service outreach described above and our implementation targets (Section 2.i.). Cenpatico will establish the following:

1. Member & Stakeholder Engagement:
    a. All member and stakeholder committees (persistence targets met) within Year 1
    b. Support permanent supportive housing within Year 1 and appropriate wraparound services
    c. Conduct regional community forums in first 90 days post go live and ongoing
    d. Successfully hire DHH-OBH agreed-upon key leads prior to February 1
    e. Fund 'plan of care' global process improvements and establish wraparound services
    f. Significantly impact out of home placements (end Year 1 and Year 2)
    g. Build linkages with WAAs and FSOs to effectively coordinate care
2. Provider Engagement Persistence: Year 1
    a. Integration efforts with FQHCs completed
    b. Establish statewide network within 90 days of go live including achieving targets for new providers onboarded (particularly LCSWs and substance use providers)
    c. Delivers development of wraparound services and community mental health center/FQHC and provider access that meets or exceeds access standards and reduces or eliminates wait times in all regions
    d. Maintain lowest level of complaints and highest level of participation
    e. Reduce inefficiencies by 15% in Year 1
    f. Training CMHCs and all providers to successfully submit Medicaid billing within Year 1
    g. Oversight established for new substance use benefit with fraud and abuse flags in place and reports presented 90 days post go live (claims reconciliation)
3. Agency Engagement: Year 1
    a. Establish stakeholder advisory board
    b. Establish interfaces needed for transparency within 60 days of go live
    c. Determine agreements and eligibility feeds standards to enable our stakeholder portal
    d. Facilitate stakeholder participation on QIC committees including meeting persistence targets for engagement
4. Model Fidelity: Year 1
    a. Increased access as outlined above for all populations
    b. Decreased hospitalizations and institutionalizations in Year 1 including reduced length of stay (LOS)

c. Fully operationalize crisis system network supports including development of crisis respite for children, improved ACT teams, and family-based and community services
d. Launch protocols for co-occuring issues with behavioral health challenges including appropriate transparency for plans of care within first 90 days post go-live
e. Successfully identify appropriate funding streams for services and establish processes for monitoring

5. Implement pharmacy management support processes to inform network within Year 1
6. IT System Launch successfully for all partners and agencies by go live

Year 1 will be a time of great change and upheaval. Nonetheless, we expect to establish a data point baseline for appropriate measurement going forward during implementation. However, we recognize that the first year will be about introducing structure and stability.

Year 2 will be an opportunity to influence true outcome change. We believe our infrastructure work, engagement and network build strategies, and proven processes and tools will result in significant, statistical improvements. Cenpatico will work with DHH to establish appropriate performance targets after Year 1 baseline including a reduction in out-of-home utilization and an increase in family-based and community services.

Cenpatico's success measures are based on achievement of these implementation targets timely as well as establishing baseline utilization targets we exceed.

We are so confident in our ability to deliver measurable results to DHH that we are proposing an additional profit sharing arrangement with the state that will also reinvest in providers (incentives) and the communities. *This is presented in Section 1.b. and in our Cost Proposal for your consideration.*

Implementation Expertise

Because Cenpatico's SMO program is designed to be **locally focused**, our processes are fluid and flexible to meet diverse needs *within* the regions. Our Regional Care Teams will be comprised of experts who understand the culture of their region, are trauma experts, and can facilitate change. We successfully apply our managed behavioral health care techniques and experience to meet the needs of members in rural areas, utilize multiple funding streams, address cultural differences, provide increased support for high-needs populations, increase integration and coordination of services and improve lives through the consistent delivery of overall quality of care. These key benefits are outlined in the table on the following page and in depth in *Section 2.i. Implementation Plan.*

As further evidence to Cenpatico's commitment to Louisiana's success, we will introduce expert data analytics, comprehensive transition / implementation design and execution, and our formal statement indicating our ability to comply with set delivery and performance schedules with key milestones along with a risk mitigation strategy outlined below and in depth in *Section 2.i. Implementation Plan.*

Key Attributes & *Direct* Service Experience	States									*Additional Products* (Medicare/ Medicaid)		Key Benefits	
	AZ	KS	FL	GA	OH	SC	TX	WI	IN	ABD / LTC	Uninsured	**How Cenpatico exceeds Bid Requirement**	**Substantial Benefit to DHH-OBH**
BH Management – IP, OP, Physician Svcs, TCM, Community MH, Other	X	X	X	X	X	X	X	X	X	AZ IL	MA	• Experience with BH management across the care continuum • Development of new programs like CAT or community based step-down programs	• Ongoing quality including timeliness and access with efficiency and cost savings • High stakeholder satisfaction
Multi-Agency Coordination: (e.g., BMS, DCF, SAMH)	X	X	X	X	X		X			AZ IL	MA	• Systems and processes that support multiple funding streams and data exchange • Staff expertise	• Program integrity • Responsiveness • Improved communication
Child Welfare System laws re: Foster Care experience	X						X - all 30k					• PMUR product focused on Rx mgt • Trauma focus • Skilled staff, established processes	• Best-in-Class service delivery model • Improved outcomes and placements
Justice System & Corrections experience	X											• Reduced recidivism • Scalable program	• Care coordination and reporting • Cost savings
Education System experience	X							X	X			• School administration for children with special needs (K-12) • Integration facilitation	• Cost containment • Best-in-Class integration activities

Risk Mitigation

Cenpatico recognizes that the proposed system design introduces revolutionary change and therefore perceived risks to the current delivery system. We have numerous effective ways to minimize risk which are described throughout our response. *Our key differentiators include:*

- **Unmatched** expertise with children (CSoC and non) and with adults with SMI and addictive behaviors across state agencies
- Strong **quality** program with continual evaluations and trend reports
- History of **transition success** for complex, large implementations
- **Operational success** demonstrated by our performance metrics and outcome results
- **Fiscal responsibility and stewardship** resulting in contracts with steady improvement

	Potential Negative Impact To:				Risk Assessment Scale	
Proposal Risk	**Schedule**	**Cost**	**Contract Req's**	**End User Mission Readiness**	Likelihood / Magnitude	Cenpatico Risk Mitigation Feature
Lack of expertise to address scope of services			X	X	Very Low, Very Low	• Expert personnel including trained counselors in all programs – foster care, TANF/SSI, SOBRA, community re-entry • Trauma trainers • Community Liaison experts
Lack of credentialed providers			X	X	Low, Medium	• Adherence to NCQA credentialing standards • Baseline network meets adequacy standards – need for greater incentive strategies • Dedicated network contracting team
Lack of financial resources to perform contract			X	X	Very Low, Very Low	• Balance sheet strength • Dedicated financial management team to review cost estimates, billing, and manage budget
Lack of necessary technology or technical skills	X		X	X	Very Low, Very Low	• Maximize technology including web portals, smart phones, web-based trainings • Development of LA-specific data architecture for critical activities (e.g., enrollment)
Lack of collaboration and responsiveness to multiple govt agencies involved	X	X	X	X	Low, Very Low	• Clear reporting interfaces • Project portal for contract • Ongoing outreach to stakeholders • Proven *direct service* experience with multiple agencies • Large corporate operations support

	Potential Negative Impact To:				Risk Assessment Scale	
Proposal Risk	**Schedule**	**Cost**	**Contract Req's**	**End User Mission Readiness**	Likelihood / Magnitude	Cenpatico Risk Mitigation Feature
Lack of useful, actionable data (service delivery results)		X	X	X	Low, Very Low	• Beyond reporting requirements – dashboards with drill down options • Highly integrated financial and operational technology systems with real-time, customized reporting • Sophisticated access and edit security controls over financial and operational data to ensure accuracy and integrity

Our proposal reflects our belief that members and their families can successfully recover from mental illness and substance use disorders; and that member-driven care is necessary for long term outcome success if the right community supports exist and all areas of government, the private sector, and community resources work together to support those in need.

Summary

Cenpatico brings extensive implementation and system transformation experience that we've outlined throughout our response. We undertake each new contract with an individualized locally oriented approach and dedicate sufficient knowledgeable and well-trained resources to provide compliance with all contract deliverables and individualized service. Our implementation process accesses corporate wide resources and is supported through the utilization of standard project management principles, methodologies and techniques. Our goal is always to transition recipients with transparency and organization. For this reason, we work to get on the ground with Louisiana based staff as early as possible. We begin early with communication first to the LGEs and identified WAAs then to members, their families, providers and other stakeholders in the community. We have found that opening the lines of communication improves the transition to a new managed care company and improves ongoing involvement with Cenpatico.

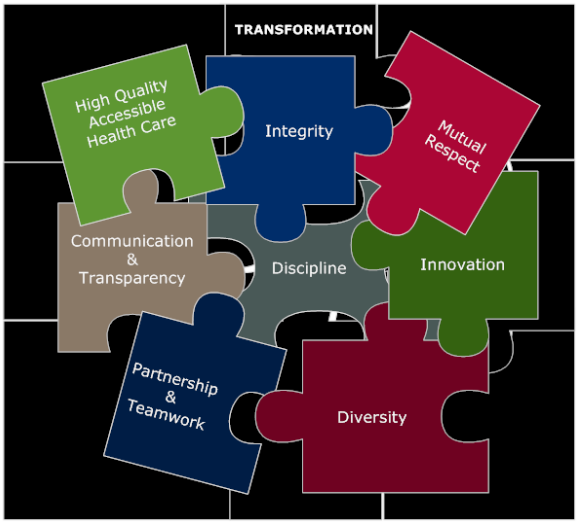
Cenpatico is excited to present our response for DHH-OBH's request for proposal for The Louisiana Behavioral Health Partnership (LBHP). Our primary goal in this proposal is to introduce our philosophy and passion for *intelligent innovation* that improves outcomes and establishes appropriate infrastructure for seamless service delivery and creates the space for our expertise with trauma-informed care and work with vulnerable children and adults can breathe and inform each decision. This combined with facilitated opportunities for members to receive care that supports their goals for recovery, empowers them to be active participants in their care which in turn enables them to live fulfilled lives in their communities is our mission.

We believe that the foundation for achieving all the outlined goals already exists in the preliminary infrastructure DHH-OBH has established and that together, we can deliver change that **improves lives**. We want to delivery that system that is responsive to the needs of Louisiana's children and adults with behavioral health challenges. Cenpatico welcomes the opportunity to demonstrate our value to you.

1.b. Introduction/Administrative Data
This introductory section should include a description of how the Proposer's organizational components communicate and work together in both an administrative and functional capacity from the top down. This section should contain a brief summary setting out the Proposer's management philosophy including, but not limited to, the role of Quality Control, Professional Practices, Supervision, Distribution of Work and Communication Systems. This section should include an organizational chart displaying the Proposer's overall structure including advisory and other related committees the Proposer will establish for this project.
Suggested number of pages: 3 exclusive of organizational chart

Cenpatico's structure and culture is one of transparency, innovation, quality, partnership, communication, diversity, integrity, respect and discipline are how we facilitate **Transformation**. These are inherent core values that inform all we do operationally, how we integrate input, and they way in which we communicate internally and externally.

Figure 1: Cenpatico Philosophy & Values



These values are what determines our approach to our staffing structures and model development for all new programs, products, or pilots. All protocols and procedures stem from this philosophy of *service first.* Weaving this with our passion for intelligent innovations is what allows us to establish fluid communication channels that allows for information to flow up, down, and out ensuring decisions are made based on data and stakeholder feedback.

Data is critically important to all we do and is the foundation for Cenpatico's Quality Control processes as well as the structure of our quality department and committees. We believe that it is important to know where you are before you can determine where you are going and then measure the effectiveness of the journey. All areas from initial network assessments to implementation and go live efforts to the design and roles of our staffing models or subcommittee choices must be based on data obtained from multiple viewpoints (voice of the customer), sources of truth (systems of record), and through external data mapping (historical trends, 1:1 or 1:many comparisons, etc). As such, the primary role for our Quality Improvement Committee (diagram presented below) and its related subcommittee infrastructure is to decide and inform change and measure success of the LBHP program. These roles are cross-referenced to our staff to ensure vertical and horizontal integration balanced by culturally and linguistically competent communication.

We believe our philosophy mirrors that of DHH-OBH in that it has **always** emphasized comprehensive community-based system of care. Our solutions include structured processes for creating collaboration among other state and local organizations, including formal agreements and informal referral support resources.

Cenpatico values and incorporates stakeholder input, business practices, and behavioral health advocacy/expertise through our management and committee structures, which have been planned to govern and inform our organization. The following chart is Cenpatico's Advisory Committee structure designed to ensure we begin and end with a disciplined, quality focus rooted in results and outcomes. The Quality Improvement Committee (QIC) co-chaired by our Chief Executive Officer and led by the Chief Medical Officer, *Dr. Cheryl Bowers-Stephens* who will be the primary decision-making body that will inform and oversee all aspects of the service delivery continuum and system transformation. This

structure is explained in detail in *Section 2.d.i.* **The QIC and its subcommittees ensure that all departments communicate and work together on all agreed upon performance improvement tasks and goals. The department heads chair committees with representation internally and externally to ensure all are working together both administratively and functionally to achieve our goals.**

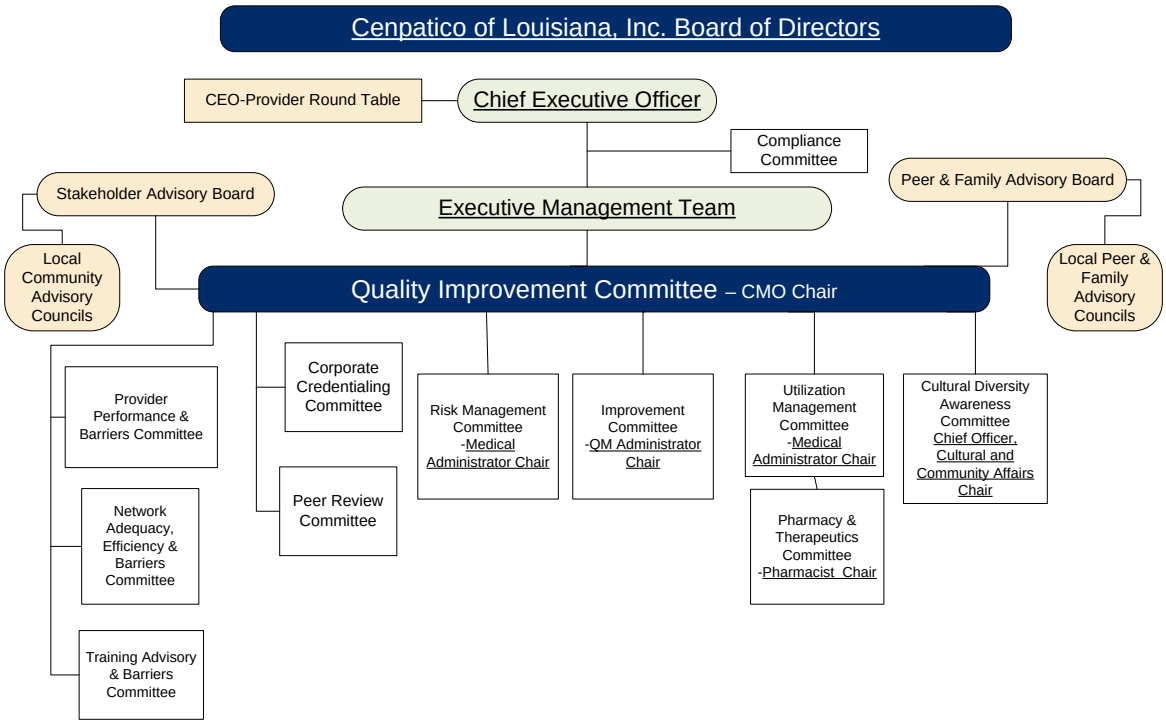
Our QIC has been designed to support our Quality Management Strategy (QMS) which meets the federal requirement for programs receiving Medicaid funds. Its purpose is to facilitate continuous improvement across the enterprise, program, and systems which means also being able to get data and measure results plus outcomes. The goals of the QMS include ensuring:

- eligible Louisiana citizens have access to Medicaid funded managed care programs
- the programs have competent staff and an adequate network to deliver services
- outcomes meet SMO, Medicaid, and State standards

The QIC and its subcommittees will work inform Executive Leadership of their performance measures and clinical outcomes on a macro level so appropriate decisions may be made regarding changes or growth, etc. On an individual level, it will define, evaluate, and review all aspects of the delivery of behavioral health services to each individual. The goal is to ensure appropriate treatment options are provided to members in a culturally and linguistically competent manner, is quality-driven within a supportive environment, and is measureable.

This infrastructure will also be the primary mechanism for immediately handling any/all critical events whether that involves a single individual or a catastrophic event. *The processes for oversight, risk mitigation, learning/improvement, and all communications will be managed here and we have found that this approach prevents organizational silos.* We believe by incorporating all stakeholders in this way, which has been successful in our other programs, Cenpatico engenders trust that results in persistent engagement.

Committee Structure



We would further note that it is Cenpatico's intention to initially staff our committees with relevant experts nationally and from within the Centene families to mentor and coach all of us. Our staffing design presented below reflects this.

Cenpatico understands that success in delivering high quality coordinated care means engaging with traditional Medicaid/CHIP providers, locating in communities where members live and work, and collaborating with community-based organizations to serve the whole individual in the context of family and informal supports via Wraparound Agencies (WAAs). As such, our hiring efforts will begin with these principles. Still yet, we are creating not only a formal network of providers and programs to support member health and wellness, but we also are actively investing in community relationships to coordinate care and well being, including for non-covered services such as help with home safety. Our sustained community involvement and investment are major factors in building member confidence and proficiency in adopting new ways to seek health care and establish healthy lifestyle behaviors.

Since 2008. Our community involvement in Louisiana began in September 2008 when Hurricane Gustav hit, and Centene helped DHH by contacting hospitals, nursing homes and other providers to determine whether and to what extent they were operational and serving low-income Louisianans. We also flew in behavioral health professionals and toiletries to help the thousands of people who were relocated to shelters. Our involvement formed the basis of continuing relationships with many entities, including the Louisiana Hospital Association and the Louisiana Rural Hospital Coalition. Today, we are actively engaging community mental health centers as well as the plethora of providers who are not currently accepting Medicaid, and the number faith and community based service providers who are the natural supports to adults, families and children. As previously described in Section 1.a., Cenpatico recognizes and has built our model to incorporate both process and expertise for trauma informed care for Louisiana's uniquely traumatic circumstances that have impacted the *whole population* year after year.

Through this approach, we believe Cenpatico will bring a fundamentally unique viewpoint to our SMO role and will rate our success also on our community engagement and persistence. This measured activity and responsive learning is also what we used to determine the structure of our committees, their roles, and our staffing model outlined above.

Management Philosophy

We have the responsibility and ability to ***improve lives*** and all of our activities are undertaken with this goal in mind.

Each of the areas in the graphic to the right represent one facet of a management organization in successfully delivering treatment services that are accessible, high quality and that deliver measurable improved outcomes. Our management philosophy involves not only our staff, but also local stakeholders, practitioners and our consumers in shaping the service delivery system as we believe in transparency, engagement and full participation by all.

Cenpatico management as well as front-line staff understand the intricacies that multiple agencies like child welfare, juvenile justice, departments of education, corrections, as well as local or county departments introduce. It is our extensive experience in developing community service supports to complement our clinical programs and provider network therapies that has facilitated the development of flexible system platforms and innovative partnerships. These systems support our staff as they work across agencies to bridge communications and link data to provide real information for the benefit of our members overall care. While others may tout the achievements of individuals who go above and beyond, Cenpatico has created a *culture of creativity* that empowers **all** our staff to do more or solve issues differently. This freedom to introduce *intelligent innovation* is what distinguishes Cenpatico from any other company or group because it is the basis for our supervisory roles and work distribution methodology.

Therefore, our approach is 3-fold: administrative, educational and supportive resulting in enhanced performance by clinicians, providers, and agencies resulting in improved outcomes for our members. We embrace the ideas that it is our job to provide an environment for providers to focus on services as opposed to administrative work.

Within the organization as well in our external management efforts, we believe in maximum efficiency and in effectively distributing resources to ensure priorities are addressed as well as that key deliverables are in focus. Our organizational structure represents this philosophy and in the community we work collaboratively with provider and community agencies to ensure appropriate resources are available in direct proportion to the work to be accomplished.

With this in mind, it's important to note that Cenpatico places a very high value on recipients' right to direct their recovery. We recognize that members must guide their relationships with our providers; therefore, we created supports across service domains and our management strategies reflect the value we place on recovery principles. We offer:

- Care Management staff to guide our recovery focused approach and engage the community in awareness of recovery issues
- Peer support services to enhance recovery options for substance abuse and mental health

Our **local** staff, with leveraged support from Cenpatico's corporate resources, will implement a recovery-oriented service delivery system that coordinates and integrates services provided by the local community mental health provider network and by working to strengthen a substance abuse treatment provider network. This matters because our staffing model has been structured from the ground up as we endeavored to understand needs across agencies, providers, members, and community groups including advocates. Again our commitment is for cultural and linguistic competencies so we may effectively coach and monitor all stakeholders.

Role of Professional Practices

Finally we would note that our long term expectation and immediate focus for these partners will be based on bringing evidence based practice patterns to the continuum, training or coaching and fidelity auditing. We also want to ensure adherence to professional codes of conduct and ethics given that it is one essential component in keeping our consumers safe and in addressing wellness. We look for professional providers who agree with our philosophy of provide service to members in need in the least restrictive settings and basing that on a Recovery model versus "maintenance."

Cenpatico staff review nearly all authorizations for appropriateness on multiple levels – not simply medical necessity criteria. We review for improvement patterns. We review for use of the latest, most effective guidelines. We review for member-specific goals not generic responses used to fill out a 'form.' Our goal is to partner with our providers to deliver unprecedented quality results. Additionally, we have created very specific population and/or provider filters designed to maximize effectiveness and reward

positive outcomes with simplified administration over time. We work to influence improvement and innovative practices.

We introduce this level of review in an effort to engage with our network provider partners. Our goal is to be informed, effective, clinically conscious resources that solve problems, bridge care gaps, and work to educate, train, and coordinate quality care service delivery.

Communications Systems

There are clear access and use patterns that must be culturally/linguistically competent, ethnical, and gender specific incorporated into all program aspects from member communications to call center responses and educational materials that supplement appropriate treatment based on member diversity. Beyond this, the systems and infrastructure is designed to support these nuances ensuring Cenpatico is doing all we can to establish trust within individuals and communities. Our goal is always bi-directional feedback so Cenpatico works to infuse our partners – providers and advocates – with information they need to be successful. We detail our communication supports in Section 2.a.x. however, we would highlight the following:

- **State Agency Portal** designed to provide access to the multiple agency partners and their designees to facilitate information sharing and communication when appropriate
- **Web-based Referral Capabilities** that will allow providers across the continuum to see if there is a "referred person" in our system (presumptive eligibility)
- **DHH-OBH Online Access to EDW** which is our data warehouse that will present dashboards, standard reports, and allow users flexibility for drill-down or creation of ad hoc reports any hour of any day
- **Member and Provider Portals** that will be a central location for information – including but not limited to member health records – statewide that is also mobile accessible. These will also present relevant functional transactions that are easy to use reducing administrative inefficiencies.

Cenpatico's goal and role as your SMO is to ensure we are communicating effectively with all stakeholders about what we are doing, what is available, why it matters, and how to access us and the system of care minimally. We are experts in this area of information management, which allows our staff (presented on the following page) to focus on their job rather than spending time fighting systems or software to get information they should readily have.

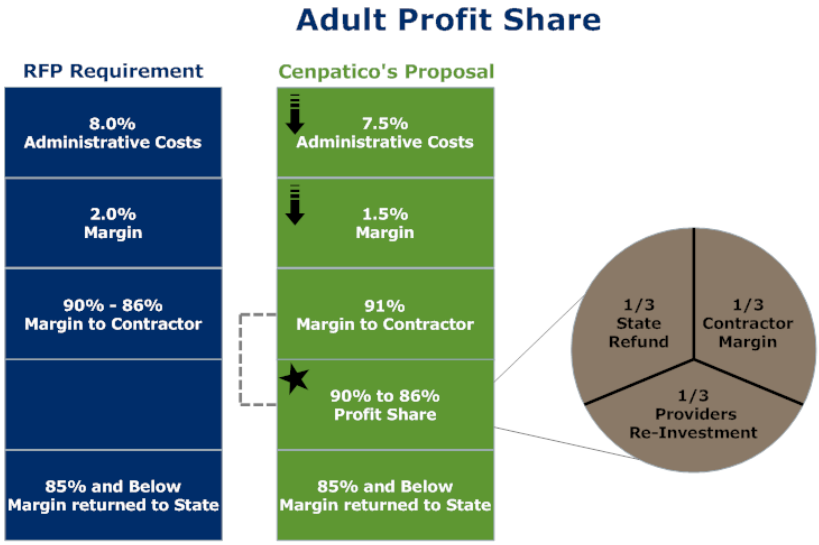
Fiscal Responsibility

As stewards of the public trust, Cenpatico diligently and thoughtfully manages to ensure long term positive outcomes for all we serve: members, states, government officials, and our providers.

Cenpatico recognizes DHH-OBH's initiatives to bring additional services to Louisiana members while also realizing financial savings. Cenpatico is committed to partnering with DHH-OBH in these initiatives and sharing the risk for adults. We understand the contract is for administrative services only for the children's populations. We are confident that our proposed management structure will provide cost savings and thus our proposal includes a risk-sharing arrangement, by which Cenpatico would reimburse DHH-OBH if we are unable to provide a financial savings for the children's populations as calculated below.

Prior to contract go-live, Cenpatico will collaborate with DHH-OBH to determine the baseline claims expense per member per month (PMPM) for the children's populations as of the contract start date. This PMPM would be adjusted for any program changes, utilization trend, state fee schedule changes, and health status/risk adjustment factors. Cenpatico and DHH-OBH will evaluate the year-end actual claims expense after the first contract year to determine if savings was achieved. If the actual year-end PMPM is greater than the baseline PMPM, Cenpatico will reimburse DHH-OBH up to the amounts paid in profit margin for the respective children's ASO populations, estimated at 2% of claims costs.

Further our at-risk Proposal for Adults assumes approximately a ***17% savings over the current utilization*** trends for these populations with an administrative plus margin component of 9.0%. This includes ***administrative costs of 7.5% and margin of 1.5%***. By helping providers build needed supportive services, we can decrease institutional levels of care to improve members' community tenure and realize significant savings. Through our regional care management teams, network training and technological innovation we believe we can significantly improve the system of care.



As a value add, Cenpatico will also ***share in profits*** realized above and beyond our cost model savings assumptions. We understand the RFP requirement that any savings below a medical loss ratio of 85% requires rebates according to the Affordable Care Act and Cenpatico will comply with this requirement. However, we understand Louisiana's need for additional services, so we are proposing that any savings below 90% medical loss ratio and above 85% be shared equally with DHH-OBH, the provider community and Cenpatico.

1.c. Introduction/Administrative Data
This section should also include the following information:
i. Location of Active Office with Full-Time Personnel, include all office locations (address) with full time personnel;
ii. Name and address of principal officer;
iii. Name and address for purpose of issuing checks and/or drafts;
iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation;
v. If out-of-state Proposer, give name and address of local representative; if none, so state;
vi. If any of the Proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number;
vii. If the Proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not, so state;
viii. Proposed location and functions of the required Louisiana-based operations in the Baton Rouge area; and
ix. Proposer's state and federal tax identification numbers.

i. Cenpatico of Louisiana, Inc.'s principal office will be located at:

543 Spanish Town Road

Baton Rouge, Louisiana 70802

Cenpatico of Louisiana, Inc. will serve as the Statewide Management Organization for the Department of Health and Hospitals and have approximately 200 full time personnel in our Baton Rouge, Louisiana office, in addition to over 70 staff located across the state serving on regional teams and performing community liaison activities.

Cenpatico of Louisiana, Inc. is a wholly-owned subsidiary of Cenpatico Behavioral Health, LLC. Cenpatico Behavioral Health, LLC is headquartered in Austin, Texas with over 475 full time personnel. In addition, Cenpatico Behavioral Health, LLC has staff located in satellite offices in 11 states across the United States.

ii. Cenpatico of Louisiana's principal officer is Sam Donaldson, Ph.D. Dr. Donaldson will be located in Cenpatico Louisiana's main offices at:

543 Spanish Town Road

Baton Rouge, Louisiana 70802

iii. Checks and/or drafts should be issued to:

Cenpatico of Louisiana

543 Spanish Town Road

Baton Rouge, Louisiana 70802

iv. Cenpatico of Louisiana is a wholly-owned subsidiary of Cenpatico Behavioral Health, LLC. Cenpatico Behavioral Health, LLC is a wholly-owned subsidiary of CenCorp Health Solutions, Inc. (CenCorp). CenCorp is a wholly-owned subsidiary of Centene Corporation (Centene), a publicly-traded, Fortune 500 Company.

v. Cenpatico of Louisiana, Inc. is incorporated in Louisiana.

vi. Personnel previously employed by DHH. ***Please see Section 5. Additional Information, for our signed attestation outlining Cenpatico of Louisiana, Inc.'s compliance with DHH-OBH Addendum #4 regarding personnel previously engaged in a financial, contractual or employment relationship with DHH.***

Dr. Cheryl Bowers-Stephens has been working with Cenpatico of Louisiana, Inc. in a consulting capacity during our response development process. We are currently in discussions with Dr. Bowers-Stephens to

assume the role of Chief Medical Officer for Cenpatico of Louisiana, Inc. upon award. Dr. Cheryl Bowers-Stephens was employed by the Department of Health and Hospitals - Office of Mental Health from 7/1/2000 through 4/3/2009 as a Physician IV serving as Medical Director; Deputy Director – Area A; Medical Director Infant, Child and Adolescent Services; and Assistant Secretary. Dr. Cheryl Bowers-Stephens is currently on the Board of Directors for the Metropolitan Human Service District, an unpaid position, which she agrees to resign from if hired.]

Redacted

vii. Cenpatico of Louisiana, Inc. does not currently, and has not previously held contracts with the Department of Health and Hospitals.

viii. Cenpatico of Louisiana, Inc.'s principal office will be at:

543 Spanish Town Road
Baton Rouge, Louisiana 70802

The following functions will be performed from this office:

Function	Description
Administration	CEO, COO and support positions
Compliance Administration	Grievance and appeals, auditing, compliance analysis
Network Management and Development	Contract negotiations, provider relations, supportive housing, community reentry, provider coaching
Adult and Child Program Administration	Community liaisons, peer support, family support, school liaisons, regional teams, training
Care/Utilization Management	Clinical management, care coordination, transition and discharge planning, utilization management/review
Medical Administration	CMO and other medical specialists, quality management
Financial Services	Information systems administration, claims/encounter administration, data analytics, finance management, office management
Cultural and Community Services	Diversity and communication specialists
Member and Provider Services	Data services administration, referral services, customer, workforce development and provider services

ix. Cenpatico of. Cenpatico Louisiana's state and federal tax identification numbers are:

State Charter: 40565333
Federal EIN: 45-2303998

1.d. Introduction/Administrative Data
The following information must be included in the proposal:
i. Certification Statement: The Proposer must sign and submit the attached Certification Statement (See Attachment I).

Please see the signed Certification Statement, Attachment I, on the following page.

CERTIFICATION STATEMENT ATTACHMENT I

The undersigned hereby acknowledges she/he has read and understands all requirements and specifications of the Request for Proposals (RFP), including attachments.

OFFICIAL CONTACT. The State requests that the Proposer designate one person to receive all documents and the method in which the documents are best delivered. Identify the Contact name and fill in the information below: (Print Clearly)

Date	**August 9, 2011**
Official Contact Name	**Sam Donaldson**
Email Address	**sdonaldson@cenpatico.com**
Fax Number with Area Code	**512-480-0574**
Telephone Number	**512-406-7200 or Toll Free at 877-264-6550**
Street Address	**504 Lavaca Street, Suite 850**
City, State, and Zip	**Austin, TX 78701**

Proposer certifies that the above information is true and grants permission to DHH-OBH to contact the above named person or otherwise verify the information I have provided.

By its submission of this proposal and authorized signature below, proposer certifies that:

1. The information contained in its response to this RFP is accurate;
2. Proposer accepts the procedures, evaluation criteria, contract terms and conditions, and all other administrative requirements set forth in this RFP.
3. Proposer accepts the procedures, evaluation criteria, mandatory contract terms and conditions, and all other administrative requirements set forth in this RFP.
4. Proposer's technical proposal and cost proposal are valid for at least 120 days from the date of proposer's signature below;
5. Proposer understands that if selected as the successful Proposer, he/she will have business days from the date of delivery of final contract in which to complete contract negotiations, if any, and execute the final contract document
6. Proposer certifies, by signing and submitting a proposal for $25,000 or more, that their company, any subcontractors, or principals are not suspended or debarred by the General Services Administration (GSA) in accordance with the requirements in OMB Circular A-133. (A list of parties who have been suspended or debarred can be viewed via the Internet at www.epls.gov).

Authorized Signature: _____

(Must be an original signature signed in ink)

Typed or Printed Name: **Sam Donaldson**

Title: **Chief Executive Officer**

Company Name: **Cenpatico Of Louisiana, Inc.**

2.a. Member Services
i. Describe how member services will be organized. Provide an organizational chart that includes position titles, numbers of positions, and reporting relationships. Describe the qualifications of member services staff and supervisors. Suggested number of pages: 2 exclusive of organizational chart.

Overview

Cenpatico brings over 17 years implementing and operating Member Services programs that deliver superior customer service, with a specific focus on behavioral health services for Medicaid and vulnerable populations, to our members and the providers that serve them.

Our implementation of the Member Services team for the Statewide Management Organization (SMO) will be lead by Agnes Ponce, our experienced Director of Service Operations. Ms. Ponce brings ten years of experience leading Member Services, and five years with implementations similar to this project. Cenpatico's approach to implementing a dedicated Member Services program for Louisiana is informed by extensive on the ground discussions with providers, agencies and stakeholders and includes well-trained, specialized staff.

Our Louisiana Member and Provider Services team will have the support of Cenpatico and Centene's corporate structure and leadership, but will be focused and specialized to meet the needs of our Louisiana membership.

We understand implementing a managed care program in a previously unmanaged delivery system, and one that has experienced multiple traumatic events, poses significant challenges that are outside the standard implementation process and ongoing procedures of managed care companies. Our call center, located in our Baton Rouge office and operating 24/7/365 will be dedicated to meeting the needs of the Louisiana Behavioral Health Partnership, with specialized staff and focused training to ensure service excellence to all Louisiana communities.

Organization

From listening to the needs of Louisiana communities, we understand that key to our ability to deliver high quality Member Services will be well-trained staff. We will achieve this through specialized staff for Member Services, Provider Services, Referrals and Data Services (Eligibility, Claims and Web technicians). By offering specialization within Member Services, we will deliver better service to Louisiana through optimal call resolution and faster response times, in addition to opportunities for staff career development.

Ms. Ponce will hire and train our Louisiana Member and Provider Services team, which will be led by our Member Services Administrator (MSA). The MSA will report to our Chief Officer of Cultural and Community Affairs. ***We bring Member Services under an Executive level staff person that is committed to representing communities and the cultural and linguistic needs of members as we have found this leads to an increased level of support for all aspects of communication with members.***

Our MSA leads a team of Member and Provider Services Supervisors to ensure we meet all required benchmarks for customer service standards. The MSA provides leadership and responsibility over the Member and Provider Services Supervisors and Member and Provider Services call center, ensuring timely response and adherence to performance standards. (Please see the Organizational Chart on the next page.)

Education and Qualifications of Staff

The Cenpatico call center staff is often the first contact members and providers have with our organization, and for this reason, we strive for high quality customer service at each point of contact. The following grid itemizes the experience and qualifications we require for Member and Provider Service Representatives (MSR and PSR respectively) and Supervisors.

Qualifications/Skill Set	MSR	PSR	Supervisors
Education	High school or equivalent	High school or equivalent	Bachelor's Degree
Clinical experience	No	No	No, but a plus
Prior call center experience	One year	One year	Three years
Health care industry experience	Preferred	Preferred	Yes
Crossed Trained to handle MSR and PSR calls	Yes	Yes	Yes
Bi-lingual*	Plus	Plus	Plus
Good verbal and written communication skills	Yes	Yes	Yes
Critical thinking	Yes	Yes	Yes
Quality oriented	Yes	Yes	Yes
Ability to build customer loyalty	Yes	Yes	Yes
Ability to build strategic working relationships	Yes	Yes	Yes
Leadership Skills	No	No	Yes
Ability to resolve complex issues	No	No	Yes
Technical and Professional Knowledge	No	No	Yes
Hire, motivate, coach, supervisor others	No	No	Yes
Ability to collaborate with other departments	Yes	Yes	Yes

While it is not required that all staff be bilingual, preference will be given to those who also speak Spanish or Vietnamese, and we will hire sufficient numbers of staff with bilingual expertise to ensure we meet the requirements of this procurement.

2.a. Member Services
ii. Describe how the required toll-free twenty-four (24) hour, seven (7) days a week call line will be staffed. Distinguish between Baton Rouge area staff and those located outside of Louisiana within the continental United States. Also describe the system back-up plan to cover calls to the toll-free line.

We will provide Member Services 24/7/365 from our Cenpatico of Louisiana, Inc. Baton Rouge Louisiana office location. Our member services team approach promotes the values of recovery and resiliency with dedicated and responsive staff and support technology. Our toll-free line dedicated to serving Louisiana is the primary access point for members and providers to behavioral health (BH) services, including CSoC eligibility screenings and emergency services, all of which is available 24/7/365. We offer on-demand, single point of entry to BH and CSoC service information. While our Louisiana based service center will provide all Member Services support for this contract, we believe we bring added strength and assurance to DHH-OBH and the people of Louisiana through our ability to leverage call routing to our National Service Center located in Austin, TX during any emergency that results in loss of power to our Louisiana service center, offering uninterrupted service and information to Louisiana members.

Staffing for Baton Rouge Service Center

Cenpatico's toll-free line allows callers to speak directly with Member Services Representatives or Licensed Clinicians for one-call resolution for crisis and non-emergent care needs.

We will maintain a robust staff of Member Service Representatives (MSRs) and Member Services Center Supervisors (Supervisors), available live within the Baton Rouge call center 24/7/365. Service center staff have all-hours access to Utilization Managers and all required physician support to meet members' needs. MSRs handle the bulk of the calls, are highly trained and knowledgeable regarding call handling for behavioral health services and all required elements of this contract, including but not limited to Medicaid, waiver and CSoC eligibility, local providers for each community and support services available. Utilization Managers are licensed clinicians located in our Baton Rouge service center and receive all emergency calls or calls that require a specialized clinical skill set. Our toll-free line offers members 24/7 access to live clinical assistance and crisis intervention.

The call center will have access to board certified physicians 24/7 to provide clinical consultation, including a psychiatrist, a child psychiatrist, and an Addictionologist. Utilization Managers will be able to assess when these clinical resources need to be accessed and consulted. We will determine staffing numbers based upon expected call volume and our extensive expertise utilizing our technological suite detailed further in subsections 2.a.iii and 2.a.ix to ensure that we will have the proper number of staff available to meet member's needs at any given time.

From our extensive experience implementing and operating call centers, we know that the more difficult a caller find the process to access services; the more likely that members and providers will abandon their calls. For this reason there are only four initial options for the caller to choose from, and upon selection, callers are routed directly to a MSR or a Utilization Manager, whichever best fits their needs.

Emergency calls

These calls are identified as such when the caller chooses the emergency prompt and they route to a MSR, who implements a protocol that includes *immediate answer for emergency calls*. Our MSR's average answer speed for non-emergency calls is less than 30 seconds. Emergency calls can also be identified while in call, should an MSR encounter a member who is showing signs of crisis. Please see subsection 2.a.vi for a detailed description of how crisis calls are handled.

Culturally Competent Service Center

We will make all efforts to hire MSRs and Utilization Managers fluent in English, Spanish and Vietnamese, with on-demand availability to translation services to handle any other languages as needed to provide member services in the member's spoken language. As demographics shift within Louisiana, we will focus to hire call center staff who are fluent speakers of any language spoken by at least 5% of the eligible population. We will also guarantee immediate access to TDD and relay systems.

"My team is the first point of contact for over 1.7 million members. We receive calls from members in crisis, whether it's themselves or a loved one. Our team is expertly trained to identify crisis calls, and triaging to a clinician who is able to assist them immediately. I'm also a working mom. I know what it's like to have a schedule and to struggle scheduling appointments for your child who is ill and needs immediate attention. It's crucial to have someone on the other end that also cares for your child." - ***Agnes Ponce, Service Operations Director***

Supportive Technology

Cenpatico uses the Avaya Call Management System which delivers call routing, advanced vectoring, messaging and information tracking to allow for seamless and efficient call answer/service capabilities and reporting. CMS' automated phone system answers all calls by the first ring. Callers to Cenpatico never receive a busy signal. There is no maximum call duration limit so callers are free to get complete answers to their concerns. The CMS system places the call in queue upon receipt, therefore minimizing hold time, unless the caller chooses the emergency call prompt.

Back-up Service Operations

We recognize the many challenges that being located in a Gulf Region in the path of hurricanes and tropical storms can present. Cenpatico operates in Texas and Florida, both on the gulf coast and subject to similar challenges, as well as plains states which experience tornadoes and other natural disasters that require advance planning to ensure coverage and support to members and communities. In the event of a power-outage, a natural disaster, or any other event that causes the Baton Rouge Member Services call center to become inoperable, services will automatically and seamlessly shift to our Austin National Services Center. The notification can be made by any Louisiana-based Supervisor, to our Austin location. Upon notification of a system outage and/or an emergency evacuation, the Austin National Service Center immediately serves as back-up and calls are routed systematically via the Avaya system to prevent a gap in service. As a result of our shared platform for operations, we have the capacity for a simple, uninterrupted shift of service that takes less than 60 seconds.

Louisiana Business Continuity and Work Area Recovery. If a disaster is limited to a local office (such as our Baton Rouge office), our local Emergency Response Team would work with Centene's Corporate Crisis Management Team to execute the business continuity plan. Should the local office be inaccessible or destroyed, work area recovery services will be initiated at a SunGard Recovery facility, which provides computers, telephones and connectivity to our systems at Centene's data center so staff can resume activities quickly. Per the BCP, within minutes, member and provider calls will be re-routed to pre-designated Centene operations in other areas, and systems and servers will be gracefully shut down through remote controls except for environmental monitoring systems. A Crisis Command Center would be established and displaced employees would be reassigned to designated areas and able to log on to our systems and continue to support the needs of our members and providers remotely. *(Please see section 2.g.xiv for more detailed information on our Business Continuity Plan).*

Additionally, because of our Regional Care Teams and local community outreach staff, Cenpatico will always have staff based in Louisiana that are able to respond to members, even in the event that some areas are evacuated or without power. Our Austin National Service Center is able to transfer member or

provider calls to Care Managers, Care Coordinators or other staff based in Louisiana located in areas not impacted by service outage to maintain continuity of service. Our Regional Care Teams each maintain a designated Emergency Response Team Lead, who provides guidance and direction when our Emergency and Disaster Response Plan is activated by our Louisiana-based Emergency Response Administrator. In this way Cenpatico provides superior customer service to DHH-OBH during any circumstance.

2.a. Member Services
iii. Describe the capabilities of the telephone system with respect to warm line transfer, live call monitoring and other relevant features. Suggested number of pages: 2

Cenpatico uses and will implement in our Baton Rouge Service Center, the proven technology of Avaya's integrated and modular high capacity telephone system, including Avaya Call Management (Avaya) System, to provide seamless and efficient call answering capabilities, warm call transfer and live call monitoring. Through Witness Quality Monitoring (Witness QM) synchronized on Avaya, we are able to offer enhanced monitoring of staff and service levels for the highest caliber of customer service for the state of Louisiana. Better monitoring helps us to provide targeted training to all Member Services and Provider Services Representatives (MSR and PSR respectively).

Routing Inbound Calls

When members call the toll-free number, our MSR will answer the call, determine the nature of the call and route appropriately for assistance. For members with linguistic, physical, cognitive or communication impairment, Cenpatico MSRs immediately route the call to a bilingual representative, translation or appropriate Relay service. All calls are answered promptly, in the order received, and by the first available MSR. Upon approval from DHH-OBH, we will implement our integrated Avaya Voice Portal Interactive Voice Response system (IVR) with voice recognition capabilities (allowing the caller to speak commands as an alternative to touchtone command entry on their phone). This technology has been deployed to four affiliate Centene plans where they have experienced to date IVR usage approximately six times higher than in plans that do not have a voice recognition option. This shift to self-service of routine calls allows our MSRs to focus on more complex issues.

Routing Calls Among Hotline Staff/Transferring Calls

MSRs provide the single point of entry for all individuals seeking information about services. MSRs obtain demographic information and emergency contact information from members; gather demographic information, including verification of Medicaid eligibility and render assistance with authorizations and benefits. The MSR determines the reason for the call and provides assistance or determines the appropriate party to which the call should be “warm” transferred. Due to the shared platform within the Call Center, callers will be easily transferred between applicable staff to ensure that callers are not lost or required to call a separate telephone number. All call transfers are “warm” or three-way transfers, during which the MSR stays on the line and verbally introduces the member to the appropriate staff person to ensure continuity, and to remain in touch with the caller. Members need to use only one phone number and place only one call. MSRs have immediate access for urgent and non-urgent matters to Care Managers, who are licensed clinicians who handle emergency calls or calls that require a specialized clinical skill set. Care Managers can access the physician resources available at all times to the Cenpatico SMO Call Center, which is detailed in subsection 2.d.iii. Members calling about grievance or appeals are warm transferred to a Grievance and Appeals Coordinator for assistance navigating the grievance and appeal process. Calls are *not* normally routed *among* Call Center staff, because all MSRs have similar comprehensive training, plus information online or at their workstations, to minimize the need for routing. To ensure our MSRs always have immediate access to a Supervisor to address an urgent question, our Supervisors are equipped with wireless headsets that are part of our virtual telephonic platform. The headsets provide an immediate connection to a Supervisor minimizing the time needed to obtain an answer to a question. Additionally, if a member requests to speak to a Supervisor, the headset provides a seamless transfer which eliminates the need for call back or message and provides immediate call resolution.

Live Call Monitoring

The quality of call interaction by an MSR is monitored utilizing the Witness Quality Monitoring

(Witness QM) system. Witness QM provides synchronized voice and data recording that captures conversations between the MSR and caller, as well as the corresponding activities taking place at agents' desktops, such as keystrokes, data entry, screen navigation, and after-call wrap-up. Witness QM serves as a tool that enables Supervisors to monitor, record, and evaluate the quality of member interactions in the call center. Call recordings enable us to better manage processes and customer satisfaction. Supervisors have the ability to monitor a MSR in real-time or can select calls for evaluation at random. Recorded interactions are reviewed and evaluated by the Supervisor and can be tagged and stored automatically for easy search and replay when the call is being used as a coaching or training opportunity. 100% of calls are recorded and accessible for quality monitoring to a Supervisor.

Redundant Systems and Networking to Assure Availability

As with all our local health plan offices, our Baton Rouge Service Center will be networked securely to Centene's nationwide wide area network (WAN) for ***both*** voice and data communications. We engineer both voice and data connections to our WAN with ***full redundancy***: meaning there are at least two redundant network connections, from *different* telecommunications carriers, from each local office to our WAN. In addition, should any local office experience a local site outage (e.g. hurricane) leading to an interruption of phone service for that office, inbound calls are immediately re-routed to a pre-defined alternative Cenpatico office, fully equipped with knowledgeable staff to handle those calls. Please see Section 2.g.xxxvi for more information on our data and voice networking assets.

Documenting Calls

MSRs currently document inquiries in MACESS, a flexible call tracking system that supports online communications between departments, and prompts event triggered follow up to ensure proper and timely resolution. In Q1 2012, Cenpatico will replace MACESS with our proprietary Member Relationship Management (MRM) System. The MRM system is our new member services inquiry and member data management application specifically designed for member related data and workflow processing in Medicaid program administration, while supporting customization needed or appropriate for any other Department of Health and Hospitals-Office of Behavioral Health (DHH-OBH) program covered by the Statewide Management Organization (SMO) in Louisiana. MemberConnect (the integrated contact relationship management component of MRM) will allow Cenpatico MSRs and clinical staff to view and interact with our members, family members/caregivers, providers, stakeholders or any other caller seeking information or support in a holistic and coordinated fashion, across the breadth of the caller's behavioral health, wellness, clinical care, and administrative and financial matters. In addition, MRM combines, integrates and deploys data from multiple internal systems, such as AMISYS Advance, our claims and eligibility transaction processing system, our Member Portal, and TruCare, our integrated, Member-centric health services management platform, presenting a single view patterned by user type and user need. MRM presents staff with all relevant information right at their fingertips so they may quickly and accurately address inquiries without having to access multiple systems independently (such as through separate logons). This application provides our MSRs with information and functionality such as:

- ***Member Information***. Includes contact and eligibility information, including preferred mailing address and phone number, other insurance coverage, and current provider assignment, languages spoken, any special needs or additional assistance required, and authorized callers who may act on the member's behalf.
- ***Program Information***. Detailed program information or "benefit summaries" specific to the member enable MSRs to quickly research inquiries and ensure the member is accessing the maximum benefits depending upon their program eligibility
- ***Provider Demographic Information***. Information such as specialty, practice restrictions, languages spoken, demographic information, and appointment availability.

- ***Authorizations.*** The MSR can view all authorizations and their status.
- ***Care Gaps/Wellness Alerts.*** Upon receipt of an inbound call, MRM will prompt the MSR that a care gap or wellness alert exists for the member so they can transfer the call to the appropriate department for handling once the MSR has addressed the originating issue. This functionality will be particularly valuable when a Care Manager identifies and documents a member's care gap in TruCare
- ***Member Location Relative to Provider Location.*** This feature allows the MSR to display a map highlighting the member's location in comparison to a provider's location. The MSR is able to advise the member exactly where the provider is located, directions to the provider's office, including available public transportation options and routes.
- ***Member Inquiry History.*** The system displays a real time summary of historical inquiries received from members by Cenpatico of Louisiana, Inc. SMO staff. All inquiries are assigned a "call type and sub type" category for inquiry tracking and monitoring purposes. Should a MSR detect that a member has inquired several times regarding the same or similar issue, they can attempt to determine the underlying reason for these repeat inquiries. For example, if a member's MRM inquiry history notes that the member has had several inquiries categorized as *Provider Change*, they would attempt to problem solve with the member to identify a compatible provider to meet their needs on an ongoing basis.
- ***Manage Calls from Non Members.*** MRM allows MSRs to document inquiries from non members such as callers seeking information eligibility, or callers who are seeking information regarding services on behalf of someone else.

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

2.a. Member Services
iv. Describe the Proposers plan to train member services staff. Suggested number of pages: 2

Cenpatico's plan for training Member Services Representatives and all other positions on the Member Services Team includes a robust initial training curriculum, and provides ongoing monitoring for additional training opportunities. During implementation we will recruit and hire talented individuals from the local area to staff our call center. We recognize that Cenpatico will be a premier employer in both the Baton Rouge area and around Louisiana and we will look for individuals that are ready to work, willing to be trained and developed. ***We recognize the importance of providing on-the-job, real-time support and tools that allows service representatives to provide timely, accurate responses to inquiries from a culturally competent, member-focused perspective.*** Upon joining the Member Services team, staff will undergo two weeks of extensive training that will be delivered in a class-room setting. This focused training will provide in depth orientation regarding our philosophy on providing care, benefits and services offered to members, technological systems and policies and procedures. This approach provides the foundation for our hands-on skill building sessions. During the initial training period, staff will receive program specific curriculum in addition to special sessions dedicated to amplified learning of the technology and eligibility processes. At the conclusion of the second week, staff will transition to a hands-on training approach. During this phase, staff will participate in role-playing activities that will mimic live scenarios expected in the call center. Staff will utilize the resources and tools given to them to resolve each scenario encountered. Additionally, during these supplementary two weeks, staff will be exposed to appropriate telephone usage, telephone etiquette, call center performance expectations, reporting and monitoring, and call recording and audits. At the conclusion of the fourth week of training, staff will be tested to evaluate their readiness to proceed into the call center production environment. Those that meet the requirements will transition to the call center environment and will be paired with an experienced agent, using a mentor approach, to offer support for questions. Staff who transition to the call center environment will always have a Trainer and/or Supervisor available for questions. To this end, we will have ready for implementation a centralized, intranet based Knowledge Center that will contain support information on all topics relevant to Member Services staff. The following table outlines sample training topics and timeframes in which they will occur.

Service Operations Training Call Center			
Training	30-Day Readiness	60-Day Readiness	90-Day Readiness
Coordinated System of Care (CSoC)	Phase 1 Hires: • Management of services for children eligible for the CSoC • CSoC Goal • Eligibility criteria & enrollment in the CSoC • Wraparound Agencies (WAAs)	Phase 2 Hires: • Management of services for children eligible for the CSoC • CSoC Goal • Eligibility criteria & enrollment in t he CSoC • Wraparound Agencies (WAAs)	Refresher Training: • Management of services for children eligible for the CSoC • CSoC Goal • Eligibility criteria & enrollment in the CSoC • Wraparound Agencies (WAAs)
Member and Provider Portals	Phase 1 Hires: • Functionality • Set-up and Access • Navigation • Content • Technical support	Phase 2 Hires: • Functionality • Set-up and Access • Navigation • Content • Technical support	Refresher Training: • Functionality • Set-up and Access • Navigation • Content • Technical support
Systems	Phase 1 Hires: • Navigation • Member look-up	Phase 1 Hires: • Navigation • Member look-up	Refresher Training: • Navigation • Member look-up

Service Operations Training Call Center			
Training	30-Day Readiness	60-Day Readiness	90-Day Readiness
	• Provider look-up • Eligibility Verification • Creating/verifying authorizations • Admission/Referral Events • Documentation	• Provider look-up • Eligibility Verification • Creating/verifying authorizations • Admission/Referral Events • Documentation	• Provider look-up • Eligibility Verification • Creating/verifying authorizations • Admission/Referral Events • Documentation
Covered Benefits	Phase 1 Hires: • Benefit Overview • Authorization requirements • Covered Services • Provider Referrals • Transportation Services	Phase 2 Hires: • Benefit Overview • Authorization requirements • Covered Services • Provider Referrals • Transportation Services	Refresher Training: • Benefit Overview • Authorization requirements • Covered Services • Provider Referrals • Transportation Services
Crisis Call Management	Phase 1 Hires: • Identifying a Crisis Call • Triaging a Crisis Call • Documentation	Phase 2 Hires: • Identifying a Crisis Call • Triaging a Crisis Call • Documentation	Refresher Training: • Identifying a Crisis Call • Triaging a Crisis Call • Documentation
Cultural and Linguistic Competency	Phase 1 Hires: • Interacting effectively with people of different cultures • BH and medical communication and translation • Awareness of one's own cultural worldview • Attitude towards cultural differences • Knowledge of different cultural practices and worldviews • Cross-cultural skills • Developing cultural competence results	Phase 2 Hires: • Interacting effectively with people of different cultures • BH and medical communication and translation • Awareness of one's own cultural worldview • Attitude towards cultural differences • Knowledge of different cultural practices and worldviews • Cross-cultural skills • Developing cultural competence results	Refresher Training: • Interacting effectively with people of different cultures • BH and medical communication and translation • Awareness of one's own cultural worldview • Attitude towards cultural differences • Knowledge of different cultural practices and worldviews • Cross-cultural skills • Developing cultural competence results
Disability Sensitivity	Phase 1 Hires: • Developing awareness for the abilities of persons with disabilities • Creating a general awareness about persons with physical and mental disabilities, highlighting similarities as well as differences • Techniques and strategies to use when interacting with persons with	Phase 2 Hires: • Developing awareness for the abilities of persons with disabilities • Creating a general awareness about persons with physical and mental disabilities, highlighting similarities as well as differences • Techniques and strategies to use when interacting with persons with	Refresher Training: • Developing awareness for the abilities of persons with disabilities • Creating a general awareness about persons with physical and mental disabilities, highlighting similarities as well as differences • Techniques and strategies to use when interacting with persons with

Service Operations Training Call Center			
Training	30-Day Readiness	60-Day Readiness	90-Day Readiness
	disabilities • Keys to effective communication with a person with a disability • Key elements of the Americans with Disabilities Act (ADA) • Increase awareness of accessibility issues with practical application	disabilities • Keys to effective communication with a person with a disability • Key elements of the Americans with Disabilities Act (ADA) • Increase awareness of accessibility issues with practical application	disabilities • Keys to effective communication with a person with a disability • Key elements of the Americans with Disabilities Act (ADA) • Increase awareness of accessibility issues with practical application
Persons of Limited English Proficiency	Phase 1 Hires: • Language and cultural barriers • Language Service Associates • Over-the-phone • Face-to-face	Phase 2 Hires: • Language and cultural barriers • Language Service Associates • Over-the-phone • Face-to-face	Refresher Training: • Language and cultural barriers • Language Service Associates • Over-the-phone • Face-to-face
Member Handbook	Phase 1 Hires: • Member rights, responsibilities and protections • Language and cultural barriers • Language Service Associates • Over-the-phone • Face-to-Face • American Sign Language	Phase 2 Hires: • Member rights, responsibilities and protections • Language and cultural barriers • Language Service Associates • Over-the-phone • Face-to-Face • American Sign Language	Refresher Training: • Member rights, responsibilities and protections • Language and cultural barriers • Language Service Associates • Over-the-phone • Face-to-Face • American Sign Language
DHH Marketing Guidelines and Member Materials	Phase 1 Hires: • Member education materials • Member handbook • Member outreach • Welcome packets • Prohibited marketing methods	Phase 2 Hires: • Member education materials • Member handbook • Member outreach • Welcome packets • Prohibited marketing methods	Refresher Training: • Member education materials • Member handbook • Member outreach • Welcome packets • Prohibited marketing methods

Service Operations Training Call Center			
Training	30-Day Readiness	60-Day Readiness	90-Day Readiness
HIPAA privacy	Phase 1 Hires: Privacy Rule • Statutory and Regulatory Background • Who is covered by the Privacy Rule • Business Associated • What information is protected • Permitted uses and disclosures • Authorized uses and disclosures • Limiting uses and disclosures • Enforcement and penalties for noncompliance • State Law	Phase 1 Hires: Privacy Rule • Statutory and Regulatory Background • Who is covered by the Privacy Rule • Business Associated • What information is protected • Permitted uses and disclosures • Authorized uses and disclosures • Limiting uses and disclosures • Enforcement and penalties for noncompliance • State Law	Refresher Training: Privacy Rule • Statutory and Regulatory Background • Who is covered by the Privacy Rule • Business Associated • What information is protected • Permitted uses and disclosures • Authorized uses and disclosures • Limiting uses and disclosures • Enforcement and penalties for noncompliance • State Law
Security Requirements	Security Rule • Statutory and Regulatory Background • Who is covered by the Security Rule • Business Associates • What information is protected • General Rules • Risk analysis and management • Administrative safeguards • Physical safeguards • Organizational requirements • State Law	Security Rule • Statutory and Regulatory Background • Who is covered by the Security Rule • Business Associates • What information is protected • General Rules • Risk analysis and management • Administrative safeguards • Physical safeguards • Organizational requirements • State Law	Security Rule • Statutory and Regulatory Background • Who is covered by the Security Rule • Business Associates • What information is protected • General Rules • Risk analysis and management • Administrative safeguards • Physical safeguards • Organizational requirements • State Law
Other	Phase 1 Hires: • Special needs members • Referring members to clinical team • Grievance and Appeals process • Community Resources	Phase 2 Hires: • Special needs members • Referring members to clinical team • Grievance and Appeals process • Community Resources	Refresher Training: • Special needs members • Referring members to clinical team • Grievance and Appeals process • Community Resources

Ongoing Training. At least annually, our staff completes refresher training on the following topics: Confidentiality and HIPAA Training, Nondiscrimination and Cultural Competence Training, Ethics and Clinical Updates. These ongoing training activities are conducted as part of a comprehensive effort to improve the quality of our Member Service team. As applicable, staff participates in courses regarding changes in programs' purposes, objectives, and/or desired goals and outcomes, as specified by the DHH-OBH. Training also serves as an opportunity to highlight our corporate mission to provide better overall

health outcomes. Training evaluation forms are collected at the completion of all trainings and reviewed to ensure quality training and delivery.

Cultural and Linguistic Competency. Cenpatico believes that every member deserves to be treated with respect and dignity; therefore, all employees will receive Cultural Competency Training. Through the Cultural Competency Training Program, Cenpatico employees will:

- Learn about various cultures
- Explore factors that influence decision making among various cultures
- Learn about health-related contributions made by various cultures
- Confront their own misconceptions about various cultures
- Learn about how non-health problems, such as poverty, racial discrimination, and low-income housing affect health status
- Understand that conflict and grievance resolution processes are to be conducted in a culturally and linguistically sensitive manner
- Learn to identify cultural and language differences that may engender misunderstanding, lack of compliance, or other factors that negatively influence behavioral and clinical situations
- Work together to identify activities aimed at improving the health of members

2.a. Member Services
v. Describe the Proposer's plan to ensure that all callers to a common single point of contact are provided accurate information that fully addresses their need, including call transfer and tracking of calls requiring follow up.
Suggested number of pages: 3

The purpose of our Member Services Call Center is to ensure that every caller has their needs met when they contact us, regardless of who that caller is, or the reason for the call. Cenpatico call centers provide a single point of entry into our extensive network of information, supports, and assistance. We will maintain this standard of excellence through our Louisiana Member Services Call Center.

Our approach to ensuring all callers are provided accurate, complete information that fully addresses their need is twofold: our ***robust training program*** and ***intensive quality management*** of the Call Center. The training program will target a broad range of behavioral health (BH) topics, but also through our ***intranet accessible Knowledge Center***, will provide our Member Services Representatives (MSRs) with extensive information about enrollment and eligibility options, and the local community resources available to our members *(all described in greater detail in section 2.a.iv.)*. MSRs are qualified, knowledgeable, and ready to assist callers with a wide variety of needs, and are specifically trained to identify emergency or crisis calls, or calls requiring a more specialized skill set, and know how to transfer these calls to a Supervisor or Care Manager to meet the member's needs.

Knowing we have staffed our Call Center with well-trained and knowledgeable staff, we will utilize our state of the art Avaya Call Management System and Member Relationship Management (MRM) technology suite to its fullest potential. Please see previous section 2.a.iii for more detail regarding the technology features available to the Call Center staff.

Monitoring for Quality

Our Member Services Call Center Supervisors monitor response timeliness via real time, on screen, call queue monitoring tools. These tools enable the Supervisor to make immediate staffing adjustments to ensure coverage for all inbound calls and timely handling per Department of Health and Hospitals-Office of Behavioral Health (DHH-OBH) requirements. The Supervisor analyzes call volumes and performance indicators (number of calls received, average speed of answer, percentage of calls answered within 30 seconds, and call abandonment rate), call trends, and staff productivity and scheduling.

Managing the Moment

Cenpatico recognizes that while we are here 24/7/365 to serve members, our experience tells us there are times when call volume is expectedly higher. We manage to these moments by organizing, training and scheduling our Member Services Call Center staff to ensure adequate distribution of resources across the call queues to serve our members. MSRs receive primary and secondary queue assignments, based on successful completion and certification of training, to allow rapid reassignment should call volumes rise in a particular queue. Our Supervisor's ***online dashboard*** provides a real time view of our active call distribution for and the number of MSRs currently assigned and prepared to take calls for a specific queue. If the Supervisor detects an increase in call volume in a particular queue, they immediately identify available MSRs designated as secondary and reassign the MSRs as needed to ensure seamless coverage. The Supervisor provides immediate notice of the reassignment by instant-messaging the MSR and the respective Supervisor of the change. The Supervisor also provides management a variety of Call Center reports and recommendations to enhance forecasting models, staff distribution, and scheduling. For example, the Supervisor can analyze phone statistics, call traffic, and call trends based on half hour increments within the workday, day of the week, or timeframes within the month (beginning, mid or end) to ensure staff schedules are in sync with peak call times. (If the Supervisor is temporarily unavailable during the day or due to illness or scheduled time off, a member of the management team fulfills the Supervisor's duties.)

Service Fulfillment

We ensure complete service resolution and fulfillment by monitoring inquiry age. In addition to monitoring to ensure live-call timeliness, Supervisors monitor "inquiry age," that is, age of an inquiry that requires further action and a callback by a MSR to a member, to ensure that inquiries are managed in a timely manner. MSRs will document all inquiries in MRM by assigning a "call type and sub-type" category, which has a predefined timeframe within which the inquiry should be addressed. For example, should MSRs require help from an internal department to answer a member's question; they will document it, and "pend" the inquiry in MRM. Should the inquiry remain open beyond the predefined time allotted for the pend code (usually one business day), MRM will highlight the aged item for the Supervisor and prompt the MSR to initiate follow up.

Electronic documentation of incoming calls in MRM

Electronic documentation enables easy follow-up and promotes response accuracy. Our Quality Specialist further evaluates all MSRs' interactions with our members as well as the effectiveness of our training programs by monitoring at least 10 calls per month per MSR via our Witness Quality Monitoring audit tool. Witness Quality Monitoring (Witness QM), a software application integrated with the Avaya System, records all Call Center phone interactions and retains a record of any applications that staff touch or use on their computer to resolve a call. The system synchronizes the captured voice and desktop activity allowing management to observe and analyze the complete customer interaction as it actually occurred. This software also archives calls for six months, which enables the management team to review historical calls to incorporate "live" call examples into our initial and ongoing training programs as well as to investigate and address a caller complaint. Based upon each MSR's audit threshold configured within Avaya, the system provides the Quality Specialist with a system selected random sample of calls from which they conduct their review. Our call audit criterion includes evaluating the accuracy and effectiveness of the interaction, accuracy of call documentation, and cultural appropriateness. Trends across multiple MSRs are addressed via our *Learning Management System (LMS) and Knowledge Center*, which allows the management team to develop electronic notices and related tests or assessments for all or targeted staff to reinforce training.

Personal and Public Feedback on Timely and Accurate Response

We provide each MSR with a daily snapshot of their individual performance and department wide performance, highlighting achievements and opportunities for improvement. Member Services Department performance is summarized and published in our monthly department newsletter, which will also contains helpful hints and information about DHH-OBH Program updates, membership, and Cenpatico's SMO Provider network.

Performance based Advancement

To demonstrate the importance of ongoing accuracy and link it to career advancement, Call Center Supervisors document the audit results in each MSR's monthly performance report cards. This industry best practice**,** as cited by the Call Center Optimization Forum, compares individual performance to predefined performance goals, including measures for number of calls handled, quality audit results, percentage of documentation compared to calls taken, and attendance. The Supervisor reviews the performance report card monthly with each MSR, except in cases where immediate correction is warranted. In the monthly performance review, Supervisors discuss the MSR's strengths, deficiencies, and specific training needs. Follow up activities may include informal coaching, retraining, or in the event of substandard performance, corrective action including a Performance Improvement Plan (PIP) that may lead to termination if prompt and steady improvement does not ensue.

2.a. Member Services
vi. Describe the member experience when calling the member services line and the transition to care managers: Suggested number of pages for both examples: 2

Ensuring that callers to Cenpatico's Member Services Call Center have a positive experience that fulfills their needs is a commitment we make every day. We will meet the needs of any caller, regardless of who they are or the reason for their call. As we do in all our programs, Cenpatico will ensure that our Louisiana Members are treated in a respectful and culturally appropriate manner.

(a) Provide a description of the process for transitioning an adult caller from member services to care management, including the process for determining and addressing a psychiatric crisis.

Adult Member Caller

When callers contact Cenpatico's Statewide Management Organization (SMO) Call Center via the toll-free number, they will be greeted by our MSR who will assess the member's preferred language or special needs and if necessary route the caller appropriately. The member will be asked if the call is related to a clinical emergency, or eligibility, benefits, or authorization. If related to a clinical emergency, they receive immediate response from the MSR All MSRs are trained to evaluate when a member is in need of urgent or emergent consultation with a mental health professional (further detail of crisis response call handling is described below in the Crisis Call section). Regardless of the nature of the call, all calls are answered promptly, in the order received. Cenpatico will, with approval from DHH-OBH, be expanding on our current Service Center telephonic capabilities to include interactive voice response (IVR) technology with voice response activation.

Transitioning to the Care Manager. Since Cenpatico staff will all share the same telephone platform regardless of office location across the state of Louisiana, calls are easily transferred to ensure callers are not lost or required to call a separate telephone number. All call transfers are "warm" or three-way transfers, in which the MSR stays on the line and orally introduces the caller to the appropriate staff person, to ensure continuity and to remain in touch with the caller. Callers need to use only one phone number and place only one call. For example, a call received in the Baton Rouge Service Center can be warm transferred to the member's Care Manager (CM) located in one of our regional Louisiana locations. Our MSRs are trained to be knowledgeable regarding benefits, eligibility processes, access to providers in the specific regions and local community service organizations. MSRs can easily warm transfer members requiring additional support, screening or assistance from a clinician to a CM staff member. The CM staff can assist in engaging peer supports, address questions about various levels of care or provider treatment services, facilitate exchange of information between providers or offer other aid in navigating the system. CM staff and MSR staff all access the same software system that maintains documentation of all member-specific previous contacts and historical information such that the caller does not have to begin again explaining their situation if they have previously contacted the SMO.

Crisis Calls. MSRs are specifically trained to identify a caller in crisis. Our crisis call response protocol instructs the MSR to immediately obtain the caller's name and a telephone number where they can be reached in the event the call is disconnected. ***MSRs never transfer a caller who is in crisis;*** rather they alert their MSR "buddy" via our instant messaging technology, to locate an available licensed clinician such as our Utilization Managers (UM) or CM, who immediately comes to the desk of the MSR and assumes responsibility for the call. While the licensed clinician talks with the member to maintain member safety, the MSR engages the Program Coordinator assigned to the member's service area that reviews the member's record and identifies local providers and other appropriate referral sources, including mobile or other community crisis services. The licensed clinician remains on the line with the member at all times through crisis resolution. Our Service Center teams are trained to serve all individuals in crisis, including individuals not currently enrolled with Cenpatico. When indicated, the licensed

clinician may call 911 with the member on the line or instruct another team member to access emergency services through a 911 call.

(b) Provide a description of the process for transitioning a family member/parent of a child/youth from member services to care management, including the process for determining and addressing a psychiatric crisis.

Parent/Caregiver Caller

The process for handling calls when the caller is the parent or caregiver of a child member is closely aligned with the process described in (a) above but will include screening when appropriate for additional referral for services. When the parent or caregiver contacts Cenpatico's SMO Call Center they will be greeted by our MSR who will greet the member and assess language or special needs and if necessary route the caller appropriately. The parent or caregiver will be asked if the call is related to a clinical emergency, or eligibility, benefits, or authorization. If related to a clinical emergency, they receive immediate response from the MSR (further detail of crisis response call handling is described in Crisis Calls section below). Regardless of the nature of the call, all calls are answered promptly, in the order received. As mentioned above, with approval from DHH-OBH for the implementation of this program, we will consider expanding on our current capabilities to include IVR technology with voice response activation.

Transitioning to the Care Manager. All call transfers are "warm" or three-way transfers, in which the MSR stays on the line and orally introduces the caller to an ICM, or other appropriate staff, to ensure continuity and to remain in touch with the caller. Callers need to use only one phone number and place only one call. Our MSRs will be well prepared to assist parents/caregivers in finding appropriate local services and supports to meet individual member needs and will transfer callers to a CM who will discuss the needs of the child, conduct the brief Child and Adolescent Needs and Strengths (CANS) screening if this has not previously been addressed, and will provide appropriate referrals to the local Wraparound Agencies (WAAs), Independent Assessors and Family Support Organizations (FSOs) if the child/youth appears to be eligible for CSoC services. When the child is in an out-of-home placement or at risk of out-of home placement, the CM staff will be able to initiate authorization for necessary services for an initial period while additional assessments are completed and a sustainable Plan of Care is completed. Both the CM and MSR staff can access member-specific historical information through our system such that the caller will not need to explain previous calls, treatment history or other prior interactions that have occurred with any department or staff member through the SMO.

Crisis Calls. MSRs are specifically trained to identify a caller in crisis. Our crisis call response protocol requires the MSR to immediately obtain the caller's name and a telephone number where they can be reached in the event the call is disconnected***. MSRs never transfer the call;*** rather they alert their MSR "buddy" via our instant messaging technology, to locate an available licensed clinician such as a UM or CM who will come to the desk of the MSR and assumes responsibility for the call. While the licensed clinician talks with the parent/caregiver to maintain their safety, the MSR engages the Program Coordinator assigned to the parent/caregiver's service area to review the member's record and identify local providers and other appropriate referral sources, including mobile or other community crisis services. If the individual has already been engaged with a provider, WAA, FSO or natural supports, the Program Coordinator can enlist their assistance and ensure any identified crisis intervention or wellness plan is engaged. The licensed clinician remains on the line with the parent/caregiver at all times through

crisis resolution. Our Service Center teams are trained to serve all individuals in crisis, including individuals not currently enrolled with Cenpatico. When indicated, the licensed clinician or another team member may call 911 while the parent/caregiver is on the line.

2.a. Member Services
vii. Describe the Proposer's plan to manage and respond to complaints, including the process for logging, tracking and trending complaints, call resolution or transfer, and staff training.
Suggested number of pages: 2

Cenpatico of Louisiana Inc., Statewide Management Organization (SMO) advocates for, and protects the rights of members. In accordance with the RFP Scope of Work section, 6.b.ii, we will not improperly label or refer to grievances as complaints as that creates a barrier for our membership. We will provide members, their families and their supports an uncomplicated system to submit complaints, or any expression of dissatisfaction with SMO services, via a "No Wrong Door Approach". Members, their designee, any provider or stakeholder, can contact any member of the SMO staff and receive assistance in accessing and completing the complaint process. We document the receipt, acknowledgement, investigation, and timely disposition of each complaint and resolve all complaints within the statutory and contractual timelines required by the state. Trends in complaint reporting and tracking are used for performance improvement activities overseen by the Cenpatico Quality Management (QM) Department.

Member Education and Support

Cenpatico communicates, educates, and provides advocacy assistance for all members regarding the complaint process. Through a variety of media and means, such as our Member and Provider Handbooks, written communications, website, and staff contact with members, we make members aware of the procedures and their right to file a complaint either orally or in writing, and to obtain assistance from a Community Connections Representative to file a complaint.

All complaint process information Cenpatico provides to members, including how to file a complaint and written acknowledgement and resolution letters, are written in English, Spanish and Vietnamese at no more than a 5th grade reading level. Cenpatico will receive prior approval from DHH before disseminating member materials.

Staff Training

Cenpatico trains all staff on the complaint process in new employee orientation and annually thereafter. The training includes the identification of a complaint and the rights of both members and providers to file a complaint, in support of our "No Wrong Door Approach".

Complaint Process

Cenpatico's complaint process complies with all applicable federal, state and NCQA requirements and regulations. Our complaint process is centralized to ensure the timely, efficient and appropriate processing and resolution of member complaints, and affords our members an uncomplicated system to voice their concerns. The Cenpatico complaint process ensures all issues will be addressed by a competent and neutral party. Typically, complaints are received through our Member Services Call Center, though members may also submit complaints in writing to Cenpatico, via email, post, or fax. The Cenpatico complaint handling process is described below:

1. Upon receipt of a complaint, the Member Services Representative (MSR) completes our electronic Complaint Form with the member and immediately transmits the information to the QM Department for processing. For implementation of the Louisiana Behavioral Health Partnership contract, our innovative Member Relationship Management System (MRM) will allow MSRs to pull up a Complaint Form pre-populated with basic member information from the member's record and, after entering the current complaint specific information, attach the completed form to the member record in MRM. The MSR will inform the member of the complaint process, next steps and that they will be contacted for follow up and resolution of the complaint. There is no need to place a caller on hold or transfer them to another staff member

when they call with a complaint; our MSRs are highly trained on how to facilitate the complaint process.

2. The QM Department acknowledges, in writing, a member's oral or written complaint within five business days of receipt, and provides a written resolution within 30 calendar days. If the SMO receives a complaint regarding waste, fraud, and abuse (WAF), staff are trained to immediately refer to the Centene Special Investigations Unit. The QM Department forwards grievances related to HIPAA violations or PHI disclosures immediately to the Compliance Department.
3. The QM Department tracks all member complaints and resolutions according to standardized categories. Complaints that upon investigation pertain to an "action" (denial, reduction or termination of services) are immediately routed to the Cenpatico Grievance system for appropriate processing. Complaints, that upon investigation indicate an adverse outcome, or serious potential for an adverse outcome, are routed to the QM Clinical Coordinator for review and investigation via the Cenpatico Quality of Care (QOC) concern process.

Complaint Appeal. Cenpatico's complaint appeal process is compliant with all applicable regulations regarding Dispute Resolution. If a member is not satisfied with the grievance response and chooses to file an appeal, the Grievance Team provides a written acknowledgement to the member, which includes an explanation of the process and the member's rights, within three business days after receipt of the written grievance appeal request. The grievance appeal process is completed no later than 30 calendar days after the date Cenpatico receives the member's written request for an appeal. The Grievance Appeal Resolution Letter contains all required elements, including information on how to file a grievance with DHH if the member is dissatisfied with the panel's resolution.

Complaint Tracking and Trending. Tracking: The QM team utilizes a separate, protected database to log and track all member complaints. All required timeframes for acknowledgement and resolution are included in the database, along with outreach activities and supplemental documentation. Cenpatico's Compliance 360 (C360) program assists in the tracking of complaints, as any Cenpatico staff can "trigger" a member complaint to QM using C360. The C360 trigger includes the complaint receipt date and reminders for all complaint process turnaround times.

Tracking. The C360 software tracks where the grievance is routed for investigation, and allows staff to designate the deadline for the investigation summary and proposed resolution. The C360 software also generates an email to the assigned investigator with a description of the grievance, requirements for the investigation and response, the deadline for submitting the investigation response to the Grievance Team, and includes all pertinent documentation as an attachment. In addition, C360 sends periodic automated reminders to the investigator regarding the due date of the investigation response, as well as a notice to the investigator if response is not received by the date due.

Trending. Cenpatico's complaint process follows standardized categories for complaint type and resolution, which allows for easy reporting and trending. Complaint data is extracted quarterly for longitudinal tracking, trending and analysis, Complaint elements evaluated include: complaint category, complainant, acknowledgement and resolution turnaround times, and resolution category. Complaint trends are used by the QM Department to identify areas for targeted performance improvement and as a qualitative proxy measure to all UM, Quality and SMO business monitoring.

2.a. Member Services
viii. Describe the ongoing monitoring protocols for member services staff, including the nature and frequency of supervision, documentation of audits, call monitoring, quality review, and any other oversight activities. Suggested number of pages: 2

Member Services Supervision

Cenpatico's Member Services team for the Louisiana Behavioral Health Partnership, Statewide Management Organization (SMO) contract will have a robust management structure in place to ensure a high level of quality for all Member Services activities. Please see the organizational chart for the SMO Member Services Team provided previously in subsection 2.a.i for a full explanation of the staffing and supervision plan. The call center will be staffed using a one Supervisor-to ten Member Services Representative (MSR) ratio at all times. Our Avaya Call Monitoring System detailed previously in subsection 2.a.iii has multiple fail safes built into the technology suite to notify Supervisors of a variety of quality issues, examples include but are not limited to:

- Call abandonment
- Multiple calls from one member regarding the same issue
- Hold times exceeding acceptable limits
- Inquiries or requests for feedback not being followed up and closed out

Cenpatico brings the technology to support real learning and performance improvement techniques through observing real calls. Supervisors can review the scenarios from a specific call, and the lessons learned are then taken back transferred into knowledge shared with all MSRs and every caller benefits from our commitment to Quality Monitoring.

Cenpatico MSRs historically perform extremely well overall in their Quality Monitoring scores with a monthly departmental average that consistently exceeds 92%.

Ongoing Monitoring and Supervision Protocols

Side-by-side Monitoring. During initial training for MSRs we use side-by-side monitoring where our experienced trainer sits with a newer MSR, listens to the call in progress, provides support and instruction to help resolve the call in real time and, most importantly, provides additional training under real scenarios to further develop the skills and knowledge base of our new MSRs.

Silent Call Monitoring. The Member Services Supervisor evaluates all MSRs' interactions with our callers as well as the effectiveness of our training programs by monitoring at least 5-10 calls per month per MSR via our ***Witness Quality Monitoring (Witness QM) audit tool***. Witness QM, a software application integrated with the Avaya System, records all MSR phone interactions and retains a record of any applications that staff touch or use on their computer to resolve a call. The Witness QM system synchronizes the captured voice and desktop activity, allowing the Supervisor to observe and analyze the complete customer interaction as it actually occurred. This software also archives calls for six months, which enables the management team to review historical calls to incorporate "live" call examples into our initial and ongoing training programs as well as investigate and address in the event of a caller complaint.

Based upon each MSR's audit threshold configured within Avaya, the system provides the Supervisor with a system selected sample of calls from which they conduct their review. We choose complimentary as well as instructive calls to share with our agents. Listening and reviewing tape with them in their monthly one on one reviews and hearing themselves on tape is a valuable teaching tool. The examples provided in this medium resonate and the lessons are learned well and taken back to the phones to the benefit of all our members and providers who call seeking our assistance.

Supervision. Our Member Services Call Center Supervisors monitor response timeliness ***via real time, on screen, call queue monitoring tools.*** These tools enable the Supervisor to make immediate staffing adjustments to ensure coverage for all inbound calls and timely handling per DHH-OBH requirements. The Supervisor analyzes call volumes and performance indicators (number of calls received, average speed of answer, percentage of calls answered within 30 seconds, and call abandonment rate), call trends, and staff productivity and scheduling.

The Supervisor also provides management a variety of Call Center reports and recommendations to enhance forecasting models, staff distribution, and scheduling. For example, the Supervisor can analyze phone statistics, call traffic, and call trends based on half hour increments within the workday, day of the week, or timeframes within the month (beginning, mid or end) to ensure staff schedules are in sync with peak call times. Supervisors also monitor "inquiry age," that is, age of an inquiry that requires further action and a callback by an MSR to a member, to ensure that inquiries are managed in a timely manner. MSRs will document all inquiries in MRM by assigning a "call type and sub-type" category, which has a predefined timeframe within which the inquiry should be addressed. For example, should MSRs require help from an internal department to answer a member's question; they will document it, and "pend" the inquiry in MRM. Should the inquiry remain open beyond the predefined time allotted for the pend code (usually one business day), MRM will highlight the aged item for the Supervisor and prompt the MSR to initiate follow up.

Monitoring Call Documentation. Cenpatico MSRs currently electronically document incoming calls, in MACESS, in Q1 2012 we will implement our Member Relationship Management (MRM) call tracking system detailed previously in subsection 2.a.iii, which enables easy follow-up, promotes response accuracy, and facilitates post-call quality assurance review.

Performance Documentation

Our Member Services Supervisors document the MSR call audit results in a monthly performance report card. This industry best practice**,** as cited by the ***Call Center Optimization Forum***, compares individual performance to predefined performance goals, including measures for number of calls answered, quality audit results, percentage of documentation compared to calls taken, and attendance. ***Performance report cards are reviewed monthly with each MSR during their one-on-one supervision***, or sooner if immediate corrective action is warranted. In the monthly performance review, Supervisors discuss the MSR's strengths, deficiencies, and specific training needs. Follow up activities may include informal coaching, retraining, or in the event of substandard performance, corrective action including a Performance Improvement Plan (PIP) that may lead to termination if prompt and steady improvement does not ensue.

Quality Monitoring is also used to identify "Quality Role Models" on our Member Services team. These are MSRs who consistently perform above standard thresholds for quality customer service. Once identified through our Call Witness tool, we train Quality Role Models to perform side-by-side monitoring and training with newer MSRs who benefit from the experience shared with them. Silent monitoring identifies the leaders who assist with side-by-side monitoring and stronger MSRs are developed through both. In fact, in our Austin Service Center, our strongest Quality Scorer who consistently scores between 99% and 100% on her monthly averages, has now been enrolled in the Quality Monitoring and is the Training Liaison of our team.

Quality Review: Member Services quality metrics will compose a significant portion of our Quality Assurance/Performance Improvement (QA/PI) program being created for the Louisiana SMO. Member Services quality metrics will be stringently monitored, as they will measure the crucial direct interactions with the members themselves. In order to optimize success for the overall Louisiana Behavioral Health Partnership, members must have a direct portal to obtain information and to access services, and the

QA/PI program's Member Services metrics will grade the overall SMO on how well we are achieving our goal to make the entire Partnership easy to access and to meet each member's needs.

Examples of Member Services metrics to be tracked by the QA/PI program include, but are not limited to:

- Calls to the Call Center must be answered within 30 seconds
- Call abandonment rates shall not exceed 3%
- Crisis calls are positively identified and handled according to established protocols
- Proper, accurate, and complete information is provided to callers
- Eligibility information is provided in a complete and accurate manner
- Information regarding grievances and appeals is provided in a complete and accurate manner
- Inquiries requiring follow up are completed within the established time frames

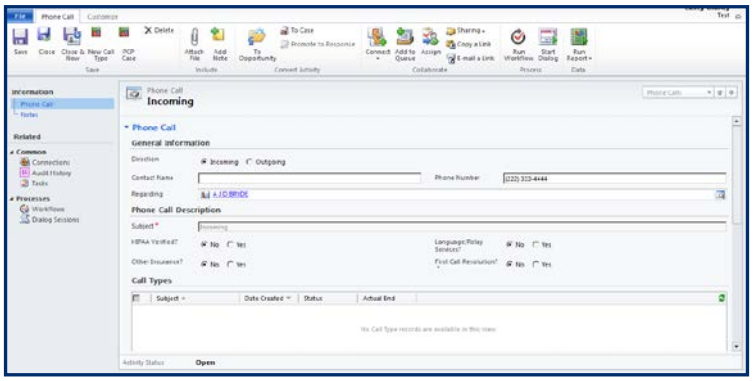
Our proven quality monitoring and Member Services processes are part of our commitment to ongoing quality monitoring for our Louisiana Member Services Call Center. We are a stronger team and company because of the valuable Quality Monitoring tools we use at Cenpatico.

2.a. Member Services
ix. Describe how the Proposers information management system will support member services activities. Suggested number of pages: 1

Member Relationship Management

Our Member Relationship Management system (MRM) supports all aspects of our members' relationship with Cenpatico. MRM is comprised of the following:

- ***Member Demographics System (MDS).*** MDS is similar in design to a Master Patient Index application in that it employs a Master Data Management (MDM) approach to member data. Our MDM design provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing member data throughout our organization to ensure consistency and control in the ongoing and coordinated maintenance and use of member data.
- ***MemberReach*** will automate, manage, track and report on our workflows for outbound and outreach member campaigns.
- ***MemberConnect*** is our Customer Relationship Management (CRM) member services application which allows us to easily extend and expand and caregiver information that we can collect, transmit, display, route and use. MemberConnect will support the following:
  - Basic Customer Relationship Management (CRM) functions, including call inquiry entry, categorization, routing, follow-up tracking, management and reporting.
  - Support for Member Care - MemberConnect supports *inbound campaign management*. If a member or caretaker we have been trying to reach happens to call us for any reason, our Cenpatico Member Services Representatives (MSRs) can address the member's immediate issue, then they or another staff member can talk to the member about the issue that is the subject of our outreach attempts.



Our MRM will enable Cenpatico to identify, engage and serve LBHP members in a holistic and coordinated fashion across the breadth of their wellness, clinical, and administrative matters.

Our MRM platform provides real time dashboard metrics, and a built-in query tool for instant operational reporting for Call Center management staff. For example, call center management staff utilize the *Call Type by Subcategory Report* (e.g. claims, member materials request, case management, authorization, etc) to review the types of calls received in a given day, or over a period of time. This information provides insight for staffing, education, or "real time" shifts in workloads. The *Frequent Caller Report* provides insight into members who frequently call, and the nature of the call, helping our staff determine a need for personal outreach and education. The *Queue Aging Report* helps manage open items for follow up by call queue. For example, the call service representative may have referred a call for further follow up to the claims queue. For more information on our MRM, please see our response to section 2.g.iv.

Augmenting Member Services Through the Web

We will deploy an LBHP customized version of our Cenpatico public website, with non-secured (no login required) information on LBHP and its programs (including CSoC), provider directories, and other timely, vibrant, and engaging content. In addition, we will offer members a secured Member Portal - allowing members to access their specific protected health information (PHI) in HIPAA compliant fashion - including the ability for self service functionality (update demographics, order replacement ID cards, etc.) and view important health information (online care gaps, care service plans). Please see Section 2.a.x for more information.

Member Services - Telephone Communications

Our telephone system and supporting software and networking functions is another integrated part of our overall, integrated enterprise information management system (MIS). Today, Cenpatico plans serve our members through telephony services which we will extend for our Louisiana Behavioral Health Partnership (LBHP) Plan. We use the Avaya Call Management System, Avaya Voice Portal (AVP) with Interactive Voice Response (IVR) and Predictive Auto Dialing (PAD) technology fully integrated with MRM. Please see Section 2.a.iii for more information on our telephone system.

2.a. Member Services
x. Member Services Website
Propose a plan for implementing a website to be utilized by members and family members, providers, stakeholders and State agencies that provides a provider directory, education and advocacy information as described in the RFP. Discuss the proposed content of the website with respect to promoting holistic health and wellness. Provide an example of an active web based site that has been developed for a State agency and include information to permit access to the site. Describe the development tools that will be utilized to create the Louisiana website as well as the proposed security protocols that will be used. Suggested number of pages: 8

Leveraging the Communicative Power of the Internet for LBHP

The internet continues to create new opportunities to communicate with members and health care stakeholders through targeted and general information campaigns that help to educate and engage the community.[1] Cenpatico of Louisiana, Inc.'s Statewide Management Organization (SMO) will configure and maintain a customized version of our website with informative and *compelling* content for members, family members, providers, state agencies and all Louisiana Behavioral Health Partnership (LBHP) stakeholders. One key subset of stakeholders we will serve through our website are the extended CSoC Child and Family Teams (CFT) of Wraparound Facilitator, FSO peer support staff, engaged providers, state agency professionals, and SMO care managers - and any member of the general public wishing to be educated on the CSoC program, or any other aspect of the LBHP.

Planning for Implementation Using Proven and Industry Standard Project Practices

Almost half of all Louisianans are on Facebook. Cenpatico's Internet and Facebook presence offers new opportunities to engage communities in Mental Health awareness.

The website content and functionality design; state client review; configuration; test; and deployment activities that comprise our website plan follow Centene's best practices approach to software change management (grounded in the ***Agile*** methodology) and MIS ***Information Technology Information Library*** (ITIL) service management discipline. In addition, following our standard process, our website implementation tasks are an integrated component of our **overall implementation plan**, including appropriate task inter-relationships with other aspects of the implementation (see Section 2.i for more information). This approach assures, for example, that our telephone system configuration, our written member and provider materials, and our operational procedures are all harmonized with the content and functions of our website.

Service Content and Functionality for Members, Providers, and State Agencies

Cenpatico websites are each customized to fit the needs of our local plans, and our LBHP public website and secured *Provider and State Agency Portals* (Portals) will feature content, links, and website support specific to the holistic health care needs of our Louisiana members.

Secured Web Portals for LBHP Providers and State Agency Users. In addition, our secured Portals will supply the administrative, clinical, and reporting "self service" tools needed by network providers (including LGEs, WAAs, FSOs, LEA school employee providers, and other network providers) and state agency users to support LBHP members. Please see Sections 2.g.v through xi for more information on how our Portals will support a wide variety of secured applications for inter-agency, SMO, and provider collaboration and HIPAA compliant data sharing. These applications include (among many others) - the online referral of adults and children to LBHP programs (e.g. CSoC), the submission or online entry of

[1] According to the social media analysis site, Social Bakers, almost half of all Louisianans are on Facebook. Information available at: http://www.socialbakers.com/united-states-facebook-statistics/louisiana

assessments (e.g. Comprehensive CANS), submission or entry of plans of care, online claims or encounter entry, sharing of care and service plans amongst the collaborative care teams, and much more. We will also offer to DHH-OBH designated users, online and interactive access to our Enterprise Data Warehouse, our Teradata powered data integration engine; with an SAP BusinessObjects front end for standard reporting and ad-hoc analysis and reporting.

See Section 2.g.xi for a description of how we propose to use our Portal technology to support behavioral health (BH) and physical health care coordination. Among other measures we are offering in the name of BH and PCP collaboration, we are proposing to work with CCNs to provision LBHP Provider Portal accounts for PCP's - with adherence to HIPAA privacy and security rules; to enable enhanced data sharing across the BH and medical care system.

Finally, see Section 2.g.xxx for more information on how we will use our Portal for DOE/LEA encounter submission support.

Publicly Available Content for BH Education, Holistic Health Promotion, and Engagement. Our LBHP public website will meet all requirements stipulated in the RFP Sections II.B.3.c and II.B.3.d, with content available to any user, and no login information required. We will provide all of the contractually required information in an easy-to-read format of a 5th grade reading level, accessible in English, Spanish and Vietnamese, including but not limited to the following features:

- **Provider directory** search function by zip code and provider type as well as a PDF listing of all providers.
- **Education on the various types of mental illnesses**, including resources to find additional information, an interactive screening process that allows the user anonymously to screen for such diagnosis as bipolar disorder, depression, eating disorders, PTSD, Substance Use Disorders, generalized anxiety or brief juvenile depression screenings
- **Interactive features to learn about various physical health disorders**, their symptoms, and some options for treatment, and basic screening tools for common physical health issues.
- **Information on committees and councils** available for members, their families, community members and stakeholders to participate with and to bring their voice to the discussion regarding the LBHP
- **Information on advocacy agencies**, what they do and how to reach them
- **Protocols** between state agencies and Cenpatico
- **Presentations** created to educate members on prevention and wellness topics

Content on our websites are separated into 6 sections: Home, About Us, Find a Provider, Community Spotlight, Providers, and Participants. Each section contains multiple pages with valuable information. Cenpatico regularly solicits information from members, their families, community stakeholders, our state clients and providers on how to improve the website and make it easier to use. With a local website administrator on staff, changes to the website are quickly and easily made.

The table below provides an overview of the site that we will customize for the LBHP:

Cenpatico Website Customization for Louisiana	
Section	**Content Type**
Home	This section contains the information we want visitors to the site to see first. Information on how to reach our crisis line, a welcome greeting, a listing of our press releases (with links to the full release), our accreditations, our funding source, and a blog to share the latest information on a topic we feel is important to share with our visitors. The Louisiana homepage will feature links to the DHH-OBH, CSoC, and all of the CCN-P and CCN-SS health plan websites, and in case of an emergency, prominently feature updated information.
About Us	This is where visitors will find our Mission Statement, our goals and vision, a listing of our Executive Management Team with short bios for each, an overview of our cultural competency program (including our annual plan with quarterly updates), provider performance dashboard reports, our Quality Improvement Program overview and Plan, our philosophy regarding Recovery and Resiliency, the Arizona State Vision and Principles (to be revised to meet Louisiana's standards and expectations), our Guiding Principles and an overview of our service area. We will include information regarding the CSoC and all of our partners within the Louisiana Behavioral Health Partnership.
Find a Provider	This section includes contact information on our crisis line, explanation on how to access services and, to the right of the page, a provider search function that narrows the search to zip code and provider type or will search by specific provider name. In addition, we post lists of individual providers, contracted pharmacies and substance use disorder (SUD) specialty providers who offer prevention programs in our areas. There is also a comprehensive list of all our contracted Network Provider sites as well as a specific list of intake provider agencies, which cities they are located in and links to their websites. Wraparound Agencies (WAAs), Family Support Organizations (FSOs) and other Louisiana Behavioral Health Partnership providers will be featured on this page. We will include listings of FQHCs and RHCs to ensure members have information for ***total health care needs.***
Community Spotlight	The community section holds comprehensive information for all general community resources, stakeholders and state agencies. This section contains information on our Peer and Family Advisory Councils, our Community Advisory Councils and our Youth Advisory Councils to highlight that with community participation, we are better able to meet the needs of those we serve and be a real partner with our communities, collaborating on processes to better serve our members. It is here that we post our member and stakeholder newsletters, stakeholder protocols, and overviews of some of our initiatives such as the Meet Me Where I Am (MMWIA) Campaign and our prevention services. We have information on our efforts to fight stigma, facts and statistics on behavioral health conditions and a listing of myths to help educate our communities on some misguided beliefs surrounding mental illness. It is in this area that we also provide a search function for local resources such as utility assistance, food pantries, school supplies and rental assistance. We offer various mental and physical health screenings that can be completed anonymously, then printed and taken to the user's provider. Although there is a log on screen for this section, each user simply makes up their user name and log on, without having to divulge personal information such as their name, address or phone number. Only a user name and password is required. We will include a section on this page providing information on local Louisiana community forums, volunteer activities, and opportunities for CSoC children, other children within the membership, parents/families/caregivers, providers and stakeholders to get involved in their communities.
Providers	Any visitor to our website can access most of the information in this section, with the exception of the secure portal where providers can perform eligibility searches, access claims, check claims status, create institutional or professional claims, batch claims, view payment histories, search and create authorizations, change their security information, view information on our Best Practices and Credentialing programs, and learn about our Grievance & Appeals processes. Please refer to

Cenpatico Website Customization for Louisiana	
Section	**Content Type**
	subsection 2.g.vii Technical Requirements for the full functionality of the Provider Portal.
Members	For our members, we have information regarding Best Practices, Grievances and Appeals, the Member Handbook, Rights and Responsibilities and the Medication Formulary. The Louisiana webpage will have extensive information regarding the CSoC and how to access all of the services involved in that program, and the Emergency Preparedness and Response page, which in the case of an emergency; will also be featured prominently on the Home page.

Engineering Website Accessibility. Centene and Cenpatico public websites are Section 508 compliant. We adhere to web design guidelines that ensure the information we present is readily accessible and easily understood by our member audience. We will comply with all DHH-OBH contractual requirements to ensure that our website is accessible to our complete membership by formatting the language in a large, easy-to-read font at a 5th grade reading level. Our SMO website will be available in three languages: English, Spanish and Vietnamese. In addition, we will be able to add additional languages to support our growing and changing membership as needed. Translations for the website will be 100% certified.

Aside from Section 508 requirements, we work hard to ensure that our website provides the utmost in information accessibility for all our members and their caregivers. We periodically conduct usability testing of our website with actual members, who try out the website's features and provide us with feedback. We subsequently use this feedback to continually enhance the website. Our member usability testing is designed to evaluate how easy it is to use our provider directories, the appropriateness of website font size and reading level, intuitive content organization, and ease of user navigation. Members who participate in website usability testing are provided with a tool that guides them through testing website features and scoring their experience completing the tasks. Members also provide written feedback and suggestions regarding their experiences and improvement opportunities.

Centene and Cenpatico adhere to web design guidelines to ensure that the information we present is readily accessible and easy for our users to understand. Our approach includes:

- Having textual description alternatives for informative images displayed
- Ensuring that information conveyed with color is also available without color
- Providing guidelines to ensure that all our website visitors can use our websites to the fullest
- Providing functionality that allows users to download information using multiple web browsers and software options.

Example of Active Website

Cenpatico website examples can be found at www.Cenpatico.com and www.CenpaticoAZ.com (the latter being an example of our website customized for our plan in Arizona). Anyone can access the community and member information screens. Contracted provider agencies must log on in order to use the secure provider portal for claim submission and member information correction access, to view payment histories, check on service authorization submissions, or determine member eligibility for specific services and programs.

Please note that we are in the process of enhancing our "corporate Cenpatico front door" website at www.Cenpatico.com, based on feedback from users, to offer an even cleaner interface, while offering a constantly refreshed menu of behavioral health topics for visitors to our sites to engage. Please see ***Figure 2.a.x.-A*** below for a "snapshot" of our new design, scheduled for deployment in October, 2011.

Technology and Tools Architected for Availability and Responsiveness

Ensuring Website Availability Through Multi-Path Networking. A critical factor in any service delivery system is ***availability***. Our websites run on Centene's (Cenpatico's parent company) redundant, dual carrier, high speed wide area network (WAN). In the first six months of 2011, Centene's data network delivered 99.98% availability (see Section 2.g.xiii for more information). Beyond network availability, the software applications serving the information to our websites must also be available, and this is where our fault tolerant and scalable Service Oriented Architecture (SOA) MIS comes into play, delivering over 99.5% availability in the first six months of 2011; and this number is actually *higher* for those applications that directly support our websites, powered through our integrated IBM Websphere standards based technology.

Enabling Fast Response Time. Website ***responsiveness*** is another crucial factor in any website's "user experience". Users rapidly lose interest in sites that do not respond with alacrity. We continuously monitor our website performance using *CA Wily Introscope* (Introscope) application performance monitoring software. Introscope runs on our web application servers and enables visibility into simple and complex transactions for our end-to-end ("user clicks" to "web page served") performance monitoring. We also monitor our overall MIS infrastructure performance using *HP Business Availability Center with OpenView Operations Manager* - so that we are systematically monitoring both internal and external processes that would impact our website service. Again, our *scalable architecture* allows us to rapidly deploy additional website capacity well before web traffic demands it.

Minimal User Computer Prerequisites. Our websites are designed such that no significant memory or disk resources or special software is required beyond a reasonably recent version web browser. Today our website supports Internet Explorer and Firefox browsers. During 2011, we are expanding this compatibility, so that our websites will be viewable/usable on reasonably recent versions of Safari, and popular personal digital assistants.

Security

For all portions of our websites: both publicly available content as well as secured Portal content for providers and state agencies; we secure our sites to

- Guard the protected health information (PHI) we house for our members and state clients within our internal network,
- Ensure website availability and security by guarding against access attacks such as Denial of Service.
- Protect the content on our websites from defacing or other malicious activities, viruses, and "malware",

Protecting Against Unauthorized Penetration.

Network Security. To prevent any penetration into our internal network of applications and databases through our websites, we employ HIPAA security compliant controls (per federal regulations in 45 CFR 164.312) for network security.

Figure 2.a.x.-A

These controls include an array of industry best-practice technologies such as firewalls, Access Control Lists (ACL), Terminal Access Controller Access-Control System Plus (TACACS+), Demilitarized Zones (DMZ), Intrusion Prevention Systems (IPS), Virtual Private Networks (VPN), Data Loss Prevention (DLP), Secure communication protocols (SSH, SFTP, etc.), and SSL encryption for secured web communications (for our secured Portal applications serving providers (including LGEs, WAAs, FSOs, as well as other network providers) and state agency users. Our information technology (IT) supervisors monitor network security using advanced event management and correlation tools on a routine basis, and our network engineers routinely implement restrictive virtual private network (VPN) tunnels for secure connectivity with our external Trading Partners, such as our state clients. All such implementations are

audited and approved prior to production by our Information Security staff to ensure adherence to policy and observance of least privilege.

Managing Security Breach Risk: Intrusion Prevention Systems. The primary function of an Intrusion Prevention System (IPS) is to monitor and prevent attempts to breach security and gain unauthorized access from inside or outside our network. Centene and Cenpatico employ next-generation SourceFire 3D® IPS appliances together with SourceFire 3D® virtual IPS sensors to keep unauthorized users from infiltrating our network via our websites, e-mail, VPN, or any other external data interface we employ. By utilizing an array of sensors strategically placed throughout our internal network, we are able to simultaneously protect multiple gigabits of network traffic traversing all of the subnets on our local and wide area networks. In addition, our RSA enVision Security Information and Event Management (SIEM) system monitors and alerts security staff, in real time, of internal and external system threats and configuration changes that could be exploited.

Penetration Testing. Our IT Security Department conducts penetration testing on our systems, networks, and websites on an on-going basis. During these penetration tests, we attempt to penetrate our websites and email systems via such mechanisms as Denial of Service attacks, phishing, spoofing, and other tactics, as well as occasional social engineering tests, such as false emails allegedly from Centene or Cenpatico employees inviting the receiver to click a malicious link. We also periodically retain an outside firm to perform penetration tests. In 2010, Centene contracted third-party firms to conduct both external and internal penetration tests using Via Forensics and Ernst & Young respectively. All identified issues were prioritized by risk, remediated, and retested to ensure compliance. Additional third-party firms will be contracted to provide penetration testing services in 2011 to independently verify the security of Centene applications, systems, and networks.

Ensuring Appropriate Access for Website Content Updates. To ensure that ***only authorized Centene and Cenpatico personnel*** have access to updating website content, we employ HIPAA security compliant Administrative Safeguards (per 45 CFR 164.308). Our Administrative Safeguards engage our internal users, contractors and clients through documented policies and systematically enforced procedures.

Access Management. We use Oracle's Virtual Private Database (VPD), Microsoft Active Directory Application Mode (ADAM) and IBM Tivoli Directory Server (TDS) to restrict access to all our internal applications, Protected Health Information (PHI), and website administration functions - all based on a user's job function. We manage access through Role Based Access Control (RBAC). Centene and Cenpatico have implemented RBAC for all core business applications (including website management). RBAC eliminates the problems inherent with assigning access rights on an individual basis. RBAC addresses security risks by defining employee access rights based on the employee's job functions or responsibilities, including whether that employee has access rights to update information or view only. To implement RBAC, department managers define the functions and minimum access rights (roles) employees need to accomplish their jobs. Centene then maps each job function or position to a set of responsibilities associated with that job function, and to a collection of work roles and security RBAC profiles. Centene's IT Security Department conducts Role Based Access Control (RBAC) tests to ensure application access has been appropriately provisioned, as described below. Our IT security staff may, depending upon an employee's job responsibilities, expand, limit, or eliminate that employee's access to PHI or other confidential information at any time. In addition, a Centene information security officer or a Cenpatico Manager must approve an employee's access to information if that access request is not part of a standard security profile commensurate with the normal responsibilities of the employee's position. Depending on the type of access being requested, the Centene security officer or manager must obtain the approval and sign-off from the appropriate functional vice president.

Password Controls. Centene's IT security staff strictly control password length, complexity, and lifetime to ensure that passwords cannot be easily compromised. Centene and Cenpatico users (including website

administrators) are systematically forced to change passwords every 42 days and they are unable to reuse the last 10 passwords they created. Inactive PC workstations are automatically locked. After three failed login attempts users are locked out and must contact the Centene Service Desk to have the account unlocked.

Auditing Systems Access and Usage. In addition to controlling access, Centene monitors and audits logins as a second layer of security. As part of our auditing process, IT system administrators routinely check log files to ensure unauthorized login attempts have not occurred. Our IT Security professionals ensure that any access identified as inappropriate or conflicting with defined and approved segregation of duties rules is immediately addressed. IT system administrators maintain an incident reporting file providing the date, time, and comments regarding any unauthorized attempts. We use BindView software to automate, monitor, and record the regular certification by Centene and Cenpatico managers of appropriate subordinate access to our systems, including administration of our websites.

Security for Providers and State Agency Portal Users. From the perspective of our authorized Provider and State Agency Portal users, we provision Portal accounts through the use of validated identification data - obtained through our provider network credentialing process; and (in the case of our state agency users) from authenticated user lists we obtain from our state agency clients. Once provisioned, users can activate their accounts by registering securely with our Portals, supplying the validated identification we have on the user during the registration process; and supplying challenge questions and answers and other information to ensure ongoing secure access. Once a user registers on our secure portals, access is subsequently granted via login ID and password - with protocols (e.g. password length/complexity) adhering to HIPAA security guidelines. If a user forgets his ID or password, our website offers secure and HIPAA compliant methods for efficient - yet compliant - methods for password reset and/or ID validation.

A Focus on Member Service and Engagement

Our dedication to providing education, tools and information to our membership is the driving force behind the design of our websites, and we strive for transparency with our members, their families, stakeholders, state agencies, and our contracted providers. Our website is another opportunity to achieve transparency and provide a tool that is easy for the entirety of our membership to access. Through our website, Cenpatico will offer Louisiana and DHH-OBH a superior communication tool for outreach to members, providers and communities.

2.a. Member Services
xi. Member Handbook
Describe the Proposer's experience demonstrating compliance with annual notification to members of member rights and other required information given confidentiality concerns and the transient lifestyle of some members.
Suggested number of pages: 2

Transparency, accountability and confidentiality are fundamental values that inform our delivery on the promise to improve the lives of vulnerable populations through innovation and community involvement in system transformation. We focus exclusively on populations funded through the public sector, such as Medicaid, CHIP or state funding. With over 17 years of experience working with this membership, we understand the transient lifestyle of an adult with serious mental illness (SMI), or a child in the foster care system, or an individual re-entering the community after incarceration. We are sensitive to the fact that we must apply ever more creative and innovative approaches to connect members with vital information regarding their behavioral health plan, going beyond simply sending the Welcome Packet and Handbook upon enrollment, we work to reach Louisianans where they are through direct community outreach and media campaigns, ever sensitive to the confidential nature associated with behavioral health information.

Fundamentals

Cenpatico has six years of direct experience with the delivery of Member Welcome Packets that include the notification of member rights and responsibilities. Cenpatico of Louisiana, Inc. will follow established processes to meet this contract requirement. In this process, we will ensure all members served by Cenpatico of Louisiana, Inc., receive the required information included in the Handbook by mailing an initial Welcome Packet upon enrollment. The Welcome Packet includes the Member Handbook which includes all contract required information and a current provider directory. To maintain the privacy of members, all materials sent via mail are sent in envelopes that do not identify in any way with mental health or substance abuse treatment. We re-send this packet to the membership as a whole annually or as updated information needs to be disseminated. We strive to maintain an accurate and current member demographic database via reconciliation of our daily/weekly/monthly eligibility loads and take special care to confirm current contact information at any opportunity of contact with a member. Because of this we have been able to minimize the amount of returned mail on our Welcome Packet mailings due to incorrect or invalid addresses as well as ensure our members have the information needed. Within 48 hours of receiving returned mail we then re-validate the members address and update as necessary and resend. The re-validation process consists of cross referencing the State translated eligibility files and the State's secure eligibility web site with our AMISYS Advance system.

Cenpatico respects the confidential nature of behavioral health information. To protect our members, we do not mail information regarding a member's specific health condition without a confirmed valid address.

Creative Approaches

We recognize that many Louisianans have been displaced due to a combination of natural and man-made disasters; perhaps disproportionately so in the Medicaid, CHIP and eligible populations to be served by the LBHP SMO. Providing basic information, such as annual notifications and benefit package information to these members and other transient members is both challenging *and critical.* We have created ***targeted community outreach programs*** to reach the especially transient populations who are often in the greatest need of information regarding their health care and behavioral health program, services and options. To connect with hard to reach members, our Cenpatico Community Liaison (CL) staff on our Adult/Children's Systems teams conduct member and community outreach aimed at improving annual notification of member rights and other required information. The CL staff conducts

on-site visits and informational outreach to public places which typically have contact with members to provide materials and information on contacting Cenpatico. We have found that engaging places including schools, libraries, FQHCs/RHCs, LGEs/HSDs, other community health centers, homeless shelters, and churches enhances our ability to reach members. Our CLs make arrangements with staff at these locations to keep a supply of Cenpatico informational materials displayed and available for individuals to take at their discretion, and to provide our contact information should a member present with a desire to be contacted. Our Community Liaisons work with community agencies to reach members where they are and to be a resource. Their role is to represent Cenpatico as a partner in the communities we serve. Our CLs will add to their outreach routes any locations identified by the community, DHH-OBH or by the CSoC Statewide Governance Body.

Community Liaisons provide general Welcome information and information about benefits, behavioral health services, community supports, and Cenpatico programs. All Cenpatico staff that engage with the community are able to answer general questions on who is eligible for our services. They share this information by distributing the brochures flyers and handbooks at community meetings and events, health fairs and festivals, and they also will ask members they encounter to supply them with updated contact information if it is available.

Experience Guaranteeing Compliance

We have found that it is best to distribute Member Handbooks at the place of service to ensure member handbooks are distributed and reviewed with members. In Arizona we have accomplished this, by requiring all Intake and Care Coordination providers to distribute handbooks during member intake appointments and during annual updates. Additionally, we ask that providers conduct home visits as necessary to distribute the handbooks and review them with members. We then monitor through providers to ensure compliance by auditing provider charts annually for signed receipts verifying the distribution of the handbooks are in the member's files.

In Arizona the quality audit team reviews a sample of charts at each agency to verify presence of signed receipts. When the results show less than 85% meeting the standard "Member was given a handbook within 10 days of intake or 30 days of significant change to the handbook", they are put on a corrective action plan which is then monitored by clinical operations staff who work to with providers to ensure they improve their process to make this happen. Cenpatico of Arizona is then checked by Arizona's Division of Behavioral Health Services' (DBHS) data validation team to ensure that Cenpatico has taken adequate steps to deliver notification, and that we are checking for this standard. ***In 2010, Cenpatico of Arizona was in Full Compliance on this measure.*** As discussed above, we will implement similar techniques in Louisiana to ensure annual notification to members of member rights and other required information.

Experience with Respectful Outreach to Transient Populations

Cenpatico, in partnership with our Florida health plan affiliate, has actively participated in events and outreach opportunities with Health Care for the Homeless in Florida. Our Community Liaison attends health fair opportunities to provide all attendees with general health care educational materials, giveaways and other onsite resources to encourage engagement in their healthcare and awareness of behavioral health options. Cenpatico's contact information is provided; however no member or eligible person is singled out for communication. In Louisiana, we will partner with local Health Care for the Homeless Centers and similar organizations to maximize notifications and engagement for populations that may benefit from outreach.

2.a. Member Services
xii. Member Communications
(a) Describe how the Proposer will ensure a comprehensive communication program to provide all eligible individuals, not just those members accessing services, with appropriate information about services, their rights, network providers available, and education related to benefits and accessing BH services. Include a description of the standard materials to be included in the communications program at no additional cost to the State. Suggested number of pages: 3

Cenpatico of Louisiana, Inc. Statewide Management Organization (SMO) is dedicated to ensuring the communities we serve are aware of who we are, how to reach us, and the services that are available through the Louisiana Behavioral Health Partnership.

a) Comprehensive Communication Program:

We have experience in reaching out to members and potential members in rural and urban parishes as well as to diverse and underserved populations. We use a variety of methods of outreach, as well as both targeted and general information packages. Some examples of our informational items include:

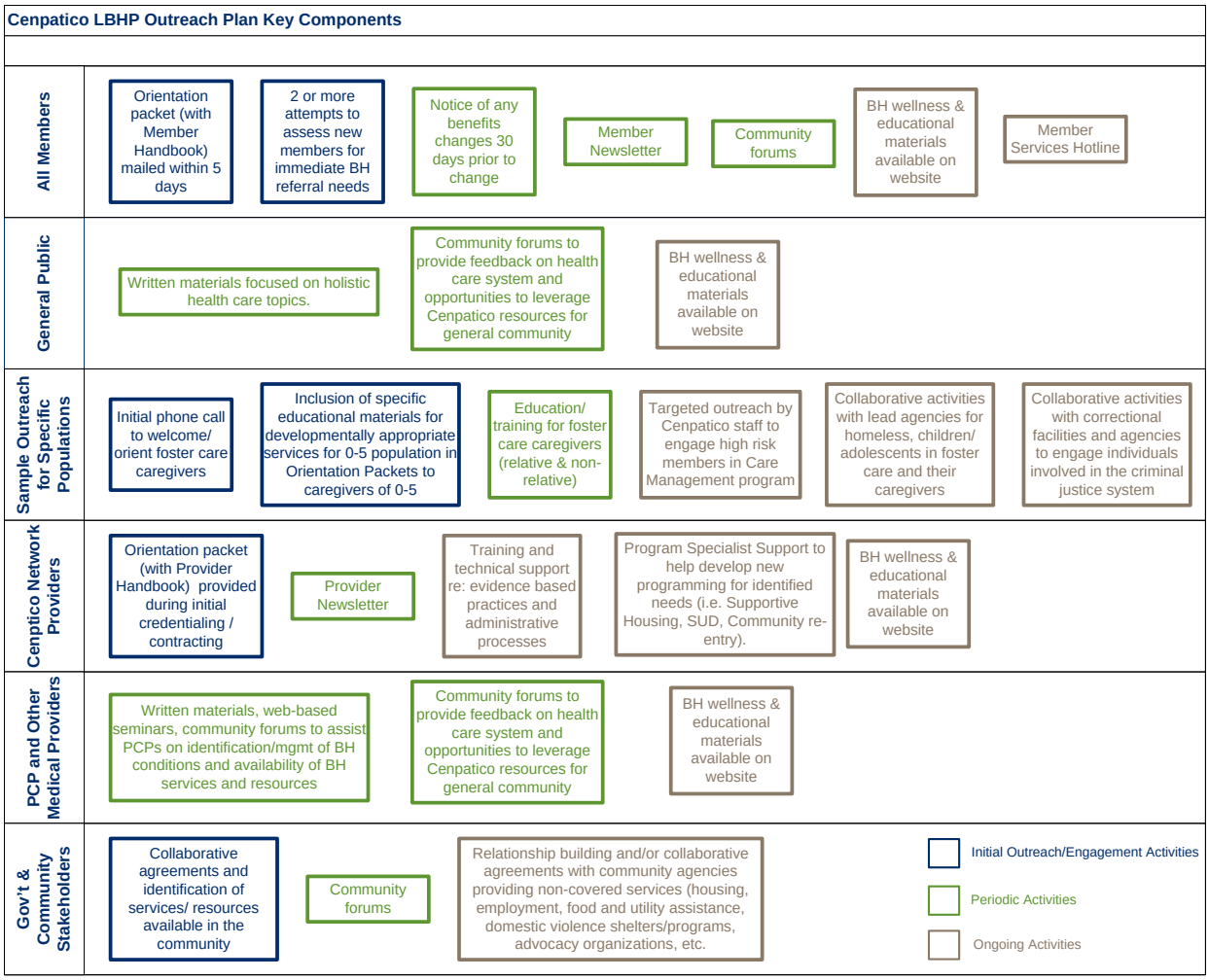
General brochure. This brochure primarily targets community stakeholders and legislators. This brochure gives a general overview of who we are, how to reach us and what services we provide to what populations. It also gives some information on our mission statement, vision and principles and our desire to work as a community partner to improve the lives of those we serve. We have found that many times our most vulnerable and underserved populations sometimes do not reach out to us for help but interact with other systems such as law enforcement, hospitals, shelters, etc. By letting all these various stakeholders know about us, they many times will either refer those who need our services to us, or contact us to let us know about a constituent or community member that needs our assistance.

Access to Care brochure is focused more to those members who will actually be using our services or their family members. It explains how to reach us and what they can expect when they contact us for services. It explains what to bring to their first appointment, how long it will take and what the timelines are for setting up a first appointment and a follow up appointment.

Condition specific brochures give some general information on the signs and symptoms of such conditions as depression, ADHD, and substance use disorders. These are targeted to those members who will actually be using our services or their family members. It explains how to reach us for their first appointment, and makes it easier to reach out for help by explaining that they are not the only ones dealing with these issues and that recovery is possible.

Crisis Cards and Flyers give our crisis phone number, explain that crisis services are available 24/7, and that there is someone one the other end of the call that will get them the help they need. Cenpatico crisis services are available to everyone in the community. You do not have to be a member of the Cenpatico SMO to access crisis services.

Member Handbook and inserts are sent to all new members per contract requirements, and will be available to members upon request at any time. We will post the Handbook and inserts upon the Member Website, and will also supply the Handbook to providers, Wraparound Agencies (WAAs), Family Support Organizations (FSOs), and many other community service agencies to ensure this important information is available to the membership. This is a detailed handbook, written in an easy-to read and understand format of a 5th-grade reading level that gives them all the information they need on services, rights and responsibilities, how to file a complaint, grievance or appeal, and much more. In addition to the handbook, we provide inserts that highlight important information from the handbook, this material will be provided to everyone in both English and Spanish, but can be provided in any language upon request and will be available on the website in English, Spanish and Vietnamese.



Getting the Word Out. While all Cenpatico staff are part of our unofficial communications team, it is our local Community Liaisons that conduct primary outreach to disseminate information and conduct community forums. These staff on the Adult/Children's System team work with community agencies and common public facilities such as churches, libraries, community health centers, schools and homeless shelters. Community Liaisons provide information on behavioral health services, community supports, and answer general questions on who is eligible for our services. They share this information by distributing the brochures and flyers at community meetings and events, health fairs and festivals. They also make themselves available for presentations at schools, churches and senior centers to speak on multiple topics such as how to access services. They develop relationships and provide education on how and when Cenpatico can help. Community Liaisons are also a valuable feedback tool for Cenpatico as we are better able to assess the needs of the communities we serve.

In addition to the face to face presentations, presence at events, and visits to stakeholder's offices, our Community Liaisons staff and Peer and Family Program Coordinators hold monthly meetings with stakeholders and members and their families to talk about the issues in the behavioral health system. In these meetings, Cenpatico staff arranges for speakers to come in and address topics that interest the members, such as Understanding the Individual Educational Plan (IEP), presented by the Parent Information Network from the Department of Education for special needs children.

These meetings called Community Advisory Councils (for Stakeholders) and Peer and Family Advisory Councils (for members and their families) are the conduit to bring the community and member voice into the system. Cenpatico Community Liaisons document the comments and issues raised and submit them via a formal work plan to the Chief Officer of Cultural and Community Affairs who sits on the Executive Management team. These issues are discussed with the leadership team; staff assigned to resolve the issue with due dates, and the progress is reported back to the councils at the next meeting.

Our facilitation of Council meetings, participation in various coalition, network and juvenile justice/probation meetings, presence at community events and presentations to diverse audiences in our communities, as well as our community reinvestment program is a testament to our commitment to solicit and listen to the voice of those we serve and partner with our communities to improve the lives of our members and their families.

(b) Illustrate an example of the Proposer's most successful member communication effort that best embodies the system principles outlined in the RFP. **Suggested number of pages: 2**

b)Successful Communication Effort Embodying the System Principles Outlined in the RFP

Cenpatico's approach to behavioral health care starts with the belief that recovery is possible. Our programs align with Louisiana's Guiding Principles, and those of the Children's System of Care including but not limited to: respect for the individual, culturally competent family-centered care, community based care in the least restrictive setting, access to a full array of services that support recovery, advancement of evidence-based practices and empowered individuals participating in their care.

Start Smart for Your Baby®: *High-Risk Pregnancy Management Program.* Cenpatico has successfully implemented communication and care coordination programs for members designed to improve holistic health outcomes. One example of this is Start Smart For Your Baby® (Start Smart) a high risk pregnancy program offered in partnership with our Centene affiliate health plans. Start Smart is a comprehensive pregnancy and postpartum management program, which incorporates the concepts of case management, care coordination, and disease management. Start Smart is designed to improve birth outcomes and infant health by focusing on early identification and risk screening, one-one-one case management, increased frequency of recommended pre- and post-natal care, member and provider incentives, and member education and empowerment. While the key objectives of the program target improved health of the newborn, such as extending the gestational period and improving baby's birth weight; reducing risk of pregnancy complications, premature delivery, and infant disease; and ensuring a healthy first year of life for their newborn; one part of this program is aimed at reducing perinatal and postpartum depression. In 2010, this program received the inaugural URAC/ Global Knowledge Exchange Network International Health Promotion Award, and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, Start Smart was named an NCQA Best Practice.

Within 15 business days of identifying a high risk pregnant member, a Care Manager contacts the Member for assessment and Start Smart enrollment. Start Smart includes, but is not limited to the following components.

Member Outreach, Education and Referrals. A weekly report generated from our TruCare care management health record identifies newly pregnant Members, ***triggering the mailing of our Start Smart educational packet.*** The packet explains Start Smart, the risk of perinatal and postpartum depression and our CentAccount Pregnancy Incentive Program, which provides incentives for completing and submitting a Notification of Pregnancy (NOP) form and attending prenatal and postpartum appointments.

The packet includes our toll-free phone number and Start Smart website address; member rights and responsibilities; our recommendation and process for changing their PCP to an OB; information about our 24/7 nurse advice line; and pregnancy-specific information. Additionally, the packet includes behavioral health information including the Edinburgh Depression screening tool, directions for completion and a self-addressed envelope to expediently return the screening to Cenpatico.

To keep pregnant members engaged in the program, we invite members to Start Smart events focused on prenatal visits, breastfeeding, stages of birth, oral hygiene and care, mental health, family planning, and newborn care. Our staff partner with providers and community-based organizations such as schools and community centers to present educational workshops and other events. These events provide a venue for expectant moms to ask questions and share concerns, as well as for us to identify and outreach to potential high or moderate risk pregnant members and provide education about WIC and other community resources. In many states, we provide incentives of nominal value, such as a Start Smart digital thermometer or onesie, to encourage completion of NOPs, Edinburgh Screenings and participation in events. Centene and Cenpatico staff partner for the Start Smart® Baby Shower Program, which is designed to educate pregnant members about prenatal and postpartum care for themselves and their newborn, and are conducted in a class environment by health plan staff. Led by a registered nurse and assisted by Cenpatico Care Managers or community outreach staff, the classes cover the basics of prenatal care, including nutrition; the risk of smoking and benefits of smoking cessation; the progress of a fetus throughout pregnancy; the importance of regular follow-up with medical providers; and common health and mental health issues that occur during pregnancy including the risks associated with drug or alcohol use during pregnancy.

Provider Education. The Start Smart program includes a provider education component designed to engage the member's health care providers as active participants in the mother and child's overall wellness. This includes, with the member's permission, outreach to any behavioral health providers that may be working with the member. To encourage early detection of perinatal or postpartum depression, Cenpatico provides Edinburgh screenings to PCPs, OBs and behavioral health providers with instructions for returning to Cenpatico for follow-up.

Pre- and Post-partum Depression Screenings. We will include the Edinburgh Depression Scales in the education packets sent to newly pregnant and post-partum members, and instruct the member to complete and return the screening via a prepaid, addressed envelope. A Care Manager will complete the Edinburgh screening during prenatal and post-partum outreach calls, if not already completed by the member. A Care Manager will score the completed tool and analyze results to stratify the member and determine future interventions. For members with positive screening results, the Care Manager with support of the regional Care Management Team will coordinate access to basic and specialty behavioral health assessment and treatment as needed.

Integrated Care Management. Members at high risk of pregnancy complications and poor birth outcomes receive integrated prenatal care management by a Case Manager with obstetrical nursing expertise. For moderate and high risk Members, the Case Manager, with support from the regional Care Management Team, will facilitate access to prenatal care, educate the member on health care needs, assist with social needs, and coordinate any specialty referrals. The Case Manager will contact high risk Members by telephone at least every two weeks and moderate risk Members at least monthly to monitor their condition, and ensure access to needed services and community resources. High risk Members will also receive a home visit if an assessment indicates the need for closer monitoring. The regional Care Management Team will work with providers to contact members who miss prenatal appointments and reschedule or problem solve to address barriers.

Outcomes. Start Smart has achieved improvements across Centene and Cenpatico plans in key indicators of birth outcomes from 2007 to 2010. This included statistically significant decreases in NICU admission rate and NICU days/1000 births, and decreases in all three measures of low birth weight.

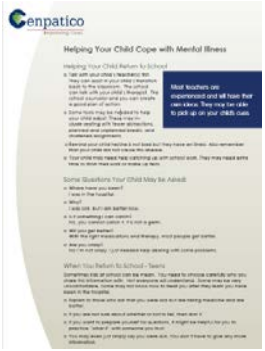
Other Examples of Outreach and Education.

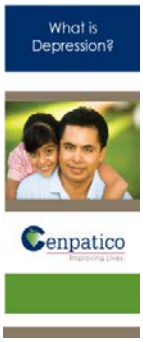
Trauma Informed Care. We have worked to bring increased awareness of evidence-based practices such as Trauma Informed Care, Strengthening the Families and Child and Family Teams. In 2010, Cenpatico provided over 733 trainings on Trauma Informed Care, clinical practice guidelines, program

services and benefits for Texas foster families, providers, judges, DCF case workers, and CASA to help improve awareness of the needs of children and adolescents engaged in the child welfare system. Through successful management and engagement of stakeholders, we achieved a 21.7% decline in the average length of inpatient stay for Foster Children from 2008 to 2010.

Mental Health First Aid. We believe in collaboration and partnership within our community to create effective community-based services. To that end, we recently collaborated with the State of Arizona to sponsor 23 community members from Arizona, in addition to Cenpatico staff in Arizona and Ohio, to become trainers on Mental Health First Aid (MHFA) Certification. This program trains community members on how to recognize when someone is in a mental health crisis and what to do to keep everyone safe until help arrives. MHFA has helped reduce the stigma of behavioral health issues in the general community. We offer presentations throughout our service area explaining MHFA and how to request training for the community. Currently, those trainings are at no charge, but when the current funding for the program runs out, a small fee may be charged for the training handbook provided. Anyone interested in MHFA certification can register on our website. We currently have several trainings scheduled for specialty groups such as police, CPS workers, and college students. One of our local community colleges has agreed to imbed the certification training into their Psychology 101 class, creating the community-sustained presence that lends a sense of permanence to this valuable behavioral health tool.

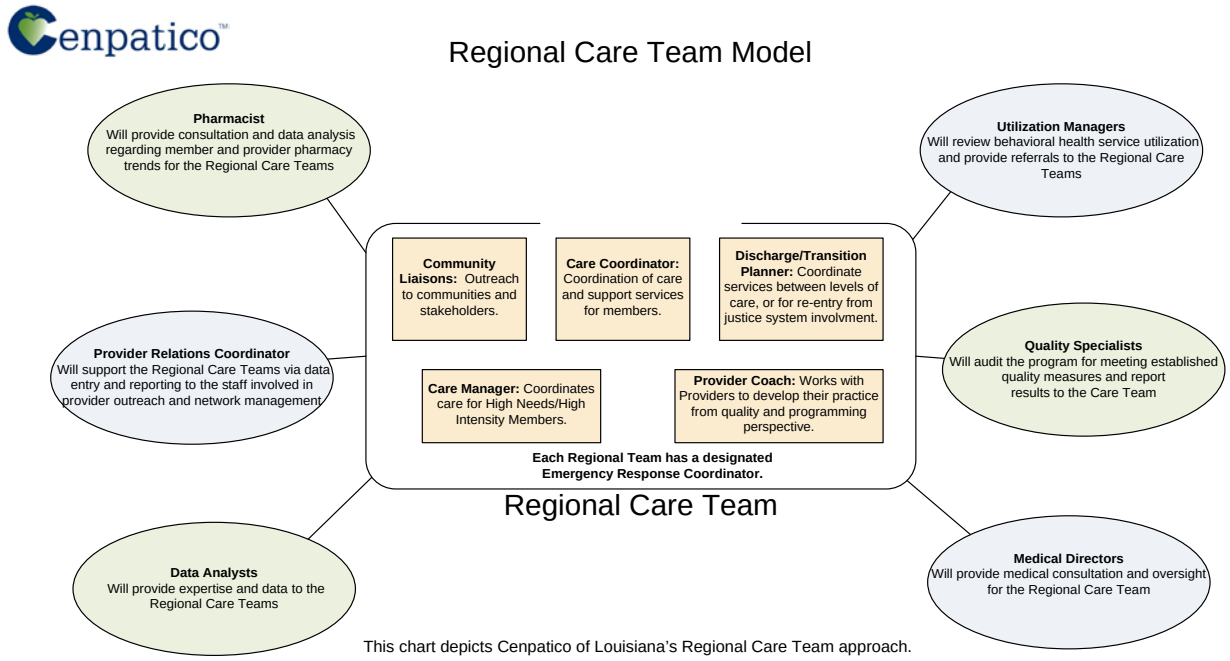
A sample of Cenpatico's library of written educational and outreach materials includes:

View	Title	View	Title
	**Talking to Your Friends & Family About Mental Illness**		**Helping Your Child Cope with Mental Illness**
	**Your Role in Behavioral Health and Wellness**		**Common Behavioral Health Disorders & Famous People Who Have Them**

View	Title	View	Title
	**What is Substance Abuse & Addiction?**		**What is Depression?**

2. b. Care Management
i. Describe how the Proposer will conduct CM and UM of BH services. Describe how CM and UM will be integrated and organized for all covered populations, including workflow. Suggested number of pages: 6, exclusive of workflow

Cenpatico will use a regionalized, integrated Care Management/Utilization Management (CM/UM) model to conduct CM and UM of Behavioral Health (BH) services for the Statewide Management Organization (SMO). Our model is driven by our **person-centered, family directed, culturally appropriate approach** that strives to achieve the least restrictive setting possible for each vulnerable child and adult member that we serve. As a community focused organization; Cenpatico understands the vast geographic, demographic, and cultural differences in each of the ten DHH/OBH regions, as well as the special needs of each population to be served. To effectively serve populations across Louisiana, Cenpatico will establish regionally based teams, consisting of licensed (Masters Level) and non-licensed (Bachelors Level) clinical and community staff with expertise in child, adult and specialty populations. These regional teams will include population specific CM/UM staff. To better integrate CM/UM and coordination of care services at the community level, each Regional Team will include Community Relations Liaisons with expertise in children and adult issues, to include expertise with the foster care population. Because of the unique nature and needs of both assisting with the establishment of, and collaboration with, the Wraparound Agency (WAAs) and Family Support Organization (FSOs), Cenpatico has created a designated WAA/FSO Community Relations Liaison to assist with integration of CM/UM across various regions.



This chart depicts Cenpatico of Louisiana's Regional Care Team approach.

This chart depicts which of those positions will be part of the Regional Care Team and how they will be supported by other centralized functions and positions throughout the Cenpatico organization in Louisiana.

Cenpatico is proposing Regional Care Teams that will be placed throughout the state in order to provide the most efficient and effective, local service for the members and providers that we will serve under this contract.

The CM/UM staff assigned to the regional teams will conduct <u>population specific</u> CM/UM functions as well ensure regional system collaboration. CM/UM staff includes Inpatient and Outpatient Utilization Managers, Discharge/Transition Planners, Care Coordinators, and Care Managers. There will be Community Relations Liaisons assigned to each Regional Team who will be in the community, focusing on collaboration involving Adult and Children's Systems, Community Re-entry, Wrap Around

Agency (WAAs), Family Support Organization (FSOs) and School-based Services. In addition, each regional team will be supported by a Provider Coach. All members of the Regional Teams will work with various stakeholders and focus on collaboration. More information about our regional teams is contained later in our response to this question.

Our Regional Teams will be trained on the System of Care values and principles: Family-driven and youth-guided; Home and community based care; Strength-based and individualized; Culturally and linguistically competent; Integrated across systems; Connected to natural helping networks; Data-driven and outcomes oriented.

Cenpatico's Louisiana CM/UM Program will be overseen by the CM/UM Administrator who reports directly to the Chief Medical Officer (CMO). The CMO has overall responsibility for CM/UM program outcomes. Policies and procedures, best-practice clinical guidelines, comprehensive training programs, robust integrated information management systems, well-developed staffing configurations, and quality measures serve as the framework for our CM/UM integration and organization.

Conducting Utilization Management of Behavioral Health (BH) Services

Cenpatico *will adhere to the UM requirements outlined in Section 2.q and 2.r of the Statewide Management Organization (SMO) Request for Proposal (RFP).* Our UM activities will be targeted and focus on outlier reviews to assess whether or not the member is meeting goals. For example, when a review identifies a member where there is a lack of progress and goals are not being met, the UM will coordinate with the CM team, review the history and services and together, the team will reach out to the provider and appropriate stakeholders (family, case worker, caregiver) to see what changes in services or treatment approach can be made to further support progress for the member.

Our regional-team approach is designed to promote a person-centered, family-driven, community approach that moves away from traditional UM service denials and drives toward use of:

- stakeholder involvement by members, families, caregivers and others
- evidenced-based practices and guidelines
- less restrictive levels of care such as wrap around supports and home and community-based services
- coordination with medical services
- access to referrals for needed covered services;
- provider coordination and clinical practice competency
- integration with government and community agencies

The following program supports contribute to Cenpatico's overall success with UM programs and will be prevalent through the UM program in Louisiana. *The program supports are briefly described below, and are also described in more detail in responses to questions located in Section 2b and 2c.of this RFP.*

Our goal is not to duplicate services, but to facilitate access to the appropriate services and ensure coordination across the delivery system. We serve as a resource for any assistance and/or care necessary through the CSoC and the broader Louisiana BH system of

Policies and Procedures: Cenpatico has extensive experience in establishing the policies and procedures (P and Ps) used to conduct UM activities for BH services. Our P and Ps will direct the processes that we use to ensure the consistent provision of medically-necessary

quality covered services to the populations eligible for services by the Statewide Management Organization (SMO). They will guide the assistance we provide to LGEs and WAAs for UM functions.

Established Clinical Criteria and Practice Guidelines: The respective child and adult utilization managers will review the medical necessity of health care services using established criteria and practice guidelines. Interqual ® Medical Necessity criteria is used for authorizations of acute inpatient and residential behavioral health services. Condition-specific practice guidelines supplement Interqual® use. The Level of Care Utilization System (LOCUS) is used to support adult level of care determinations. The Child and Adolescent Level of Care Utilization System (LOCUS) and/or Child Adolescent Needs and Strengths (CANS) tools are used to support child level of care determinations. *Additional detail concerning clinical guidelines and their application of is included in our response to question 2.c.i.-viii of this response.*

Staff Training: Cenpatico's staff education programs for Utilization Managers ensure training is provided on the person-centered, family-driven principles that drive our CM/UM program. Our training goes beyond use of guidelines. It will educate staff on the Coordinated System of Care (CSoC) and provide a thorough review of alternative levels of care including community-supports and wrap-around services. Staff training will also incorporate cultural competency, population specific issues and the concept of integration through all staff training activities.

Integrated Information Management Systems: Cenpatico's robust integrated information management systems supports every aspect of our CM/UM activities. ***TruCare*** provides real-time integration of CM and UM activities. All regional team members have appropriate levels of access to the system based on their role. TruCare affords a comprehensive view of every member by integrating multiple data sources. Clinical staff use TruCare to review notifications of admissions; authorization requests; conduct concurrent reviews; attach pertinent clinical information; record review results; make referrals for physician advisor reviews, specialty programs such as the CSoC and care coordination and care management services; perform assessments and care planning; and, review treatment plans and plans of care. Managers use trending and other analytical reports generated by TruCare to evaluate operational, clinical, and administrative components of utilization management activities. *Further detail concerning the Care Management components of our system are contained in Section 2.b.ii.b of this RFP response.*

Staffing Components: Our CM/UM organization chart is provided in our *response to question 2.b.ii. of this RFP*. It depicts our managerial structure and staffing plan which is designed to fully support our regional model and the covered services and covered populations outlined by the DHH/OBH. The regional component of our program fully supports a community-focused, person-centered and integrated approach to include WAA implementation and development. The UM program staff will include Utilization Managers who are Licensed Mental Health Professionals (LMHPs) and Licensed Addition Counselors (LACs). The UM staff will have expertise in child, adult and specialty populations, to include expertise with co-occurring substance abuse and foster care populations. As appropriate, adult experts will perform UM activities for adult members and child experts will perform UM activities for children and adolescents.

The UM staff will be divided into two subsets: 1) inpatient UM and 2) outpatient UM. Each group reviews the medical necessity of health care services using established criteria and practice guidelines. *They are described in more detail in our response to question 2.c.i.-viii of this SMO RFP response.* The goal of UM is to ensure the right services, in the right amount, are delivered at the right time. In order to achieve this goal we evaluate both the severity of need and the intensity of services. As an example, as required by the Section 2.q. of the RFP, ***we will ensure that face to face inpatient psychiatric reviews are performed by an LMHP for each eligible member referred for psychiatric admission in a general hospital.*** As mentioned above, not only will UM staff be assigned to either inpatient or outpatient UM,

they will also be assigned to serve adult or child populations. This will allow for greater specialization in the needs of each respective target population.

The Adult UM staff will have the following skills and/or backgrounds:

- Specialized experience in working with persons designated as Seriously Mentally Ill (SMI),
- Experience in working with Psychiatric inpatient, substance abuse inpatient and/or residential care services, etc.
- Experience with outpatient behavioral health treatment services, outpatient substance abuse treatment services, crisis services etc., wrap around supports, use of peer and family services.
- History in working with members with co-occurring substance use disorders, addictive disorders, and severe co-morbid physical health conditions, etc.

The Children and Adolescent UM staff will have the following skills and/or backgrounds:

- Specialized experience in working with developmental disabilities (DD), intellectual disabilities (ID) and/or seriously emotionally disturbances (SED), etc.
- History in working with Psychiatric inpatient and/or residential care services, etc.
- Experience with outpatient treatment services, crisis stabilization services, home and community-based waiver services, etc., peer and family supports, Children's Systems of Care.
- UM Staff assigned to the foster care population will have experience with the foster care system.

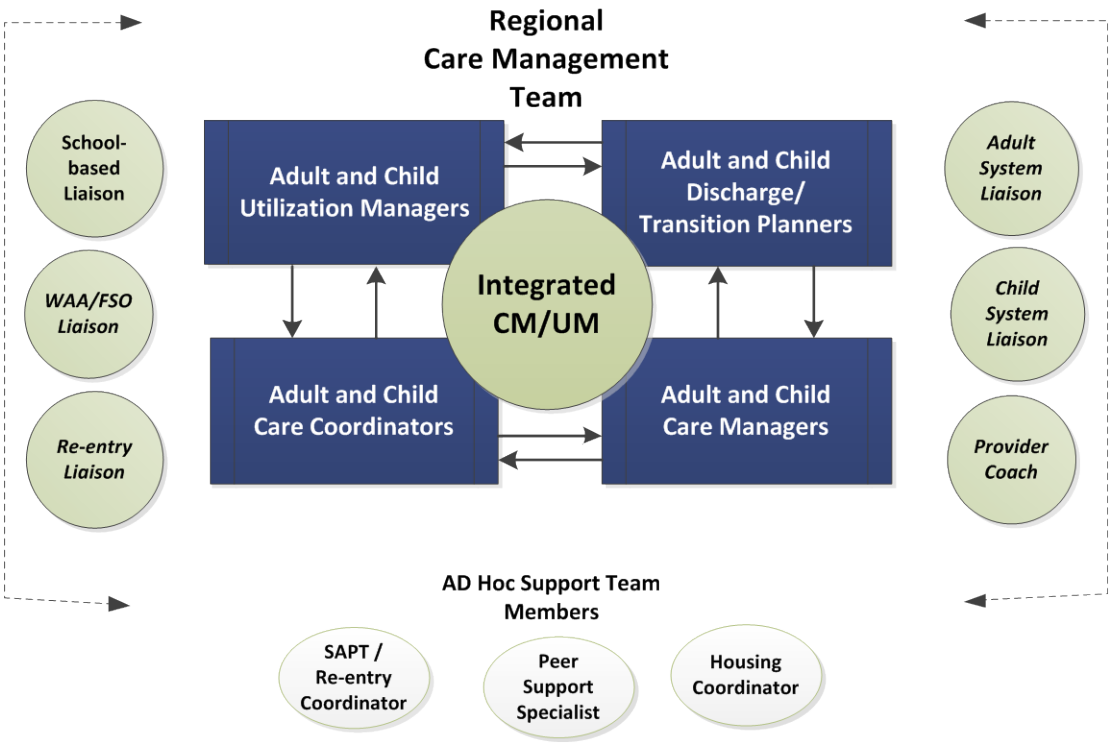
Utilization Management Quality Measures: Our Chief Medical Officer will work closely with our CM/UM and Quality Management Administrator to ensure tracking, trending, and analysis of utilization management data. Activities will target reduction in the number of general and psychiatric hospitalizations, the use of residential levels of care, the length of inpatient and residential stays and strive to increase use of wrap around services and community supports. *We provide a comprehensive description in our responses to 2.c.i.d, 2.c.iv, 2.c.vii and 2.c.viii of this response*.

Conducting Care Management of Behavioral Health Services

The Cenpatico Care Management (CM) program will serve as the hub of our behavioral health service management program. We recognize that each of the Partnership's ten regions have unique geographies, demographic needs, and cultural considerations. We know that it is the person receiving services who is most impacted by these regional differences and that ensuring improved services at the member-level and population-level requires transformational change at the local level. Our regional approach is designed to directly support regional and systemic integration and change.

Regional Care Management: As a learned best practice from our Arizona and Texas programs, Cenpatico realizes that care management program success requires the development of collaborative relationships with the all systems of care, to include LGEs, local stakeholders, providers, and community and governmental agencies. Cenpatico looks forward to joining existing interagency collaborations and building strong collaborations at the local, regional and state levels. As we develop and build on existing and new community and regional efforts, we will immediately begin serving members, supporting LGEs, and work with existing WAAs/FSOs as well as assist with the development of new systems. The utilization of Regional Teams will assist us to build relationships in existing communities while we concurrently provide the services necessary as required by the RFP, and necessary for a truly integrated system of care. Because Cenpatico focuses so much on the populations served and the community stakeholders in each community, we will continue to successfully conduct a vast array of comprehensive, integrated care management services. Regional Team members will work locally and our central service center in Baton Rouge will serve as their home-base.

Each regional care management team will incorporate staff with the necessary clinical, provider management and operational liaison expertise to focus on the various populations we are serving. The diagram and table below depicts the configuration of our integrated Regional Care Management program.



Regional CM/UM Team Staff Title	Regional CM/UM Team Staff Title
Adult and Children Utilization Managers – Inpatient	Community Re-entry Liaison
Adult and Children Utilization Managers – Outpatient	Adult System Liaison
Adult and Children Discharge / Transition Planners	Community Re-entry Liaison
Adult and Children Care Coordinators	WAA/FSO Liaison
Adult and Children Care Managers	Children's System Liaison
Provider Coaches	

The actual numbers of staff per team will be based on the regions' geographic size, provider network capacity and capabilities, and number of eligible enrolled members. Due to population density, a few teams will be responsible for two or more regions. Liaison team members may be shared between teams. Non-team members who provide ad-hoc support will include the Supportive Housing Specialist, SAPT Re-entry Coordinator, and the Peer-Support Coordinator, these staff members are shared between teams and support the needs of specialty populations, such as persons with Serious Mental Illness. Below, we have provided detail on the Care Management team roles of Discharge/Transition Planners, Care Coordinators and Care Managers. Additional detail concerning the roles of liaisons and ad hoc support team members is *available in* ***Section 5, Appendix 2.b.i***.

Discharge/Transition Planning: Discharge/Transition Planners have a major role in our CM processes. Each Discharge/ Transition Planner is responsible for ensuring that specific care management functions are provided. Discharge Planners champion the transition from inpatient and residential levels of care to less restrictive care and community-based services. They will maintain resource lists and develop relationships with network providers, case managers (if assigned to the member) and caregivers while tracking the member's progress in the current setting and upon transition to a community based setting or next placement. Discharge/Transition Planners help *plan the next move*, reducing administrative delays

and increasing the appropriateness of alternative services. Discharge planners work closely with the Provider Management team and the regional team's Provider Coach to develop and expand network resources to meet the specific needs of members transitioning out of inpatient and/or residential care. They also work closely with Care Coordinators and Care Managers to obtain a person-centered view of the member and to ensure that the services that are provided are culturally appropriate and member and/or family directed.

Care Coordination: Care Coordinators will ensure the timely and appropriate delivery of a variety of services needed by members, to include members who have co-occurring disorders or who are receiving waiver services. Care Coordinators assess member needs, determine appropriateness of medically-necessary waiver services, and authorize services. Care Coordinators focus on the elimination of service duplication, and the provision of person-centered, community focused, and culturally competent covered services that are delivered in the least restrictive setting possible. Because many Louisiana SMO members will be involved with the behavioral health system following encounters with the criminal justice system; receiving school-based waiver services; or receiving Substance Abuse Prevention and Treatment services, we expect that the Care Coordinator will work closely with our community relations liaisons and that this effort will be directed to the level of the individual member and the system as a whole. Due to the state of the current behavioral provider network in many regions, we also expect that the Care Coordinator will work closely with the Provider Development and Management departments, the regional team Provider Coach and will consult frequently with the Medical Aministrator and Addictionologist. Members receiving waiver services will transition to the Care Manager when eligibility for the Coordinated System of Care is determined. In these cases, the Care Coordinator will work closely with the team's Care Manager to transition services.

Care Coordination Success Story

MM is a 23 year old male with a long history of inpatient psychiatric admissions due to psychosis. He is diagnosed with Schizophrenia and has been suffering from significant delusions and hallucinations and as a result has engaged in numerous dangerous behaviors. Upon enrollment into Medicaid services, a Care Manager was immediately assigned, and began working with MM, his family and the case manager. His family was unable to help him access appointments and it was clear traditional outpatient services were not adequate. The Care Manager coordinated involvement with a therapist, prescribe, vocational counselor and team leader to provide wrap around services, to include transportation. There were issues with his adherence to medication and together, the team was able to engage MM with his compliance with his medication regimen. MM has been out of the hospital for three months, and the Care Manager connects with MM and the team regularly to make sure he is still in treatment, and assist with working towards personal goals. The Care Manager was able to help overcome barriers, bring together the team, access community resources and develop a plan that directly met MM's needs.

Care Managers: Care Managers will provide **intensive** care management services to all adult and child members with complex needs that are high risk members. Care Managers will be involved in extensive collaboration with the members, families, caregivers, case workers and/or any other stakeholder involved in the member's care, as well as the treatment providers. Using a fully integrated, holistic approach is imperative to a quality and effective system of care. Care managers serve as the *facilitator, coordinator – the glue* - that pulls all of the services, perspectives, people and needs together.

Persons with Serious Mental Illness (SMI) need continuous and constant support. Care Managers will have ongoing contact with the member and the treatment provider to track and help coordinate care. Care Managers will embrace the recovery model, taking a person-centered culturally competent approach that meets the person where they are and strives to ensure the highest quality of life possible. We recognize that fully engaging these vulnerable members is critical helping them stay in the community. The integration of our Peer Specialist position into this service delivery model significantly aids with the engagement of this vulnerable population. Our Peer Support specialist will serve as a valuable resource for our Care Managers. We are aware that the delivery system may be fragmented and limited in several of the regions. Thus, we anticipate that care managers will also work closely with the Supportive Housing Program Specialist, Provider Coach, Provider Relations Coordinator and others to coordinate effective, quality care.

Specifically, we know that adults with SMI need quality assessment and evaluation, access to multiple levels of treatment; support, psychosocial, housing and vocational services; referral and coordination with community resources, utilization of peer supports, home care coordination and crisis intervention services

The Care Managers assigned to this population will have extensive experience working with adults with SMI as well as the community supports necessary to pull the system of care together.

Members who are enrolled in the Coordinated System of Care (CSoC) will also receive Care Management; however, the approach will be somewhat different based on the services available through, and needs of, the WAA and FSO. The Care Manager will coordinate with the WAA Facilitator once referrals are made to the CSoC, through the development and implementation of the Plan of Care, and for all services while the member is in care. **Our goal is not to duplicate services, but to serve as a resource for any assistance and/or care necessary through the CSoC**. In addition, the Care Manager will work closely with all of its Regional Team members, to include the WAA/FSO Community Relations Liaison and the Children's System Community Relations Liaisons, to promote the use of community-based services. The Care Manager will be part of the community treatment team, a resource to all who are serving vulnerable populations in Louisiana.

For youth involved with DCFS and/or OJJ, there are often multiple placements, significant behavioral issues that often present as a mental health issue, siblings that are separated, parents that are going through services and recurring trauma experienced by the youth by the mere fact they are in out of home placement. It is the Care Manager's responsibility to assess the situation, the extent of previous and ongoing trauma, identify overarching needs and work with the WAA/FSO and the Child and Family Teams as appropriate to design and implement a comprehensive, achievable and successful plan to return this child to his/her home setting. If that is not possible, the Care Manager will work diligently with the WAA, DCFS and involved CPAs to assist with transition to other permanent solutions.

Instead of coming in and 'telling the providers how to do things', our team members will learn about the providers current UM and CM activities, determine provider competencies, offer improvement strategies, facilitate use of new funding streams, and assist the providers to access covered services for clients.

Care managers will utilize TruCare, our integrated care management system that provides real-time, web-enabled functionality to promote care management activities and service integration. Furthermore, TruCare, with the appropriate member and systems permissions, promotes provider access to the member's TruCare record. *For*

further information on our clinical information management systems see our response to 2.b.ii.b.

Approaching Providers: We appreciate the challenges that Louisiana providers have faced over the last several years and recognize that as a result they have been in "survival mode" frequently developing their own systems of care, with or without Medicaid funding. *Therefore, the approach of our regional teams will be on collaboration and collegiality*. When practice improvement is deemed necessary, team members will consult with the Chief Medical Officer, Physician Advisor and/or Medical Administrator Management, and/or Quality Management Administrator. We will work with providers to gather feedback regarding systems improvements, streamlining processes and assisting them to do their job better. Providers are one of most important assets, and as such, meeting their needs and reducing barriers to their service delivery will ultimately increase the quality of care provided to the member.

Integrating CM and UM

Care Managers and Utilization Managers work hand in hand. Often, UMs will work with the provider, reviewing medical necessity, the treatment modality being implemented, member goals and ongoing progress to those goals while Care Managers are working directly with the member and other stakeholders to identify specific needs, help facilitate access to resources, and coordinate care. Neither the UM or CM functions should, nor will, operate independently. Together, the CM and UM can coordinate the holistic approach to care. For example, the Utilization Management staff will review multiple a multitude of information from a variety of sources. These UM reviews will not only support medical necessity decisions *(described in our responses to questions 2c.i-2.c.viii)*, but will also serve to facilitate care management activities. For example, if a child is in a psychiatric facility, the UM will coordinate with the hospital on the care being provided. The care manager will work with the family (or case manager) to identify the triggers that led to hospitalization and the care needs upon discharge. The discharge/transition planner will coordinate placement days; help prepare the next placement for issues that may arise upon and after transition, whether it is back to family or to a less restrictive community setting. During transition, there are multiple *moving pieces* and together, the CM/UM team helps make this process as smooth and seamless as possible for the member, and caregivers as appropriate. Coordination of care among this team is supported by the TruCare system *(described in our response to 2.b.ii.b.)*.

Care managers utilize a broad variety of information to assess member needs, to include the information derived directly from the member as well as those closest to the member. In addition, below is a partial list of information sources the care management team will review:

Child and Adolescent Needs and Strengths (CANS) evaluations	Individualized Education Programs (IEPs)
Plans of Care	Treatment plans
Behavioral health claim and cost data	Pharmacy data
Crisis plans	Medical claims and lab data (if available)
Clinical behavioral treatment information	Substance abuse treatment information
Functional assessments	Child and Family Team documentation
LOCUS© and condition-specific assessments	Discharge Plans
Interqual® review criteria	Health Risk Assessment (HRA) data

Our integrated care management model takes advantage of the synergies that exist between UM and CM services. It is built on holistic member-centered principles that provide a comprehensive view of the strengths and needs and the member and family. The program provides activities specific to the member's eligibility status and the covered service that is being required. Each member of the team

performs a specific role that contributes to the member receiving services in the least restrictive setting and to family-driven care.

CM/UM Integration for Covered Services and Eligible Populations*: *Appendix 2.b.i in Section 5 is a comprehensive table that depicts the role of the regional team members specific to the covered service and the eligible population. Activities performed by the team members are outlined along with their corresponding integration activity. Below, is an example of the role of the team's Care Coordinator.

Care Coordinator- Covered Services and Populations

The Care Coordinator, a non-licensed Social Worker arranges unlicensed rehabilitation services for the following populations:

- Medicaid children
- CSoC
- Medicaid Adults eligible for the 1915i waiver
- OBH adults and children
- OJJ/DCFS

The Care Coordinator also arranges *rehabilitation substance-abuse* services for following the SMO eligible populations:

- Medicaid children
- CSoC
- Medicaid Adults
- Medicaid Adults eligible for the 1915i waiver
- OBH adults and children
- OJJ/DCFS

Care Coordinator - Activities for Outpatient and Waiver Services:

- Provision of person-centered, family-driven, culturally appropriate care coordination with a goal to increase use of community supports, and reduce the use of higher levels of care such as inpatient hospitalizations
- Coordination of referrals for rehabilitation (nonprofessional) for Community psychiatric support and treatment; psychosocial rehabilitation; and, crisis stabilization, ensure the member and the family (when appropriate) are active participants in referral processes
- Coordination of referrals for substance abuse treatment; ensure the member and the family are active participants in referral processes
- Coordination of referrals to qualified community providers according to access standards and/or to the SMO Care Manager for WAA/FSO for CSoC eligible members, ensure the member and the family are active participants in referral processes
- Collaboration with service providers regarding treatment plans and revaluations ensure the member and the family(when appropriate) are active participants in referral processes
- Perform immediate crisis screening for access of care requests, warm transfer as required if needed; conduct appropriate health risk screening: CANS brief assessment for youth; LOCUS for adults
- Identify those under 22 with significant BH challenges, co-occurring disorders or out of home placement risk (functionally eligible for CSoC) and those under 22 using multiple systems,

Adults eligible for 1915i HCBS, IV drug users, Pregnant substance users as well as substance using women with dependents or dual dx, adults eligible for 1915i State plan services

- Authorize covered services to the lowest level of care that meets the member assessed needs
- Track authorization timelines, perform re-assessments when indicated.
- Obtain signature for release of information from the member (or family/caregiver for children) to coordinate care with the PCP, other health care providers, and MCO
- Coordination of regional emergency responses

Care Coordinator – CM/UM Integration Activities

The Care Coordinator has the responsibility to document all UM activities that are provided through Care Coordination in the TruCare system so that they are accessible for viewing by all Regional Team Members. Additionally, the Care Coordinator will:

- Participate in weekly clinical rounds with the Medical Administrator and weekly Regional Team meetings to discuss care coordination concerns and issues and plan strategies at the member and system level.
- Receive referrals via TruCare for OP services from Outpatient UM, Discharge planner, Care Coordinators, and, Care Managers.
- Generate referrals for Care Coordination and Care Management via TruCare.
- Collaborate with school-based services community liaison regarding DOE and school related issues.
- Collaborate with Provider Coach for provider education on covered waiver services.
- Collaborate with Community re-entry/SAPT Program Specialist for members re-entering BH system from the justice system
- Obtain records from providers, attach to TruCare System, for team availability.
- Document collaboration in TruCare.

Workflow for the Integration of CM and UM Initiatives

CM and UM staff will work together to ensure that Cenpatico's membership in Louisiana receives quality behavioral health services. All practices will support integration of CM and UM activities in an effort to provide continuity of care as members move from one level of care to another. Documentation in the TruCare system is a key mechanism for keeping all parties informed of action taken on any case.

Integration of Inpatient (IP) UM and (CM): Upon admission to an inpatient facility, the IP UM staff will complete the following action steps:

1. Using the referral mechanism in TruCare, alert the appropriate Discharge Planner of the admission
2. If the member has an open CM case, use the referral mechanism in TruCare to alert the assigned CC/CM of the admission.
3. Participate in weekly clinical rounds with the Medical Administrator, IP UM staff, and the CM Team to share pertinent case updates.
4. Clearly document all concurrent reviews and clinical information obtained from hospital staff for use in treatment authorizations.

Upon admission to an inpatient facility, the CM staff will complete the following action steps for members assigned to his/her caseload:

1. Participate in weekly rounds with the Medical Administrator, IP UM staff, and the CM Team to share pertinent case updates.

2. Provide IP UM staff and Discharge Planning staff with information related to outpatient treatment prior to the admission and any knowledge related to events that might have triggered the most recent admission.
3. Respond to requests for information made by the Discharge Planner. If this is a readmission, the Discharge Planner will contact the assigned Service Manager to request any information that might assist in the plan for discharge.
4. Screen for any changes to the member's needs.
5. If the member has a Plan of Care, review the plan to determine if updates are needed. If clinically indicated, update the plan to incorporate changes to goals, medications, or demographic information.
6. Document all case activity in TruCare to ensure it is readily available to UM and Discharge Planning staff

Upon discharge from an inpatient facility, the Discharge Planner will complete the following action steps:

1. If the member has an open CM case, use the referral mechanism in TruCare to alert the assigned CC/CM of the discharge.
2. If the member does not have an open CM case, use the referral mechanism in TruCare to alert the regional Clinical Supervisor of the discharge.
3. Follow up with member to ensure that he/she attends scheduled outpatient appointments within 7 days of discharge.
4. Fax discharge clinical information obtained from the hospital to the PCP and other outpatient treatment providers, including the psychiatrist and therapist.
5. Participate in weekly clinical rounds with the Medical Administrator, IP UM staff, and the CM team to share case updates.
6. Clearly document all action taken on the case in TruCare.

Integration of Outpatient (OP) UM and CM: When OP UM staff review outpatient treatment requests, the following actions steps will be taken:

1. Review the clinical record in TruCare to obtain as much information about the treatment history of the member.
2. If the member has an open CM case, contact the assigned staff for input regarding progress toward outpatient treatment goals.
3. If a service denial is issues on an open CM case, send an alert through TruCare to the assigned staff so that he/she can follow up to provide referrals to other treatment providers or community supports if needed.
4. If a service denial is issued on a member who does not have an open CM case, send an alert through TruCare to the appropriate regional Clinical Supervisor for assignment to the CM team for follow up in providing referrals.
5. When review of an outpatient treatment request leads to knowledge of additional unmet needs, alert the CM team for follow up to ensure those treatment needs are met.
6. Participate in weekly rounds with the Medical Administrator, OP UM staff, and CM team to discuss cases and processes.
7. Document all action taken on a case in TruCare.

CM staff will take the following action steps in support of OP UM activities:

1. Respond to requests for additional information regarding member progress.
2. Outreach to members when services are denied to link with new providers or community resources.
3. Participate in weekly rounds with the Medical Administrator, OP UM staff, and CM team to discuss cases and processes.
4. Document all action taken on a case in TruCare.

2.b. Care Management
ii. Provide an organizational chart for the CM/UM department(s) that includes position titles, numbers of positions, and reporting relationships. Describe the required qualifications for each position, (with the exception of Psychiatrist, Psychologist Advisors that will participate in the CM/UM program, which are addressed later in this section).

Cenpatico's proposed Care Management/Utilization Management organizational chart for the Louisiana Behavioral Health Partnership Statewide Management Organization is shown below.

Cenpatico CM/UM Positions, Qualifications and Experience		
Position	**Credentials/Required Qualifications**	**Experience & Expertise**
Care Management/ Utilization Review (UM) Administrator	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 5 years experience in public sector, managed behavioral health care, including experience with the implementation of a UM program with emphasis on community and family-based services • At least 5 years experience as a Clinical Administrator or similar role for a managed behavioral health care organization • Knowledge of utilization review procedures, case management and familiarity with mental health and substance abuse community resources in the geographical area
Clinical Manager (Adults)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 4 years case management experience • At least 2 years of supervisory experience • Knowledge of case management, utilization review procedures, and familiarity with family-based, mental health, and substance abuse community resources in the geographical area
Clinical Manager (Children)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 4 years case management experience • At least 2 years of supervisory experience • Knowledge of case management, utilization review procedures, and familiarity with mental health and substance abuse community resources in the geographical area • Knowledge and familiarity with consumer and family organizations for children and youth including child-serving agencies (child welfare, juvenile justice, schools, mental health and addictions)
Utilization Management Manager (Adults & Children)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 4 years of utilization management experience • At least 2 years of supervisory experience • Knowledge of utilization review procedures, experience in psychiatric health care settings, and familiarity with all levels of mental heath treatment • Knowledge and familiarity with mental health and substance abuse community resources in the geographical area including consumer and family organizations for children, youth and adults
Utilization Management Supervisor (Adults & Children)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years utilization management experience • At least 1 year of supervisory and/or lead experience • Previous experience in psychiatric health care settings including utilization review

Cenpatico CM/UM Positions, Qualifications and Experience		
Position	**Credentials/Required Qualifications**	**Experience & Expertise**
		• Knowledge and familiarity with mental health and substance abuse community resources in the geographical area including consumer and family organizations for children, youth and adults
Clinical Supervisor (Adults)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years case management experience • At least 1 year of supervisory or lead experience • Previous experience in behavioral health care settings • Knowledge of case management, and utilization review procedures and familiarity with mental health and substance abuse community resources in the geographical area • Knowledge and familiarity with consumer and family organizations for adults
Clinical Supervisor (Children)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years case management experience • At least 1 year of supervisory or lead experience • Previous experience in behavioral health care settings • Knowledge of case management, and utilization review procedures and familiarity with mental health and substance abuse community resources in the geographical area including consumer and family organizations for children and youth
Utilization Manager (Adults & Children)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years in psychiatric and/or substance abuse health care settings including utilization review • Knowledge and familiarity with mental health and substance abuse community resources and network providers in the geographical area • Expertise in authorizing mental health and substance abuse services using psychosocial necessity to address needs for those with multiple, serious or chronic needs and special needs of adults and children and their families
Care Manager (Adults)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years experience of case and/or utilization management experience • Experience in behavioral health care settings • Knowledge of case management and utilization review procedures and familiarity with mental health and substance abuse community resources in the geographical area • Knowledge and familiarity with mental health and substance abuse community resources in the geographical area including consumer and family-based organizations for adults •

Cenpatico CM/UM Positions, Qualifications and Experience		
Position	**Credentials/Required Qualifications**	**Experience & Expertise**
Care Manager (Children)	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years experience of case and/or utilization management • Experience with behavioral health care settings, child behavioral health conditions and members with special needs • Knowledge and familiarity with mental health and substance abuse community resources in the geographical area including consumer and family organizations for children and youth
Care Coordinator (Adults & Children)	• Bachelor's degree in Social Work or related field or equivalent experience	• At least 2 years of experience in managed care and/or behavioral healthcare setting • Practical knowledge of Medicaid and Health Plan administration • Familiarity with mental health and substance abuse community resources in the geographical area
Discharge Planner (Adults & Children)	• Bachelor's degree in Social Work or related field or equivalent experience	• At least 2 years of experience in managed care and/or behavioral healthcare setting • Practical knowledge of Medicaid and Health Plan administration • Knowledge and experience with treatment planning process • Familiarity with mental health and substance abuse community resources in the geographical area
Community Re-Entry Transition Planner	• Bachelor's degree in Social Work or related field or equivalent experience	• At least 2 years of experience in managed care and/or behavioral healthcare setting • Practical knowledge of Medicaid and Health Plan administration • Knowledge and experience with treatment planning process • Familiarity with mental health and substance abuse community resources in the geographical area • Familiarity with justice system and re-entry programs

***NOTE:* Licensed Mental Health Practitioner (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance abuse acting within the scope of all applicable state laws and their professional license. A LMHP include the following individuals licensed to practice indepently:**

Medical Psychologists	Licensed Psycholgists	Licensed Clinical Social Workers (LCSWs)	Licensed Professional Counselors (LPCs)	Licensed Marriage and Family Therapists (LMFTS)
Licensed Addiction Counelors (LACS)	Advanced Practiced Registered Nurses (must be a nurse practitioner specialist in Adult Psychiatric & Mental Health, and Family Psychiatric & Mental Health or a Certified Nurse Specailist in Psychosocial, Gerontological Psychiatric Mental Health, Adult Psychiatric and Mental Health, and Child-Adolescent Mental Health and may practice to the extent that services are within the APRN's scope of practice)			

In our response to Question 2.b.i, we describe our Regional Care Management Teams. The Utilization Managers, Discharge Planners, Care Coordinators, and Care Managers described above report to the Care Management Department's Organizational Structure. The other team members include a variety of specialty liaisions and a provider coach. These staff members organizationally report to the Chief Operating Officer; however, they are assigned as Regional Team support members.

(a) Describe the ongoing monitoring protocols for CM/UM staff including the nature and frequency of supervision, documentation of audits, call monitoring, and any other oversight activities. **Suggested number of pages: 4**

Cenpatico has comprehensive and efficient behavioral health policies and procedures outlining protocols for monitoring Care Management/Utilization Management (CM/UM) staff. Supervision of staff occurs through a variety of processes, to include weekly clinical rounds with the Medical Director to review complex cases, individual case audits, call monitoring, and inter-rater reliability. The CM/UM policies and procedures ensure that utilization and care management decisions are made in a fair, impartial and consistent manner that also takes into account the unique circumstances of each individual.

Staff Supervision/Weekly "Rounds"

Our CM/UM staff have on-demand access to clinical supervisors and managers (all of whom are licensed behavioral health clinicians), and to medical directors and physician advisors. Care Management/ Utilization Management staff meets weekly with the clinical supervisor and medical director to review complex cases. For example, consumers who have been in the hospital two or more times within the prior 30 days are reviewed to ensure appropriate discharge plans are in place to prevent readmission. Both Care Managers and Utilization Managers, as well as Discharge/Transition Planners, participate in rounds ensuring optimal collaboration on complex cases. Staff has the opportunity to present cases and ask questions related to treatment plans and medication regimens, and then are better able to offer input to treating providers during the review process. The CM/UM staff may also request that the medical director make a consultation call to the treating provider as needed.

Audits

Cenpatico regularly monitors Care and Utilization Managers' documentation of member care. Charts are reviewed on a monthly basis using a standardized audit tool to ensure that all policies and procedures are consistently followed and that specific information in the members' utilization management record is documented appropriately.

Care and Utilization Management personnel are required to capture specific information during assessments and reviews. A random sample of charts from each CM/UM staff member is pulled monthly by the Clinical Supervisors to identify if the standards of documentation are being met and ensure that records are clinically complete, and to ensure that policies and procedures are consistently followed. CM/UM staff is required to score greater than 90 % on record reviews.

If the score of 90% is not achieved, the clinical supervisor will discuss identified concerns, provide feedback on areas for improvement and identify any training needs. A follow up audit will be conducted one week after this session to determine if improvement has been made. If CM/UM scores less than 90% at the follow up audit, a verbal counseling session with the clinical supervisor and Medical Director will occur to provide feedback on areas for improvement and to identify additional training needs. A follow up audit will be conducted one week after this session to determine if improvement has been made. Ongoing scores that are less than 90% will result in the development of a performance improvement plan designed to increase required core competencies through ongoing training. Audits will be repeated weekly until the score meets the accepted threshold.

Results of the monthly chart audits are presented on a quarterly basis to the Utilization Management Committee. Completed audit forms are maintained in the UM department files for a period of three (3) years.

Call Monitoring

A Quality Management system is used to record phone calls made and received by staff. Clinical Supervisors monitor staff interactions with clients by listening to recordings made by this system. An audit tool is used to measure staff performance in this area. In addition to reviewing the calls to determine the appropriateness of clinical information exchange, the supervisor also reviews the engagement techniques used by the staff member.

Our CM/UM staff are trained in the Guiding Principles of Family-Driven driven care as outlined *on page 35 Section A.2.x of the Statewide Management Organization (SMO) RFP*. Also, organizationally we embrace the Recovery Philosophy. We hold our staff accountable to use person-centered and holistic approaches and to demonstrate respect for the concept of shared decision-making and responsibility for outcomes when speaking with clients, their families and/or other stakeholders. Call monitoring is a component of the strategies we use to maintain staff focus on the importance of client recovery and resilience.

In order to effectively develop collaborative relationships with Wraparound Agencies (WAAs), Psychiatric Residential Treatment Centers (PRTFs), Qualified Service Providers including Federally Qualified Health Centers (FQHC) and Community Mental Centers, and other stakeholder agencies it is essential to develop and maintain collegial relationships. Therefore, call monitoring is used to identify vocal changes and words that could be perceived negatively by the listener.

Calls are reviewed for each staff member monthly, and results are reviewed with staff. Areas of concern identified are discussed with staff and plans for improvement are developed. When appropriate, retraining and/or role modeling exercises are provided, if follow-up monitoring does not indicate improvement, progressive actions occur.

Inter-rater Reliability

At least annually, we use inter-rater reliability processes to evaluate the consistency with which physicians and Utilization Managers (UM) apply UM criteria in medical necessity decision-making. Data from the annual inter-rater reliability assessment is reported to our Quality Improvement Committee, including a side-by-side comparison of reviewers' determinations on sample cases or scenarios:

a. The percentage of concordance among reviewers.

b. Appropriateness of application of medical necessity criteria for each reviewer.

All CM/Clinical staff who apply medical necessity criteria as a functional requirement of their position must participate in this annual assessment. Where opportunity for improvement is identified as a result of this process, we initiate additional training or other corrective actions as needed through our continuous quality improvement process.

Cenpatico has experience maintaining inter-rater reliability for assessments/evaluations. Cenpatico will also demonstrate and ensure inter-rater reliability of evaluation and assessment tools, including the Children Assessment of Needs and Strengths (CANS) tool and the LOCUS© level of care placement assessment instrument for psychiatric and addiction services for adults. An inter-rater reliability tool will be developed and implemented to be administered annually to ensure consistent application of each of the assessment tools required for use by the SMO contract. Cenpatico staff administering these assessments will also receive annual refresher training which will include administering the instruments based on case vignettes. Additional training will be provided to those who do not demonstrate competency. Clinical supervisors will audit charts for each staff. The audit instrument will include elements that evaluate appropriate application of the assessments used. Team discussions will occur on an ongoing basis during staff meetings which will allow for the opportunity to ensure consistency among evaluators.

The Child & Adolescent Service Intensity Instrument (CASII) is an assessment tool utilized by provider agencies in order to determine the complexity of needs and necessary service intensity for youth aged six through seventeen. Fidelity to the tool and inter-rater reliability are important components of the process since this assessment tool is utilized on a state-wide basis in order to determine the necessary capacity for "Dedicated Case Managers."
All individuals utilizing this tool are required to participate in a live CASII training which is administered by a certified CASII trainer (either a Cenpatico employee or a provider agency employee who has been identified as a CASII trainer). In addition, Cenpatico Provider Mentors complete a minimum of five medical records reviews at each of the child-serving intake agencies in order to evaluate fidelity to the tool on a monthly basis. During medical records reviews, Provider Mentors will complete the CASII tool based on information available in an array of documentation included in the record (i.e. various assessments, service plans, crisis plans, progress notes, etc.). If a score or rationale for scoring does not correlate to that of the provider agency assessor, the Provider Mentor will discuss these findings with the Clinical Director. In turn, the Clinical Director is expected to relay and explore information further with the individual who completed the CASII assessment. When there is a variation in scoring, it is typically the direct result of either a lack of concise or current documentation or a misinterpretation of the tool. Provider Mentors will then re-review any medical records with questionable CASII scores during the following month's provider agency site visit. The process is then repeated. Based on recent findings, Cenpatico facilitated a CASII technical assistance webinar which was mandated for all CASII trainers and participation was highly encouraged for all CASII assessors. The purpose of this webinar was to address observed trends and discuss clarifications based on observations made during CASII reviews.

(b) Describe how the Proposer's information management system will support the CM program. **Suggested number of pages: 4**

In Section 2.b.i. above, we discussed the TruCare System. In this Section we will describe Centelligence and TruCare and explain the roles of these and other applications which enhance our entire Care Management program. Our information management system, Centelligence™, includes best of breed modular components which augment the functional components of the CM/UM program and the components of the system are strategically integrated to ensure timely and effective member identification, assessment, and care management activities for at-risk members and promote the essential exchange of information between staff, members, and providers.

The Role of Actionable Information in Care Management

Centelligence™ represents our proprietary and comprehensive existing and planned family of integrated decision support and health care informatics solutions. Our Centelligence™ enterprise platform integrates data from multiple sources and produces *actionable* Care Management *information* including:

- Population level health risk stratifications
- Service request and authorization information
- Medical, Pharmacy, Behavioral, and laboratory claims data
- Assessment results
  - Health Risk Assessment information
  - Child and Adolescent Needs and Strengths (CANS)Assessment
  - Level of Care Utilization System (LOCUS)
- Concurrent review data
- Treatment plans
- Plans of care
- Standard and ad-hoc desktop reports
- Care Gap and Wellness Alerts

Centelligence™ continually analyzes an enormous amount of transactional data (e.g. claims, lab test results, authorizations), producing "business intelligence" and delivering the right information products to the right person (e.g. Member Service Representative (MSR), Utilization Manager, Care Coordinator, Care Manager, Provider) for the right task (e.g. clinical intervention, internal workload adjustments, client reporting) at the right time (e.g. on schedule, or "in real time"). *Please refer to our response to question 2.g.xii for more information on our Centelligence™ platform.*

Two of the components of Centelligence™ that support CM/UM activities include:

- ***Our Enterprise Data Warehouse*** (EDW) integrates available medical, behavioral, pharmacy claims, member and provider demographics, and Health Risk Assessments (HRAs) into a centralized repository. Our Enterprise Data Warehouse (EDW) incorporates the **Teradata®** Extreme Data Appliance which improves our ability to handle truly large amounts of data in much shorter timeframes. The increased speed of the application results in CM/UM staff receiving more timely notifications of a member's care gaps. They also serve to support identification of members who may be appropriate for Care Coordination or Care Management activities.
- ***Centelligence™ Foresight*** - incorporates our Impact Pro, Catalyst HEDIS, and Centene proprietary predictive modeling and Care Gap/Health Risk identification applications. Reports are developed that are used routinely by staff to determine members who require screening due to suspected high-risk conditions or fragmented care.

The Role of the Member Relationship Module in Care Management

Our Member Relationship Module (MRM) is an integrated repository of "all things member" and has three core integrated components:

- ***Member Demographics System*** (MDS) - MDS is similar in design to a Master Patient Index application in that it employs a Master Data Management (MDM) approach to member data. Our MDM design provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing member data throughout our organization to ensure consistency and control in the ongoing maintenance and application use of member data.

- ***MemberReach*** **-** automates, manages, tracks and reports on our workflows for *outbound and outreach* member campaigns, as well as targeted outbound interventions (such as engaging high risk members in our care management program).
- ***MemberConnect*** **-** is our Customer Relationship Management (CRM) member services application which greatly expands the efficiency and extent of member and caregiver information that we can collect, transmit, display, route and use.
    - MemberConnect also supports *inbound campaign management*. If a member or caretaker we have been trying to reach happens to call us for any reason, our Cenpatico Member Services Representatives (MSRs) can address the member's immediate issue, then they or another staff member can talk to the member about the issue that is the subject of our outreach attempts.
        - For example, the member's Care Manager may have been trying to reach the member because our Centelligence™ Foresight Predictive Modeling (described below) system detected an important gap in care for that member. Unfortunately, the Care Manager has been unsuccessful because of an incorrect phone number. The Care Manager documented the need to talk to this member in our TruCare system (described below) and the information flowed into MemberConnect. When the member calls about another issue, the MSR can see that the Care Manager needs to talk with the member when they pull up the member record. The MSR addresses the subject of the member's call, and then offers to warm transfer the member to their Care Manager.

The Role in Clinical Management Tools in Care Management

Our information management system provides a broad range of reporting capabilities that track demographics, therapeutic activities, medications, placement days, inpatient events, and various outcomes for specialty programs. Reports from the information management system assist in identifying program effectiveness, as well as over- and under-utilization of services by specific provider and by member population.

- ***CaseNet TruCare*** **-** Cenpatico clinical staff will use TruCare, our member-centric health management platform for collaborative utilization management, care coordination and care management activities. TruCare automates all the clinical components of our care management programs into a single platform, integrated with our other applications that allow us to proactively serve the members of our Statewide Management Organization (SMO).
    - TruCare will enable a collaborative care partnership among CM/UM and Regional Care Team staff, our members, their parents/caregivers, and providers. TruCare provides a person-centered view of the clinical and psycho-social needs of our members so that CM/UM staff can easily see the entire available medical and behavioral health status and history of members. The clinical workflow for clinical decision support criteria, prior authorization, and medical necessity reviews is customized to meet our CM program specifications.
    - TruCare will support the analytics that will enable us to capture and track requests for covered services. TruCare will acknowledge receipt of the request and upon authorization, sends the approval back to the provider immediately. Its analytics are essential for CM/UM tracking and managing of authorization timelines and benefit limits for inpatient, outpatient, and waiver services.
    - Discharge Planners will use TruCare to document and track activities associated with the transition of levels of care.

- Care Coordinators will use TruCare to develop, follow, and revise treatment plans for members receiving 1915(c) and 1915(i) waiver services and Substance Abuse Prevention and Treatment (SAPT) services.
- TruCare is used by Care Managers to develop, follow, and revise person-centered Plans of Care for members enrolled in the Coordinated System of Care or the high-risk care management program.

- ***Clinical Portal*** **-** immediate access to clinical practice guidelines and content supporting medical practices and policies; provider profiling that provides data analytics regarding practice patterns and performance, access member health record plus ability to feed continuity of care documents to some EMR systems
- ***Member Portal*** **-** enhanced online provider directory with Google maps and public transportation information; view access to members' TruCare service plans; condition-specific care alerts for members with chronic conditions
- ***Provider Portal*** **-** member eligibility verification; online authorization request submission; immediate authorization request acknowledgement; immediate authorizations for selected services; care gap notifications regarding potential member need for services

Further information about our clinical systems is provided in Section 2.g.iv. The system diagram is available in our response located in Section 2g.iv.A.

(c) Describe how the Proposer will provide an outreach program to ensure that high-risk members understand the benefits and services available to them. Include how the Proposer defines and identifies high-risk members. Provide an example of a successful outreach program. **Suggested number of pages: 3**

Outreach Program

Cenpatico's comprehensive outreach program to target high-risk members is built on the principles of engagement that are continuously used by our staff in communicating with members, providers, government agencies, and other stakeholders. Our staff training programs embrace the Recovery Philosophy and use person-centered approaches to promote family-directed services and personal decision-making. Along with our hiring practices, these efforts support the enthusiasm, passion and focus of staff and create a culture that places meeting the needs of the every member, and especially those that are high-risk, at the forefront of every activity we undertake.

In each of Cenpatico's public sector contracts we have developed and implemented a detailed outreach program that is tailored to the local communities and populations that we serve. Our Louisiana Statewide Management Organization (SMO) outreach program will have three facets which include:

- determination of target populations and regional considerations
- identification of high-risk members appropriate for targeted outreach through use of analytic systems and CM/UM staff screenings
- implementation of appropriate member outreach methods

Target Populations and Regional Considerations

We recognize that each of the Department of Health and Hospitals – Office of Behavioral Health's (DHH-OBH) ten regions and their associated Local Governing Entity (LGEs) are different, – for example high-risk members residing in one region may have different unmet needs those residing in different region. This may be caused by population concentrations or insufficient access to housing, community support services, transportation etc. We will collaborate with DHH-OBH and the LGEs to determine the needs of each region that may have a direct impact on individual member needs and use this information when developing our analytic metrics and screening procedures. .

High-Risk Member Identification

Analytical Tools

Impact Pro® is a multi-dimensional, episode-based predictive modeling and care management analytics tool integrated with our enterprise data warehouse (EDW). EDW will regularly update Impact Pro with data, including eligibility) and demographic data, behavioral and pharmacy claims data, and medical and lab test results (if available).

Impact Pro contains a rich set of features that provide Cenpatico the flexibility to identify all members with specific high-risks related to diagnoses, co-morbidity, medication non-adherence, and/or other risk factors. Impact Pro can be utilized to identify the following:

- Over-utilization of services, including frequent emergency room visits, multiple inpatient admissions, or poly-pharmacy
- Under-utilization, such as: failure to adhere to evidence-based and clinically accepted practices; members with emergency room visits or inpatient admissions and no claims indicating visits with a psychiatrist or other treating provider; or missed medication refills, such psychotropic medications

Care Gap Alerts™ serve to notify the CM/UM team and the member's provider when at-risk members are potentially in need of clinical interventions. For example, when prescriptions are not refilled at appropriate times, emergency services are accessed, or follow up appointments are missed, etc. Care Gap detail serve to supplement Impact Pro's analytics.

Reports from Impact Pro and Care Gap alerts are provided to our CM/UM Administrator and used to determine high-risk members appropriate for screening by CM/UM staff members.

High-Risk Member Screenings

Cenpatico's CM/UM staff will screen all members to identify those having special needs. Screening criteria for special needs members include the following:

- Children and youth under age 22 that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement.
- Children with behavioral health needs with multi-system involvement.
- Adults eligible for the 1915(i) HCBS; IV drug users; pregnant substance abusing women; substance abusing women with dependent children; or dual diagnoses.

Cenpatico CM/UM staff will screen adults and children who enroll as new members in the plan. All children and youth under age 22 will be screened using the Children's Assessment of Needs and Strengths (CANS)-Brief Assessment tool. Those qualifying for the Coordinated System of Care (CSoC) will be referred to a Licensed Mental Health Professional (LMHP) to administer the comprehensive CANS assessment. The LMHP completing the comprehensive CANS will participate in the development of the Plan of Care. Those not meeting eligibility criteria for the CSoC will be further screened to determine if they fall into one of the following categories:

- Meets eligibility for DCFS or OJJ services
- Youth is an IV drug user
- Youth is a pregnant substance user
- Youth is a substance abusing female with dependent children
- Youth has a dual diagnosis
- Youth meets criteria for CSoC but there either is not a WAA in the service area or the WAA does not have an available opening

Children identified in a high risk category will be followed by a Care Manager who specializes in children using an intensive case management approach. Cenpatico will provide case management services at a level that is consistent with child or youth's needs. Children and youth at risk will also be identified through review of inpatient treatment records, review of outpatient service utilization, or referral by providers or community stakeholders.

Staff will screen all adults presenting as new members to determine if they qualify for DHH-OBH behavioral health services. Those meeting the eligibility criteria for 1915(i) will be referred to an LMHP for an evaluation using the LOCUS©. The LMHP will then develop a treatment plan consistent with the DHH-OBH treatment planning requirements.

Those not meeting the criteria for 1915(i) will be screened to determine if they fall into one of the following categories:

- IV drug user
- Pregnant substance user
- Substance abusing woman with dependent children
- There is a dual diagnosis

We will ensure that those meeting one of the above criteria receive an evaluation using practices consistent with the American Society of Addiction Medicine (ASAM) Patient Placement Criteria. The evaluator will develop a treatment plan consistent with the DHH-OBH treatment planning requirements. These individuals will receive case management services consistent with their needs.

Our staff will use a general health risk screening instrument to identify those adults in need of follow up by our case management team. Needs identified through this process will determine the level of support needed. Additionally, we will routinely review inpatient and outpatient utilization data to identify adults who are at risk and in need of case management services. Providers and community stakeholders may also refer adults for screening.

Screening activities will be documented in TruCare, a member-centric integrated care management and utilization management product. CM/UM staff proactively manages members with integrated workflow tools, and capture data necessary to track outcomes and identify program/quality improvement initiatives. TruCare offers clinical appropriateness tools based on evidence-based criteria, customized assessments and care plans for members, stratification of risk, and tracking/reporting/improvement data.

Outreach Methods

We will use several outreach methods to communicate and educate high-risk members about the benefits and services that are available to them. These include individual member and population strategies.

CM Staff Follow-Up. Care Managers embrace the critical nature of connecting with high-risk members, to include their caregivers or case worker, which ever is appropriate for each individual. Once high-risk members are identified, the Care Manager will use a variety of outreach approaches. First, an introductory letter will be sent and then followed-up by a phone call. For children and youth, caregivers will contact the medical consenter – family, caregiver or case worker. For adults, the Care Manager will contact the member directly. When the Care Manager is not able to reach the member, or the member's representative, and there is an indication of critical need, the Care Manager will reach out to known service providers.

Once the member is reached Care Management staff use person-centered approaches to communicate with the member and explain the benefits and services are available. The Care Management staff will also take the time to learn more about the member including his or her strengths, desired outcomes, and goals for the future. This will allow the Care Management team to link the member to appropriate resources that will truly meet the member's needs while also demonstrating that our staff care about each of those

enrolled. This effort may be enhanced through mailing of specific content that is of interest to the member and/or family. When appropriate due to member need and/or condition, the Care Management staff member who is working with the member can choose to enhance educational efforts through a referral for peer and family support services. We understand that peer to peer interactions are often the best form of outreach and engagement since peers have a true understanding of a member's experience and have the ability to inspire hope for the future. Peer and Family coordinators are available through our Peer and Family Program that reports to our Chief Officer of Community and Cultural Affairs.

As part of the CM/UM follow up, staff will attempt to identify barriers to treatment and then assist the member in overcoming those barriers. Sometimes this is done through general problem solving and other times it can be done by providing referrals to community resources. For example, an individual who does not have reliable transportation might find it difficult if not impossible to access outpatient care. As a result this individual will access crisis services and often inpatient acute care. Once the CM/UM learns of this barrier, we can assist the member by coordinating Medicaid transportation services and by locating providers who are willing to provide services in the member's home.

Regional Community-Based Orientation. Cenpatico will develop and implement regional community-based orientation sessions. These will be available to high-risk members statewide to ensure understanding of the benefits and services available. In addition to this member orientation, topic specific sessions such as Trauma Informed Care, Child Development, Behavior Management, Substance Abuse, Skills training, and other relevant topical training will be offered to members and their families, peer supports, providers, and other stakeholders.

These regional orientation sessions will allow members to gain a better understanding of Cenpatico while also giving us an opportunity to learn more about each community. Identifying the unique needs of each community will allow us to tailor our outreach efforts in order to ensure that our services and supports are in line with the needs and desires of each region. This will allow us to better support members, providers, and community stakeholders.

Member Handbook. All members will receive a Member Handbook outlining their benefits and how to access services. Our new enrollee materials are designed to be easy to understand, give members the information they need to get to services now. Our informative and user-friendly recipient orientation packet includes a Member Handbook with provider directory and additional state-approved, written materials to provide members with an understanding of services and the delivery system. Cenpatico will provide the handbook to the members in an appropriate language, including English, Spanish, Vietnamese and French. Ongoing informal education will be provided telephonically, through printed materials and on the Cenpatico website.

Example of an Outreach Program. Some children in our Texas Foster Care market experience frequent admissions to inpatient psychiatric facilities. Approximately 200 children experience 3 or more admissions during a six month period. In the world of Foster Care, frequent inpatient admission is also an indicator of frequent placement changes. Placement changes can occur within a geographic area, but more often children are moved to other regions around the state. This means that the child not only changes caregivers and addresses, but they also experience a change in treatment providers including therapists and psychiatrists, which adds to the ongoing trauma experienced by these already wounded children. This then leads to inconsistency in outpatient care and a lack of progress for the children who are at risk. In an effort to break this cycle, Cenpatico implemented a Complex Care Management Program specifically targeting those children and youth who experience 3 or more inpatient admissions during the most recent 6 month period. We identify these children monthly based on reports generated by our IT department. The Complex Case Manager begins by making outreach calls to those identified as medical consenters for the child. This is typically the CPS caseworker and the caregiver with whom the child resides. If phone calls are ineffective, the case manager sends letters requesting contact. Complex

Care Management staff use a strengths based approach when working with this population, focusing on the child's strengths and desired outcomes rather than merely focusing on problem areas. The Complex Care Manager seeks to engage all providers and individuals working and interacting with the child or youth in an effort to ensure that everyone is focused on the same goals. By gathering information from all parties, the Complex Care Manager serves as a central source of information that can be shared with various members of the treatment team. Additionally, the Complex Care Manager looks for informal supports available within the community in an effort to decrease reliance on formal services and supports. We have found that this approach to outreach has been effective in engaging children, families, and community providers in working with this high risk population. Outcome data shows a decrease in inpatient admissions for those enrolled in this specialized care management program.

In Florida, Cenpatico has conducted several homeless- and HIV-population preventive outreach activities designed to assure that needed services are accessible, provided when necessary in the service-delivery areas, and have the potential to prevent the need for future inpatient services and/or involvement with the criminal justice system. Beginning in March 2011, the Florida Community Clinical Liaison has participated in and/or co-sponsored eight (8) Health Fairs and other events (attended by approximately 2,300 people) in Broward, Miami-Dade, DuVall, Palm Beach, and Orange counties. Events included the Back to School Health Fair sponsored by the Broward County Department of Juvenile Justice and the Leading Change-Inspired Innovation, a Justice System Conference sponsored by Partners in Crisis. The Cenpatico Liaison has followed up with Dean Aufderheide, Orange County Director of Mental Health Services for the Florida Department of Corrections, to begin collaboration on discharge planning needs, including housing, for members being released from correctional facilities.

(d) Describe how the Proposer will assist the WAA in developing POC for the 650-750 CSoC children/youth currently living in out-of-home placements to facilitate their transition to family- and community- based services.
Suggested number of pages: 3
Address the following components:
(i) Involvement of youth, families and caretakers enrolled and not enrolled in a WAA, including WF for enrolled children;

Cenpatico's policies and procedures for managing services to children and youth will incorporate the *Guiding Principles of Family-Driven Care as outlined in the RFP Scope of Work, page 35.* Cenpatico will support the involvement of youth, families and caretakers in wraparound facilitation for enrolled children by ensuring that Wrap Around Agencies (WAA) utilize Child and Family Teams (CFT) to achieve a wraparound process that relies on a family-driven approach. During CFT meetings, providers will offer tools/training/technical assistance and ideas to assist in making everyone's role easier. Input and feedback from provider agency staff, families/caretakers, and child serving agencies will be obtained prior to the WAA implementing new procedures or processes, such as new tools or forms. We will support families and caretakers in having primary decision-making roles in the care of their own children, as well as the policies and procedures governing care for all children in their community, state, tribe, territory, and nation.

Our contract with the WAA will include requirements that families are supported in choosing culturally and linguistically competent supports, services, and providers; setting goals; designing, implementing, and evaluating programs; monitoring outcomes; and partnering in funding decisions. We will work with the WAA to include CFT Coaches in their staffing models. CFT Coaches view their role as partnering with provider agency staff to support them in service delivery to children and families. They engage in a supportive partnership with providers, system partners (and with families during CFT meetings). Where

the WAAs are not yet developed, Cenpatico will require children's service providers to develop and support CFTs. Our WAA Family Support Organization Liaison will coordinate providers training and education. :

- CFT Coaches will develop working relationships with all members of the wraparound team including the family, child/youth, and treatment providers.
- CFT Coaches will serve as the links among providers, caretakers, families and child serving agencies to ensure that all members of the CFT have all pertinent information and are fully engaged in the wrap around process. This includes involving youth, families, caretakers in:
    - Making decisions about treatment and placement;
    - Identifying youth/family desired outcomes;
    - Identifying youth/family strengths so that services and supports that will build upon those strengths are implemented; and
    - Identifying community and other natural supports.

Cenpatico Family Support Coordinators (FSC) will further engage families in the process by emphasizing that CFT practice is family-driven and by explaining and clarifying the purpose of teams and meetings. Family Support Coordinators are family members who have been in a caretaker role with a family member who has lived experience in the mental health system. Usually they are mothers of children in the system but not always; they can be any family member of a consumer. They assist consumers (mostly other families with children or other members receiving behavioral health services) to lend emotional support as well as provide information about how to navigate the system. They attend Child and Family Team meetings to support the family and children. They are the people who have "been there" and are often easier for consumers and their families to relate to than traditional staff.

The Family Support Coordinators are trained on behavioral health services and how to assist families appropriately. Topics include but are not limited to confidentiality, working with schools as an advocate for the family and the Guiding Principles of Family Driven-Care. *It is important to have the right person for the job...they must be able to discuss their experiences with families and be able to support the CFT in the goals.*

(ii) Collaboration with the CSoC child serving agencies on service planning;

Cenpatico will work closely with Louisiana's child serving agencies, including the Department of Children and Family Services (DCFS), Department of Education (DOE), Department of Health and Hospitals-Office of Behavioral Health (OHH-OBH), Department of Health and Hospitals-Office for Citizens with Developmental Disabilities (DHH-OCDD), and Office of Juvenile Justice (OJJ), to ensure comprehensive service planning.

Through the WAA, in communities where a WAA exists, Cenpatico will work with the WAA Facilitator to support all CFT and FSO programs and initiatives. Where a WAA is in development, Cenpatico will lead the effort in developing CFT's and community resources, coordinating and collaborating with all child serving organizations, as well as other community and faith-based organizations that can support the wrap around services.

Cenpatico will assign liaisons to each child serving agency to establish a dialogue and process for maintaining and qualitatively improving all aspects of comprehensive service planning at a systems level. Cenpatico's Children's System Administrator, Care Management/Utilization Management Administrator, Quality Management Administrator and Chief Officer of Cultural and Community Affairs will all work closely with child serving agencies and other stakeholders to ensure that all are engaged in the development and implementation of quality improvement activities to support comprehensive service planning across the Coordinated System of Care.

(iii) Needs identification and collaboration with the Proposer's network management and development staff; and

All Cenpatico staff will report any identified network deficiencies to their supervisors. A defined communication process will ensure that network deficits and issues are reported to the Network Development and Management team. For example, if during the POC development it is determined that a child needs services not available in a certain area, this information will be communicated to the Network Development Administrator for inclusion in the Network Development Plan, so that resources and alternatives are developed and the quality of the Network is continually improved. See *Section 2.e.i* for further detailed description of communication among all departments to support network management and development.

(iv) Strategies the Proposer has found useful in other programs.

Cenpatico recognizes that Louisiana has culturally and demographically diverse regions. Our practice is to develop locally-focused programs that meet community needs, rather than design a homogenous program and expect it to work statewide. We will bring this expertise to Louisiana. An example of our success in this area is highlighted in our Texas Foster Care program.

Cenpatico's Texas Foster Care program has developed partnerships with foster care and mental health stakeholders across the state of Texas. Texas has 11 regions as designated by the Texas Department of Family and Protective Services. These regions all have regional leadership and differing community stakeholders. Some of these regions are rural, some are urban, and they all have some form of coordination at the local level. Cenpatico has staff in all 11 Regions. Regional staff includes service coordinators, service managers and clinical trainers for providers, members/family, foster parents/caregivers, child serving agencies and other stakeholders.

Within each Region, there are committees and taskforces with participants ranging from judges, child welfare works to street outreach teams. At the state level, there are workgroups and taskforces made up of policy professionals and executives from the state, Texas Supreme Court, Texas Judiciary, universities and foster care organizations that work together to impact systemic change at the state level. Cenpatico has representation on the majority of the taskforces. Cenpatico is viewed as the 'mental health and behavioral health' resource for children in foster and thus, part of not only service delivery, but overall system initiatives. A few of the key stakeholder collaborations Cenpatico is involved in are listed below:

- Texas Supreme Court Children's Commission (chaired by Texas Supreme Court Justice Eva Guzman, the Children's Commission consists of regional associate judges that represent Texas' 254 counties along with the Commissioner of the Texas Department of Children and Family Services, Casey Family Programs and the Center for Public Policy Protection and various foster care advocacy and child placing agencies. Cenpatico participates as the behavioral health component to the foster care system).
- Psychotropic Medications Workgroup is an subcommittee of the Texas Supreme Court Children's Commission
- Travis County Model Court (a national pilot program through the Office of Juvenile Justice that creates a one-judge, one child cross over court philosophy that impacts child protective services courts as well as juvenile justice
- Beyond the Bench Work Group is an annual 3-day conference with judges and regional planning groups that address barriers to permanency in the child welfare system (judicial, behavioral, placement, resources, etc.) and work to develop new policies, procedures and practices to improve services
- Public/Private Partnership Restraint Reduction Committee is a committee co-chaired by a representative from the Department of Family and Protective Services and an Executive Director from a Texas Residential Treatment Center. This committee consists of Residential Treatment Center leadership across the state and Cenpatico, to bring forth the behavioral health perspective.
- Child Abuse Prevention Coalition

- West Texas Crisis Consortium
- Partners in Child Protection Reform
- Ready by 21 (works with youth aging out of foster care)
- Infants and Toddlers Court (Harris County workgroup led by Judges)
- El Paso CPS & CPA Meeting
- Regional Community Resource Coordination Groups (CRCGs) are local interagency groups, comprised of public and private providers who come together to develop individual services plans for children, youth, and adults whose needs can be met only through interagency coordination and cooperation.
- Regional Interagency Foster Care Committee (IFCC) consists of child placing agency representatives who address issues monthly

Other examples include pilot programs in various markets where we identified gaps in service, including offering Respite as a value-added service in Indiana to divert inpatient admissions; Crisis Stabilization Unit in Ohio for post-discharge to help ABD population further stabilize; partnerships with Community Mental Health Centers (CMHCs) in Ohio and elsewhere; joint treatment planning examples for CMHC's in Ohio and Indiana for high needs individuals, as well as:

- Smaller case management caseload for complex cases
- Frequent communication with caregivers and treatment providers
- Creative problem solving
- Focus on child's strengths and desired outcomes
- Giving the youth and caregivers a voice in establishing goals for treatment
- Focus not only on clinical goals for treatment but also real life goals such as going to college, obtaining a driver's license, developing friendships, etc.

2.b. Care Management
iii. Describe strategies the Proposer has used to collaborate with wraparound facilitation staff/child and family teams and families, including family support type organizations in another client state. Discuss the Proposer's successes and challenges and provide a reference that can validate the Proposer's approach. **Suggested number of pages: 3**

Our approach to collaboration with wraparound facilitation, staff/child and family teams and families, includes a systems approach including all stakeholders. We put particular emphasis on training and data feedback loops to better engage and inform the system of care. This approach was developed from our experience in Arizona, where we participated in the statewide implementation of wraparound services and supports, much like the CSoC program in Louisiana. In Arizona, Cenpatico operates as the Regional Behavioral Health Authority (RBHA) for three of the state's six RBHA contracts. Our service areas include Geographic Service Areas (GSA) 2, 3, and 4. In 2005, during our contract implementation, the Arizona Department of Health Services (ADHS) was responding to the children's lawsuit known as Jason K. vs. ADHS. Needless to say it was a challenging time for children's services in Arizona due to access to care issues, over-utilization of residential treatment, and increased encounters with the juvenile justice system. In collaboration with ADHS' Division of Behavioral Health Services (ADBHS), children's services for our Arizona RBHAs were implemented using the Systems of Care Model. Our goal was to leave no child behind by moving to a system that was person-centered and family-driven. Covered services included wrap-around supports including Child and Family Teams. From the time we implemented our initial contracts to the current day we have tirelessly worked to promote the use of wrap supports and to significantly increase the number of children with Child and Family Teams (CFTs). Family Support providers share our success.

Five years ago, Cenpatico regions had few children with an assigned or functioning CFT; however, as a result of our aggressive activities to promote use of CFTS, in May 2007 45% (average) of children had an assigned CFT, and by January 2008, 98% of all children engaged in a CFT with a certified CFT Facilitator.

Strategies Used to Collaborate with Wraparound Facilitation

In addition to our system-wide approach of engaging all stakeholders, the use of multi-modality, targeted training strategies increase effectiveness of collaborative efforts with wraparound facilitation of staff/child and family teams. Strategies include:

- Cenpatico staff members facilitate CFT Regional Practice Improvement meetings in all regions on a bi-monthly basis. Agendas address updates and clarification related to children's services, trending and updates related to System of Care Practice Reviews (SOCPR), CFT-related skill building activities, local provider and community resource sharing, and collaborative discussions among participating agencies. Local system partners as well as family members are invited to attend.
- Cenpatico created ten on-line CFT training modules. Modules are available to provider agencies, system partners, and family members (anyone who wants the training)
- Cenpatico utilizes Licensed BH Professionals to offer, develop, and facilitate trainings, technical assistance sessions, and skill builders. Sessions are tailored to meet the needs of specific agencies, and/or staff.
- Trainings are culturally competent – for example: when facilitated with the tribal communities involved, an element of group discussion focuses on tailoring CFT practice to the needs of specific tribal regions.
- Group activities have been facilitated with provider agencies to enhance skills. Some examples include: role plays, group discussions, group activities etc.

- Cenpatico has presented CFT related awards and recognitions to celebrate fidelity to the practice at CEO meetings and CFT Regional meetings. Certificates and/or engraved plaques have been awarded. There is also an annual Lighthouse award for the agency who has most effectively integrated the practice of family support into their agency.
- On a quarterly basis, Cenpatico recognizes "CFT Platinum" Facilitators, that are CFT Facilitators who demonstrate an enhanced skill level and act as role models within their agencies.

We also use detailed data gathering and analysis processes to ensure children receive wraparound services as appropriate, including:

- Cenpatico has developed standardized CFT documentation (i.e. CFT meeting notes, SNCD documents, and a children's crisis plan).
- "CFT Coaching Tips" are distributed electronically on a weekly basis to provider agencies and CPS Mental Health Specialists.
- All CFT Facilitators are certified through Cenpatico. In order to become certified, an individual must complete the on-line CFT training modules and must be observed facilitating three CFT meetings, in which a meeting observation tool must be completed by a Supervisor.
- Cenpatico develops tools to assist service providers in implementing fidelity to CFT Practice. Examples include: guidelines for crisis planning and service plan checklists for supervisors.

Cenpatico's Role in the CFTs

As a RBHA, our role in working with the CFTS is quite similar to the role of the SMO for Louisiana and includes the following activities:

- Cenpatico staff ensure that fidelity to CFT practice is followed.
- Cenpatico requests that intake agencies send a list of upcoming CFT meetings on a weekly basis. Cenpatico will request that providers get permission from the family or guardian to participate in a given meeting. Staff participate in meetings and complete a "meeting observation tool" to provide feedback for the Facilitator. Staff also participate in meetings at the request of providers, system partners, families, and in some instances, as the result of a complaint.
- During CFT meetings CFT coaches perform role modeling, clarify processes, assist in brainstorming efforts by offering ideas to the team, explain the purpose of teams and meetings, and summarize key points and action steps.

Cenpatico staff have witnessed the positive results that can be achieved through CFTs and wraparound facilitation. The example below represents the effective practices we have been able to encourage:

> *One of our staff was asked to sit on a CFT for a young man with moderate to severe Autism. There were extenuating circumstances that left this family and team with fears, misconceptions, and no tools to move forward with this case. In essence the team was paralyzed and unsure of what to do next. Our staff member met with the family and the team during CFT meetings, in-home visits, and group home observations. She was able to give suggestions and to provide information on behavioral techniques that would help the family and CFT better understand and cope with the young man's aggressive behavioral displays. After five meetings the family and team had successfully reduced the intensity and duration of the aggressive displays to the point that the young man was able to re-engage with the group home staff. Subsequent team work had been successful in providing the member with the tools needed to more functionally communicate. He is often able to voice his wants/needs using full sentences, work through his cognitive perseverations through verbal means, and express his frustrations without aggression. He also smiles more during interactions with others.*

Working With Family Support Partners and Family and Provider Engagement

In order "to make wraparound happen for kids" we have found that family and provider engagement is critical. Family Support Providers play a critical role in family and provider engagement. Our engagement strategies are described below:

- During CFT meetings, Cenpatico staff emphasize CFT as a family- driven process.
- Families are also engaged in the process by Family Support Partners (FSP).
    - Our FSPs are family members who have been in a caretaker role with a family member who has lived experience in the mental health system. Usually they are mothers of children in the system but they can be any family member.
    - Family Support Partners are hired by the contracted provider agencies in the Cenpatico Network.
    - FSPs provide assistance to other families with children or other members receiving behavioral health services by lending emotional support and providing information about how to navigate the system.
    - FSPs attend Family Team meetings to support the family and children. They are the people who have "been there" and are often easier for consumers and their families to relate to than traditional staff. They can also facilitate CFT meetings.
    - The Family Support Partners are trained to focus on BH services and how to assist families appropriately, for example: maintaining confidentiality in working with schools as an advocate for the family.
        - Challenge - We have found that it is important to have the right person for the job, because FSPs must be able to discuss their experiences with families and be able to support the CFT in the goals. As a mitigating strategy - Every FSP is approved by the Cenpatico Family Advisor prior to training.
- CFT Coaches view their role as partnering with provider agency staff in order to support them in service delivery to children and families. They describe their role as a supportive partnership with providers, system partners (and with families during CFT meetings).
- Providers are engaged by being offered tools/training/technical assistance, support during CFT meetings, and ideas to assist in making everyone's role easier. Awards, recognitions, and the celebration of strengths are provided during provider meetings

Monitoring Providers

Cenpatico monitors our providers to ensure children and families receive wraparound services. Providers are expected to meet established program requirements. Quality improvement processes are implemented when appropriate. Additional detail is provided below.

- Based on the results of the System of Care Practice Reviews (SOCPRs), Cenpatico staff discuss outcomes of reviews as well as trends with provider agencies. Staff assist provider agencies in developing practice improvement plans, based on the identified opportunities for improvement trends. Evidence of results, as indicated in plans are collected and analyzed on a monthly basis. If there is no improvement in an identified area, we discuss this with the provider and determine a plan (i.e. for training, coaching, the implementation of a new process, etc.). Agency and regional trends are discussed during the CFT Regional meetings so that provider agencies can get feedback from each other in terms of what is working well for them.
- Provider Mentors review several children's medical records at each intake agency one time per month. Assessments, service plans, and other documents are reviewed. Technical assistance is provided to each agency.

- Meeting observation tools (which measure fidelity to CFT Practice during CFT meetings) are collected monthly from intake providers. Information is entered into a database; trends are shared during CFT Regional Meetings.
- Based on trended results, Cenpatico provides targeted training, coaching, and technical assistance to provider agencies

Use of Data to Validate Our Approach

System of Care Practice reviews are performed using brief telephone surveys and through complex in-person interviews. Cenpatico uses the results to determine on-going improvement activities. The results of our 2011 GSA 4 "brief survey" results are contained below.

Overall Strengths

One area achieved 100% positive responses in six of the 17 question areas. Included were:

- Services and supports have helped the child be more successful living with the family
- Services are easily available
- Satisfaction with where the child receives services
- Caregivers and children have been provided with the tools to avoid a crisis situation
- Services and supports are respectful of the family's cultural traditions and preferences
- If the caregiver contacted the agency, they feel the agency would respond quickly to assist them.

Opportunities for Improvement

- Ensuring services and supports help the child be more successful in school
- Ensuring the people involved with the family participate in creating and following the service plan
- Connecting families with extended family members, friends, community, or family organizations to help support caregivers and their children.
- Ensuring the primary behavioral health needs are being addressed to the caregiver's satisfaction.

Reference

Ms. Vicki Johnson, the Executive Director of Mentally Ill Kids in Distress (MIKID), a Family Run Organization, located in Phoenix, Arizona has provided a reference concerning Cenpatico's success in expanding and improving the quality of Child and Family Teams in Arizona. ***Please see Section 5, Appendix 2.b.iii – MIKID Letter for this reference***.

Reference Name, Title	*Contact Information*
Ms. Vicki Johnson Executive Director Mentally Ill Kids in Distress (MIKID)	2642 E. Thomas Road Phoenix, Arizona 85016 602-253-1240 800-35-MIKID E-Mail: vickij@mikid.org

2.b. Care Management
iv. Describe how the Proposer will develop treatment planning for adults in the 1915(i) State Plan and adults eligible for treatment planning under the 1915(b) waiver, adults eligible for the 1915(i) HCBS services, IV drug users, pregnant substance abuse users, substance abusing women with dependent children or dual diagnosis, including from the point of access to the point of either case closing or reduction in CM activity to the point of care monitoring:
Suggested number of pages: 7
(a) Involvement of individuals, certified peer specialists and families, when desired by the individual;
(b) Collaboration with community providers on assessment and treatment planning;
(c) Needs identification and collaboration with the Proposer's network management and development staff; and
(d) Approaches to treatment planning for individuals with co-occurring disorders;
(e) Experience with managing care for individuals living in permanent supportive housing; and
(f) Strategies the Proposer has found useful in other programs.

Cenpatico Care Managers, Care Coordinators and Utilization Managers will ensure that treatment planning for all adults in these special populations occurs in full compliance with DHH-OBH treatment planning requirements through the direct efforts of our staff, through contractual requirements with network providers and in collaboration with all treating providers and community resources. Cenpatico Care Managers (CM), Care Coordinators (CC) and Utilization Managers (UM) will also coordinate care with medical providers to assess and address medical-behavioral co-morbidities. They will reach out and re-engage members who do not follow through with recommended services, and will provide ongoing care management to ensure appropriateness and quality of care in the least restrictive setting, as well as assist with coordinated discharge and transition planning.

Cenpatico brings to the SMO contract an understanding of how to operationalize the system of care principles within the treatment planning process. Our treatment planning processes include strategies to **(a)** involve other individuals such as families/caregivers or certified peer specialists (when desired by the member); **(b)** collaborate with community providers on assessment and treatment planning; **(c)** identify needs and collaborate with Cenpatico network management and development staff to improve the overall system of care and its responsiveness to member and community needs; and **(d)** develop treatment plans for individuals with co-occurring disorders. Those strategies and approaches are woven into the following response.

When Cenpatico receives a referral of a potential participant from a provider, state or other agency, or a direct request from a member, we will screen the individual for 1915(i) eligibility. Staff will screen all adults presenting as new potential members to determine if they qualify for DHH-OBH behavioral health services.

Those **individuals meeting the eligibility criteria for 1915(i),** will be referred to an LMHP in our provider network for an evaluation using the LOCUS. Cenpatico will refer 1915(i) eligible individuals not enrolled in Medicaid to DHH for enrollment by a Financial Eligibility Worker. The LMHP will develop a treatment plan consistent with the DHH-OBH treatment planning requirements. The plan is designed to prevent the provision of unnecessary, high-cost care and is guided by best practices. Based on the independent assessment, the individualized plan of care will be consistent with the following principles:

- Developed with a person-centered process in consultation with the individual, and others, at the option of the individual, such as the individual's spouse, family, guardian, and in collaboration with treating and consulting health care and support professionals. The person-centered planning process must identify the individual's physical and mental health support needs, strengths and preferences, and desired outcomes;
- Takes into account the extent of, and need for, any family or other supports for the individual, and neither duplicates, nor compels, natural supports;

- Prevents the provision of unnecessary or inappropriate care;
- Identifies the State plan HCBS that the individual is assessed to need;
- Includes any State plan HCBS in which the individual has the option to self-direct the purchase or control;
- Is guided by best practices and research on effective strategies for improved health and quality of life outcomes; and
- Is reviewed at least every 6 months and as needed when there is significant change in the individual's circumstances.

The treatment plan will be developed in collaboration with the member's primary care physician (PCP), with participation by the member and in consultation with any needed specialists, to include an LAC or ASAM-certified physician for members with co-occurring substance abuse disorders. ***The member's family and/or certified peer specialists may be included in developing the treatment, if the member so desires.*** If the PCP is not available or willing to participate, then the LMHP will communicate the final plan to the PCP.

Cenpatico staff will review the treatment plan and document participant's sign off on the treatment plan. A Cenpatico UM will formalize the treatment plan, enter it in the Electronic Health Record (EHR), facilitate any needed referrals to treatment providers and issue appropriate authorizations for any initial services requiring prior authorizations.

Those **individuals not meeting the criteria for 1915(i)** will be screened to determine if they fall into one of the following categories:

1. IV drug user
2. Pregnant substance user
3. Substance abusing woman with dependent children
4. Dual diagnosis

Individuals meeting any of the above criteria will be referred to a LMHP in our provider network for an evaluation using the LOCUS and the American Society of Addiction Medicine Patient Placement Criteria (ASAMPPC). For substance abusing women with dependent children, we will not refer the adult to a LMHP who is already providing services to the children. Cenpatico will refer individuals not enrolled in Medicaid to DHH for enrollment by a Financial Eligibility Worker.

The LMHP will develop a treatment plan consistent with the DHH-OBH treatment planning requirements. Treatment plans for all members are individualized with attention to the full spectrum of medical, behavioral and substance use conditions affecting the member. For example, co-occurring chronic pain and substance use conditions will be addressed, ensuring referral and access to appropriate pain management services which do not inhibit recovery from substance use disorders. The treatment plan will be developed in collaboration with the member's primary care physician (PCP), with participation by the member and in consultation and collaboration with community supports and any needed specialists, to include LAC or ASAM-certified physician for members with co-occurring disorders. ***The member's family and/or certified peer specialists may be included in developing the treatment, if the member so desires.*** If the PCP is not available or willing to participate, then the LMHP will communicate the final plan to the PCP.

For individuals with substance use disorders who do not meet treatment planning eligibility requirements, are not eligible for the 1915(i)/(b), or who are DHH-OBH non-Medicaid eligible adults not meeting 1915(i)/(b) criteria, a Cenpatico utilization manager will determine if the adult is eligible for medically necessary services and prior authorize necessary services. If the adult needs rehabilitation substance abuse services, the utilization manager will refer the individual to a provider who

will develop a rehabilitation service plan consistent with the Medicaid state plan requirements and the ASAMPPC for addiction. Medically necessary services that require prior authorization will be authorized by the utilization manager.

Our staff will use a general health risk screening instrument to identify those adults in need of follow up by our care management team. Needs identified through this process will determine the level of support needed. Additionally, we will routinely review inpatient and outpatient utilization data to identify adults who are at risk and in need of care management services. Providers and community stakeholders may refer adults to be screened for Cenpatico's care management program.

Should the Care Management team identify needs during the treatment planning process for any individual for which appropriate services are not available within our provider network, that service gap will be promptly forwarded to our Network Development Administrator so that Provider Relations Coordinators and Contract Negotiators can take timely steps to improve the network capacity.

Example of Cenpatico Experience: Substance Use Disorder and Dual Diagnoses Treatment Services. Cenpatico has developed best practices within its service network in urban and rural areas to address the needs of IV drug users, pregnant women, women with dependent children and those persons with dual diagnosis. Pregnant women and women with children who use substances are given priority to receive services. Health care issues, housing and HIV testing and education all occur within 72 hours or less. This priority population has immediate access to Level II residential treatment. Cenpatico participates on a state wide wait list system that notifies Cenpatico if a woman is delayed in gaining access to the appropriate treatment facility. Possible alternatives are explored and addressed within the same day.

Cenpatico has significant experience contracting with providers who specialize in women's issues. Treatment programs are delivered through best practice models such as responding to gender-specific symptoms where trauma-informed care can be offered. Contracting for women's substance use residential programs and intensive outpatient services in one location provides for a continuum of care that promotes hope for recovery through planned treatment and step-down services. When a woman who is faced with significant substance use or her family calls Cenpatico for assistance, an intermediate treatment plan is developed, urgent needs are assessed including safe housing and care of children, and barriers to treatment are documented. Assessment of the treatment needs is then reflected in the ongoing treatment plan. Services are provided at the appropriate level of care. Case Management, peer support services and ongoing supportive counseling are arranged. Peer Supports are widely used and serve as an effective aftercare support system for women.

Cenpatico has opiate dependency treatment alternatives available. Methadone and Buprenorphine is available throughout the provider network. As with the priority women, IV drug users are given immediate assistance to address treatment needs. Cenpatico has an open network which means there is no wrong door to get help and services will be coordinated using any of the network resources. Methadone dosing is followed by a complete assessment and physical which is completed by specialist in substance abuse treatment. Buprenorphine alternatives are widely available in the network. Our experience with Medication Assisted Treatment has indicated that it is successful in easing symptoms of alcohol or opiate dependencies, thus promoting recovery.

Cenpatico has developed a network of substance abuse treatment providers who can address the various levels of placement and services needed. Providers performing outreach to ER's, law enforcement agencies and other first responders to assure safe transport to substance abuse detoxification and treatment has become a very successful strategy in Arizona. Social detoxification, as a community intervention, is available in rural areas at Level IV Rural Detoxification Facilities. This has been widely praised in communities as an important resource for all community stakeholders dealing with persons with addiction and substance abuse conditions. The Rural Detoxification facility treats initial symptoms of withdrawal

and is followed up with outpatient services. Medical detoxification is available as assessed in each case through a Level I hospital and arranged by the Level IV facility. Outpatient follow up and peer support services are offered to maintain sobriety until services are no longer necessary.

(e) Experience with managing care for individuals living in permanent supportive housing.

Supportive housing can play a crucial role in helping members recover and empower them to take an active role in their health and community. Cenpatico staff work both on an individual level and at a programmatic level to improve access to and maintenance in supportive housing environments. In a number of our markets, members have access to supported housing programs and have assigned community case managers who are affiliated with their local Community Mental Health Center. Our care management staff collaborates with those case managers to ensure needs assessments occur, which can include concerns with housing placement, particularly when housing issues result in utilization of inpatient services. Our staff assist and coordinate when needs are identified. For example, in San Antonio, Texas, our staff has developed strong relationships with case managers at Haven for Hope a local shelter. This housing environment offers a safe place for members who are actively engaged in substance abuse services. Our CM staff reaches out to and works with members to ensure they have access to and are attending the necessary services that keep them eligible for supportive housing.

In Texas and Florida, many of our Medicaid members through the SSI or STAR+Plus program (as it is called in Texas), reside in assisted living facilities through their 1915 waiver status. Cenpatico CM staff maintain regular communication to staff in these facilities to monitor the care that members are receiving and assess any additional service or support needs that a member may require in order to safely be maintained within this supportive housing environment. Additionally, our CM staff collaborates with the assisted living facility staff to find ways to keep members engaged in their treatment plan and support overall treatment adherence. In Texas when Cenpatico CM staff identify members who do not have 1915 waiver enrollment but who might benefit from this waiver, our staff work with the member and the facility staff to complete a waiver assessment thus optimizing the benefits available.

In Arizona, Cenpatico has integrated the ***Housing First principles*** into its overall operations pertaining to Supported Housing and in the provider agency contracts. Housing First principles suggest that an individual is more easily engaged in therapeutic and clinical services and more successful when they have a permanent, safe place to live. Housing First principles emphasize the importance of housing not being utilized as a reward for sobriety or being psychiatrically stable and instead, as an intervention for successful community integration. In order to maintain someone in safe and permanent housing, contracted providers cannot evict an individual from housing due to achievement of treatment goals or when they decompensate psychiatrically or experience a relapse.

Arizona behavioral health providers are responsible to assist participants in locating, obtaining and ***maintaining permanent housing***. Integration of individuals into their community of choice, with access to both informal and formal services, utilized to assist the individual in meeting their individualized needs, is paramount. Contracted behavioral health providers not only assess the housing needs of the individual, but also assess for other needs such as legal assistance or vocational and rehabilitation assistance. Delivery of services necessary to assist the individual in achieving and maintaining the ability to live independently within their community of choice is the responsibility of the behavioral health provider. Cenpatico also requires that individuals receiving services have access to 24-hour on-call assistance to assist in psychiatric or housing emergencies.

Arizona housing providers are responsible for coordinating with the behavioral health providers, Adult Probation, ***Vocational Rehabilitation*** and other service providers in regards to the individual receiving services. A housing representative and a behavioral health representative should both be active participants on the individual's Adult Recovery Team (ART) to ensure that the individual is receiving the services they need to continue to living independently. This is especially important when there are

identified clinical or other issues that may impact the individual's continued eligibility for Supported Housing services.

(f) Strategies we have found useful in other programs include but are not limited to:

- To ensure members have an opportunity to include ***Certified Peer Support Specialists*** in the treatment planning process, in Arizona we require network providers to employ Certified Peer Supports and use them to participate in the discharge planning process from a higher level of care. Peer supports meet with the member prior to discharge, share their story and encourage the member to be engaged in their treatment plan and recovery process. We have found that peer supports help strengthen the resiliency of members; in Louisiana we will hire Certified Peer Support specialists in community liaison roles to help develop this capacity with LGE/HSD providers and support these services as they develop through the FSOs.
- Cenpatico engages in high needs rounds for members with ***co-occurring medical and behavioral conditions***. We participate in clinical rounds both with health plan representatives and with community providers depending on the member's individual need. This effective technique helps integrate care and treat the whole person. We will do this in Louisiana.
- We work in all markets to match member needs with the appropriate provider expertise and attributes to help serve them. In Massachusetts we serve the Aliens with Special Status (AWSS) population which includes a very diverse population of individuals from around the world. To meet the needs of this population our ***CM/UM team works consistently to alert Provider Relations*** staff when a member requires a provider with linguistic or cultural expertise that maybe hard to find. By keeping our Provider Profile Reports regularly updated, our first hand knowledge of our network ensures members can see the provider that meets their needs, or that we can identify gaps and pursue network development opportunities.

2.c. Utilization Management
i. Address how the Proposer will perform the following UM activities: **Suggested number of pages for all above items: 7 exclusive of report samples**

Cenpatico's utilization management philosophy is to direct member care to the least restrictive level possible to meet the members' needs. We know our approach is in alignment with the goals and values of DHH-OBH and other Louisiana state agencies, but transforming a system must be approached with the same kind of plan and attention that we give to each member reaching out for behavioral health services. For this reason we use recognized medical necessity criteria that are designed specific to the needs of special populations and enable appropriate treatment planning for the member. When we receive information that a member is in crisis, our first priority is always to attempt de-escalation of the crisis situation and divert the member to a community-based setting when safe, and when possible. At times it is medically necessary for the member's stabilization and safety to provide care in a more structured environment such as an acute inpatient hospital or psychiatric residential treatment facility (PRTF). When this occurs, we systematically apply nationally recognized, Interqual Medical Necessity criteria, to authorize this more intensive level of behavioral health care. This process ensures compliance with federal requirements pertaining to timely receipt and review of Certifications of Need (CONs) and Re-certifications of Need (RONs) necessary for concurrent and retrospective review.

(a) How the authorization process will differ for acute and ambulatory levels of care for adults, CSoC and non-CSoC children;

Acute care – Adults

Cenpatico will comply with federal requirements and facilitate independent review for Certification of Need for admission to inpatient (IP) facilities while also ensuring timely concurrent review. Additionally, Cenpatico UM staff will conduct telephonic review at regular intervals to monitor member progress and ensure the facility is actively treating the member while maintaining a high quality of care. Cenpatico will also facilitate discharge planning beginning at the point of admission with a focus on developing treatment plans within the higher level of care which address not only the member's needs and symptoms that necessitated the admission, but also include a plan for successful community reintegration. With the member's permission, Cenpatico will involve family and caregivers in the treatment and discharge planning processes to facilitate successful transition into their community. Following the discharge, our Care Management Team will actively work to facilitate service plans that will support the member in maintaining community tenure. Care Management staff will use recommendations included in the discharge plan to initiate outpatient services designed to meet the member's needs in the community and avoid preventable readmission to higher levels of care. Cenpatico Care Managers share treatment information pertaining to the acute stay with both the member's assigned primary care practitioner and behavioral health providers.

Cenpatico's UM staff advocate for better use of family-centered and community based care as part of a recovery focused Plan of Care. We partner with providers to connect members to these services.

CSoC and Non-CSoC Children

Children who are admitted to acute levels of care will also receive a face-to-face evaluation to ensure the appropriate medical necessity for admission and continued stay are met. Cenpatico will contract with independent practitioners to provide this evaluation. As with the adult population, Cenpatico will make telephonic outreach to the facility at frequent intervals to review treatment plans, medication, and to ensure family and caregivers have been appropriately involved in treatment. This will also allow our staff to immediately facilitate planning for successful discharge to the community. Higher levels of care should be used for crisis stabilization and to provide structure needed to maintain safety. Cenpatico is committed to swiftly moving individuals back into their homes and

communities where additional treatment and services will be made available. For individuals served through the CSoC, we will ensure the CFT is engaged in identifying an appropriate Plan of Care (POC) post discharge. Our staff will review and approve the sustainable POC and facilitate access to needed services in a timely manner. The WAA will conduct UM activities for ongoing services once the youth has discharged to the community. Some youth who admit without receiving CSoC services will functionally qualify for CSoC services upon discharge from acute or PRTF care due to ongoing risk of out of home placement. Cenpatico staff will refer those children and youth to the WAA in their region for enrollment in the CSoC and further assessment and care planning. Individuals not eligible for CSoC services will be referred to an LMHP in our network for a detailed CANS assessment to determine need for services. The LMHP will develop a treatment plan consistent with the DHH-OBH treatment planning requirements. Cenpatico will review and approve the treatment plan and authorize needed services.

Ambulatory Care

For all populations, outpatient and community-based services are authorized through submission of written requests. Outpatient providers of routine services submit an Outpatient Treatment Request (OTR) to Cenpatico's UM Department. The OTR contains written clinical information regarding treatment goals and progress. A LMHP who is part of Cenpatico's UM Team reviews this information. The LMHP sends a response back to the provider in writing indicating the number of sessions approved. Utilization Managers also monitor the progress toward treatment goals and potential need for changes in treatment strategy. If necessary, the Utilization Manager contacts the treating provider by phone or mail to discuss the treatment plan. The UM staff may also send OTR Feedback forms, Best-Practice Intervention Strategies, and other information that will assist the provider in gaining a better understanding of the UM process. Concerns about the quality of care are referred to the Quality Improvement Department for investigation. At any point, Utilization Managers may consult with the Clinical Director or Medical Director to discuss specific cases or questions related to the provider's treatment plan.

If subsequent continued care is needed, the provider must submit a new OTR prior to exhausting the authorized sessions. The number of authorized visits as well as the intensity or frequency of services may vary. For children enrolled in the CSoC, Cenpatico will authorize the Plan of Care in partnership with the WAA. In keeping with the principles of system of care for children, we expect that POCs will include a broad array of services such as family-centered and community based care; therefore, we will partner with other agencies to develop service packages that meet the intensive needs of each child.

(b) Describe the UM workflow and processes for denial of care;

Utilization Review Workflow and Process for Denial of Care

Utilization review is conducted to assess medical necessity and appropriateness of initial and ongoing behavioral health services at all levels of care. Cenpatico will work with WAAs and other agencies to ensure a clear Plan of Care identifies ongoing treatment needs and that authorization for all needed services is in place. A copy of Cenpatico's utilization workflow, process for denial of care, and routine appeals process can be found in ***Section 5, Appendix 2.c.i-A***.

Medical necessity determinations are based upon approved medical necessity criteria, using the medical information available at the time of the utilization review. Utilization review determinations take into account special circumstances of each case that may require a deviation from the norm stated in the criteria. The frequency of utilization reviews is based on the complexity or severity of the patient's condition, or on necessary treatment and discharge planning activities.

The Utilization Manager initially obtains information to assess medical necessity at the current or requested level of care from the treating provider. The Utilization Manager reviews the documentation and determines whether the clinical information presented meets medical necessity criteria.

If the information provided to the Utilization Manager does not support the medical necessity criteria, a licensed physician or qualified behavioral health professional designated by the Medical Director reviews

the case to make a determination about the appropriateness of the clinical services requested. This is considered a Peer Review. For acute care requests, the physician or treating provider is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. As a result of the Peer Clinical Review process, Cenpatico makes a decision to approve or deny authorization for services.

If the request meets criteria: Approval notices are provided to the attending physician/provider of record and the facility. The notice includes:

- An authorization tracking number;
- Number of days or services approved;
- If extension of continued stay, total number of days or services approved;
- Next anticipated review point; and,
- Date of admission or service initiation.

If the request does not meet criteria: In the event that medical necessity criteria are not met for acute or routine services, a denial will be issued. For those enrolled in the CSoC, Care Coordination staff will attempt to obtain information from the CFT for consideration prior to a denial of service being issued. The provider is not paid for services provided to an individual during the appeals process, except for those children and youth enrolled in the CSoC. Providers can continue to serve and be reimbursed for services provided to children enrolled in the CSoC while an appeal is in process.

Cenpatico complies with contractual agreements regarding processing of adverse determinations in accordance with guidelines set forth by the State. Cenpatico will notify enrollees and providers of any proposed notice of action and clearly provide information on how to file an appeal or grievance as well as information and forms for requesting an external review.

When Cenpatico determines that a specific service does not meet criteria, Cenpatico completes and sends a written proposed notice of action within 24 hours to member, persons acting on behalf of the member, and attending and treating practitioners and providers. If the service requested is related to post-stabilization care subsequent to emergency treatment, written notification is provided within one hour.

Notification includes:

- The reason(s) for the proposed action in clearly understandable language.
- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary.
- A statement that the member-specific criteria, guideline, benefit provision, or protocol will be provided upon request.
- Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed actions. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination.
- Instructions for filing a complaint or an appeal, including the right to submit written comments or documents with the appeal request; the enrollee's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- The enrollee's right to request review by an independent review organization or State Fair Hearing and instructions for submitting this request.
- For all urgent precertification and concurrent review clinical adverse decisions, instructions for requesting an expedited appeal.

- Where applicable, the right to have benefits continues pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Upon request from the member, attending physician, or other ordering provider or facility rendering service, Cenpatico provides the clinical rationale for the non-certification, including the specific clinical review criteria upon which the decision was based.

(c) Describe appeals process, including the Proposer's standard and expedited appeals procedures, including the impact on the member and involved providers during the appeal process; and

Appeal Process

Denial determinations are never issued without opportunity for the requesting member/provider to discuss the decision with the qualified professional making the determination. Every effort is made to seek agreement regarding service requests; however if adverse determination is issued, the provider and member are notified in writing of the decision. This notification includes appeal rights and timeline for appeal, expedited appeal option, explanation that appeals are sent to a second independent physician, timeline for appeal resolution, reconsideration options, and State Fair Hearing options. Members, practitioners, and facilities have the right to appeal an adverse determination. Cenpatico follows the NCQA guidelines for processing appeals.

Cenpatico recognizes enrollees have the following rights in the appeals process:

- Designate an authorized representative to represent them in the appeal
- Request an appeal either verbally or in writing
- Submit written comments, documents, records, and other information related to the appeal regardless if such information was submitted or considered during the initial adverse determination.
- Obtain access to, and copies of documents relevant to the appeal, when requested, including information about the appeals process.
- Request an independent review of the adverse determination and receive information and forms to assist in this process.

Cenpatico expedites appeal requests when a provider or practitioner with knowledge of the enrollee's medical condition determines the appeal to be urgent. Appeal decision makers have no previous involvement in the case. For appeals of decisions to reduce, deny, or terminate requested inpatient behavioral health services, or quality of care issues, the Clinical Consultant making appeal decisions is a board-certified psychiatrist who holds an active, unrestricted license to practice medicine, is of the same or similar specialty as the treating practitioner, has no prior involvement, and is not a subordinate of the individual who made the initial adverse determination. For outpatient or intensive outpatient treatment, the clinical consultant may be a psychologist, psychotherapist, social worker, or counselor.

As part of the appeals process, Cenpatico staff take into account all documents, records, or other information submitted by the enrollee, practitioner, or facility related to the case. This is the practice regardless of whether or not such information was available at the time of the original decision.

Standard/Routine Appeal: Cenpatico accepts appeal requests after the adverse decision notice within thirty (30) calendar days from the date of the notice of action. Appeal requests received after the filing timeframe are returned with a letter indicating the filing timeframe has expired, and the request is no longer eligible for review. Cenpatico may waive the filing timeframe requirement for enrollees who demonstrate exceptional circumstances that delayed their appeal request.

The enrollee, person acting on behalf of the enrollee or practitioner may appeal the adverse determination verbally or in writing. Requests made orally must be followed with a written, signed appeal request unless an expedited resolution is requested. Cenpatico staff issue an appeal acknowledgement letter to the

appealing party within three (3) business days after receipt of the appeal request. The appeal acknowledgement letter contains the following elements:

- Date of Cenpatico receipt of appeal;
- The name, address, and phone number of Cenpatico representative that may be contacted about the appeal;
- A list of documents the appealing party must submit to Cenpatico for review and the time frame for response;
- Availability of assistance to members in filing appeals

A full investigation of the substance of the appeal is conducted by a physician or qualified behavioral health professional designated by the Medical Director not previously involved in the initial decision. The investigation includes but is not limited to review of any documentation submitted by the enrollee or practitioner of service, research of relevant documentation completed by Cenpatico staff, and obtaining information from other sources such as the health plan or treating practitioner. The Clinical Consultant makes the determination to uphold or overturn the adverse determination and provides the rationale to the Appeals Coordinator for communication of the decision.

The Appeals Coordinator prepares the resolution notice communicating the appeal decision and sends written communication to members, treating and attending practitioners. If the adverse determination reviewed is upheld, in whole or in part, the notice includes:

- Decision in clear terms, with benefits or medical necessity rationale
- Reference to benefit provision, guideline, protocol, or other similar criterion on which the decision is based.
- Notification that enrollee can obtain, upon request, a copy of the benefit provision, guideline, protocol, or other similar criterion on which the decision is based.
- Informs enrollee entitled to receive free of charge copies of all documents, records and other relevant information upon request regarding the appeal.
- List of titles and qualifications of the individuals participating in the review, and the specialization of the providers consulted.
- The right to request a State Fair Hearing, and how to do so.
- The right to continue to receive benefits pending a state fair hearing including how to request this continuation.
- Explanation that if the decision is upheld in a hearing, the enrollee may be liable for the cost of any continued benefits.

If the decision is overturned wholly in the enrollee's favor, the notice includes the decision, and the medical or contractual reason for the decision.

Expedited Appeal: Cenpatico conducts an expedited review for proposed actions related to urgent or life threatening conditions, continued hospital stays, and decisions regarding ongoing or planned services that warrant immediate review.

A member, person acting on behalf of the member, or practitioner may request an expedited appeal verbally or in writing. Health care professionals (physicians and other licensed professionals consistent with state law) with knowledge of the enrollee's medical condition are permitted to act as authorized representatives in urgent situations.

The attending practitioner may request an expedited appeal during the peer to peer discussion with the Clinical Consultant. In this case the Utilization Manager will forward all case documentation, along with any additional information submitted by the practitioner or enrollee, to another board certified Clinical

Consultant who has not previously reviewed the case and who is not a subordinate of the Clinical Consultant who initially made the adverse determination.

The second Clinical Consultant reviews the case documentation and attempts to contact the attending practitioner. This Clinical Consultant makes a decision in a time frame that is based on the medical immediacy of the condition, procedure, or treatment, but no later than three (3) working days from receipt of the appeal request.

Cenpatico notifies the treating practitioner by phone of the expedited appeal decision. If the Clinical Consultant is able to discuss the case with the treating practitioner by phone, he/she communicates the expedited appeal decision at the time of that discussion. If the Clinical Consultant does not reach the treating practitioner by phone prior to the expiration of the three business decision-making period, the Utilization Manager contacts the treating practitioner or designated facility's Utilization Review staff by phone to notify him/her of the decision. In addition to notifying the practitioner via telephone within three working days of receipt of the request, a letter indicating the decision is sent to the practitioner/provider and the enrollee within three (3) calendar days.

(d) Describe the methodology and criteria for identifying over- and underutilization of services. Provide sample reports and how the information in those reports would be used.

Identifying Under/Overutilization

Cenpatico will utilize existing service utilization data provided by the state to establish Louisiana specific baselines for all levels of service utilization. Cenpatico will collect, evaluate and analyze service utilization patterns. These patterns will be stratified by region and member population to determine shifts and trends in service utilization. This will enable us to identify any specific region or member population that may be influencing an increase or decrease in utilization patterns for a targeted intervention. Using the historical data as a baseline, Cenpatico will calculate the mean utilization rate for each level of care and establish thresholds consistent with standard statistical processes. We will use upper and lower control limits at no more than three standard deviations above or below the mean to identify outliers and assess for process control. Some utilization metrics, such as readmission rates, will have no lower control limit as the goal is to provide community based services in such a manner that readmissions are not routinely expected. Cenpatico will analyze the utilization data formally on an annual basis to account for claims lags. We will also respond to a full data set in order to identify trends in utilization as compared to the baseline, identify any practitioner/provider group outliers and develop targeted interventions to support the shift from costly inpatient services to community based care.

An example of under/over utilization reporting can be found in ***Section 5, Appendix 2.c.i-B Provider Profiling Report***. The Provider Profiling report is used in all our public sector behavioral health markets and includes the number of outpatient visits per member, admission rates per 1,000, readmission rates per 1,000, service codes used, age, and diagnosis. These reports are reviewed and shared with providers at provider meetings. Comparisons are made between providers with similar populations to identify outliers of under/over utilization. Thresholds and expectations are set for service utilization including penetration rates by population and service category. Variations among populations and services are reviewed and trended to understand changes in service usage patterns.

One example of how Cenpatico has used data showing over-utilization of services is the Georgia Strengthening Families Program (SFP) Pilot program. Members who are being maintained within their homes must receive effective community-based care in order to acquire the necessary skills and resiliency factors required to solve their own problems and avoid hospitalization. In 2009, Cenpatico's Profiling data identified numerous community-based services providers in Georgia that were delivering care that did not appear to reflect a consistent and planful approach to treatment. The providers had required continuous feedback and even medical necessity denials due to inappropriate service requests and/or

excessive lengths of treatment. In many cases, there was little or no significant amelioration of symptomatology and/or improvement in member functioning.

Utilizing an internationally-recognized, evidence-based approach to care (the SFP), Cenpatico developed a Pilot Program designed to engage high-utilizing community-based service providers in a way that would improve their treatment practices and member outcomes. Three Georgia providers were selected and Cenpatico contracted with Lutra Group, Inc., the sole authorized source for SFP staff training, to provide a two-day on-site training for SFP service development and delivery to the three identified Pilot providers.

Results from the first Lutra Group SFP Georgia Outcomes Report stated, "The children enrolled in the SFP Pilot at two Atlanta sites had significant behavioral and mental health problems that were almost twice as severe as those children who generally participate in SFP, resulting in a particularly high-risk population and therefore appropriate for the SFP intervention... 100% of the five family change variables were improved significantly." The report also stated, "Hence, it appears that the SFP programs are having a dramatic impact on the overall family environment, beyond that found normally in other SFP sites nationally. This is a very positive effect and a tribute to the Cenpatico strategy."

In addition to positive member outcomes for members and their families, SFP parent graduates reported favorable responses to the program. One parent said, "It helped me to build a closer relationship with my son." Another parent stated, "It was nice to be with other mothers who had similar issues, and we could share different techniques for handling the same problems." And a third parent said she was initially resistant about attending the weekly SFP training sessions, but by graduation was better at expressing her own feelings and was able to get her son to communicate more with her instead of "keeping things bottled up inside."

2.c. Utilization Management
ii. Describe how the Proposer's information management system will support UM activities. **Suggested number of pages: 1**

Integrated Technology to Support Utilization Management Cenpatico Management Information Systems (MIS) are functionally rich and they are integrated where they need to be to assure efficient, quality care operations. We leverage this technology to simplify Utilization Management (UM) activities and workflow processes. Essentially, our systems allow our UM staff to quickly and efficiently identify all prior treatment services an individual received, review available clinical history, identify wellness plans and supports in place as well as review service requests for medical necessity using clear guidelines. Since our UM and CM staff utilize the same integrated system, all information is easily exchanged, staff can trigger activities and follow up needs to one another and there is clear documentation of all communication with members and providers that is dated and accessible. Additionally, our system allows for easy retrieval of utilization data for tracking, trending and intervention and also provides tracking capabilities for decision-making timeframes as well as tracking of all authorization and denial decisions as well as appeals and appeal processes. Since we are able to synthesize information about each individual, our decision-making processes are efficient, opportunities for identifying quality of care issues, moving people through the continuum of care and coordinating such activities is simple and well-documented.

Below we describe how each system supports this process and how they are configured and integrated allowing us to perform these activities in accordance with the National Committee for Quality Assurance (NCQA) for Full Managed Behavioral Health Care Organization (MBHO), an accreditation awarded to Cenpatico in 2010.

Member Relationship Management (MRM) Our MRM is a master data management and contact management system that holds all data we receive from the state on the HIPAA 834 enrollment file including age, gender, ethnicity, and is designed for member related data and processing workflow needs in health care administration. Member enrollment data will be loaded into our MRM from which it is systematically promulgated to all systems requiring this data, including our TruCare, care and utilization management system, AMISYS Advance our claims processing system, our Provider Portals supporting eligibility requests, on line claims entry and authorization requests, and our Enterprise Data Warehouse (EDW) enabling us to leverage the full set of our Centelligence™ reporting tools (see below) to report on utilization based on member demographics.

TruCare For service authorization, Cenpatico will utilize TruCare, our care management and utilization software system which is integrated with AMISYS Advance our core claims processing system and our EDW. TruCare utilizes rule-based architecture, which allows customized clinical workflow related to clinical decision support criteria, prior authorization, and medical necessity review. TruCare's interface capabilities allow it to transmit authorizations in real time to our AMISYS Advance claims subsystem, and TruCare's data granularity allows authorizations to be issued at the procedure code level, enabling the highest level of specificity for subsequent claim adjudication, and enhancing claim payment turnaround times to our providers. TruCare is integrated with McKesson's industry leading ***InterQual*** evidence based Behavioral Health Criteria to automate all workflow related to level-of-care and continued stay decisions. InterQual criteria allow our UM and Case Management (CM) staff to consider the severity of the illness and episode-specific variables and match the level of care appropriately and in a consistent and objective manner. InterQual Behavioral Health Criteria are used by over 300 payers and provider organizations including managed care organizations, managed behavioral health organizations, hospital systems, general hospitals and free-standing psychiatric centers. TruCare is scalable and fully customizable to exceed DHH-OBH Program requirements surrounding service authorization. TruCare's customizable capabilities empower our clinical staff to reduce duplicative or unnecessary services. AMISYS Advance,

is configured to look for service authorizations, and where required, will access the authorization file to obtain the authorization number for the service, and return it to the claim entry screen as described in the adjudication process below. TruCare maintains member demographic information, identification of Provider delivering service and his/her national provider identifier (NPI), diagnosis code(s), and authorized service units related to an authorization.

Enterprise Date Warehouse Centelligence™ Cenpatico uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, integration, and reporting of all information from the systems described above, including: clinical claim/encounter data; financial information; medical management information (referrals and authorizations); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status and demographics) as required by the UM Program. In addition, EDW houses data from external sources including data supplied by DHH such as pharmacy data and medical utilization data as available, and information gathered from agencies such as OJJ, DCFS and DOE. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository, using our Centelligence™ suite of reporting systems to build and tabulate key performance indicators and provide drill-down capability to the individual provider or member level for investigation of suspected under- or over-utilization. Centelligence™ Foresight (our predictive modeling system) enables us to not only assess appropriateness of delivered services against evidence-based behavioral health guidelines, but also against the average risk of members or subgroups of members receiving the services. The software assesses whether the members receiving specific programs or services are the ones who can receive the most value from them.

Delivering Utilization Management Reports Our information technology infrastructure combined with skilled Information Technology staff, Health Economics staff, and a local decision support team provide an array of regular, consistent utilization reports as well as ad hoc and member and provider level reports to support our UM staff. Regular reports that UM staff and the UM Committee review will include inpatient measures such as:

- days and admissions per 1,000 members and by age grouping,
- readmissions within 30 and 90 days, and
- average length of stay, overall and by diagnosis;

Routine outpatient measures include, but are not limited to:

- follow-up care to inpatient stays,
- average length of treatment,
- rate of family therapy for children (as compared to individual treatment),
- use of evidence-based treatment modalities

We also review quality of service indicators such as:

- the rate of notices of actions to reduce or deny authorization of service and the types of services impacted,
- quality of care concerns,
- member and provider satisfaction
- timeliness of authorization review, and telephone responsiveness data

2.c. Utilization Management
iii. Describe the medical necessity criteria and level of care guidelines utilized by the Proposer's organization in managing care, include the source of the criteria/guidelines with which the Proposer has experience and the Proposer's experience in utilizing guidelines provided by contracting agencies. Suggested number of pages: 3

Approach to Treatment authorization and medical necessity review

Cenpatico believes members should be actively involved in their behavioral health care so they can achieve their goals and desired outcomes. We support a recovery-focused approach to treatment that provides the most appropriate services at the right time and in the least restrictive setting. Our culturally- and linguistically competent approach paves the way for appropriate utilization of the full array of covered services available to our membership.

Medical Necessity Criteria: Cenpatico currently uses InterQual Medical Necessity Criteria, a nationally recognized criterion set produced by McKesson and integrated into our software program to facilitate utilization review processes. InterQual includes a collection of tools to assess the appropriateness of care and facilitate treatment through the continuum of care. The criteria allow reviewers to consider the severity of illness as well as episode-specific variables and match the level of care to the patient's current condition. InterQual has separate criteria available for seniors, adults, adolescents and children. This age-specific content considers the significantly varying behavioral, developmental and treatment needs of child, adolescent, adult and geriatric populations.

Through a rigorous content development process, InterQual offers utilization managers and providers a common language that enables consistent, clinically validated and objective decision making through the continuum of care. Clinical Research Summaries are available to providers and utilization reviewers to support these decision paths and further validate how decisions are made.

InterQual pioneered the development of educational tools and clinical criteria for hospitals to develop utilization review and quality assurance programs almost 30 years ago. With evidence based and clinically validated content as their hallmark, InterQual products have expanded and evolved with the changing healthcare landscape. InterQual Behavioral Health Criteria were launched in 2000 and are used by over 300 payers and provider organizations including managed care organizations, managed behavioral health organizations, hospital systems, general hospitals and free-standing psychiatric centers.

InterQual Criteria sets are developed and updated in annual cycles with five stages to maintain current clinical accuracy. The stages include indentifying new topics for inclusion and existing content for revision, updating research citations that support clinical decision making (there are currently more than 10,000 citations used), reviewing and revising criteria, validating clinical accuracy and final formatting and review for quality assurance.

The following table depicts the scope of InterQual Medical Necessity Criteria for Psychiatry and Residential Treatment:

InterQual Behavioral Health Criteria	Levels of Care	Criteria Subset
Geriatric Psychiatry (Ages >65)	· Inpatient/Observation · Partial Hospital · Home Care · Intensive Outpatient · Outpatient	· Anxiety · Mood Disturbance · Behavior Disturbance · Psychosis · ECT Acute/Short-term · ECT Continuation/Maintenance · Psychiatric Testing · Neuropsychiatry Testing
Adult Psychiatry (Ages 17 to 65 years)	· Inpatient/Observation · Partial Hospital · Intensive Outpatient · Outpatient · Residential (Eating Disorders Only)	· Anxiety · Depressed Mood · Mania/Hypomania · Reckless/Impulsive · Psychosis · Eating Disorder · ECT Acute/Short-term · ECT Continuation/Maintenance · Psychiatric Testing · Neuropsychiatry Testing
Adolescent Psychiatry (Ages 13 to 17 years)	· Inpatient/Observation · Partial Hospital · Intensive Outpatient · Outpatient · Residential (Eating Disorders Only)	· Anxiety · Depressed Mood · Mania/Hypomania · Disruptive Behavior · Psychosis · Eating Disorder · ECT Acute/Short-term · Psychiatric Testing · Neuropsychiatry Testing
Child Psychiatry (Ages 6 to 12 years)	· Inpatient/Observation · Partial Hospital · Intensive Outpatient · Outpatient	· Anxiety · Depressed/Irritable Mood · Mania/Hypomania · Disruptive Behavior · Suspected/Identified Psychosis · Psychiatric Testing · Neuropsychiatry Testing
Residential (Psychiatry)	· Psychiatric Residential Crisis Program · Psychiatric Residential Treatment Center · Psychiatric Supervised Living · Psychiatric Assisted Living · Psychiatric Sub-acute Care · Psychiatric Residential Treatment Center · Psychiatric Therapeutic Group Home	Adult Adolescent and Child

When reviewing for substance use treatment, we use the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for substance use treatment. ASAM criteria are also age-specific. This is nationally recognized as appropriate medical necessity for substance use disorders and levels of care. Four features characterize the ASAM Patient Placement Criteria: (1) individualized treatment planning, (2) ready access to services, (3) attention to multiple treatment needs, and (4) ongoing reassessment and modification of the plan.

Functionally, the criteria are used to match treatment settings, interventions, and services to each individual's particular problems and (often-changing) treatment needs. The ASAM criteria advocate for individualized, assessment-driven treatment and the flexible use of services across a broad continuum of care. The criteria also advocate for a system in which treatment is readily available, because patients are lost when the treatment they need is not immediately available and readily accessible. By expanding the criteria to incorporate outpatient care, especially for those in early stages of readiness to change, the ASAM criteria have helped to reduce waiting lists for residential treatment and thus have improved access to care. The criteria are based in a philosophy that effective treatment attends to multiple needs of each individual, not just his or her alcohol or drug use. To be effective, treatment must address any associated medical, psychological, social, vocational, and legal problems. Through its six assessment dimensions, the ASAM criteria underscore the importance of multidimensional assessment and treatment.

Guidelines Provided by Contracting Agencies:

For **Community-Based Services** (CBS), Cenpatico uses state-specific guidelines that are consistent with Medicaid policy manuals and local service definitions.

We are well able to incorporate medical necessity criteria and unique service definitions or requirements as required by contract. The definition and scope of community-based services tend to be individualized to each state, varying significantly in how services are interpreted and delivered. Rather than potentially imposing an unfamiliar interpretation in new markets, Cenpatico has chosen to embrace the uniqueness of state-defined community-based services. Cenpatico spends time prior to implementation to fully understand the local service delivery culture. Where appropriate, we adopt the service definitions and criteria as defined by the state, thereby ensuring we speak the same language with our providers when collaborating on effective treatment. Cenpatico has adopted state criteria for community based services in Arizona, Georgia, Florida, Illinois, Massachusetts, Texas, and Kansas. Taking this individualized approach to critically important wraparound services has demonstrated to our providers and members the value we place in their local delivery system.

We work collaboratively with providers, families, community organizations and stakeholders to ensure the most effective treatment methods are implemented and that treatment methods are individualized to the specific needs of each recipient. The SMO plays a significant role in facilitating access to care, ensuring children and adults are supported within their local communities and homes, and enhancing the use of evidence-based practices across the state. We believe a key role for the SMO is to provide technical assistance to support providers, WAAs, FSOs and other stakeholders. This technical assistance will help them achieve the vision of providing coordinated care and services that involve community support and empower consumers and their families. Utilization Management and Care Management are inextricably intertwined as we work to support effective and efficient care that decreases reliance on institutions and improve access to crisis intervention and local supports that facilitate positive outcomes.

2.c. Utilization Management
iv. Describe the specialties/expertise areas of the Psychiatrist, Psychologist Advisors that will be assigned to this contract.
Suggested number of pages: 2

Cenpatico's experience in managed behavioral health and system transformation informs our understanding of the depth and breadth of knowledge and skills necessary to effectively encourage recovery for members and responsibly manage behavioral health care. For this purpose we maintain consulting relationships with approximately fifty psychiatrist advisors. The specialties and expertise of these doctors include:

- Child & adolescent psychiatry
- Geriatric psychiatry
- Addictions
- Forensics
- Internal medicine

In addition to expert psychiatrists able to work with a broad range of populations and conditions, we also have consulting relationships with approximately 8 psychologist advisors with a wide range of expertise serving children and adults. We work with two independent companies who offer consultation with a varying range of specialties that can be offered on a case by case basis.

Cenpatico utilizes consulting physicians and psychologists in a variety of ways including training opportunities for Cenpatico staff in the consultants' various areas of expertise, review of new technology or medications that may be beneficial, review of clinical practice guidelines and participation on Cenpatico's advisory committees. All consulting physicians also maintain at least a part time active practice, which ensures up to date knowledge of behavioral health treatment and evidence based practices. Cenpatico capitalizes on this knowledge and frequently relies on the consulting physician to speak with attending physicians and community providers to offer alternative approaches that might result in better outcomes.

Cenpatico typically accesses independent consultant Psychiatrist and Psychologist reviewers to conduct peer reviews when there is a request for a specific treatment or level of care that does not appear to meet medical necessity criteria. A consultant is also used when an individual is not demonstrating progress despite continued treatment. In this case a consultation is beneficial to review the treatment plan for consistency with diagnosis, evidence based practices and efficacy. The consulting Cenpatico physician makes contact with the requesting provider to discuss specific aspects of the case and to review progress. The consultant will discuss alternate levels of care if appropriate. Additionally, he/she will coordinate with other professionals or community supports as needed to address any concerns related to a member's care. Consulting physicians can also be accessed in the case of an appeal, to explore quality of care concerns or to offer guidance to the clinical team regarding complex treatment needs.

Consulting physicians and other specialized behavioral health professionals are an important part of Cenpatico's utilization management team. The Cenpatico Medical Director oversees activities conducted by consulting physicians. Consulting physicians bring meaningful insight into determining the appropriate level of care for our members. They participate in the annual review and approval of medical necessity criteria. Consulting physicians also participate in the annual Inter-rater Reliability exercise, ensuring consistency in the application of medical necessity criteria.

Cenpatico will take the unique needs of Louisiana into account when determining specialty advisors needed. The populations covered by the SMO have individual needs that can be best addressed by those who have appropriate experience and training. Since the SMO will cover a large population of children, there is a clear need for expertise in child and adolescent psychiatry. Experience serving the foster care

population is an added benefit as these children present with unique and complex issues not seen in the general child and adolescent population. With the focus on those with substance use disorders, there is also a need for psychiatrist advisors with experience working in the field of addiction. As in our other markets, we will maintain the flexibility needed to obtain the necessary expertise and consultation needed for appropriate treatment of adults and children in Louisiana.

National physician experts are tapped to offer expert clinical advice for developing clinical programs, implementing evidence-based and promising practices, and training community-based physicians. Cenpatico frequently consults with local clinical experts to ensure that staff and contracted providers understand the uniqueness of each and every community served.

2.c. Utilization Management
v. Practice Guidelines. Describe the Practice Guidelines for utilization of care proposed for the program. **Suggested number of pages: 2**

Cenpatico uses a community, population-driven approach in the identification and utilization of Practice Guidelines. To ensure we always identify the most appropriate and effective Practice Guidelines, Cenpatico collaborates with behavioral health organizations nationally (such as The National Council on Behavioral Health and the American Psychiatric Association) as well as within the community to ensure clinical practice guidelines effectively meet the needs of each target population. In addition to *clinical* practice guidelines, Cenpatico collaborates with organizations serving specific populations, such as foster care, juvenile justice, and adults with co-occurring disorders, to determine and incorporate best practice guidelines for each population. Quite often, the providers in the community and those closely linked to the population served are the best source for identifying appropriate and effective practice guidelines.

Our goal is to ensure excellence in clinical practice for each specific population served. For example, Cenpatico collaborates with the Child Welfare League of America, Foster Family-Based Treatment Association (FFTA) and the National Council of Juvenile and Family Court Judges to continually learn of new best practice guidelines for serving youth engaged with DCFS and OJJ. It is through community-based and wraparound services that appropriate practice guidelines are effective.

For Louisiana, Cenpatico will adopt, disseminate and apply practice guidelines developed in collaboration with DHH-OBH for the CSoC population.

For other populations, Cenpatico ensures that Clinical Practice Guidelines (CPG) are consistent with CMS requirements, as well as for the specific needs of the Louisiana populations.

CPGs will ensure consistency with regard to all decisions relating to UM, member education, covered services and other areas to which the practice guidelines apply.

Cenpatico's CPGs for Louisiana shall meet the following requirements:

The integration of clinical practice guidelines with population specific best practice guidelines is a process that Cenpatico continually reviews and assesses both internally and through stakeholder committees and collaborations and modifies as appropriate to meet ongoing and changing needs.

- CPGs are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in a particular field;
- CPGs consider the needs of our members;
- CPGs include emphasis on community based and wrap around services delivery models;
- CPGs are adopted in consultation with Providers; and
- CPGs are reviewed and updated periodically, but at least annually.

In addition**,** Cenpatico has established *policies and procedures* to govern the process of adopting, developing and implementing evidence-based clinical guidelines to help providers, consumers and family members, and Cenpatico makes appropriate treatment decisions in support of recovery and resiliency outcomes. These procedures will be modified as necessary in accordance with Louisiana's process to approve policies and procedures.

Clinical Practice Guidelines Proposed by Cenpatico

Cenpatico has adopted the following Clinical Practice Guidelines (CPGs) from the referenced nationally recognized source. These Practice Guidelines will be recommended for implementation in Louisiana:

For adults

- ***Treating Major Depressive Disorder*** American Psychiatric Association
- ***Treating Bipolar Disorder*** American Psychiatric Association

- ***Treating Substance Use Disorders*** American Psychiatric Association
- ***Treating Schizophrenia*** American Psychiatric Association
- ***Treating Patients with Acute Stress Disorders and PTSD*** (2009 guideline watch update) American Psychiatric Association
- ***Trauma Informed Care and Trauma-Specific Interventions*** Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Traumatic Stress Network (NCTSN)

For Children

- ***Mental Health Practice Guidelines for Child Welfare*** The REACH Institute, Case Family Programs & The Annie E. Casey Foundation
- ***Trauma Informed Care and Trauma-Specific Interventions*** Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Traumatic Stress Network (NCTSN)
- ***Wrap Around Practice Model*** National Wraparound Initiative
- ***Guiding Principles of Family-Driven Care*** National Federation of Families for Children's Mental Health
- ***Practice Parameter for the Assessment and Treatment of Children and Adolescents with Attention-Deficit Hyperactivity Disorder*** American Academy of Child/Adolescent Psychiatry
- ***Practice Parameter for Assessment and Treatment of Children and Adolescents with Depressive Disorders*** American Academy of Child/Adolescent Psychiatry
- ***Practice Parameter on Child and Adolescent Mental Health Care in Community Systems of Care*** American Academy of Child/Adolescent Psychiatry
- ***Practice Parameter for Assessment and Treatment of Children and Adolescents with Anxiety Disorders*** American Academy of Child/Adolescent Psychiatry

More information on practice guidelines:

- American Psychiatric Association: http://www.psychiatryonline.com/pracGuide/pracGuideHome.
- American Academy of Child/Adolescent Psychiatry: http://www.aacap.org/cs/root/member_information/practice_information/practice_parameters/practice_parameters
- National Federation of Families for Children's Mental Health: http://ffcmh.org/r2/publications2/family-driven-defined/
- National Wraparound Initiative: http://www.nwi.pdx.edu/
- Substance Abuse and Mental Health Services Administration (SAMHSA), National Center for Traumatic Stress Network (NCTSN): http://www.samhsa.gov/nctic/
- The REACH Institute, Case Family Programs & The Annie E. Casey Foundation: http://www.aecf.org/KnowledgeCenter/Publications.aspx?pubguid={FAAABEF9-2E5C-4D63-8584-73205D3B7CA4}

Clinical Practice Guideline Review

Cenpatico reviews and updates Clinical Practice Guidelines annually. Cenpatico will adhere to the Louisiana RFP requirements for adoption, dissemination and application of guidelines developed for the Louisiana population. If a particular CPG is not required to be reviewed by Louisiana, Cenpatico will review and update Clinical Practice Guidelines through the Austin based Provider Advisory Committee (PAC).

Best Practices Committee

Cenpatico will establish a Louisiana Best Practices Committee consisting of consumer, family, provider and community service organization involvement. The Best Practices Committee will convene sixty days prior to the implementation start date, and will review and recommend for approval the Clinical Practice Guidelines (CPG) appropriate to Louisiana. The Best Practices Committee will recommend CPGs to the CSoC Statewide Governance Body and the DHH-OBH for adoption.

Community responsiveness and consumer influence is not just a value for Cenpatico; this shapes our programs and our clinical model. After meeting with providers and consumer advocates throughout Louisiana, we learned that many adult consumers are diagnosed with Post Traumatic Stress Disorder. Our Best Practices Committee will make recommendations for Clinical Practice Guidelines for Post Traumatic Stress Disorder in its initial efforts to expand adoption of CPGs in Louisiana.

Plans for Dissemination and Communication of CPGs to Providers

We recognize that provider adherence to Clinical Practice Guidelines requires training, coaching, and fidelity monitoring. We have built an organizational structure to support adherence to and communication of our Clinical Practice Guidelines. To ensure that our providers are aware of and understand the appropriate application of each Clinical Practice Guideline Cenpatico will take the following steps:

Step 1: Communication All Clinical Practice Guidelines will be provided to network providers upon contracting with Cenpatico. Additional copies will be provided to community advocates and other interested stakeholders. These guidelines will be accessible on the Louisiana provider portal of the Cenpatico website at all times. The Network Development Manager will ensure that updates and revisions to these resources are made available in print and on the web to all network providers.

Step 2: Provider Training The Training Administrator will oversee the development and implementation of a Training Plan which will include training related to Clinical Practice Guidelines. Curricula related to each Clinical Practice Guideline will be developed and will be made available through e-learning. Provider and Cenpatico staff will be required to complete the training and receive passing scores on post tests. Providers will be monitored on a quarterly basis to ensure completion of training requirements.

Step 3: Technical Assistance Cenpatico will provide ongoing technical assistance to providers to facilitate appropriate application and understanding of the Clinical Practice Guidelines. Technical assistance will include coaching activities, regular monthly telephonic meetings, and a review of organizational charts, staffing and individual provider work plans appropriate to the effective utilization of the Clinical Practice Guidelines.

Step 4: Fidelity Audits Provider Coaches will conduct fidelity audits related to the Clinical Practice Guidelines. Nationally accepted fidelity audit tools will be used for each Clinical Practice Guideline when available. We will create fidelity audit tools when nationally recognized tools are not available.

Providers will be issued corrective action letters when performance on the audits falls below targets. Should corrective action be required Cenpatico will, in collaboration with the provider agency, explore methodologies to improve performance such as additional training, strategic incentives, and formal corrective action planning.

Expanding and Sharing Knowledge through Non-Traditional Sources

Cenpatico seeks out clinical guidance to inform professionals about treatment that can best serve the populations in their care. For example, in the Texas Foster Care program Cenpatico has adopted the National Child Traumatic Stress Network (NCTSN) curriculum and toolkit designed to train case workers and others within the child welfare system as an introduction to trauma and the impact on children in care. Essential elements of the training include:

- maximizing safety for the child

- reducing overwhelming emotions
- helping children make a “new meaning” of the trauma event and current experiences
- addressing the impact of trauma
- coordinating services and interventions
- using a comprehensive assessment that includes trauma and its impact on development and behavior that is used to guide services
- supporting and promoting positive stable relationships
- promoting support and guidance
- managing professional and personal stress of caregivers and treatment staff

To be successfully applied to child welfare, it is critical that the entire system of care (caseworkers, judges, advocates, foster parents, treatment providers and other stakeholders) receive similar training and support the use of these strategies. In one of our largest training initiatives ever, Cenpatico launched these trainings in January 2010 targeting an estimated 36,000 staff, caregivers, kinship givers and CASAs.

2.c. Utilization Management
vi. Describe how the Proposer will address the high utilization of inpatient services in Louisiana through the CM and UM process. Discuss strategies the Proposer has used successfully in other programs to divert children and adults from inpatient and residential settings, and prevent readmissions. **Suggested number of pages: 2**

A primary goal of Cenpatico's Care Management and Utilization Management Program is to serve children and adults in the least restrictive environment possible. We believe that children, youth, and adults are best served in a natural setting within the community as opposed to inpatient hospital and residential settings. Quite often, children are admitted to inpatient services because of a lack of resources in the community and/or within the family, such as a lack of knowledge of effective trauma based interventions, skills of the caregiver/family member and access to services.

Cenpatico has demonstrated success with a variety of strategies to reduce hospitalization. These strategies, which will be implemented in an integrated manner in the Louisiana System of Care, include:

Utilization management and intensive care management	Training of providers in evidence based practices to improve targeted, specialized community driven services
Appropriate assessment and screening	Crisis planning and intervention services offered *in* the community
Connection with outpatient services that *fit* the needs of the member	Working with hospitals, residential centers and case workers for more appropriate placement decisions
Family Driven Care	Child and Family Teams

Early Intervention and Intensive Care Management Practice

Cenpatico has been very successful in other states with reducing inpatient hospitalization, especially for the foster care population in Texas. Over a three year period, Cenpatico was able to reduce psychiatric inpatient utilization by 23%.

Cenpatico takes a proactive and preventive approach to caring for our members. Through intensive care management practices, we strive to prevent inpatient and residential treatment. Early intervention strategies allow for the ability to apply the right treatment at the right time in order to resolve issues and problem areas before they escalate to a point of needing to be addressed through restrictive levels of care. Additionally, connecting both adults and children with appropriate providers that "fit" the individual's needs based on a quality and accurate assessment. One size does not fit all when it comes to providers and "fit" between the individual's needs and the providers skills is imperative. If the adult or child is receiving the appropriate interventions in the community, hospitalization can be avoided. In Texas, Cenpatico spends a considerable amount of time training case workers, foster parents and residential staff about trauma informed care, to include the identification of trauma triggers. If the system as a whole is more mindful of the individual's needs and is able to view the situation through the "trauma lens" (an empathetic perspective), then situations that would have previously led to crisis can be adverted. In Texas, Cenpatico is working with a psychiatrist on staff at a large psychiatric hospital. The psychiatrist approached us, asking us to partner in a psychiatric hospital diversion pilot project because he felt too many children in foster care were admitted to the hospital when it was not necessary.

For the children of Louisiana, we plan to work closely with the CSoC Statewide Governing Body, WAAs, and FSOs in order to fully support wraparound facilitation processes for those who qualify. Cenpatico shares the vision of the Louisiana Partnership that community based, family driven services can keep both children and adults in their homes. We understand Louisiana has been reliant on institutionalized care due to the lack of community infrastructure and the lack of comprehensive services to meet the needs of the target populations. Cenpatico will work with DHH-OBH, all state agencies and the community through regional teams, local community involvement and statewide efforts to develop alternatives to higher levels of care. This can be done, and has been done in other days. It takes a proactive, committed leadership with the ability to engage systems at all levels. Cenpatico has this expertise, and most importantly, the desire to make a difference in the lives of children and adults.

We are aware that many children will not qualify for the CSoC or will simply not be served through that entity due to capacity issues. However, we fully support and embrace the efficacy of wraparound principles, and thus, will incorporate that same strengths-based, child- and family-driven approach to all aspects of care we provide. Similarly with our adult population, we will work to build on individual strengths while focusing on the whole person instead of just their diagnosis. Cenpatico has established forums and processes designed to encourage staff to "think outside the box" to develop creative solutions, treatment strategies, and member care plans that address the specific needs of each individual and prevent many inpatient admissions.

An important piece of our care management process will include *crisis and safety planning*. We will facilitate the development of crisis plans with all adult and child members served through our care management program, and we will develop safety plans for those who have a history of risky behaviors (e.g., previous suicide attempts, use of alcohol or drugs). Crisis plans will involve detailed, step-by-step strategies that the individual or family members can implement when behavioral health symptoms are exacerbated. Crisis plans include identification of people within the members' formal and/or informal support networks that can be contacted to help, or a designated place where the member can go that will make them feel safe. Cenpatico will work to develop collaborative relationships with regional crisis response teams to ensure that members have access to crisis intervention and crisis resolution services in their communities 24 hours a day, 7 days a week.

Safety plans will include specific, proactive steps that will minimize risk of harm to the member, including safeguarding the home to remove objects that can be used as weapons, locking medications to prevent access that could lead to overdose, and making changes in the environment that reduce or eliminate known "triggers" for member decompensation. When inpatient or residential treatment is required, our Utilization Management (UM) discharge planning staff will begin working with the hospital at time of admission to help identify the appropriate step-down level of care and arrange for outpatient follow-up.

Members who are readmitted to the hospital within 30 days of discharge from their previous inpatient event are identified on a daily census log are staffed with the Cenpatico Medical Director during weekly clinical rounds. The Medical Director and other members of the clinical team provide feedback and suggest new clinical and support strategies to prevent need for hospitalization. Upon discharge, our Care Management staff helps the members focus on health and wellness strategies and ensure their knowledge of and access to both formal and informal supports necessary to promote community tenure and prevent hospitalization or treatment in a residential setting. In addition to ensuring the member attends appointments with a psychiatrist or therapist, the Care Manager links the member with supports available within the community including faith-based organizations and peer support services. With the knowledge

that the residents of Louisiana have experienced significant trauma related to natural disasters, our Care Managers will be trained in trauma- informed care practices and principles. They will view all cases through a trauma lens to ensure those who experience traumatic events receive services that will assist them in effectively identifying and coping with the trauma triggers that can precipitate inpatient admissions. As we work more in the community, we will strive to identify needs that are unique to Louisiana and to various areas within the state.

Clinical Pilot Programs and Initiatives

Cenpatico's Provider Profiling Initiative (PPI) generates data on a quarterly basis that identifies high-utilizers of inpatient services. From those data, clinical Pilot programs and other initiatives are generated to expand the array of services available to those high-utilizers. One example exists in Ohio, where the Aged, Blind, and Disabled (ABD) population of Cuyahoga County had comparatively high admission, readmission, and emergency department (ED) utilization rates for both behavioral health services and for medical services associated with substance abuse. The Orca House Pilot Program was created to link high-utilizing (medical and behavioral health) members with Residential Substance Abuse Treatment in a timely and coordinated manner by contracting directly with a provider for Residential Substance Abuse Treatment. The goal was to reduce inpatient (behavioral health and medical) readmissions and ED utilization by 5%. As of April 2011, 24 high-utilizing members have been enrolled in the program. The impact on Behavioral (BH) and Physical Health (PH) inpatient admissions, as well as Emergency Room (ER) visits, was analyzed for the period 180 days pre-intervention compared to the period 180 days post-intervention. Results of that analysis reported that BH admissions decreased by 73% (from 69 to 19), PH admissions decreased by 61% (from 301 to 119), and ER visits decreased by 55% (from 212 to 96). The total savings for the Buckeye Health Plan was $161,367.

Another clinical initiative developed specifically to target high-utilizers of inpatient services is the Caring Voices (CV) Program. High-utilizing members often have unreliable phone service or no service at all. This is a barrier to successful member contact with the Intensive Case Management Team and the members' other providers, and also a contributing factor to increased inpatient utilization. The CV Program provides pre-programmed cell phones to high-risk members so they can access their support network in times of crisis and take a more active role in their outpatient treatment. The CV phones are provided free of charge to members, pre-programmed with the phone numbers for their Primary Care Physician, Psychiatrist, Therapist, Case Manager, local 911, and a few primary supports such as family members. The Caring Voices Program helps bridge the communications gap between members and their treating providers, increases member compliance with outpatient care, increases community tenure, increases member involvement in their treatment and with their support system, and improves overall health outcomes. As of 6/8/2011, a total of 248 phones have been provided to members in seven different Cenpatico markets (182 in Ohio). The latest available cost-savings report (for Q3-2010) shows that, for the 110 CV members in Ohio at that time, the projected annual net cost savings was $283,879.

2.c. Utilization Management
vii. Assuming that pharmacy data for members will be provided to the Proposer by DHH, describe how the Proposer will review, monitor and analyze pharmacy data for medication side effects, adverse drug interactions, and member adherence. Describe strategies to detect under-and over-utilization and potential inappropriate utilization of medications by members and by providers.
Suggested number of pages: 2

We have managed BH pharmacy benefits for health plans across the country for more than 17 years. These contracts require us to work with multitude PBMs, government sponsored programs, agencies and other vendors to coordinate member pharmacy benefits. We have extensive experience collaborating with States to manage and control pharmacy costs through utilizing data analytics, reporting and network education.

How we review, monitor and analyze pharmacy data for medication side effects, adverse drug interactions and member adherence

We utilize an automated process to routinely review large volumes of pharmacy claims data to identify psychotropic medication poly-pharmacy (by class and number of medications prescribed), potential drug interactions and adverse effects, and frequency of refills. We will collaborate with Louisiana's PBM to manage pharmacy benefits by addressing medication cost factors such as generic vs. non-generic options, and prior authorization of more expensive medication. In addition, we will add a level of pharmacy data analysis that is not available in traditional pharmacy benefits management companies. We will model this new pharmacy data process after our **Pharmacy Management Utilization Review (PMUR)** program. This automated program runs monthly and integrates pharmacy, and BH treatment claims to identify members who fall outside key prescribing parameters based on age, medication class, and number of psychotropic medications prescribed. Since implementation last year of PMUR for Texas foster children, there has been a 16.95% decline in the number of foster children prescribed psychotropic medications overall and specifically an 81.18% decline in poly-pharmacy. In addition to implementing PMUR, we use the predictive modeling tool Impact Pro that integrates BH claims, pharmacy claims, and lab data to identify members with unsatisfactory treatment outcomes. We will use the data to review prescribing patterns, medication side effects, and member adherence concerns that may be leading to the poor outcomes identified in the report. We also will utilize pharmacy software provided by our PBM, US Script, to monitor prescribing patterns, medication side effects and member adherence concerns. We will also train our providers to report to us medication side effects, adverse drug interactions and member adherence issues. In addition, our Care Managers (CMs) and Utilization Managers (UMs) will monitor medication adherence, drug interactions and side effects in the course of authorizing care and identify members at risk. These members' treatment plans and risk factors will be reviewed by our medical team for further action.

Strategies to detect under- and over-utilization and potential inappropriate utilization of medications by providers

Cenpatico has demonstrated experience in detecting under and over-utilization and potential inappropriate utilization in Arizona, Georgia and Florida and the Texas Foster Care Program. Cenpatico will review, monitor and analyze pharmacy data provided by DHH for under and over-utilization. We monitor for providers who are prescribing a dose less than the recommended dose (under-utilization), providers prescribing a dose greater than the recommended dose (over-utilization) and providers prescribing two or more drugs in the same class (inappropriate utilization of medications). We will produce reports (provider profiles) of under and over-utilization monthly, comparing provider prescribing practices. Each profile compares total participant count, number of prescriptions filled, total cost for all prescriptions filled, average cost per prescription, average number prescriptions per participant, number of adult and child/adolescent (C/A) intra-class poly-pharmacy, number of adult and C/A inter-class poly-pharmacy along with top five medications filled for all prescribers. We will report under and over-utilization as the percentage of time under- and over-utilization occurs each month. We will report inappropriate utilization of medications as percentage of prescriptions involving two or more drugs in the same class. In Arizona, we reduced the percentage of adult intra-class poly-pharmacy from 1.12% to .97% from July 2009 to June 2010. For the same period, the child/adolescent percentage decreased from .40% to .21%. In addition, our efforts to ***reduce use of antipsychotics with youth*** in Arizona resulted in a 20% reduction from Q1 of FY11 to Q3 of FY11. In Q3 FY11, only nine children out of 72,000 total eligible children were being prescribed two or more atypical antipsychotics concurrently. We accomplished this by producing the monthly reports and providing the information to providers. Providing the comparison data to the providers had the effect of reducing over-utilization and inappropriate utilization of medications. In addition, our Care Managers (CMs) and Utilization Managers (UMs) will conduct comprehensive health screenings in the course of authorizing care and identify medication regimens that appear to be outside of evidence based prescribing practices. These concerns will be brought to the attention of our CMO, Medical Administrator and Pharmacist for review and action.

Strategies to detect under- and over-utilization and potential inappropriate utilization of medications by members

As discussed above, both Impact Pro and PMUR produce data that show under- and over-utilization and inappropriate utilization of medications by members. From these data, we can monitor "fill patterns" to determine how frequently members are filling prescriptions and identify members who are obtaining multiple prescriptions by "doctor shopping". We will produce monthly reports identifying members with multiple provider and pharmacy claims for narcotic medications. Our Addictionologist will review these data and collaborate with Louisiana's Medicaid Lock-in Program to reduce the inappropriate utilization of opioids and other controlled substances by members. Our CM/UM staff will review medication utilization with members and providers in the course of authorizing care and identify utilization patterns which appear to be outside of guidelines. This information will be brought to the attention of providers and our medical management staff for review. Determinations of under- and over-utilization of medications by members will be discussed with members as part of the treatment planning process.

2.c. Utilization Management
viii. Assuming that DHH will provide utilization data for individuals who are not enrolled as members of the SMO, but receive their BH services from other sources (e.g., Federally Qualified Health Centers (FQHCs)/Rural Health Clinics (RHCs), Louisiana's Community Care Network), describe how the Proposer will review and monitor this data for utilization, trends and other QM purposes. **Suggested number of pages: 1**

As the SMO for Louisiana, Cenpatico will review and monitor service utilization data for individuals not enrolled as SMO members, receiving services from other Louisiana behavioral health service networks, upon receipt of the data from DHH. Federally Qualified Health Centers, Rural Health Clinics and the Louisiana Community Care Network provide a broad spectrum of comprehensive health and mental health services to unique populations, for example, public housing, homeless, migrant, etc and have integrated data tracking systems within their networks. This information will be integral in monitoring and evaluating overall state trends and services for full integration and coordination of care under the Louisiana's vision for a Coordinated System of Care.

It is anticipated DHH will provide the utilization data for individuals served through these other sources and Cenpatico will apply its routine, core business analytics to this data as a viable input into the overall SMO service management and quality system. Cenpatico anticipates working with DHH to identify the best format for receiving the information, to ensure it is comparable to the information tracking systems implemented by Cenpatico, thus, enabling us to compare apples to apples. **Because Year 1 for Cenpatico will be a year of establishing the SMO System of Care baseline, this additional information will provide insight into existing community and population baselines for comparison.** Cenpatico will review the evaluate the data in order to identify trends in service utilization patterns for comparable member population groups, including historic and current use, to identify areas for network capacity building and inpatient diversion. This data will also be used to provide coordinated and continuous care for potential CSoC, block grant/waiver and SMI members upon initiation of services with the SMO.

Cenpatico will be supported in review and monitoring of data by Centelligence™, our state of the art reporting and comprehensive family of integrated decision support and health care informatics solutions. Centelligence™ 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 program assessment and provider profiling program. In keeping with the consistent application of quality improvement tools and statistics methods used by Cenpatico to improve analysis and use of service utilization data, **all core SMO measurements will include a comparison to the non-SMO enrollee network trends.** Cenpatico will provide this information to DHH-OBH and DHH-BHSF at a frequency approved by DHH-OBH and in a format that is meaningful to both the SMO and DHH. The use of this data as a routine data feed into the Cenpatico's quality, utilization and service management measurement processes ensures real time comparison data for the SMO and aids in alleviating service system gaps, potential quality of care concerns while building community based infrastructure. **Cenpatico's data and reporting system, Enterprise Data Warehouse (EDW) is flexible and scalable such that data from external sources can be imported into EDW in order to run preset, customized, and ad hoc reports, queries and data analysis.** Cenpatico can utilize the available data to document service trends outside of the SMO and compare to services provided by the SMO and the provider network. Outliers, those on both the high and low end of service utilization, could be examined more closely to determine whether there are unmet access needs, whether there may be waste, fraud or abuse and whether technical assistance, training or other intervention may be most impactful in improving outcomes. **Utilization trending and comparison can be provided to the state to share with these providers as a means of**

feedback that will shape future service delivery. Data regarding the typical population, ages, diagnoses, and other consumer trends may also be helpful to identify if there are variations in services in a particular region of the State.

2.d. Quality Management
Describe how QM functions will be organized, including staff that will be Louisiana-based and staff available from the Proposer's corporate operations. Provide an organizational chart for QM that includes position titles, numbers of positions, qualifications and reporting relationships. **Suggested number of pages: 2, exclusive of organizational chart**

Cenpatico's Quality Management (QM) program drives a "culture of quality" throughout the organization. Data collection and analysis is embedded in each Cenpatico functional area and supported by the QM program's work plan and day to day activities. Cenpatico supports its QM program with the belief that dedication to constant process and outcomes measurement, supported by all functional areas of the organization, are the driving forces to improved health care outcomes for members. Cenpatico's functions are identified, prioritized and implemented based on the tenets of Total Quality Management (TQM) and Continuous Performance Improvement (CPI), utilizing the Plan, Do, Study, Act (PDSA) model of CPI in the measurement, reporting and improvement of Cenpatico's administrative processes and clinical outcomes. Using real time data and the application of scientific research methods, Cenpatico's QM program systematically collects, analyzes and reports data for every functional area: medical management, customer service, network management, clinical services, and operations, to assist Cenpatico in prioritizing targeted areas for improvement, based on the needs of the membership and state it serves. The application of the PDSA model of CPI provides an industry standard template for the identification and rapid improvement of performance, based on the concept that processes, not people, affect outcomes.

Cenpatico actively seeks and receives member, family and stakeholder input into its QM program. This input is received through peer, family and stakeholder participation in all QM related committees, through member and customer satisfaction surveys, and through participation in targeted performance improvement work groups. Cenpatico uses trends in member complaints and quality of care (QOC) concerns to support its administrative data analysis. By incorporating member, family and stakeholder perception in its QM program, Cenpatico provides a complete picture of the quality of its health care management, as decisions are not driven by hard data alone. Cenpatico's QM team knows that perception of care and services affects service utilization and member wellness. Implementing QM activities identified by members, families and stakeholders, and engaging these key groups in the implementation and analysis of these activities, not only assists Cenpatico in managing the quality of its system: it empowers members in taking control of their behavioral health needs and improving their lives.

The Cenpatico of Louisiana, Inc. quality management (QM) program is supported by an organizational structure that incorporates clinical and administrative expertise in evaluating publicly funded behavioral health systems, includes policies and procedures that effectively direct quality activities, and is focused on improving the lives of the members Cenpatico serves through targeted outcomes monitoring. The Cenpatico QM program in Louisiana will be freestanding with its own infrastructure and management, but will also have the support of Cenpatico's corporate QM Director and will also have access to key Centene corporate resources to include, but not limited to Information Systems and Technology (IS/IT). The following organizational chart identifies our QM staffing structure with support from Cenpatico and Centene corporate offices.

Please see the QM Organizational Chart noted below and in ***Section 5, Appendix 2.d***.

Cenpatico Quality Management Positions Descriptions:

Quality Management Administrator: Must be a licensed behavioral health professional with certification as a Certified Professional in Health Care Quality (CPHQ) and have a minimum of five years experience in the delivery, management and evaluation of complex, publicly funded behavioral health systems. The QM Administrator reports to the Medical Administrator.

Requires excellent written and verbal communication skills and extensive knowledge of the following:

- Research methodology including the development and implementation of performance measure technical specifications, measurement and statistical analysis;
- Managed care principles and models of oversight and monitoring;
- Continuous Performance Improvement (CPI) principles, including the development and implementation of systemic Performance Improvement Projects (PIPs) and Rapid Improvement Cycling;
- Implementation and facilitation of Cenpatico's Improvement Team;
- Development of the QM Program Description, Quality Assurance/Performance Improvement (QA/PI) Program, Annual Work Plan and Annual QM Work Plan Evaluation;

- Development of Dashboard and Provider Scorecards;
- Responsible for National Committee for Quality Assurance (NCQA) accreditation.

Quality Improvement Manager: This position requires at a minimum, a Bachelor's degree in a behavioral health or related field, a CPHQ and/or at least 3-5 years of QM experience, preferably in a public behavioral health program. The position must have extensive knowledge of the Louisiana publicly funded behavioral health system, principles of CPI and performance measurement. This position reports directly to the QM Administrator. This position is responsible for:

- Development of monthly, quarterly and annual reports to the Department of Health and Hospitals-Office of Behavioral Health (DHH-OBH) and to Cenpatico/Centene;
- Direct development and oversight of performance measures and Healthcare Effectiveness Data and Information Set (HEDIS) technical specifications;
- Responsible for the ongoing implementation, collection and analysis of HEDIS and other quality data sets, including: complaints, quality of care concerns (QOCs) and provider monitoring reports;
- The development and implementation of Corrective Action Plans (CAPs) based on routine performance monitoring and evaluation against established standards;
- Implementation and monitoring of Dashboard and Provider Scorecards;
- Collaboratively provide technical assistance to providers;
- Oversight for all CSoC performance indicators and measurements developed in conjunction with DHH-OBH;
- Implementation and monitoring of the QM Work Plan; and
- Coordination and implementation of NCQA, state and external quality review organization (EQRO) audits.

Clinical QI Specialists: This position requires a current clinical license (RN, LMSW, LCSW or similar). The Clinical QI Specialist must have excellent customer service skills and database management experience. Experience in publicly funded behavioral health programs preferred. This position reports directly to the QI Manager. This position is responsible for:

- Front line receipt, acknowledgement, research and response to member/provider complaints;
- Front line receipt, acknowledgement, research and response to potential QOCs;
- Tracking and research for resolution of potential adverse/sentinel events;
- Development of routine quality monitoring reports;
- Participation in CSoC fidelity monitoring activities;
- Participation in peer review activities; and
- Participation in clinical quality reviews as indicated through routine quality monitoring.

QI Coordinators: Requires at least a Bachelor's degree in a behavioral health or related field, CPHQ preferred, with a minimum of 2-4 years experience in the monitoring, evaluation and measurement of system and member outcomes. Must possess excellent verbal and written communication skills. Knowledge and experience in performance measurement and application of statistical analysis a must. This position(s) reports directly to the QI Manager. This position is responsible for:

- Ongoing collection of internal and provider performance data;
- Statistical and qualitative analysis of performance data;
- Ongoing technical assistance to providers to improve performance;
- Participation in data validation and CSoC fidelity audits;

- Review and analysis of provider submitted and administrative QM reports; and
- Monitoring of provider/SMO CAPs and PIPs.

Support Position Descriptions:

Cenpatico's Decision Support and Information Systems team play a critical role in the performance of our program and our ability to monitor and report on key behavioral health indicators. As such, the ***Data Analyst*** position interfaces regularly with our QM team. This position requires at least a Bachelor's degree in Data Mining/Computer Sciences, Information Systems, or comparable experience in processing, analyzing and producing quality reports; five years of related work experience; understanding of industry-defined tools / methodologies; advanced understanding of database tables, relations, data types, and values; understanding data modeling concepts (i.e., the entity-relation model) and their application: entities and tables, relations and constraints, attribute data types and column data types; and a thorough understanding of IT and database management.

- Responsible for the development of QI business rules for administrative performance measurement and monitoring.
- Supports the QM Manager and Clinical QM Manager in quality database management, report extraction and report production.
- Responsible for the application of statistical testing to all QI data sets.
- Manage SMO Dashboard and Provider Scorecards and the development graphic presentation of QI data for SMO reporting.
- Reports to the Information Systems Administrator, but works closely with the QM Manager.

2.d. Quality Management
i. Describe the essential elements of the Quality Assurance/ Quality Improvement Plan the Proposer would develop for the program and how the Proposer will assure it is a dynamic document that focuses on continuous QI activities; include:
(a) Covered BH services and administrative and clinical processes and functions to be addressed;
(b) Committee structure, responsibility and membership
(c) Necessary data sources;
(d) Proposed outcomes measures and instruments;
(e) Monitoring activities (e.g., surveys, audits, studies, profiling, etc.); and
(f) Feedback loops.
Suggested number of pages: 5

The Cenpatico Quality Management (QM) program is fully accredited by the National Committee for Quality Assurance (NCQA) and applies an integrated approach to quality through a cross functional organizational structure that champions total quality management (TQM) from the top down. Guided by the Plan, Do, Study, Act (PDSA) model for Continuous Performance Improvement (CPI), Cenpatico implements measurements, performance goals and improvement activities based on industry-recognized best practices and robust data collection and analysis. We take seriously our obligation to provide members with a level of care that meets or exceeds recognized professional standards, that is delivered in the safest and most appropriate settings. We aggressively identify barriers and systemic problems by integrating quantitative, cross-functional health care business metrics, such as service utilization data, coordination and access to service measurements, readmission rates, and service authorization data, with available qualitative metrics, such as member and provider complaints and member/stakeholder surveys. We will develop a comprehensive QM program for Louisiana based upon these principles.

Our organic Quality Assurance and Quality Improvement Plan (hereafter QM Plan) guides all quality activities, highlights program successes and areas for improvement. It will include clearly defined goals, measurable objectives, data feeds, responsible parties, frequencies of activities and target dates for activities completion. In keeping with CPI principles, an annual, year-end review of QM program successes and continued areas for improvement will be reviewed prior to development of the next work plan, allowing the QM program to adapt and adjust its interventions from a data driven, strategic focus. We value input from members, providers and community stakeholders, and seek their feedback through regularly conducted satisfaction surveys as well as provider and community based sub-committees that support the QM program.

a. Covered Behavioral Health (BH) services and administrative and clinical processes and functions to be addressed:

Cenpatico's QM program will systematically monitor, evaluate, and intervene when necessary, to ensure the provision of all covered behavioral health services are easily accessed by members, are clinically appropriate, and serve to improve clinical and functional outcomes for members. QM activities address both acute and chronic behavioral health and substance use disorders across all available treatment settings: inpatient care, intensive outpatient (IOP), partial hospitalization (PHP), residential treatment centers, and community based outpatient care. To support this monitoring and evaluation, the Cenpatico QM program will develop, implement, and monitor BH Clinical Practice Guidelines (CPGs) based on current industry research and best practice. CPG adherence and effectiveness will be evaluated annually through the implementation of standard performance metrics based on national benchmarks, typically using the Health Effectiveness Data Inventory Set (HEDIS) measures to allow Cenpatico to compare its performance on a national platform.

Examples of clinical processes to be included in the QM program are:

- After care, outpatient follow up after an acute inpatient discharge within 7 days of leaving the hospital

- ensuring continuity and coordination of care activities occur on behalf of the member between health care systems and within the Cenpatico provider community to ensure appropriate intensity, scope and duration of services are provided in the least restrictive, most cost effective setting
- review of under and over utilization of all covered services to ensure adherence to medical necessity criteria
- evaluation of monthly, quarterly and annual inpatient readmission rates trends in order to identify provider/network gaps in the community setting, assist members in successful community tenure and target providers/facilities with high readmission rates

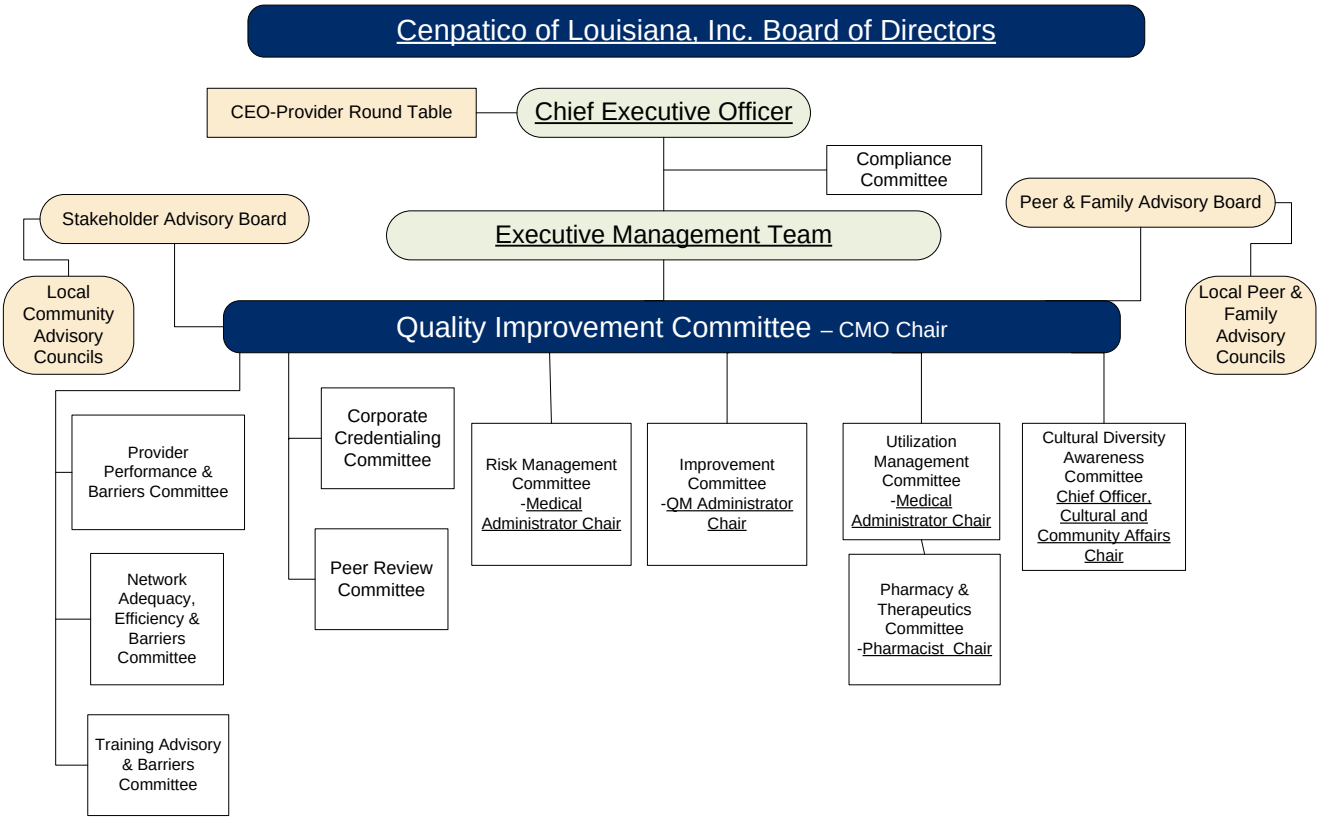
To support our clinical quality activities, we will include the monitoring of the following administrative functions to support quality clinical service provision:

- periodic surveys of providers' availability to provide urgent and routine appointments to new and established behavioral health members
- timely receipt, acknowledgement and resolution of member and provider complaints
- timely receipt, acknowledgement and resolution of potential quality of care(QOC) concerns
- tracking and profiling of providers, specifically the numbers of complaints filed, QOCs and adverse incidents
- Corrective Action Plan (CAP) implementation and monitoring for providers above profiling thresholds and providers out of compliance with Cenpatico established performance metrics
- member and provider satisfaction surveys

All administrative and clinical quality monitoring activities will be utilized along with member demographics, behavioral health diagnostic prevalence data and the unique cultural characteristics of the membership in the development of the QM program.

b. Committee structure, responsibility, and membership:

The structure and purpose of Cenpatico's quality committees ensures that our QM Plan and activities drive all of our processes. All quality activities are analyzed and reported into the Quality Improvement Committee (QIC) – chaired by our Chief Medical Officer – with quality subcommittees providing regular updates on all improvement activities. All subcommittees report into the QIC at least quarterly, with more frequent updates as requested. We foster a goal of improved quality, integrated care and member satisfaction, and to that end, the QIC will report to our Executive Management Team, CEO and Board of Directors. Our QM Administrator and the Medical Administrator, each of whom will be fully involved in the committees described in detail below. This direct reach of members, providers, and stakeholders into our committee structure proves that we value the voices and points of view of our membership. The Cenpatico Board of Directors will provide corporate support, oversight and ultimate accountability for our QM Program, while the day to day management of the program is the responsibility of the QM and Medical Administrators and oversight of the QM Program is provided by the QIC, closing the quality feedback loop.



Quality Improvement Committee (QIC)

The QIC is a cross functional, multidisciplinary committee comprised of the senior level managers from each Cenpatico business unit, behavioral health professionals in the provider network and the Cenaptico SMO QM team. The QIC is chaired by the Chief Medical Officer (CMO). The mission of the QIC is to prioritize, direct and hold ultimate accountability for the QM program. The QIC synthesizes data across multiple clinical and administrative measurement sets in setting the strategic and quality direction of the organization. QIC functions include but are not limited to review and approval of the QM Program Evaluation, Work Plan and all quality policies; review and approval of Medical Necessity Criteria (MNC) and Clinical Practice Guidelines (CPGs); analysis and response to the Cenpatico Dashboard and Provider Scorecard; and the delegation of performance improvement activities and projects conducted by the QIC subcommittees. The QIC reports to the Cenpatico Board of Directors at least annually and provides input into all Cenpatico sub-committees, provider and member advisory groups and ad hoc workgroups.

QIC Subcommittees:

Advisory and Barrier Committees

Cenpatico's advisory and barrier committees are comprised of members, families, and behavioral health providers and designed to provide member input and subject matter expert analysis into the monitoring and evaluation of barriers to improved member outcomes, provider performance, network management and training success. Each committee is chaired by a senior level Cenpatico manager, supported by cross functional administrative representation and reports at least quarterly into the QIC. The *Provider Performance and Barriers Committee* evaluates provider performance across key scorecard indicators and

provides technical assistance to providers in root cause analysis and improvement plan development. Trends in provider performance needs are reported to the QIC for the development of systemic improvement activities. The *Network Adequacy, Efficiency and Barriers Committee* focuses on service access and network sufficiency measures; develops, implements and monitors our Network Management Plan and provides input regarding potential system gaps that could impede access to clinically necessary services. The *Training Advisory and Barriers Committee* monitors our training plan, reviews member and provider feedback on current trainings and evaluates the effectiveness of all training curricula.

Corporate Credentialing Committee

The Cenpatico Corporate Credentialing Committee (CCC) conducts all initial, provisional credentialing and re-credentialing activities. The CCC ensures adherence to national and state credentialing requirements and supports the Network Adequacy, Efficiency and Barriers Committee and QIC. The CCC is chaired by our Medical Administrator with network providers acting as voting members.

Peer Review Committee:

The Peer Review Committee is chaired by the Cenpatico Medical Director and is comprised of a cross functional representation of behavioral health professionals and network practitioners. Medical professionals are invited to the Peer Review Committee as indicated by the nature of the peer investigation. The Peer Review Committee reports aggregate committee actions to the QIC quarterly, operating under the federal and state protections afforded this quality committee.

Risk Management Committee

Issues that may pose a risk for the people we serve or the organization are reviewed by the Risk Management Committee, chaired by the Cenpatico Medical Administrator. Particular focus is placed on the detailed analysis of complaints, incident, accident and death reports, the use of seclusion and restraint, as well as grievance and appeal trends. Monitoring timely service provision to the high needs population is also a function of the Risk Committee. Recommendations for corrective action and system performance improvement initiatives are made by the Committee when concerns are identified. The Committee reports to the Quality Management Committee on a quarterly basis.

Improvement Committee:

The Improvement Committee is chaired by the Quality Administrator and comprised of cross functional representation of the administration team, network practitioners, peers, family members and stakeholders. The purpose of the Improvement Committee is the prioritization, development and implementation of systemic performance improvement activities and projects, based on a rapid improvement cycle. Administrative and clinical processes, along with targeted member health outcomes, are the primary data feed for this quality subcommittee. The Improvement Committee reports at least quarterly to the QIC.

Utilization Management Committee (UMC):

The UMC monitors trends in utilization as well as consistency and efficiency in conducting utilization related activities and case management. The UMC researches current MNC for QIC consideration; monitors shifts and trends in service utilization patterns across all service levels; conducts analysis of provider utilization review activities; and develops and implements UM inter rater reliability activities. The UMC is chaired by the Medical Administrator and comprised of cross functional representation from Cenpatico departmental leadership. The *Pharmacy and Therapeutics (P&T) Committee* is a working UM subcommittee, chaired by Cenpatico's Pharmacist, and is comprised of Cenpatico staff who are licensed behavioral health professionals. The P&T Committee reviews pharmacy prescribing and utilization trends; reviews, analyzes and approves or denies provider requests for utilization of off formulary medications and conducts new and existing clinical technology studies in support of best practices.

Cultural Diversity Awareness Committee

The Cultural Diversity Awareness Committee is chaired by the Chief Officer of Cultural and Community

Affairs and comprised of members, families, and community stakeholders. The purpose of this committee is to ensure that all aspects of the Cenpatico's service system are designed with the unique cultural needs of its members in mind. This committee is responsible for Cenpatico's Cultural and Linguistic Competency Plan; ongoing cultural competence training of Cenpatico and network provider staff; and review of all member and provider materials for cultural sensitivity, using member demographic data and community stakeholder input as its primary data feeds. The Cultural Diversity Awareness Committee reports to the QIC at least annually.

Peer &Family and Stakeholder Advisory Boards and Councils

Peer & Family and Stakeholder Advisory Councils will meet regularly, in multiple geographic locations, to allow members a chance to voice their opinions and participate in the oversight of their care systems. Council schedules and direct instructions on how to participate will be posted on the Member Services Website, and distributed to a wide variety of local providers, advocates and other stakeholders to disseminate the information as widely as possible. These councils provide a forum for members, family members and stakeholders to communicate with Senior SMO leadership, have their concerns addressed, and to improve the behavioral health service system.

These Advisory Councils will provide input to the Stakeholder Advisory Board and the Peer & Family Advisory Board. The Boards' functions include but are not limited to: assessment of all aspects of the quality program as it pertains to the services and care provided to members, their families, their communities and their providers; making recommendations for systemic improvement activities and assisting in the development and implementation of member and provider surveys. The Advisory Boards are chaired by the Chief Officer of Community and Cultural Affairs and report to the QIC at least quarterly.

c. Necessary Data Sources:

The Cenpatico QM program uses multiple administrative data sources to drive decision making, allocate resources and develop improvement activities. Our QM program will rely on TruCare, Cenpatico's utilization management software, to provide raw service utilization data across the populations served under this RFP. TruCare provides comprehensive member demographic data, including fund source, program type and diagnoses, and aids in targeting high utilizing and underserved members for outreach and engagement. Supporting TruCare, Cenpatico uses a comprehensive claims tracking system, Amisys, which provides the QM team with the complete array of inpatient authorization data for each population, further aiding in the analysis of over and underutilized member service. Our QM program will also have access to Catalyst, an NCQA approved program for the collection and reporting of key HEDIS performance measures. Ongoing tracking and analysis of Catalyst performance data will provide us with comparative data across all of our markets to target improvements and drive continuing quality improvement (CQI) initiatives.

To supplement these data systems, the QM department will utilize current statistics software to aid in critical and effective analyses of all required performance monitoring. The QM team will utilize SAS or SSPS to calculate routine statistical analysis on provider and SMO performance, including tests for statistical significance across review periods; ANOVA to identify areas of statistically significant variance amongst populations and/or review periods to identify process improvement opportunities; calculation of mean performance and standard deviation to track outlier performance for targeted improvement action; and regression analyses to highlight how CQI initiatives have positively driven improvements in the system.

d. Outcome Measures and instruments

Cenpatico's QM program will adopt and measure Substance Abuse and Mental Health Services Administration (SAMHSA)'s National Outcome Measures (NOMs) through its administrative data sets as one outcome indicator set for the Louisiana membership. In addition, the use of HEDIS behavioral health

measures and technical specifications will be implemented to provide national benchmarks for our performance. Routine performance measures will be implemented across the service system to include comprehensive technical specifications for the collection and submission of all data, supplemented by comprehensive business rules for the use of supporting administrative databases. All performance measure sets will include the minimum performance standards and goals for each metric, as identified by DHH-OBH, nationally available benchmarks and supported by internal performance tracking. Performance and outcome indicators to be monitored by our QM staff include, but are not limited to:

- NOMs
- Coordination of Care
- Decreased inpatient utilization
- Increase of community based, outpatient services
- Access to Care/Appointment availability
- Wraparound services facilitation
- Plan of Care (POC) adherence
- Child and Family Team (CFT) Principle Adherence
- Outpatient Follow up after Hospitalization
- Reduction of Polypharmacy
- Member Satisfaction

e. Monitoring activities (e.g., surveys, audits, studies, profiling, etc.)

The Cenpatico QM program will implement focused reviews utilizing member health records to ensure compliance with federal and state record keeping standards and to validate administrative data sets and in the research of member complaints and QOCs. Data will be reported and tracked via Cenpatico Performance Dashboard and Provider Scorecards. This interactive, real time approach to information management allows for at a glance analysis of systemic as well as individual vendor performance across priority QM measures and assists in resource allocation for improvement activities; identification of high performing providers to identify best practices; and to identify outlier performance requiring increased technical assistance. Dashboard and scorecard data will be refreshed on a quarterly basis with both trended and raw data available for analysis. Any measure/outcome set utilizing hybrid methodology (both administrative and medical record data) will include pre, post and ongoing review inter rater reliability (IRR) testing to prevent drift and ensure unbiased, accurate results. Scoring guides and review tools are made available to all applicable QM and provider staff to assist in timely, viable data collection. This approach supports our commitment to transparency and accountability by providing members, families and stakeholders with current performance data, enhancing voice, choice and member input into the QM program.

To measure the performance of the CSoC and assist in routine data validation, Cenpatico will adopt and implement a hybrid methodology approach to the collection and analysis of CSoC data. Hybrid methods apply administrative data in conjunction with medical record reviews. Similar approaches have been developed and implemented by the University of Washington in the WFI/WFAS CSoC reviews and the University of South Florida's System of Care Practice Reviews (SOCPR). These review processes include a comprehensive record review supplemented by in person interviews of family members and system partners in tracking CSoC outcomes.

f. Feedback loops

Based on process evaluation and performance results, Cenpatico will develop performance improvement projects (PIPs) in order to affect large scale, systemic and member focused improvements. Data sources

to support these projects include performance measures data, member complaints, QOCs, and member satisfaction surveys. Cenpatico currently uses the ECHO survey for assessing its member's satisfaction with services. The ECHO is an NCQA endorsed behavioral health survey that evaluates Cenpatico's members', and their families', perception of access to services; general satisfaction with services; service outcomes, and involvement in service planning. All PIP studies and findings are reported to the QIC annually, used in the evolution of the QM Plan and if successful in driving improved performance, used in the development of policy and procedures.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.d. Quality Management
ii. Describe how the Proposer's information management system will support continuous QI.
Suggested number of pages: 1

Enterprise Data Collection - Focused on Public Sector Programs.
Cenpatico considers comprehensive information management as the backbone of any Quality Management (QM) program and we will take this approach for the Louisiana Behavioral Health Partnership (LBHP). Cenpatico's modular Management Information Systems (MIS) supports Continuous Quality Improvement (CQI) by systematically receiving, validating, integrating, managing, and reporting on:

- Member demographics, eligibility history, service inquiries, and other "person level" administrative data through our Member Relationship Management (MRM) system;
- Care, case, and authorization management data through our collaborative TruCare platform;
- Claims and payment stream accounting data through our AMISYS Advance system;
- Provider/practitioner demographics, credentialing, contracting and other pertinent characteristics for network management and provider service through our Provider Relationship Management (PRM) system.

Centelligence™: Integrating Data in Near Real Time to *Drive* CQI.
All the above information comes together in near real-time through our Service Oriented Architecture (SOA) and into our Centelligence™ Enterprise Data Warehouse (EDW) and supporting Centelligence™ family of health care informatics, reporting, and decision support business intelligence applications. EDW incorporates and integrates data and information from both external sources (including assessments, surveys, claims, etc.) and internal sources (care gap alerts derived from predictive modeling; authorizations and care plans approved by Care Managers; complaints, grievances and appeals). During 2010, we implemented a *significant* upgrade to our EDW with the incorporation of the Teradata® Extreme Data Appliance. This major capital investment significantly improves our ability to handle **truly large amounts of data** in much shorter timeframes, resulting in more timely reports, Care Alerts, Dashboards, and other informatics and support for both standard and ad-hoc reporting; and information needed for continuous quality improvement (CQI) processes and projects.

Tools to Produce Actionable Information - and Inform CQI.
Through our Centelligence™ platform, we have online access to the breadth of requisite data, at the most granular levels needed (e.g. person/encounter/episode level), along with an integrated set of Structured Query Language (SQL) standard SAP BusinessObjects tools to create actionable information. One key module in our Centelligence™ platform is our Catalyst QSI application: a National Committee for Quality Assurance (NCQA) certified software module for the collection, evaluation and trending of Healthcare Effectiveness Data and Information Set (HEDIS) performance data. QSI will enable our QM program to be benchmarked on performance against itself and across other Cenpatico behavioral health markets.
Centelligence™ Foresight (Foresight) is our *predictive modeling* module, enabling a number of care quality processes. Foresight allows us to categorize member health states at the overall plan population level into predetermined diagnostic and health risk groups for the identification of priority populations and targeted CQI interventions.
The combination of Centelligence's™ integrated data and supporting information tools supports our QM program by assisting us in selecting appropriate performance measures, survey sample frames based on

member demographics, while ensuring accurate validation of claims based measures for informative and timely performance monitoring.
All data submitted to any Cenpatico information system program is tested for front end edits in logic, consistency and validity. We will establish an allowable error rate for each data point required for submission to DHH-OBH and will take corrective action if error rate thresholds are reached to ensure accurate and reliable data reporting to the DHH-OBH.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.d. Quality Management
iii. Describe how the Proposer will resolve quality of care concerns and how information related to the concerns will be used to improve the quality of care provided to members at the individual and BH system level. **Suggested number of pages: 2**

Cenpatico's Quality Management (QM) program will collect, evaluate and trend quality of care concerns (QOCs) utilizing the following severity level definitions:

- Level I: No quality of care issue;
- Level II: QOC issue exists. No adverse affects on members due to QOC concern;
- Level III: Confirmed QOC issue with potential for adverse affect on member; and
- Level IV: Confirmed QOC issue with an identified adverse affect on member.

Cenpatico employs a "no wrong door" approach to the receipt of QOCs. QOCs may be reported to the QM team by any Cenpatico or provider staff person or member. Potential QOCs may be submitted verbally or in writing a by any member, family member, stakeholder and system partner. All Cenpatico staff receive new employee and subsequent annual training on the QOC process to ensure ongoing, cross functional support of the QOC process. Members, family members, stakeholders and system partners will receive information on our QOC process upon initiation of services and at least annually, via the Cenpatico member handbook and member website.

QOC investigations will be triaged for categorization into the above severity levels by the Clinical Quality Improvement (QI) Manager and Clinical QI Specialists. All potential QOCs will be acknowledged in writing within the timeframes established by DHH-OBH, not to exceed three working days within receipt of the QOC. Upon acknowledgement of the QOC receipt, no further communication with the complainant will occur until the resolution of the QOC, unless an interview with the complainant is required to complete the QOC investigation. Our QM team will complete thorough investigations of all QOCs, to include, but not limited to: provider and/or member interview, review of claims, authorization and service data, on site practitioner and/or facility reviews, research of state and national practitioner databases, and medical record reviews. Upon completion of the QOC investigation, the Clinical QI Manager will assign either a substantiated or unsubstantiated designation to the QOC. At this time, the complainant will receive written notification that the QOC has been investigated, along with whether or not the QOC was substantiated.

The results of the QOC investigation may result in the issuance of a provider and/or facility Corrective Action Plan (CAP). Our QM team will direct the scope of the CAP to address the substantiated QOC findings with a time limited duration for implementation of improvements. The provider/facility must provide us with ongoing CAP progress reports along with supporting evidence that CAP activities have been implemented and monitored by the provider/facility in order to close the CAP. We may, pursuant to state and national requirements, report QOC investigation findings to the state and/or national licensing boards or other regulatory agencies. All QOC trends are reported in the aggregate to the Cenpatico QIC and individual results are reported to the Peer Review Committee as appropriate. All QOCs, across severity levels, substantiated or not substantiated, are tracked and trended via our secure QOC database to identify areas for systemic, as well as member specific, improvements. QOC data is used in the aggregate to support the Cenpatico Quality Monitoring report and utilized in provider profiling and credentialing decisions.

2.d. Quality Management
iv. Describe the methods the Proposer will use to ensure its own and its provider's compliance with QM initiatives and requirements.
Suggested number of pages: 2

Cenpatico of Louisiana, Inc. is committed to ensuring our own and our Network Provider compliance with all Quality Management (QM) activities, performance measures and initiatives. Cenpatico will apply a multipronged approach to this task in support of the principles of Continuous Quality Improvement (CQI) and dedication to the Plan, Do, Study, Act (PDSA) model for sustainable performance improvement.

Compliance 360

We will use Compliance 360, our comprehensive database documentation system to for storage and tracking of all Cenpatico and provider deliverables; internal due dates for cross functional review and approval of deliverables before submission; and contract, state and federal timelines. *Compliance 360 provides total process management to ensure timeliness and accuracy*. Our QM Administrator and Managers will receive regular notices from Compliance 360 on upcoming deliverable submission due dates to ensure ongoing monitoring and completion of required reports. Reports and submissions will be traced in Compliance 360 to ensure that the Department of Health and Hospitals-Office of Behavioral Health (DHH-OBH) receives the most current and accurate reports and provides a mechanism for retrieval of important historical data sets.

Clearly Defined Expectations

We enable providers to meet expectations by making them clear, and being available for review. Our network staff and quality staff are accessible to providers to review contractual expectations with the SMO, and DHH-OBH requirements. To further supplement the use of Compliance 360 and our network staff technical assistance and support, our QM program ensures that all required QM reports, standardized data collection and reporting tools, QM metric methodologies and performance expectations are clearly delineated in each provider subcontract. Codifying QM expectations and requirements in this manner allows for each business unit within Cenpatico and provider organizations to understand the QM performance expectations and access the tools required to successfully meet and exceed these expectations. Additionally, each subcontract will include the remedies available to us to address poor performance, as allowed by DHH-OBH.

Some of those remedies to improve provider performance include but are not limited to:

- Increased technical assistance (TA) to providers
- Development, implementation and reporting of SMO and/or provider initiated performance improvement plans (PIPs)
- Time limited, focused Corrective Action Plans (CAPs)
- Notice to cure and sanction
- Termination of the provider relationship with the SMO

Corrective Action Process

The Cenpatico CAP process utilizes a standardized CAP form with root cause, barrier analysis and initiative prioritization embedded in the form to guide the provider in the development of a focused, viable CAP. Please see ***Section 5, Appendix 2.d.iv*** for an example of this form. Our QM program will be responsible for the timely oversight of such remedies and is held ultimately responsible for the viability and sustainability of such provider activities. Each provider under corrective action must provide routine interim monitoring reports to the QM Administrator at least quarterly.

Each quarter, Cenpatico and provider improvement and corrective action activities are reported to our Quality Improvement Committee (QIC). Upon review of the improvement activity and interim monitoring results, the QIC will recommend further remedies and/or refer the provider/practitioner to the Cenpatico Peer Review or Credentialing Committee. Also, the QM program will be responsible for the ongoing review of Cenpatico and provider performance and the timely provision of clarification and technical assistance to its providers via the Cenpatico Provider Performance and Barriers Committee. Our QM Administrator will ensure the accurate and timely documentation of all provider technical assistance (TA) activities and will report the nature and outcome of all TA to our Training Department in order to identify individual and systemic areas for improvement. Trends in PIPs, CAPs and TA activities will be reported to the QIC at least quarterly.

Proven Success

Our Arizona affiliate, Cenpatico of AZ, utilizes this process and has garnered success with the reduction in seclusion and restraint in a Residential Treatment Facility (RTC) providing care to children and adolescents. Through the routine monitoring of facility reported seclusion and restraint rates, Cenpatico AZ identified one RTC as an outlier in its overuse of this practice in managing its members. Cenpatico AZ, utilizing the CAP form, collaboratively conducted RCA, prioritized interventions to reduce seclusion and restraint, and conducted staff wide training adapted from the Substance Abuse and Mental Health Services Administration (SAMHSA) Road Map to Seclusion and Restraint Free Mental Health Services. The goal of this training was to impact how staff views the use of seclusion and restraint, taking into consideration childhood trauma events, the use of recovery techniques and the use of these techniques in the pre seclusion and restraint intervention. Cenpatico conducted two trainings to RTC staff. Pre and post tests were administered. A score of 85% was set as a successful post test threshold. However, the overall post test results were 89%. Due to the enthusiastic response from the staff during these trainings, the RTC has chosen to incorporate this training and its components as a standard part of their new hire and ongoing trainings. Review of seclusion and restraint reporting since the trainings evidenced that the staff at the RTC are utilizing the information from this training during the intervention preceding an event, indicating a reduction in reported seclusion and restraint events and improved quality of care for our members.

2.d. Quality Management
v. Describe how members, families/caretakers, providers, advocates and stakeholders will be involved in the design and implementation, and evaluation of QM information. **Suggested number of pages: 1**

Cenpatico of Louisiana, Inc. ensures the inclusion of member, family member, and stakeholder input into all aspects of the QM program, to include the identification of areas for improvement, implementation of improvement activities and the design of such activities to ensure successful implementation of interventions. To that end, Cenpatico's QM committee structure delineates the required roles of the aforementioned groups in the active participation in the committees to obtain front end input into the QM program. Please see subsection 2.d.i for a detailed description of the QM Committee structure; the following committee descriptions outline our plan for this inclusion:

Stakeholder Advisory Councils/Board

The Stakeholder Advisory Board is a subcommittee of the Quality Improvement Committee (QIC) is a comprised of community agency leaders, advocates, medical providers and behavioral health providers from multiple specialties across the Louisiana Behavioral Health Partnership. **The Stakeholder Advisory Board is utilized to obtain direct practitioner and community services provider involvement in the design and evaluation of Cenpatico's clinical quality improvement activities and routine clinical functions, such as Utilization Review (UR) and service planning guidelines, and to provide community-specific solutions to access to care and Quality of Care (QoC) concerns.** The Stakeholder Advisory Board is a dedicated subset of actively engaged participants from our Local Community Advisory Councils. To ensure special focus for children and youth services and the CSoC, we will create a CSoC-specific Stakeholder Advisory Board to include the medical providers as well as the Wraparound Agencies (WAAs), Family Service Organizations, and other CSoC stakeholders.

Improvement Team

The Cenpatico Improvement Team is a cross functional subcommittee of the Quality Improvement Committee (QIC) program. The Cenpatico Improvement Team guides, monitors and acts upon the **implementation of improvement activity work plans and interventions utilizing** the Plan, Do, Study, Act (PDSA) model of continuous quality improvement (CQI). Members and stakeholders have opportunity to participate in the Cenpatico Improvement Team to provide direction and input into quality improvement activities and to develop new initiatives.

Peer and Family Advisory Councils/Board

The Peer and Family Advisory Board is a subcommittee of the Quality Improvement Committee (QIC) and is a dedicated subset of actively engaged Peer and Family participants from our Local Peer and Family Community Advisory Councils. The local councils will meet regularly, in multiple geographic locations, to allow members a chance to voice their opinions and participate in the oversight of their behavioral health system of care. Council schedules and direct instructions on how to participate will be posted on the Member Services Website, and distributed to a wide variety of local providers to disseminate the information to the membership. Local Councils will be engaged by our Communications team to provide feedback on all member materials as well as the website. The Peer and Family Advisory Board is a smaller group of representatives from across the state that meets regularly with Cenpatico staff to provide direct feedback regarding QM initiatives and interventions. Additionally, **the Board brings to Cenpatico the concerns from out in the parishes and regions to help better evaluate the effectiveness of our QM programs and interventions.**

In addition to joining the above standing committees, Cenpatico will conduct a series of ad hoc work groups whenever a systemic problem is identified in a local community to obtain input and feedback on how to best proceed in addressing the issue. We will communicate back to Committees the results of all QM activities, and will include those results in our Member newsletters, and post them on the website.

2.d. Quality Management
vi. Describe how the Proposer will involve members, family members, the Proposer's personnel, subcontracted providers and other stakeholders in the development and ongoing work of the QM system and share results of QI initiatives.
Suggested number of pages: 1

Involvement of members, family members, stakeholders and providers in the development and ongoing working of both the Quality Management System and our overall operations and initiatives is fundamental to what we do. Cenpatico understands and operates from the long held belief with the disability rights movement of "nothing about us without us." Because of this we will begin working from day one of the contract to engage members, families, advocates, community leaders, BH providers, representatives from FQHCs, DHH and other state agencies in guiding the direction of quality improvement. We will utilize our town hall-style forums for engaging the public, and ongoing Advisory Boards/Councils for Peers and Family, and for Stakeholders to keep the guidance and feedback process alive throughout the contract. In addition to our community advisory councils, we will involve members, family members, the Cenpatico personnel, network providers and other stakeholders participation in QIC work groups, and via the timely dissemination of QM activities and outcomes through posting of the *Cenpatico Dashboard* and *Provider Scorecards*. We also embrace the 'no wrong door' approach for any complaints or grievances; our systems were mindfully designed to ensure that any member, family member, or stakeholder with a concern regarding the quality of care or any aspect of their behavioral health (BH) care is fully heard, and can access a process to have their concerns resolved. Our QM program will disseminate QM *At A Glance Reports* at least quarterly to the QIC and notify members, family members and stakeholders of the availability of interim monitoring data, Performance Improvement Project (PIP) reports, Dashboard and Scorecard updates, the Annual QM Plan Evaluation and Work Plan and revised technical specifications via email notification blasts, member website postings, member, provider and stakeholder newsletters and routine technical assistance.

Cenpatico embraces Peer and Family involvement as a fundamental value. We hire self-identified Peers in all levels of staff including our leadership level, Recovery and Resiliency Advisor who ensures the Peer perspective is included in all that we do.

We embrace the person-centered model of behavioral health care, as does the State of Louisiana, and we believe that collaboration and partnership between families and service providers truly are the keys to a successful and productive BH system. To that end, we meaningfully solicit member, family member, provider, and stakeholder feedback and participation in our system of care. Our QM program is a natural point of entry for many members and stakeholders who have an opinion or point of view regarding the Cenpatico's BH program, and we want to make it accessible and worth their while to provide their input to us. We encourage all forms of involvement from simple phone calls to the Member Services Team, response to our periodic satisfaction surveys, use of our complaint process and membership on one of our local Peer and Family Advisory Councils outlined in section 2.d.i. Cenpatico knows that member and community perception of care and services affects outcomes. Cenpatico is dedicated to member, family and community input on all QM processes, policies, and activities so that the QM program is meaningful to our BH community, reflective of the community needs, and driven by the member. ***Involving members and the community from the top down in Cenpatico's administration empowers members to improve the management of their BH needs and ultimately, improve their lives.***

2.d. Quality Management
vii. Provide the following information regarding the two most recent member satisfaction surveys with members of government/public sector managed BH care programs:
(a) Time period;
(b) Overall response rate to satisfaction survey;
(c) Percent of respondents satisfied overall; and
(d) Lowest rated item and percent satisfied.
Suggested number of pages: 1

The Cenpatico of Louisiana, Inc. Statewide Management Organization (SMO) Quality Management (QM) program will administer member satisfaction surveys to enhance the collection and incorporation of qualitative data into Quality Assurance/Performance Improvement (QA/PI) activities. We will utilize the ECHO survey which is approved by National Committee for Quality Assurance (NCQA) and is comprised of questions targeting members and families receiving behavioral health services. Surveys are conducted by the Myers Group, allowing for unbiased, standardized implementation of the surveys and expert statistical analyses of survey results.

2009

- Surveys were distributed, collected, and analyzed for two separate geographic service areas (GSAs) from May through July in 2009. The surveys collected member satisfaction on seven domains: General Satisfaction, Access to Services, Participation in Treatment, Service Quality and Appropriateness, Outcomes, Improved Functioning, and Social Connectedness.
- The response rate in GSA 2 was 53.4% for adults and 39.6% for children. In GSA 4, 39.6% for adults and 39.4% for children.
- **The percent of adults satisfied overall in GSA 2 was measured at 83.3%, children at 79.8%. In GSA 4, adults scored 88.0% and children 84.4%.**
- The lowest rated items and percent satisfied in the 2009 survey were:
  - Adults GSA 2- Improved Functioning 69.5%
  - Children GSA 2–Outcomes 61.7%
  - Adults GSA 4 – Improved Functioning 62.9%
  - Children GSA 4 – Outcomes 61.1%

2010

- The same Survey utilized in 2009 was administered for the two GSAs from April through May in 2010.
- The response rates improved in all areas in 2010. GSA 2 recorded 64.2% for adult and 48.0% for children. In GSA 4, rates posted were 75.8% for adults and 77.3% for child.
- **The percent of adults satisfied overall in GSA 2 was measured at 90.6%, children at 81.7%. In GSA 4, adults scored 87.2% and children 80.3%.**
- The lowest rated items were the same for 2010; however the percent satisfied improved in 2010:
  - Adults GSA 2- Improved Functioning 75.1%
  - Children GSA 2–Outcomes 69.1%
  - Adults GSA 4 – Improved Functioning 73.1%
  - Children GSA 4 – Outcomes 66.1%

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.e. Network Management
i. Describe how Network Management (NM) and development functions will be organized, including staff that will be located in Louisiana and staff support available at the Proposer's corporate or other operations. **Suggested number of pages: 3, exclusive of Organizational Chart**

Cenpatico's network development and management strategies are grounded in a philosophy that reflects the system of care and family-driven care principles embraced by the Louisiana Behavioral Health Partnership. The key elements of our network management (NM) philosophy are:

- Local systemic approach designed to address community specific needs and culture
- Partnership with all stakeholders reflected in how the provider network is built and developed and managed over time
- Family-driven and community based services are primary
- Training and technology support to providers and stakeholders
- Transparent exchange of communication and closing the feedback loop among all stakeholders
- Clinical excellence and high quality services

Our philosophy is demonstrated in how we organize NM functions. We build, develop and manage provider networks that are the infrastructure for systems of care for our members. To do so, we leverage internal resources across departments. Network management is led by our network department but we believe a provider partnership is a key function of our entire organization.

Cross Departmental and Corporate Support for Network Management

Cenpatico's Louisiana based-Network Department will be staffed to support two key network functions; contracting/development and management:

Network Development

- Administrator (1)
- Contract Negotiators (2)
- Provider Relations (PR) Coordinator (1)
- Community Re-Entry/SAPT Program Specialist (1)
- Supportive Housing Program Specialist (1)
- Credentialing Specialist (2)

Network Management

- Administrator (1)
- Provider Coaches (6)

Both administrator positions will report directly to the Chief Operating Officer. Cenpatico has experience in keeping these two functions separate as their functions are very distinct and require different skill-sets. Both teams are highly integrated with all other departments. This is critical so that plans are built strategically and in alignment with member needs.

Our development team will be responsible for creating, negotiating and maintaining all provider contracts. Their role also includes collaboration with the management team to assess gaps in provider types or services, and to develop and implement a collaborative plan to address gaps. Our approach to contracting is ongoing; we will continually monitor the network through GeoAccess analysis, consumer and stakeholder feedback, and developing an understanding of network needs at the regional level by member population. We understand that there are already existing gaps in the delivery system. We will brainstorm with our provider constituents and the LGEs, and the local Interagency boards to build regional-level contracting approaches. We will bring in innovative services such as tele-psychiatry to the

market. We will expand the existing provider network to include non-traditional Medicaid providers; those that are clinically licensed and appropriate to deliver the service, but are not a registered Medicaid provider. Local providers including clinically-licensed counselors, social workers and psychologists will be recruited to the network and will be assisted by our staff in the Medicaid enrollment application process. We have already initiated assessment of the potential barriers to service access in each region. Our plans for addressing anticipated barriers are outlined in response section 2.e.vii.

Our management team will be responsible for providing education, training and oversight of the provider network. This team will include regionally assigned Provider Coaches, who will assure timely inter-provider referrals and associated appointment access; assist in resolving provider grievances, disputes between providers and the investigation of member grievances regarding providers; coordinate provider site visits, review provider profiles, and implement and monitor corrective action plans as needed. Provider Coaches will meet with providers on a regular basis to ensure they are fully aware of their obligations under their Agreements, and can support them as they are working with Cenpatico.

Our Quality Management staff is tasked with provider benchmarking, surveying and performance analysis. Our Care Management staff is charged with promoting evidence based practices, monitoring the delivery of services, identifying providers or services needing improvement interventions and rewarding those providers that demonstrate continued excellence through custom authorization waiver protocols or other administrative incentives. Our Credentialing Department includes Internal Provider Relations staff who supports providers through the process of providing the necessary documentation to become participating network providers.

NM and ND Administrators will meet regularly with the Adult System and Children's System Administrators to share information gathered by System Administrators' staff from communities, members, agencies, and other shareholders. This information will be incorporated into the overall network development and management plan. We will ensure that network providers are educated about the full scope of the systems of care and that network management and development strategies address deficiencies and any barriers to access.

Identifying and addressing waste, abuse and fraud (WAF) in our provider network is a critical network management strategy. Per our WAF Plan policy, all Cenpatico employees have the responsibility to identify, investigate, and report fraud. The Special Investigations Unit (SIU) is located at the offices of our parent company, Centene Corporation. The local Compliance team, including the Compliance Manager, Compliance Auditors, and Compliance Analysts will work with the SIU Director to identify suspected WAF cases. The SIU will assist Cenpatico with investigations, conduct systematic testing, review regulatory requirements, track investigations and work with various state agencies/departments as necessary. The Cenpatico CA will be aware of all investigations and receive quarterly summary reports. For a full description of Cenpatico's Waste, Fraud and Abuse Plan, as well as examples of our success in identifying and preventing waste, fraud and abuse, please see response section 6.j.

The following Organizational Chart provides an overview of responsibility for key network management and development functions across departments, including leveraged resources in our Austin, Texas corporate headquarters *(org chart depicting reporting responsibilities is found in section 2.e.ii)*:

Position	Department / Corporate Affiliation	Functional Responsibilities
Network Development Administrator	Network Management / Cenpatico of LA	• Supervise Contract Negotiators • Identify, qualify and target new providers and strategic partners to develop a comprehensive provider network to meet and/or exceed the contractual requirements of the State • Strategic outreach to obtain information from all system stakeholders to evaluate the need for additional providers and/or services • Develop comprehensive plans based on internal (cross department) and external (all stakeholders) input to align network strategies and technologies with future needs • Develop strategies and methodologies for specific network development initiatives • Effectively integrate new networking strategies and technologies • Conduct ongoing analysis and refinement of provider network to ensure appropriate network composition and member access • Oversee recruitment and contracting of provider networks • Ensure access and availability standards in all regions • Ensure contracts are current and accurately loaded in Cenpatico's system
Contract Negotiators	Network Management / Cenpatico of LA	• Identify and initiate contracting with potential providers • Negotiate and renegotiate contracts including language and/or reimbursement methodologies • Lead assigned comprehensive negotiation strategies (i.e., hospital, physician and ancillary) and ensure that the negotiations result in the unit cost targets expected • Load contracts in required systems for programming and tracking purposes • Facilitate and provide oversight to the provider set-up and contract configuration to ensure accurate claims adjudication • Evaluate and monitor financial performance of contracts. • Coordinate with internal departments and contracted providers to implement and maintain contract compliance. • Assist with contract template maintenance and updating as may be required Assist with any contract amendments required due to regulatory changes

Position	Department / Corporate Affiliation	Functional Responsibilities
Network Management Administrator	Network Management / Cenpatico of LA	• Supervision of Provider Coaches and Provider Relations Coordinators • Ensure timely inter-provider referrals and associated appointment access • Assist in resolving provider grievances, disputes between providers and the investigation of member grievances regarding providers; • Coordinate provider site visits • Review provider profiles • Oversee the implementation and monitoring of corrective action plans as needed • Represent the Network and act as liaison between Network Management and all other departments. • Ensure timely and appropriate communication occurs between Cenpatico and provider network • Recommend, develop, and implement processes that positively impact Network Management and the organization. • Develop and direct network management policy and procedure. • Manage all provider communications • Ensure provider manuals are accurate and comprehensive • Conduct provider information audits to ensure accuracy of data. • Monitor operational performance of providers • Identify trends and develop solutions to obtain overall operational and financial goals
Provider Coaches	Network Management / Cenpatico of LA	• Conduct monthly on-site meetings with providers • Conduct provider training, education and orientation, including clinical practices and administrative processes • Review corrective actions with provider agency staff to identify and report compliance with contract requirements and identify areas for improvement • Assist provider agencies in developing corrective action plans • Provide agencies with technical assistance related to meeting contract deliverables • Audit provider charts and facilities to gather quality information • Develop and maintain relationships with provider compliance staff to ensure providers are complying with contract requirements • Participate in cross functional teams to solve system issues. • Identify provider system needs and propose solutions • Provide clinical guidance to provider agencies related to Program Development, Best Practices and operational efficiencies • Review dashboard reports with provider agency staff to identify and report compliance with contract requirements and identify areas for improvement • Develop and maintain relationships with provider training organizations to ensure provision of web-based provider training

Position	Department / Corporate Affiliation	Functional Responsibilities
Provider Relations Coordinators	Network Management / Cenpatico of LA	• Assist Provider Coaches and Network Management Administrator with daily administrative functions. • Address basic provider issues and concerns. • Initiate and process provider add, change and termination forms. • Track, update and audit provider information database. • Physical file maintenance. • Assist in audit activities.
Care Management / Utilization Management Administrator	Care Management / Cenpatico of LA	• Coordinate data collection and information from CM Department staff regarding provider performance issues, network access barriers, and additional service needs and communicate to NM and ND Administrators
Utilization Managers	Care Management / Cenpatico of LA	• Provide clinical feedback and training to network providers regarding treatment planning, evidence based practices, clinical practice guidelines and medical necessity criteria
Care Managers	Care Management / Cenpatico of LA	• Provide clinical feedback and training to network providers regarding treatment planning, evidence based practices, clinical practice guidelines, medical necessity criteria, additional community resources, Waiver eligibility, applicable services available through DOJ, DOE, OCDD, DCFS, etc
Care Coordinators	Care Management / Cenpatico of LA	• Provide information to network providers regarding additional community resources, Waiver eligibility, applicable services available through DOJ, DOE, OCDD, DCFS, etc
Quality Management Administrator	Quality Management / Cenpatico of LA	• Coordinate collection of data and provide information from QM Department staff regarding provider performance issues, network access barriers, and additional service needs communicate to NM and ND Administrators
Children's System Administrator	Children's System of Care / Cenpatico of LA	• Coordinate data collection and provide information from Children's System staff regarding gaps in population specific resources, such as school-based services, Wrap Facilitation, peer support, barriers to access, and communicate to NM and ND Administrators
Adult System Administrator	Adult System of Care / Cenpatico of LA	• Coordinate data collection and provide information from Adult System staff regarding population specific resources, such as community re-entry services, Permanent Supportive Housing, peer support, barriers to access and communicate to NM and ND Administrators

Position	Department / Corporate Affiliation	Functional Responsibilities
Credentialing Manager	Compliance Department / Cenpatico, Austin	• Oversees the Internal Provider Relations (IPR) Unit and the Credentialing and Re-credentialing Department. Establishes policies and procedures and is responsible for reviewing all incoming network contracts and provider credentialing applications. Oversees evaluation and validation of providers' qualifications. • Coordinate data collection and provide information from Credentialing Specialist and Internal Provider Relations staff regarding trending issues with provider applications, credential documentation, etc and communicate to NM and ND Administrators
Compliance Administrator	Compliance Department / Cenpatico of LA	• Collaboratively conduct investigations, systematic testing, review regulatory requirements, track investigations and work with various state agencies/departments as necessary to ensure to ensure that WAF incidents are identified and addressed
SIU Director	Special Investigations Unit, Centene Corporate	

Based on our input we've gathered from providers across the state in preparation for this proposal, we understand that the current behavioral health delivery system is fragmented and not currently functioning as a comprehensive system of care for children and adults. Therefore, our initial network development plan is a multi-phased approach:

Year One:

- Expand existing network to include non-traditional, clinically appropriate providers and assist them in enrolling in Medicaid
- Bring in telemedicine services to underserved areas
- Assess and expand upon the existing crisis response network
- Conduct face to face, statewide trainings on an ongoing basis to ensure providers understand how to bill services, verify eligibility, and obtain authorization; these types of trainings include town hall regional-based trainings, custom provider-specific trainings to address specific needs or areas of improvement for the provider; refresher billing courses, ad hoc trainings, trauma screening training, and evidence based practice training,
- Increase the number of providers submitting electronic claims

Year Two:

- Monitoring of provider performance
- Ensure timely referrals
- Appointment access surveying and monitoring
- Ensure encounters are set up correctly
- Monitor and implement Corrective Action Plans as necessary
- Continue initial trainings and orientations as needed
- Continue to expand number of providers submitting electronic claims

Year Three:

- Transition LGE contracts to a block payment arrangements to encourage them to manage all aspects of member care by down-streaming funds to them directly; in this type of an arrangement, the LGE will be ultimately accountable and responsible to the SMO to ensure 24/7 access to and delivery of services to our membership
- Ensure providers targeted for block payments, the LGEs, contract with local providers to ensure they are able to provide a full-continuum of outpatient and community-based services, including natural supports and peer support services as a condition to the block payment.
- Ensure financial readiness of these organization before executing a block arrangement and provide fiscal oversight of the funds on an ongoing basis through encounter submissions, quarterly meetings, and year end results
- Adjust block payments as indicated by expenditure reports
- Ensure providers on block payment are booking unspent portions of the payment for future services, and year end review
- Provide consulting and management expertise to ascertain block payment readiness of the LGEs and post the establishment of a block payment arrangement, provide ongoing maintenance and financial oversight to ensure the block funds are allocated accordingly
- Initiate corrective action plans, as necessary and as indicated
- Ensure Provider Coaches monitor execution of and compliance with any initiated corrective action plans

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.e. Network Management
ii. Provide an organizational chart for NM that includes position titles, numbers of positions, qualifications and reporting relationships. Discuss how provider relations, network development and network monitoring will be addressed. **Suggested number of pages: 2, exclusive of Organizational Chart**

Position	Credentials/Required Qualifications	Experience & Expertise
Network Development Administrator	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 5 years experience in public sector, managed behavioral health care, including experience with the development of provider behavioral health services for children and youth involved in multiple service systems and adults with SMI and/or addictive disorders • At least 5 years experience as a Network Development Administrator or similar role for a managed behavioral health care organization • Knowledge and understanding of the Louisiana Medicaid managed care market, regulations, practices and behavioral health system strongly preferred
Network Management Administrator	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 5 years experience in public sector, managed behavioral health care, including experience with the development of provider behavioral health services for children and youth involved in multiple service systems and adults with SMI and/or addictive disorders and evidence-based practices • At least 5 years experience as a Network Management Administrator or similar role for a managed behavioral health care organization. • Knowledge and understanding of the Louisiana Medicaid managed care market, regulations, practices and behavioral health system strongly preferred

Position	Credentials/Required Qualifications	Experience & Expertise
Contract Negotiator	• Bachelor's degree in healthcare administration, business administration, marketing, related field or equivalent experience	• At least 2 years experience in contracting or provider relations in a health care, managed care, or insurance related environment • Knowledge and understanding of the Louisiana Medicaid managed care market and behavioral health system preferred
Provider Relations Coordinator	• High School Diploma or equivalent experience	• At least 2 years experience in managed care/Medicaid customer service or 1-2 years of related administrative support experience • Knowledge in Excel and Access • Knowledge in credentialing and contracting preferred
Program Specialist - Community Re-Entry/SAPT & Supportive Housing	• Bachelor's degree in healthcare administration, business administration, marketing or related field	• At least 4 years of behavioral health experience • Knowledge and understanding of the Louisiana Medicaid managed care market and behavioral health system preferred
Credentialing Specialist	• Bachelor's degree in business or healthcare related field or equivalent experience	• At least 1 year of credentialing or relevant provider data experience
Provider Coach	• Master's degree in Behavioral Health or RN • Licensed Mental Health Practitioner (LMHP)* in the state of Louisiana	• At least 3 years training experience, preferably in health care or managed care environment • Knowledge and understanding of the Louisiana Medicaid managed care market and behavioral health system preferred

Cenpatico's network development and management strategies are grounded in a philosophy that reflects the system of care and family-driven care principles embraced by the Louisiana Behavioral Health Partnership. The key elements of our network management (NM) philosophy are:

- Local systemic approach designed to address community specific needs and culture
- Partnership with all stakeholders reflected in how the provider network is built and developed and managed over time
- Family-driven and community based services are primary
- Training and technology support to providers and stakeholders
- Transparent exchange of communication and closing the feedback loop among all stakeholders
- Clinical excellence and high quality services

We impart this philosophy on our providers across all departments. Cenpatico believes building provider partnerships is a key function throughout our entire organization. For example, our Quality Management staff are tasked with improving provider performance, and benchmarking and surveying the quality of care provided to our members. Our Clinical staff are charged with promoting evidence based practices, implementing clinical action plans, monitoring the delivery of services, identifying providers or services needing improvement interventions and rewarding those providers that demonstrate continued excellence. Our Network Development staff are responsible for creating, negotiating and maintaining a provider network and assessing the strengths, needs, and capabilities of the network.

Network Development (includes Provider Relations)

As detailed in *Section 2.e.i*, our network development team's responsibilities will include creating, negotiating and maintaining all provider contracts. This team will collaborate with the management team to assess gaps in provider types or services and develop and implement plans to address any gaps.

The network development team will monitor the provider network to ensure the number of providers/services available remain consistent with the current Medicaid fee for service program and that members have a choice of providers which offer appropriate levels of care.

Developing the CSoC Network

Cenpatico whole-heartedly supports the development of the CSoC and the wraparound approach to service delivery for children and their families. Our Network Development staff will be supported by the insight and talents of our Children's System Administrator, WAA/FSO Liaisons, Community Liaisons, Family Support Coordinators and School-based Liaisons to develop a high degree of collaboration and coordination among the child- and family- serving agencies and organizations throughout Louisiana communities. Through collaborative action, the Network Development and Children' System staff and will encourage collaborative actions among providers by working together to institute the wraparound philosophy into concrete contract language, policies, practices, and achievements that work across multiple child-serving systems.

Cenpatico has significant experience developing coordinated systems of care in other states and have a proven track record managing care for children with severe behavioral health challenges involved with the child welfare and juvenile justice systems, particularly those at risk of, or already in, restrictive services outside their home. We realize that developing a CSoC for any population it is not an overnight process. Constant training, re-training, education and support of front line clinical staff, clinical supervisors, families, and provider management should be both didactic and experiential. Our Training and Network Management staff will ensure active and ongoing training to support the principles of family-driven care.

Network Management

Our network management and training team, including Provider Coaches, provide education, training and oversight of the provider network. The functions of the Provider Coaches are detailed in Section 2.e.i, and include meeting with providers on a regular basis monitor performance improvement and offer technical support.

The network management team will also establish policies and procedures consistent with federal and state regulations for provider selection and retention, credentialing and re-credentialing criteria, cultural competency, network adequacy and appointment availability, network changes including provider terminations, provider directories and manuals, provider contract requirements and provider services.

Network Monitoring

We will continually monitor our network not only for adequacy and access but also for operational and clinical performance. Operationally, we will monitor transactions to proactively identify any claims submission problems providers are having. When challenges are identified network staff will meet with providers to provide technical support. We will monitor providers' clinical performance relative to their peers and to national norms. Where deficiencies are found we work to educate those providers so they improve their standards of care and services to members are most effective.

2.e. Network Management
iii. Describe how the Proposer's information management system will support NM and development. **Suggested number of pages: 2**

Provider Network Development and Management.

Cenpatico will use our innovative, integrated Provider Relationship Management system (PRM) system, combined with our Centelligence™ data integration and reporting capability to recruit, develop and manage our provider network. These innovative technologies are supported by our Louisiana-based Decision Support team, lead by the Information Systems Administrator, who work in coordination with Cenpatico Austin and Centene Corporate Information Technology teams to ensure that all technologies deliver on their promise to improve data quality and reporting.

The Provider Relationship Management (PRM) System. PRM is our integrated provider communication, services inquiry & provider data management application, powered by a potent combination of Microsoft Dynamics contact relationship management (aka "CRM") technology, Portico enterprise provider data management system, and Emptoris provider contracting application. PRM is integrated with AMISYS Advance for claims processing and payment; TruCare, our utilization and clinical care management application; MDE Xpress Encounter Pro (Encounter Pro) for encounter management; ProviderConnect (the Microsoft Dynamics Customer Relationship Management (CRM) component of PRM); and finally to our Enterprise Data Warehouse (EDW) for provider profiling and reporting purposes among these reports, to ensure our Provider Network meets the access requirements for each of our state contracts. PRM includes the following components:

ProviderReach is the outbound provider communications component of PRM - for coordinated broad based or targeted provider prospecting, recruiting or other information campaigns. ProviderReach features a provider prospecting and recruiting module, based on PRM's consolidated CRM, which, in conjunction with our Avaya Voice Portal (AVP) Predictive Auto Dialer (PAD), RightFax server, Microsoft Exchange messaging platform, and our secure Provider Portal, can support coordinated prospecting and recruiting campaigns across several unified and integrated technologies (phone, fax, e-mail, and web). Beginning later this year, we will be integrating with the Enclarity provider data service (see discussion below). Among other best practice capabilities, Enclarity will integrate with our PRM and ProviderReach - with several significant benefits. For example, should our Provider Relations or other Cenpatico staff identify a particular provider that we would like to recruit and contract with (e.g. to offer additional specialty service capacity in a geographic area); our staff can retrieve the latest demographic, licensure, sanction, and sub-specialty information on that provider, simply by inquiring directly from our PRM system, which will interface securely, in real time, with Enclarity; supplying us with quality provider data that we can use for outbound recruiting via ProviderReach. This "on demand" feature greatly strengthens our ability to quickly fortify our network in targeted fashion, wherever we need to, whenever we need to.

ProviderReach also allows the efficient and coordinated launch of broad based communiqués, notices, and important updates to our existing network providers across these same multiple communication channels, including telephone, e-mail, fax and web. Our CRM maintains our contact history with providers across all these communication channels, from prospecting and recruiting, through network participation and ongoing service.

Portico is our Provider data management system providing a single repository for Cenpatico's entire *core* provider functions, including: Contracting via interface with Emptoris (described below); Provider Enrollment; Credentialing; Financial Affiliation Configuration; Data Management; and Provider Directory Management. Cenpatico Provider Relations staff will enter provider data into our Portico application which is fully integrated across our Management Information System (MIS), ensuring that all provider data comes from one governing source, and is fully audited and reconciled before entering other

systems. Portico supports multiple provider locations and location contacts, support for multiple individual level provider service locations and a many-to- many linkages and affiliations between individual providers and provider groups. We also document all provider locations and languages spoken. Portico supports history tracking of all changes by electronically stamping the effective date of provider data transactions, enabling full historic audit trail support.

Emptoris our comprehensive provider contract management software, supporting efficient and collaborative provider contracting, amendment and re-contracting processes with Cenpatico providers, while ensuring regulatory compliance. Emptoris complements Portico, by systematically populating core provider data into Emptoris contracting templates and then once finalized, providing full electronic storage of provider contract information. We use Emptoris to manage provider contracts, issue relevant reminders to our local Cenpatico contracting staff when documentation, approvals, and other such contract updates are needed.

ProviderConnect is our application for creating, routing, tracking, managing, and reporting provider inquiries. The main users of ProviderConnect are Provider Service Representatives, but PSR's also can send and receive provider inquiry work items to and from any other departments, for example, requests for provider data changes are routed to our Provider Network management team who is responsible for changes to provider data in our Portico application, again, ensuring the control and integrity of our provider data throughout our MIS.

Centelligence™ to Manage our Provider Network. Centelligence™ is our proprietary and comprehensive decision support and health care informatics solution. The heart of Centelligence™ is our Enterprise Data Warehouse (EDW), powered by Teradata®'s Extreme Data Appliance, which integrates data from our PRM system above, along with data from all our core applications to produce *actionable* information and reports to drive timely and effective decisions. From a provider network management perspective, we use our Centelligence™ Negotiator. Centelligence™ Negotiator is our contract modeling application that leverages historical market information to aid in the analysis of new or modified provider contracts. New contract configurations (fee schedule, etc.) can then be electronically fed to AMISYS Advance to accelerate and simplify the implementation of provider contracts and fee schedules. Another component of Centelligence™ Negotiator is our provider network geographic access analysis software, GeoAccess, by Ingenix. GeoAccess is the industry standard for geographic network analysis. Provider data from Portico is extracted and Geo-coded. Through this, we are able to produce multiple reports to review and report on the adequacy of our provider network for each area in which we operate. Centelligence also allows us to report utilization patterns for services provided by both our network and non-participating providers. Please see our response to section 2.g.iv and 2.g.xii for more information on our Centelligence™ capability.

Enhancing Provider Data Quality. We are augmenting our provider data management operations by integrating PRM with data and interface services from Enclarity, Inc. Enclarity is the nation's leading commercial provider data supplier, a recognized expert in sourcing, maintaining, and validating provider demographic, specialty, licensure, and sanction information. Through a singular focus on "all things provider," Enclarity maintains a storehouse of correct, current, and comprehensive information by continually reviewing the most trusted sources of data in the industry, a "universe" of provider information representing over 140 million records: all synchronized and normalized in Enclarity's Master Provider Referential Database (MPRD). Through both "on demand" real time and scheduled batch provider data interfaces with our PRM, Enclarity enables Cenpatico to recruit, contract, administer, and manage the *ongoing* quality of our Cenpatico provider network with enhanced accuracy and responsiveness. For example, during the credentialing process, PDM Coordinators will cross-reference attested provider data obtained during credentialing with Enclarity's secure online database search tool (the database includes out-of-network providers) and will investigate any discrepancies between attested

provider information and Enclarity data. Enclarity also ensures on a regular basis that the provider data we house in PRM is accurate across all provider informational dimensions. Every quarter, Enclarity electronically sends us a validation file for all records housed in PRM's Portico database. Portico can then update any information from this Enclarity "synchronization file."

2.e. Network Management
iv. Address the Proposer's experience with contracting for services typically provided by child welfare and juvenile justice agencies that are funded through State general funds or Grants (i.e., not Medicaid-reimbursable services).
Suggested number of pages: 2

Cenpatico has extensive experience identifying and contracting with providers and provider networks for behavioral health services that serve Medicaid populations *and for services that are not Medicaid reimbursable* but augment Medicaid-reimbursable services for children specifically involved in child welfare and juvenile justice agencies. Cenpatico's experience goes deeper than most, as we contract with specialty providers for specialized services to non-Medicaid populations paid for by State general funds and Federal block grants for children and families involved with child welfare and juvenile justice systems. Cenpatico is the only company in the nation to exclusively provide behavioral health services to a unique population of foster care children by coordinating Medicaid-covered services with services funded by State general fund and Federal grants paid for by child welfare and juvenile justice agencies. Our broad expertise serving these populations and working with diverse funding streams gives us the foundation *and the flexibility* to be a true partner to DHH, State agencies and the community.

Cenpatico of Arizona: Developing and Implementing CSoC Using Non-Medicaid Funding Sources

While most states have not moved forward with the vision of integration as Louisiana is currently implementing and pooling its service resources into one coordinated system, Arizona has. Cenpatico has several years of experience managing and accounting for multiple funding streams including State general funds and Federal Block Grant Funds to facilitate seamless services to children involved with child welfare and juvenile justice agencies. Since 2005, Cenpatico has been managing the Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant and the Community Mental Health Services (CMHS) Block Grant for priority populations including children with SED and substance use disorders. Cenpatico contracts with non-traditional/non-Medicaid providers to ensure services are delivered to child welfare and juvenile justice involved children and adolescents who may have lost insurance or need a service that is not Medicaid reimbursable. An overview of the broad range of programs and contracted funding streams are identified below.

Child Welfare Rapid Response Services: Cenpatico uses CMHS funding to conduct behavioral health assessments for all child welfare/foster children removed from the home within 72 hours of removal. Many of these children are not Medicaid enrolled at the time of removal and we work diligently to get these children enrolled in Medicaid when possible. About 25% of these children are returned to their homes within a month of the removal and never become Medicaid enrolled. Cenpatico creates a "no wrong door" approach to services for Child Protective Services to ensure eligibility issues do not interfere with access to services. Fifty-three (53) children are removed each month in the three geographic areas we serve and 100% of them receive a behavioral health assessment through a contracted provider (regardless of being reimbursed by Medicaid or not) within 72 hours. Following the behavioral health assessment, Cenpatico works with our credentialed behavioral health providers to ensure the children receive a comprehensive and individualized service plan and prompt access to services. Cenpatico tracks each removal to make sure each child is connected into care.

Child Welfare SUD Services: Many children are removed from their home due to *parental neglect associated with substance use*. Substance use treatment is often a condition for children to return home to their biological family. Cenpatico utilizes Federal SAPT dollars to provide treatment services to substance using non-Medicaid-enrolled parents of children removed by Child Protective Services. We ensure our providers coordinate service delivery with Child Protective Services specialists to ensure they have the information they need for court proceedings on a timely basis.

Adolescent SUD Services: Cenpatico uses SAPT funding for youth who are not eligible for Medicaid services and are in need of *substance abuse treatment*. Many of the referrals for adolescent SUD

treatment come from youth involved in juvenile justice and families of children involved with Child Protective Services. Some youth are involved in Drug Court programs.

Flex Funds: Cenpatico uses SAPT and CMHS funds to provide *flexible support services* to help children remain in their homes. This can include the cost of summer camp, tutoring, recreational activities, home repairs, auto repairs and similar expenses that help a child be successful living in the community. We also use CMHS funds to cover room and board costs for Medicaid children placed in out-of-home care, including children in therapeutic foster care settings.

Mobile Crisis Services: Cenpatico contracts for *mobile crisis services* provided to anyone who requests services, regardless of their eligibility for Medicaid funding. State general funds (non-Medicaid funding) are used to provide community based mobile crisis services to non-Medicaid enrolled children. Our crisis mobile teams respond to crisis calls from Child Protective Services case workers, families, probation officers, police, teachers and other community members. Our 24/7 crisis phone line staff follow up on each mobile crisis team intervention to be sure the crisis has been resolved and the child and family are connected to appropriate follow up services.

Community Reentry Program*:* Cenpatico developed a community *reentry program* to coordinate the transition from county jails, detention centers and state facilities to the community. We contract with treatment providers to go to county jails, detention centers and state facilities to complete a community reentry evaluation (CRE) for incarcerated juveniles who are nearing their release date. The CRE determines what types of services an incarcerated participant may be eligible to receive and need upon their release into the community; such as, behavioral health and/or substance use treatment, peer and family support, vocational rehabilitation, case management and transportation. Since many children don't have or lose their Medicaid eligibility while incarcerated we use State general fund dollars to conduct facility-based assessments and SAPT funding upon release to bridge the transition until the juvenile regains Medicaid eligibility. Reentry evaluation staff pre-enrolls the participant into Medicaid and Cenpatico. In the event the participant is determined not eligible for Medicaid post-release, we utilize SAPT and CMHS funds as appropriate and available to continue care.

Child Welfare Foster Family Initiative: Cenpatico uses State general fund, SAPT and CMHS funds to develop a Foster Family Training Program. Many times foster families are not fully prepared to manage the behavioral health issues they face when taking a foster child into their home. Cenpatico has conducted training throughout the State, specifically targeting new foster parents. The training integrates Trauma Informed Care and Positive Behavioral Support strategies throughout the curriculum. Building strategic working relationships has been an essential element to the success of the training. Cenpatico staff, foster care agencies, and Child Welfare staff work collaboratively together, and have been involved in the development, and evaluation of the training. The foster parent training supports the behavioral health delivery system in achieving improved outcomes for foster children. The Foster Family initiative addresses how Foster Families can prevent multiple out-of home placements and support permanency planning.

Child and Family Team (CFT) Training: We have used CMHS funding to hire and maintain CFT Coaches in each of our regions. The CFT Coaches train child welfare and juvenile justice staff with respect to CFT principles and processes and participate in CFT meetings. In addition, the CFT Coaches train Child Protective Services staff and juvenile justice staff how to facilitate a CFT meeting.

Cenpatico STAR Health Texas: Exclusively Foster Care

Cenpatico is the Medicaid behavioral health contractor for the Texas foster care population serving more than 30,000 children and adolescents. For children in out-of-home placements, Cenpatico manages the provider contracts and pays for Medicaid therapeutic behavioral health services to children and families in the Texas foster care system. The Texas Department of Family and Protective Services (DFPS) and the Texas Department of Juvenile Justice (DJJ) manages and contracts for non-Medicaid reimbursable

services such as room and board paid for by state general and other agency funds. Quite often, youth are dually involved with child welfare and juvenile justice, and thus coordinated, joint service planning occurs.

The Texas Department of State Health Services is appropriated Medicaid and non-Medicaid funds that pay for substance use and addiction treatment services including services provided to children in the child welfare system. Cenpatico contracts with providers to pay for Medicaid reimbursable substance use and addiction screening, assessment, and outpatient services. If a youth needs inpatient substance use and addiction treatment, Cenpatico coordinates with DSHS and DFPS to coordinate access, and pays for the Medicaid-eligible substance use and addiction services while DSHS pays for the room and board.

2.e. Network Management
v. Provide an example of how the Proposer has developed, organized, or implemented another public sector mental health and substance abuse provider network to successfully achieve system goals similar to those outlined in the RFP. Provide a contact from a contracting agency that can verify the Proposer's experience. **Suggested number of pages: 2**

Example: Cenpatico of Arizona

Arizona's goals for network and system development mirror the goals Louisiana expresses in this RFP. In 2005, Arizona awarded us a contract to be the regional behavioral health authority (similar to a SMO) for two geographic service areas encompassing four counties. Based upon our success in those regions, in 2010 Arizona competitively awarded Cenpatico an additional geographic service area that included four additional counties. Each county has unique geographic and cultural differences. Our Network Development efforts have expanded individual, youth, and family-driven behavioral health and substance use services; increased access to a full array of evidence-based home-and community-based services that promote hope, recovery, and resilience; improved quality by establishing and measuring outcomes; and, managed costs through effective utilization of State, federal, and local resources. Our experience in Arizona (AZ) has given us many learning opportunities and lessons learned which inform our Network Development efforts. The chart below shows some measures of our success in meeting AZ's system development goals.

Network Development Measurement	Change
Individual-driven Services: Increase in # of Certified Peer Support Partners.	FY'06:77; FY'11↑ to 192
Access to Services: Number of Community- based SUD Rehabilitation Centers.	FY'05:1; FY'11 ↑ to 5
Quality of Services: Increase in % of SUD Programs Based on EBPs.	FY'06:25%;FY'10 ↑to 100%
Managing Costs: Increase in Support and Rehabilitation Services (S&R) and Decrease in Adult Residential Services (RES).	FY08-FY10: 50% ↑ in S&R; and 26% ↓ RES

We monitor our provider network effectiveness by measuring mental health and substance abuse outcomes related to employment, housing, criminal justice involvement, and abstinence from substance use.

Developing the Network. Our first goal in contracting with a new mental health and substance use disorder MH/SUD network is to ensure there is no disruption in services. To accomplish this goal, we offer contracts to all current providers of services. In AZ, we were successful in contracting with over 98% of the providers who had been providing services prior to the award. We conduct a thorough GeoAccess analysis to identify gaps and develop an ***Annual Network Development Plan.*** The Plan includes a thorough analysis of each community; including, population demographics, and the cultural diversity of the total population compared to the enrolled population. The contracted Network is compared to the cultural makeup and service needs of the members, community needs, health disparities, network adequacy benchmarks, and previously projected network. Based on the data, we complete a ***System of Care Plan***. The Plan includes detailed Network Development objectives, actions steps, timelines, and responsible parties. The Plan is reviewed quarterly with the State and Cenpatico's executive management. The Plan guides our Network Development efforts and ensures we are continually improving the Network to meet the goals of the State and facilitate ***recovery***. Our Provider Mentors and Training staff provide extensive technical assistance, training, and mentoring to ensure providers understand the contract, provider manual, State vision and goals, documentation standards, data reporting, claims billing and reconciliation processes and the System of Care Work Plan. Our Provider Mentors visit our largest providers twice a month to review and monitor processes to ensure providers are supported to exceed our expectations.

Organizing the Network. We organize the Network based upon the unique needs and budget limitations of each market. Our goal is to ensure members have adequate access to services founded on evidence-based practices, while efficiently managing costs. In AZ, we organize our network into four

provider/contract groups: 1) Intake and Care Coordination agencies, 2) Specialty Providers and Independent Practitioners, 3) Peer/Family Operated Agencies, and 4) Out-of- Home Providers. Each type of provider receives a different contracted Scope of Work based upon their unique role in the Network. We contract with all providers directly to ensure members are not restricted access to specialty providers. In AZ, we pay our providers with "proven managed care experience" on a ***block payment methodology*** to ensure members have adequate access to services throughout the year, effectively utilizing State, federal and local resources. We ***prior-authorize all out-of-home services*** to ensure community-based alternatives are considered and medical necessity criteria are met. This allows us to monitor discharge planning and follow-up after discharge to reduce unnecessary readmissions. Our-of-home and independent practitioners are paid on a fee-for-service (FFS) basis through our web-based claims system. ***FFS payment arrangements*** encourage providers to focus on quality and outcomes since members, stakeholders, and families make referral recommendations based upon the quality of programs and the outcomes they achieve. We encourage the development and growth of ***peer and family operated agencies*** that provide support to children/youth, members, and families. In AZ, we helped develop and expand the SUD and MH services provided by The Living Center (TLC) and Southeast Arizona Consumer Run Services (SEACRS). TLC is a peer run organization that provides community reentry services for persons coming out of correctional facilities, housing support, employment services, and support and rehabilitation services. We helped TLC develop three Turtle Bay cafes (cyber café coffee houses) in our counties. The Turtle Bay facilities offer members with SUDs and serious mental illness (SMI) employment opportunities and recovery resources. SEACRS provides peer support and employment support for persons with SMI. We organize our Network to ensure collaborative service planning, easy access to services, access to employment, peer, and community services, and access to self-help groups and natural support services.

Implementing the Network. Cenpatico is fully prepared to develop, organize, and implement the Louisiana SMO based on our experience and lessons learned. We lay the foundation for a successful transition by lining up potential staff and contractors so they are ***ready to go on day one***. Before the contract award date, we put an ***Implementation Team*** in place, assign a ***Project Manager***, and secure a temporary site. We met to finalize our implementation plan the day the contract for AZ was initially awarded. To ease the transition for members, stakeholders, providers, and members of the community, we began extensive outreach that included ***community forums and one-on-one meetings*** with providers. We put a face on our company and its operations to make the transition transparent and responsive to stakeholder needs. We wanted to know 1) what is most important for us to know during the implementation, 2) what problems we might face, and 3) what would the State like to see us do better than the previous contractor. We assured providers that they could continue to operate and serve members by meeting with them individually and setting up payment systems designed to provide continued funding during the implementation phase and beyond. This is particularly critical for smaller, specialty agencies and consumer-run organizations that may not have financial reserves and resources to cover services during the transition. We use what we learned in our community meetings to complete our ***Transition Plan***, addressing all identified issues. The plan was widely published and the Transition Team met on a weekly basis to discuss strategies for overcoming barriers. We met often with the ***State Implementation Team*** to collaborate on solutions and monitor progress. We also have experience working under difficult circumstances. In AZ, several providers were reluctant to cooperate with us during the transition. We dealt directly with providers to assure them of our intensions and make certain there was no disruption in either their payment schedule or their ability to serve members. We created a back-up plan to develop new providers if a resolution could not be reached. We continued to implement the transition during a period of uncertainty, and were successful in developing a collaborative relationship with the providers.

Contact name and phone number

Laura K Nelson, MD, Chief Medical Officer-ADHS, Deputy Director-Division of Behavioral Health Services, (602) 364-5466.

2.e. Network Management
vi. Describe the Proposer's approach to contracting with the current provider delivery system in a new client state to assure continuity of care during the program start-up and implementation period. Describe how the Proposer will transition providers that do not meet credentialing requirements or do not offer services covered by Medicaid or other funding sources identified by DCFS, DHH-OBH, DHH-OCDD, DOE, and OJJ. **Suggested number of pages: 5**

Cenpatico's approach to contracting with the current provider delivery system

Cenpatico's approach to assure continuity of care during the program start-up and implementation period is carefully researched and planned and is based upon our experience in other new client states. Cenpatico will combine our experience in other states with the unique needs of Louisiana including the provider requirements of the Louisiana Behavioral Health Partnership (LBHP) and the network requirements of the RFP. Cenpatico's detailed network plan submitted as part of the implementation plan to DHH-OBH 90 days prior to the contract start date will ensure uninterrupted services to members and the major components of the current network delivery system are not adversely affected by transition to managed care. Our Implementation Plan submitted with this response (section 2.i. and Appendix 2.i. Implementation Plan WBS) details much of our anticipated approach to contracting a network during the implementation period to ensure overall continuity of care during the transition.

Cenpatico will select, train and retain qualified service providers consistent with 42 CFR 438.214 and have written credentialing and re-credentialing policies in place upon the contract start date as approved by DHH-OBH. Cenpatico will first analyze historical HIPAA compliant encounter data provided by the State. A thorough assessment of the data provides a timely snapshot of which providers are most utilized. Cenpatico's recruitment efforts are then organized to contract with providers in the following manner:

- Credential and contract with the providers that are designated as high volume based on our review of historical encounters;
- Contract with FSOs for delivery of family and peer support services immediately in regions selected for initial WAA and FSO implementation;
- Credential and contract with needed specialty types or services to enhance the network, and
- Fulfill the State's requirement to facilitate credentialing and contracting for providers in accordance with the LBHP provider requirements for certification by DHH-OBH

A network build in this fashion with teams dedicated to each facet ensures a comprehensive network is built timely, efficiently and in alignment with Louisiana's expectations.

Our Louisiana provider network will be built in this manner to ensure all safety net providers are contracted and credentialed prior to the start date of the program, as long as they are able to substantially meet contract standards. To continue our demonstrated success in implementing provider network builds in other markets, we will leverage experienced staff from our Arizona, Florida, and Texas offices to facilitate contract negotiations, and provide our local staff back-end assistance with mass mailings and telephonic outreach, credentialing activities, provider communications and marketing collateral development and provider training development. This plan will allow our Louisiana staff the time to be available at the local level to provide face to face meetings with essential providers, host town hall meetings with providers and key stakeholders, and ensure our presence is available and widely seen.

In Louisiana, Cenpatico will contract with Medicaid providers and will include in our network non-Medicaid providers who offer services covered by other funding sources relevant to this contract, including those identified by DCFS, DHH-OBH, DHH-OCDD, DOE, and OJJ. Cenpatico will contract with LABHP providers including Behavioral Health Clinics, Behavioral Health Rehabilitation Provider Agencies, and Mental Health Practitioners will be contracted with once assurances, per contracted qualifications and training have been met.

As an NCQA accredited organization, Cenpatico's credentialing program is quite thorough and ensures verification of all NCQA and State standards and elements, including verification of a Medicaid Number for each provider. Providers will not be made effective in our provider network until they are fully-contracted and approved by Cenpatico's Credentialing Committee. Providers that apply to our network that do not meet our credentialing program expectations are submitted a denial notification, which will contain the reason why their participation was rejected. Providers may appeal the decision, which can only be overturned if the initial rationale is otherwise justified or resolved appropriately. To ensure a quality network is maintained, Cenpatico re-credentials its network providers every three (3) years, or more frequently if a State requires more frequent re-credentialing.

With the approach described above, Cenpatico has continually demonstrated success in building comprehensive provider networks efficiently and effectively. *Since 2003, we have implemented 23 managed behavioral health programs in timeframes as short as one month and as generous as 12 months.* We have proven experience with implementing complex managed behavioral health programs, and we are confident that we can contract the current provider delivery system for Louisiana with the following results:

- **No disruption to recipients**. We will maintain continuity of care throughout the transition period.
- **No noise from providers.** We will build collaborative relationships that start early to build trust and keep the focus on quality care for recipients.

In our recent Arizona regional behavioral health authority implementation, Cenpatico assured the State, recipients and providers a smooth transition of services for persons in hospitals, sub-acute facilities, residential treatment facilities, group homes, therapeutic foster homes and supportive housing. From a list provided by the state, our experienced utilization and network management teams built authorizations and immediately began discharge planning in accordance with state requirements. Any services that were reported within the first 30 days of the transition were retroactively authorized. If contracts were not fully executed by the start date of the contract, Cenpatico negotiated rates and entered into single case agreements.

Cenpatico undertakes each new contract with an individualized, *locally-oriented approach* and dedicates sufficient knowledgeable and well-trained resources to provide compliance with all contract deliverables and individualized service. We currently manage contracts in ten (10) states and as of October 2011, eleven (11) – all serving Medicaid and other publicly funded populations only. Our implementation process accesses corporate-wide resources and is based on Six Sigma principles for thoughtful program and product design with *exceptional* recipient service and value to State customers. The table below provides an overview of all our contracts, timeline for implementations and size of populations served at implementation:

Market	Product at Implementation	Implementation Date	Timeline to Implement	Initial Membership
Wisconsin: MHS Wisconsin	Full Risk: T19, CHIP	Jul-03	3 months	121,000
Ohio: Buckeye Community Health Plan	Full Risk: T19	Apr-04	2 months	109,000
Texas: Superior Health Plan	ASO: CHIP EPO	Sep-04	2 months	94,498
Texas: Superior Health Plan	Full Risk: T19, CHIP	Dec-04	3 months	149,467
Texas: Superior Health Plan	ASO: SSI	Dec-04	3 months	5,820
Kansas	Full Risk: CHIP	Jan-05	1 month	33,565
Wisconsin: MHS Wisconsin	Full Risk: SSI	Apr-05	3 months - graduated rollout of 3,500 members	101
Arizona: Cenpatico of Arizona (GSA 2 & 4)	Full Risk: Multiple Funding Sources, State & Federal	Jul-05	4 months	93,293
Missouri: FirstGuard Health Plan	Full Risk: Medicaid	Jan-05	2 months	36,077
Georgia: Peach State Health Plan	Full Risk: T19, CHIP	Jun-06	12 months - graduated rollout of 300,000 recipients	215,973
Arizona: Bridgeway Health Solutions	ASO: Long-Term Care	Oct-06	6 months	133
Indiana: MHS Indiana	Full Risk: T19	Jan-07	6 months	165,979
Ohio: Buckeye Community Health Plan	Full Risk: ABD	Jan-07	2 months - graduated rollout of 19,000 recipients	198
Texas: Superior Health Plan	Full Risk: STAR Plus (SSI)	Feb-07	3 months	11,797
Texas: Superior Health Plan	Full Risk: STAR Health (Foster Care)	Apr-08	12 months	29,024
Florida: Sunshine State Health Plan	Full Risk: Medicaid, SSI	Jan-09	2 months - graduated rollout by area based on state approval	15,602
South Carolina: Absolute Total Care	ASO: CHIP	Mar-09	6 months	1,588
Massachusetts: CeltiCare Health Plan	ASO: Commonwealth Care	Jul-09	3 months	241
Massachusetts: CeltiCare Health Plan	ASO: Commonwealth Care Bridge	Oct-09	3 months - graduated roll out by region	11,363

Market	Product at Implementation	Implementation Date	Timeline to Implement	Initial Membership
Massachusetts: CeltiCare Health Plan	ASO: Commonwealth Choice and CeltiCare Direct	Apr-10	2 months	10
Arizona: Cenpatico of Arizona (GSA 3)	Full Risk: Multiple Funding Sources, State & Federal	Dec-10	50 days	53,241
South Carolina: Absolute Total Care	Full Risk: Inpatient only for TANF and SSI	May-11	1 month	84,190
Illinois: IlliniCare	Full Risk: ABD	May-11	6 months	18,000 (projected)

Louisiana Behavioral Health Partnership Provider Requirements for Certification by DHH-OBH

Cenpatico supports Louisiana's effort to ensure that the primary provider types contracted by the SMO have the appropriate credentialing, certification, license, and training as required by the Medicaid program, State statutes, State regulation, or State policy. Prior to a provider providing services to a client for which billing will be submitted to Cenpatico, we will work with the State to ensure that providers have demonstrated completion of the Office of Behavioral Health Standardized Basic Training Program, as applicable. With regard to wrap around facilitators, once the state has certified facilitator employed by the WAA certifying completion of the required training, Cenpatico will incorporate the certification as part of our credentialing/subcontracting process.

2.e. Network Management
vii. Describe how the Proposer will secure sufficient numbers of providers to assure service access on Contract Start Date. What barriers are anticipated with having sufficient access by Contract Start Date? What strategies would the Proposer employ to address these barriers? Identify any staff or subcontractors who will facilitate the transition and discuss their qualifications. **Suggested number of pages: 3**

Ready on Day One

In an effort to ensure member accessibility to a sufficient number of providers on the contract start date, Cenpatico will begin provider recruitment and contracting immediately upon award. Cenpatico has already begun on-the-ground provider discussions to better understand the current delivery system and gauge what types of contract models should be used to facilitate an expedited network build. Our target provider listing has been developed and will continue to grow as new providers are identified including those who may or may not yet have Medicaid numbers, as WAA and FSO contracts are awarded and as the LGEs are established across the State. In an effort to maximize the expertise and depth of our contracting staff, we will call upon our staff from our Arizona, Florida, and Texas offices to facilitate contract negotiations, and provide our local staff back-end assistance with mass mailings and telephonic outreach, credentialing activities, provider communications and provider training. This plan will allow our Louisiana staff the time to avail themselves to the local community and provide face to face meetings with primary providers, host town hall-style meetings with providers and key stakeholders, and ensure our presence is available and widely seen. We have found outreach to the provider community, early in the implementation period not only facilitates contracting, but also builds relationships and a consistent feedback loop throughout the life of the contract.

Ensuring we contract with providers that are already providing services to this population will be critical. Cenpatico will assess all historical encounter data provided by the State and use our data analytics software to assess the current delivery system. To ensure our efforts are focused, collaborative and experienced, we will undertake the network build from a triaged and strategic approach. Our local team will first centralize their efforts on credentialing and contracting with the LGEs and HSD/HSAs, WAAs and FSOs. Our Texas-based contracting staff will focus on all hospitals, telemedicine and independent provider recruitment. Our Arizona staff will focus on implementing the PRTF and group home networks. In order to maximize their experience with children's services providers, our Texas-based Foster Care staff will support all WAA and FSO contracting. Our Texas staff will also be available to ensure active and ongoing communication among and between CSoC providers, potential providers and emerging WAAs and FSOs This includes FSO training and education on the fundamentals of advocacy and peer-to-peer support as they develop their understanding of CSoC principles and develop collaborative relationships with service providers. For WAAs, Cenpatico's staff will support development of intensive, individualized care planning and management through CFTs, in accordance with procedures set forth by the CSoC Statewide Governing Body.

Cenpatico will work with companies like Advanced Telemedical Services (ATS), a full service telemedicine company located in Covington, Louisiana, to provide innovative telemedicine services and web-based healthcare solutions through FQHCs to increase access to psychiatric services.

Our approach to developing the network is derived from our understanding of barriers that stem from initial managed care implementation to local access concerns from the provider community. ***In the past eight years, Cenpatico has been awarded and has implemented 23 public sector contracts all with***

unique provider network requirements. While we have learned many lessons, we have also gained extensive knowledge of contracting strategies and we will use that knowledge in Louisiana.

Assessing Implementation Barriers and Assuring Access to Care

To monitor progress and identify any barriers in access to service, Cenpatico will run GeoAccess reports to measure density and accessibility by provider specialty and/or service type as contracts are secured. These reports will be analyzed by our network staff to ensure gaps are identified throughout the implementation and addressed via corrective network actions plans prior to the start date. Early identification of gaps will ensure Cenpatico is prepared to develop and implement any transition cycles or implement any creative network solutions and alternatives.

Cenpatico's efforts to reach out to Louisiana's rural and urban communities have allowed us to become familiar with how access is currently perceived in Louisiana. We have learned that:

- There is concern about moving from a decentralized delivery system to a centralized consistent system of care;
- There is a considerable lack of transportation in rural parishes preventing individuals from accessing existing behavioral health providers;
- Some of the regions are struggling with phasing to an LGE model due to lack of communication, misunderstanding or what is "to be";
- Communication and relationships are strained and new lines of communication need to become available;
- There is a lack of supervised housing and group homes although there is significant policy direction to move members to out of state institutions;
- Unstable housing alternatives will affect persons access to appropriate community treatment;
- There is an historical over reliance on institutionalization and restrictive settings are often offered before least restrictive setting;
- Service gaps include intensive day treatment services, respite care, family homes or individual therapeutic residential homes, assistance in making the transition from services received as a child to the services received as an adult;
- There are high no show rates for treatment services at the same time Medicaid providers and medical professionals are hard to come by in many areas of the State.

Cenpatico's network staff will use this information and other information to further develop network development strategies. We continue to receive stakeholder input on the strengths and weaknesses of the provider community. Cenpatico conducted a GeoAccess assessment mapping the State's Psychiatrists, Medical Psychologists, Psychologists, Counselor/Social Workers and Hospitals. These provider target listings were primarily gathered using the State's Medicaid provider look-up tool located at: http://www.lamedicaid.com/provweb1/provider_demographics/provider_map.aspx

Utilizing a measurement of 2 providers of each type per member within 60 miles Cenpatico, and assuming there was at least 1 member in each zip code within the State, Cenpatico was able to determine the following barriers that will need to be overcome to address issues that already exist in this market:

Provider Specialty Type	% With Access Within 60 Miles	% Without Access Within 60 Miles
Hospital	58.3%	**41.7%**
State Hospital	13.4%	**86.6%**
Hospital + State Hospital	60.2%	**39.8%**
Psychiatrist	62.7%	**37.3%**

Medical Psychologist	9.5%	**90.5%**
Psychiatrist + Medical Psychologist	62.7%	**37.3%**
Psychologist	59.1%	**40.9%**
Counselor/Social Worker	53%	**47%**

As demonstrated by the GeoAccess results, the State currently does not meet the 100% accessibility requirements for these provider specialty types if the required mileage requirement were 60 miles. Blending the hospitals with state hospitals will marginally improve access to inpatient care, however, Cenpatico will need to center our efforts on recruiting hospitals that don't typically participate in Medicaid programs to help narrow the gap between the 100% accessibility requirement and the 60.2% achievement rate attained if all hospitals, free-standing psychiatric hospitals and state hospitals were in the provider network. Additionally, ensuring a strong functional crisis response network, like mobile crisis teams and crisis respite are in place will help ensure members in urgent situations are able to obtain services in the community so that the acute care units are not unnecessarily utilized and beds remain available for those whose acuity truly warrants an inpatient admission. As it pertains to medication services, merging the medical psychologists with the psychiatrists, as both are clinically licensed for prescribing and monitoring medication, doesn't impact the access rate to this grouping in a positive manner whatsoever. There are not enough licensed medical psychologists in the State to make an impact on the accessibility issues. Expanding the network to include nurse practitioners and to focus year one training and partnering with primary care clinicians including OB/GYNs and pediatricians would greatly assist in closing this gap. The type of training we are referring to is psychotropic medication prescribing and management and when a case is appropriate to stay with the primary care doctor, as opposed to being monitored and maintained by the psychiatrist. In this type of scenario, Cenpatico would utilize the psychiatrist in a consultative basis. Criteria to warrant when a member's condition/needs would fit this type of scenario would be closely developed with a subgroup to include feedback from local psychiatrists and primary care clinicians, to include at least one OB/GYN and one pediatrician on the panel. Roundtable discussions will be ongoing to ensure a program is developed to best meet the member's clinical needs. In addition, bringing telemedicine, especially tele-psychiatry services, will greatly improve the 37.3% gap that exists today in prescriber services. In order to address these gaps even further, Cenpatico will need to obtain the clinical provider rosters from each community mental health center.

It is clear that Cenpatico will need to assist the State in recruitment of non-traditional Medicaid providers to fill the following gaps and barriers identified through this assessment.

Please refer to ***Section 5, Appendix 2.e.vii*** for the listings used to provide this assessment. This Attachment will also demonstrate all specific parish gaps, by the specialty types mapped in the report.

2.e. Network Management
viii. Describe the Proposer's plan for expanding the network to include family-based and community services for the 650-750 children/youth currently in out-of-home placements. Discuss the approach to developing alternative services including:
(a) Input from the Proposer's CM and UM staff;
(b) Input of youth/families, adults and system stakeholders;
(c) Establishment of priorities for network development;
(d) Assessment of current provider capabilities; and
(e) Collaboration with WAA and the adult and child-serving State agencies in plan development.
Suggested number of pages: 5

It is widely acknowledged that the needs of children in out-of-home placement and their families are currently being served through a fragmented service delivery model that is not well coordinated, many times inadequate to meet the families' needs and difficult to navigate. Through this contract, state departments aim to leverage the 'smartest' financing to provide a coordinated system of BH services to this population. Louisiana's children with the highest level of need are often detained in secure or residential settings, which are the highest cost services with the poorest outcomes. CSoC efforts have been shown to provide solutions to common problems found in states throughout the nation, including: 1) lack of family-based and community services and supports, 2) patterns of utilization-racial/ethnic disparity and disproportional representation in out of home placements and juvenile justice involvement, 3) high cost, 4) administrative inefficiencies, 5) poor outcomes, 6) rigid financing structures, and 7) deficit-based/medical models, limited types of interventions. Cenpatico has reviewed the research on Louisiana's children in out of home placement and is pleased to help continue Louisiana's efforts to bring children back to Louisiana and into community-based services.

We help families navigate the system through family support guides, a natural support resource directory and a roadmap to CFTs.

Our Approach to Developing Alternative Services

Cenpatico will build on our 17 years of experience developing and managing behavioral health networks for children and their families in 11 states to establish and maintain a robust provider network of evidence-based, culturally competent, family-based and community services to serve the 650-750 children/youth currently in out-of-home placements. We will develop an Annual Network Plan and a Network Development Work Plan. The Annual Network Plan provides a comprehensive evaluation and review of the existing network and the Network Development Work Plan will target the development and expansion of family-based and community services. The key strategies of our network expansion plan include:

- collaborative provider, family, youth, community and stakeholder relationships;
- continuous monitoring of network adequacy, including the network's capability to provide services in the scope, amount and duration needed to meet the needs of the BH members;
- managing network changes and system transformation through collaborative work plans and provider coaching; and
- monitoring provider performance and network performance through data collection and analysis.

The development of the Annual Network Plan will include a collaborative in-depth analysis of the availability of culturally competent, evidence-based, family-based and community services, natural supports; identified gaps in the availability of family-based and community services; and evaluation of additional service needs. We have found that successful system transformation requires that we maintain a strong local presence, and build effective collaborative relationships with service providers,

stakeholders, families, and youth in their communities. We accomplish this through community, stakeholder, youth, family, and provider advisory committees and forums. By creating structures to hear the voice of youth, family members, providers, stakeholders, and community members, we ensure our network is continually "aware of" and "responding to" the needs of our members.

a) Collaborative Input from the Proposer's CM and UM staff

We will conduct a thorough review of the strengths and needs of each child/youth currently in out-of-home care, an analysis of what is needed for each child to return to a community setting and an analysis of the communities in which they live. The analysis will include a review of health disparities, cultural and ethnic differences and community differences. Cenpatico's CM and UM staff will work directly with the network providers, WAA and FSO staff, and child welfare and juvenile justice staff to identify each child's needs and what family-based and community services and natural supports need to be in place for the child to return to a community setting. As part of the regional teams, our CM and UM staff will collect up-to-date information regarding gaps in the system and additional program, service and natural support needs. Our CM and UM staff will seek out quality programs that are working well and share that information with our Network staff to expand similar services in other regions across the state. Our CM and UM staff will maintain an updated record of service and program needs by community. The CM/UM Administrator will review the spreadsheet and present recommendations monthly to the Network Development and Adequacy Subcommittee (NDAC) of the Quality Improvement Committee (QIC) for review and action.

b) Input of youth/families, adults, system stakeholders

We will conduct local community forums to hear from youth, families, stakeholders, and community members about current gaps in the system, recommendations for new culturally-competent, family-based and community services, availability of natural supports, unique cultural needs and concerns they have about the system. We will also develop a *Youth Advisory Board, a Family Advisory Board and a Stakeholder Advisory Board.* These Boards will be co-chaired by the Cenpatico CEO and an elected community member of each Board. These Boards will be provided with aggregate data about the children/youth in out-of-home care, the services and programs that are in place to allow these children/youth to return to the community and service gaps that have been identified in the provider network. The Boards will be empowered to make recommendations to Cenpatico's Executive Management Team (EMT) and the NDAC.

We will also gather recommendations from the State and Local Coordinating Councils**.** We will include the findings from these constituencies in our Annual Network Plan. The COCCA and the Network Management Administrator will provide quarterly updates regarding recommendations and findings to the *NDAC*. In addition, our Community Connections staff will meet with community leaders and civic organizations and develop an inventory of natural supports listed by community. They will solicit additional community supports to help children/youth to successfully return to their communities.

c) Establishment of priorities for network development

We will undertake a collaborative and transparent process to establish priorities for the development and expansion of culturally- competent, evidence-based, family-based and community services for children and youth in out-of-home placement. We will gather input from all the constituencies identified in this response and outline priorities as part of the Network Development Work Plan. The Network Management Administrator is responsible for developing and managing the Plan and presenting it to the NDAC and all constituencies for review. Priorities will be identified for each region and may be adjusted throughout the year as the needs of each region change. Continuous input and guidance related to the priorities will be sought through input from community forums, regional advisory councils, the Youth, Family and Stakeholder Advisory Boards, BHH, WAA and FSO staff, Cenpatico CM and UM staff and State and Local Coordinating Councils. Our WAA/FSO Liaisons will meet regularly with FSO and WAA

staff to help identify and refine priorities for the development of culturally-competent, family-based and community services and identification of natural supports. In addition, our management team will meet with BHH staff as often as needed to keep them apprised of our activities, refine priorities, and obtain feedback and recommendations. Our network priorities will be posted on our website and all constituencies can give us feedback through the website. The Network Development Work Plan will clearly identify priorities by region, articulate action steps, timelines, baseline data, responsible parties and outcomes to be achieved. The Work Plan, including the network priorities, will be developed by Cenpatico Network Development staff and reviewed by the NDAC, BHH, State and Local Coordinating Councils, and the Youth, Family and Stakeholder Boards. The Cenpatico EMT and the QIC will give final approval to the priorities and the Plan. Updates to the priorities and Plan will be reviewed by the NDAC monthly and will be reviewed quarterly by the QIC, EMT and advisory boards.

d) Assessment of current provider capabilities

We will meet with each major provider of services to build a collaborative working relationship, learn about their business plans and explore opportunities to expand the availability of culturally-competent, evidence-based, family-based and community services. As part of our Annual Network Plan, we will analyze the current network of providers, obtain details about their service locations, services provided, staffing patterns, family and community based services, specializations, and programs provided. With this information we will complete a formal GeoAccess Analysis. In addition, we will continually review additions and changes to the network, access to care, service utilization, complaints, grievance and quality data to identify network challenges and issues. We will also conduct a monthly Provider CEO meeting to keep providers informed of changes, learn about their challenges, and gain their input and suggestions. In addition, we will develop a Provider Roundtable with a select number of providers, chosen by the providers, to advise Cenpatico about the system and provide feedback regarding system changes and new family-based and community services being developed. All of this information will be included in our Annual Network Plan. The Plan will prescribe the number of programs, services, providers by type, and service locations that are needed to provide family-based and community alternatives to out-of-home care in each region. Gaps and program and network development strategies will be placed on the Network Development Work Plan. The Cenpatico CEO, COO and Network Management Administrator will meet regularly with providers to explore their interest and capacity to develop new family-based and community programs and services. We will offer new contracts or amendments to existing providers who express interest, have the financial resources and demonstrate the capacity and ability to develop and expand family-based and community services in each region. In particular, we will outreach to family-run businesses and out-of-home providers to encourage them to consider developing family-based and community services. We will also assist family members who want to develop family-based and community alternatives to congregate care to develop business plans and help execute those plans.

e) Collaboration with WAA and the adult and child-serving State agencies in plan development

We will seek direct input and recommendations for the development of culturally competent, family-based and community services and identification of natural supports from WAA and adult and child-serving State agencies though our community forums, Stakeholder Advisory Board and the State and Local Coordinating Councils. We will also receive feedback and input from our CM and UM staff who have direct involvement with direct care staff employed by the WAA and state agencies. Our Interagency Liaisons will meet regularly with WAA and State agency representatives to track and resolve issues, identify service gaps and make recommendations for the development of family-based and community services to the Network team. Findings and recommendations from these meetings will be presented monthly to the NDAC for review and action. We will give WAA and adult and child agencies copies of the Network Development Work Plan for feedback and comment through the various communication

channels identified above. The feedback, recommendations and changes to the Network Development Work Plan will be presented to the NDAC at least quarterly.

System Transformation through Collaborative Work Plans, Provider Coaching and Ongoing Monitoring and Support

We have over 10 years of experience developing and managing culturally competent, evidence-based, and family-based and community services and programs. We manage our behavioral health networks by maintaining effective partnerships with behavioral health providers, providing hands on training and coaching, providing program development support, facilitating the adoption of evidence based practices, continually monitoring network adequacy, and conducting audits. We have identified ten key elements to effective system transformation and network development and management.

Key Elements to Effective System Transformation and Network Development/Management
1. Setting the vision – clearly and emphatically
2. Identifying root causes of problems,
3. Removing barriers
4. Educating and training providers, law enforcement, and community stakeholders
5. Identifying key components critical to success
6. Reaching and coaching provider staff intimately involved in the process
7. Providing regular coaching and technical assistance
8. Regular auditing and sharing results
9. Taking appropriate corrective action up-to-and-including sanctions
10. Celebrating successes

We have learned that when problems occur in the implementation of system changes, it is due to failure to fully execute one of the 10 components. We will implement each component of this model. We will begin with a formal training program, offering face-to-face and web-based training opportunities; including, specific training in the delivery of evidence-based, culturally competent, family-based and community services. We will monitor and track training performance by provider through web-based training software. Our Provider Coaches and Program Development staff maintains frequent contact with providers. They assist them in developing programs; meeting contract, state and federal requirements, meeting credentialing requirements; and, the accurate and timely submission of claims. We have learned that the success of network development efforts and system transformation is dependent on detailed planning and meticulous and consistent tracking and monitoring of implementation work plans. Our Provider Coaches and Program Development staff apply project planning processes to ensure work plans are completed and barriers are overcome. Our Provider Coaches meet with our largest providers at least twice a month and smaller providers less frequently. We use these meeting as opportunities to help behavioral health providers understand contract requirements, enhancements and changes to the system and obtain their recommendations for making the system more effective. During these visits we review areas for improvement, address corrective action plans and provide hands on technical assistance and clinical support. Corrective Action Letters are sent to behavioral health providers who fail to meet contractual requirements, or as a result of member complaints, quality of care reviews or under performance on quality standards. Behavioral health providers are required to develop work plans to address the deficiencies and the Provider Coaches monitor progress to ensure the issue has been effectively addressed. Our Provider Coaches also work with the regional teams, provider staff, families, youth, and WAA and FSO staff to enhance the delivery of CFTs and help children/you successfully transition back to the community.

Our Program Development staff also help providers develop new evidence based services and programs such as, direct support services, and family and community based services. We require that each provider

undertakes the development of the new family-based and community services through a detailed work plan. We monitor the work plans monthly, providing guidance and technical assistance to ensure the services and programs are implemented effectively. On site audits are performed to ensure staff and program components are in place to effectively implement the new program and services. We also require under contract that all new behavioral health programs be based on best and promising practices. We review program descriptions and conduct fidelity audits to ensure that programs remain true to the best practice selected to guide the implementation of the program. The fidelity audits include: interviews with staff, families, youth; chart audits; a review of program components; and an analysis of staffing patterns and job responsibilities. Cenpatico developed a Fidelity Audit process in Arizona and it has become a best practice in the State. In addition, we conduct monthly telephonic conference calls which include all contracted behavioral health providers. These calls are used to educate providers about new requirements, new initiatives, and performance information and provide a forum for us to quickly disseminate critical information to large audiences. The information is also placed on our website for providers who cannot attend.

Monitoring Provider Performance and Network Performance through Data Analysis: The Provider Report Card:

We give providers regular feedback regarding network performance through individualized Provider Report Cards and reporting. Performance measures related to program development include evidence-based practice fidelity audit scores, percentage of family support partners to number of enrolled members, percentage of programs based on evidence based practices, number of staff employed by profession and role per enrolled members, length of stay data by level of care, admission rates to out-of-home care, access to care data by provider, number of required staff per program, System of Care Practice Review (SOCPR) measure of fidelity to the CFT practice and the delivery of services to children and families, SOCPR scores following interviews with primary caregivers of children, and many more.

In AZ, we reduced the number of (locked facility) bed days by 52%, from 6132 bed days in 2007 to 2920 bed days in 2010. During the same period, the number of children/youth in unlocked residential facilities longer than 90 days dropped from 61% to zero.

Experience and Commitment to Developing Evidence-based, Culturally Competent Family-based and Community Services and Programs

We have over sixteen years of experience developing and managing family-based and community services and programs. Most of our senior staff has over 20 years of experience developing services and programs to help children/youth live in community settings. We are committed to reducing the use of congregate care and providing children/youth the opportunity to successfully live in their home communities. We are passionate about this endeavor as evidenced by our experience in Arizona with the successful implementation of our family-based and community program called, Meet Me Where I Am (MMWIA). We significantly reduced the use of congregate care through the implementation of family-based and community services and improving access to natural supports; including community-based crisis stabilization services, family support services, family systems therapy, respite, skill building programs, culture specific programming, community based functional behavioral analysis, and 24/7 direct supports through the MMWIA program. We will use this expertise to help Louisiana achieve similar results.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.e. Network Management
ix. Describe the resources for providers to obtain information about covered services, billing requirements, payments and training, or other resources. Suggested number of pages: 3

Cenpatico recognizes the importance of quality provider training. To ensure compliance with our provider agreement and all program requirements, Cenpatico creates a milieu of provider training collateral and designs a training program unique to each of our markets. Louisiana will be no exception. In any new market, Cenpatico creates a Provider Manual which contains Cenpatico's policies and procedures for key provider functions including the following: credentialing/re-credentialing, eligibility verification, authorization of services, overview of covered services, claims, appeals/denials, cultural competency and office standards. Through signature of our provider agreement, our providers contractually obligate themselves to comply with the Provider Manual. The Provider Manual is available to all providers on our website, www.cenpatico.com, and can be provided in hard copy paper or CD format as well, upon request. In addition to the Provider Manual, we also create and post the following training items on our website as well: Frequently Asked Questions (FAQ), Quick Reference Guide (QRG), Covered Services & Authorization Guidelines, CMS-1500 Claim Form Instructions and CMS-1450 Claim Form Instructions.

Our provider training staff, which includes Provider Coaches, Provider Relations Coordinators, Training Administrator and Trainers, will work with our subject matter experts to design a provider orientation presentation for all newly contracted providers. Orientation training will serve as an overview of the Provider Manual and expectations for all involved in the delivery of member care. Prior to our start date, training staff will conduct numerous training sessions across the State to offer a variety of date/time/location options for providers to choose from. To ensure the meetings are well attended, our staff will mail an invitation to all providers and conduct follow-up phone calls to confirm RSVPs received and do outreach to non-responsive providers. If any providers are unable to attend any of the group trainings, face to face meetings will be scheduled onsite at providers' office. In addition to inviting the providers, invitations will be extended to their clinical staff, front office staff and billing personnel.

We understand this will be a significant change for the providers and not all will be perfect immediately when the program goes live. Cenpatico will conduct follow-up face to face, trainings statewide for providers needing additional help understanding how to bill services, verify eligibility, and obtain authorizations or to address specific needs or areas of improvement.

At Cenpatico, we understand it can be challenging for our providers and their staff to find time to attend trainings and search for educational opportunities. We offer online clinical education through Essential Learning. All Essential Learning courses are free of charge and available 24-hours a day, 7-days a week. Many of the Essential Learning courses offer Continued Educational Credits (CEUs), and there is no limit to the number of online courses that Cenpatico providers are permitted to take. As part of our initial provider training, Cenpatico's team of trainers will go over how providers can access these courses and much more on our website at www.cenpatico.com.

The following is a list of tools providers can access via our website:

Provider Manual	Comprehensive guide to working with Cenpatico. Contains administrative and claims how-to guides
Provider Directory	Searchable provider listing by provider name or location, language spoken and distance in miles to provider.
Covered Services and Authorization Grid	Cenpatico maintains this on line for providers to have a quick "at a glance" of available benefits for our members
Cultural Competency Plan	Emphasizes our goal of supporting the creation of a culturally competent behavioral health system of care that embraces and supports individual differences to achieve the best possible outcomes for individuals receiving services
Interpreter Request Form	To be used for members who request an interpreter on site during their visit
Chart Audit Form	To be used during routine chart audits. Cenpatico keeps this available on the website so that providers know what they should keep in their charts.
CMS 1500 Claim Form	Detailed step by step instructions for completing an outpatient claim form
Electronic Funds Transfer Agreement	For providers to complete ensuring payment via electronic funds
Medical Record Release Form	Allows members to complete for providers to release medical records
Member Written Consent for Release	For providers to assist members in the appeal process
PCP Communication Form	To assist behavioral health providers in communicating with the members' PCP
Provider Change Form	To be completed upon demographic changes
Provider Complaint Form	To provide a vehicle for which providers can submit complaints
UB 04 Claim form instructions	A comprehensive, step by step guide to completing claims for inpatient admissions
W-9	For submission of Tax Identification information
Outpatient Treatment Request Form (OTR)	To submit treatment requests for authorization for outpatient services
Outpatient Treatment Request Form (OTR) Instructions	Information for proper completion of an OTR
Inpatient & Outpatient Psychological Testing Form	To submit psychological testing requests for authorization
Clinical Practice Guidelines	To ensure providers are aware of Clinical Practice Guidelines
Practice Parameters	A link to the American Academy of Child & Adolescent Psychiatry's Practice Parameters
IOP/ Day Treatment Request Form	To submit requests for authorization for Intensive Outpatient and Day Treatment services
SMART Goals – Fact Sheet	Tips for providers to establish goals for patients
Medical Necessity Criteria – InterQual Information	Information about how InterQual's Medical Necessity criteria will be used for inpatient, partial, intensive outpatient, outpatient and residential services

Best Practice Intervention Strategies Fact Sheets	White papers that assist providers in using evidence based practices
Quick Reference Guide	A quick "at a glance" for providers that contains important phone/ fax numbers, contact information, websites, etc.
Frequently Asked Questions (FAQs)	Addresses questions most commonly asked by providers
E-learning	Cenpatico contains a link to the E-learning site which providers can use for CEUs
Quarterly Provider Newsletters	Updated information from the Medical Director to include information surrounding new initiatives, tips and techniques for providers, and best practices for their business

Cenpatico shares the goal of Louisiana Behavioral Health Partnership to improve the lives of those with behavioral health challenges. To be able to focus on appropriate care, providers must work the SMO in an efficient and satisfying manner. That means they have to understand how managed care works and have confidence in the processes. In addition to the tools and trainings mentioned above, Cenpatico will proactively monitor transaction submissions post go live to identify providers who are struggling with the system. If we notice specific provider transactions are consistently being rejected a Provider Coach will work with the provider to identify the problem and get it corrected. At Cenpatico, we know providers should be spending their time solving clinical challenges not administrative problems.

2.e. Network Management
x. Describe how the Proposer will develop service alternatives to unnecessary inpatient utilization for children and adults, including those with addictive disorders. Discuss strategies the Proposer has used to develop services that divert individuals from non-medically necessary inpatient care, decrease length of stay, and prevent readmissions. Discuss the approach for developing service alternatives including:
(a) Input from the Proposer's CM and UM staff;
(b) Input of individuals, families and system stakeholders;
(c) Establishment of priorities for network development;
(d) Assessment of current provider capabilities; and
(e) Collaboration with DHH-OBH in plan development.
Suggested number of pages: 5

Cenpatico has extensive experience developing recovery-oriented service alternatives to reduce the reliance on inpatient utilization for children and adults, and assist them to live successfully in their local communities. We understand that family-based and community services are critical to helping people recover from mental health and substance use disorders and develop resiliency.

Developing Service Alternatives

We have learned it is important to begin Network transformation with a thorough analysis and a formal plan. We will accomplish this by developing an Annual Network Development Plan. Development of the Plan involves a ten step process. Our organizational structure includes Network development staff dedicated to ensuring the plan is completed, executed, and monitored effectively. ***Step1***: We will complete a thorough ***GeoAccess analysis*** of all contracted service providers, services available in the Network and location of services. ***Step 2***: We will obtain peer, family, child/youth, stakeholder, and community input. We will conduct ***community forums*** throughout the state that include stakeholders, youth, peers, families, and community members and obtain their input about service needs and issues they are experiencing in their local communities. We will form ***Stakeholder, Peer and Family, Child/Youth, and Provider Advisory Boards*** to advise us about network development efforts and give us regular feedback and input about service needs. ***Step 3***: We will collect network development recommendations from our ***CM, UM, customer service and provider relations staff***. Staff identifies Network needs by maintaining a database of network needs and participating in the Network Adequacy subcommittee of the Quality Improvement Committee (QIC). ***Step 4***: We will develop a ***Network Development Work Plan*** based on the information gathered in the first four steps. ***Step 5***: We will ***update and revise the Plan*** based upon final input from the State, the Boards identified in step three, our local QIC, and executive management team. ***Step 6***: We will gain ***final approval of the Plan*** from the State. ***Step 7*****:** Our Network Development staff will identify providers to develop new services as identified in the Plan and collaborate with each provider to develop a Program Development Work Plan (provider work plans). The provider work plans will include clearly defined goals, objectives, Evidence-based Practice (EBP) upon which the service or program is being developed, action steps, time lines, and responsible parties. Our staff will monitor the plans monthly; provide technical assistance as needed to ensure the plans are being implemented as written. ***Step 8:*** Our Network Development staff will conduct fidelity reviews with providers to be sure the plans are being executed as written and programs and services are being delivered consistent with the EBP identified in the Plan. ***Step 9*****:** Our Network Development staff will review the Plan updates monthly through the Network Adequacy Committee, and quarterly with the QIC, Executive Team, and the State. ***Step 10*****:** We will celebrate successes. We believe the celebration of successes instills hope and is a great motivator for future successes. We will conduct celebration exercises for each new program or service developed, inviting stakeholders, members, State agency staff and local community representatives to attend.

Strategies Used to Develop Alternative Services that Divert Persons from Non-Medically Necessary Inpatient Care, Decrease LOS, and Prevent Readmissions

We have become known for our creativity in developing alternatives to inpatient care, decreasing LOS and preventing readmissions.

Crisis Team Development Strategies: A key element of our approach to reducing non-medically necessary inpatient care and preventing readmissions involves our centralized crisis system. Through our crisis line, we monitor bed availability and admissions to inpatient settings. We monitor requests for hospital admissions, including readmission, through the crisis line and ensure alternative services have been considered. We dispatch crisis mobile team providers 24/7 to address crises in the community and implement alternative community based services at the time of the crisis. In Arizona, we have expanded the availability of crisis mobile teams to ensure each community is adequately covered. We have developed effective working relationships with each community emergency department and first responder agency to identify alternatives to inpatient care and facilitate the development of protocols that reduce reliance on EDs and first responders to address MH/SUD crises.

Adult Mental Health Service Development Strategies: We have worked with providers to develop 24/7 Support and Rehabilitation Services for high need adults, known as the Road to Recovery program. The Road to Recovery Program provides intensive community-based services that prevent the need for inpatient care and allow our care managers to facilitate reduced lengths of stay. In addition, we implemented Adult Recovery Teams (ART) to facilitate recovery-oriented service planning. We train all our providers in the appropriate facilitation of Adult Recovery Teams (ART). The ARTs have learned to develop effective community-based, individualized crisis plans that have reduced inpatient admissions and readmissions. We also worked with a residential provider to develop a 24/7 Crisis Brief Intervention Program (BIP) to prevent unnecessary inpatient admissions and readmissions. The program provides a safe supervised environment for an adult to live for a few hours to several days, giving the ART time to address the cause of the crisis. The staff at the BIP is trained in crisis stabilization techniques, conflict management, suicide prevention, and family therapy. The BIP provides stakeholders, families and crisis teams an alternative to inpatient care that supports recovery and help members learn how to manage stress and life crises. The BIP also serves as an inpatient step-down option for members who are not quite ready to return to the community, reducing inpatient lengths of stay. Finally, we worked with a provider to develop a 24/7 Crisis Living Room staffed by professionals and peers. The Living Room provides a home like environment where adults can go to receive immediate help, advice and support in overcoming a crisis. The Living Room can be used as often as needed to help adults learn how to manage life crisis and prevent them from escalating into life-threatening situations. The Living Room has helped reduce inpatient admissions and readmissions.

Adult Substance Abuse Disorder Services Strategies: In AZ, we significantly expanded the availability of community-based alternatives to inpatient SUD treatment. By conducting community forums, we learned that EDs and Police Departments were spending a disproportionate amount of time responding to members with SUDs. As a result, we added four new strategically-located ***Community-based SUD Recovery Centers*****:** These centers provide 24/7 access to SUD assessment and treatment. They offer a "no wrong door" approach to SUD treatment. Police, families, and stakeholders are able to drop people off even while under the influence of alcohol or other substances. The facilities provide outpatient counseling, intensive outpatient services, Opioid treatment and social detoxification services. A key component of the programs is the extensive use of peers in the programs. Peers with the "lived experience" of substance addiction and recovery have proven to be incredibly effective at engaging people into care and helping them on the road to recovery. The Peer Support Staff also go into the community and work with persons suffering from SUDs and their families to help engage people into care. These programs have significantly reduced the number of people using EDs and inpatient facilities for SUD treatment and have reduced readmissions related to SUDs. We also developed Peer Run Re-entry services to promote recovery and offer community-based alternatives to inpatient SUD services. We worked with The Living Center (TLC), a peer operated organization, to develop community-based

support and rehabilitation services for adults with SUDs. This program provides housing support, peer support and employment support services to persons with MH and SUDs .

Child/Youth Services Strategies: In Arizona, we developed wraparound service providers to provide 24/7 rehabilitation and support services to high need children. These providers have been trained to provide "whatever it takes" to ensure the child/adolescent can live successfully in the community and avoid out-of-home placements, including unnecessary inpatient services. In addition, we work with providers to develop two crisis BIPs for children and youth. As in the adult model, these programs provide 24/7 access to crisis stabilization services in a residential environment. Staff is trained in family therapy, crisis stabilization, conflict resolution, behavior management, and suicide prevention. These facilities offer stakeholders, families and crisis teams a safe and supportive environment for children/adolescents to live, giving the Child and Family Team time to develop a plan to overcome the crisis. They also create an opportunity for all parties involved in the child/adolescent's life to come together to overcome the crisis and help the child/adolescent and family develop resiliency skills. In addition, we worked with a provider to develop an Assessment and Intervention Center (AIC). The Center provides a residential setting for a child/adolescent to receive a comprehensive psychological, psychiatric, and behavioral analysis evaluation. The child/adolescent remains in the facility for about two weeks to allow the professional team adequate time to observe behaviors, apply interventions, and finalize recommendations. The AIC team analyzes the child/adolescents symptoms and behaviors and develops a plan describing what is necessary for the child/adolescent to live successfully in the community. The recommendations are given to the child and family team (CFT) for follow-up upon discharge. The focus of the AIC is determining what is needed for the child to be successful in the community. The AIC is ideal for addressing behavior problems, which historically result in repeated inpatient admissions, and multiple out-of-home placements. Both the BIP and AIC provide step-down options for children/youth in inpatient settings who may not be ready to return to the community, reducing inpatient lengths of stay.

Youth SUD Strategies: Both the BIP and AIC are used to provide short term crisis stabilization for youth using substances. The AIC is most often used for Youth with co-occurring disorders involving substance use. The AIC is particularly adept at identifying and addressing behaviors associated with SUDs, separating them from symptoms and behaviors associated with MH disorders, and developing a plan to address both sets of disorders. The BIP for youth provides an environment to facilitate social detoxification and bring together all parties involved in the adolescent's life to develop an effective treatment strategy. We have worked with all our outpatient providers to ensure outpatient SUD programs are based on EBPs, including Seven Challenges, Matrix , CBT, and CRAFT. The table below demonstrates our success at reducing inpatient utilization for adults and children in Arizona:

	FY 2009	FY 2010	% Change
Adult SubAcute BDs/1000	366.3	330.8	9.7%↓
Child/Adolescent Acute BDs/1000	271.7	211.9	22.0%↓
Child/Adolescent RTC BDs/1000	1143.5	613.2	46.4%↓

Approach to Developing Service Alternatives

We will institute a collaborative and transparent approach to developing alternative services to reduce unnecessary inpatient care, readmissions, and lengths of stay.

(a) Input from the Proposer's CM and UM staff: Our Care Managers will facilitate effective communication among all members of the treatment team in order to ensure a collaborative and coordinated approach to treatment for each member. We will encourage creative problem solving and identification of services including the use of natural supports. These teams will ensure that all community-based options are explored before requesting inpatient services. Our CM and UM staff will provide technical assistance to treatment teams to ensure appropriate discharge planning and reduced lengths of stay. Prior to discharge, a crisis plan will be developed along with a safety plan, if needed. The purpose of the crisis and safety plans will be to allow the individuals/care takers to identify triggers leading to readmission and share them with trusted family members and friends in an effort to prevent additional readmissions to inpatient settings. By performing their duties, our CM and UM staff will have an intimate knowledge of the availability and effectiveness of community-based alternative services and the need for additional alternative services. ***A record of unmet service needs will be maintained*** and shared with the Network Adequacy subcommittee (NAC) of the QIC monthly for review and action. In addition, the UM department will provide inpatient admission, LOS and readmission utilization data and community-based service utilization data to the NAC for analysis and review.

(b) Input of individuals, families, and system stakeholders: As described above in our ten step process for developing alternative services, we will seek the ongoing input of individuals, families, and system stakeholders regarding the availability, effectiveness and need for alternative community based services. We will obtain continuous feedback and input through community forums and advisory boards. We will meet with peer and family advocacy groups and organizations to obtain their input and recommendations. We will also seek the input of system stakeholders at all levels including, state agency department administrators, regional administrators, local administrators, and direct service staff. Their feedback and recommendations will be tracked by and reported monthly to the Network Adequacy subcommittee of the QIC for review, analysis, and action.

(c) Establishment of priorities for network development: Our process to establish priorities for network development will be collaborative and transparent. As explained above in our ten step process for successful network development, we will gather input regarding the need for additional community-based services from all constituencies identified in this response. We will also review GeoAccess data, inpatient and community-based services utilization data, and regional and cultural differences. Our Network Development staff will collect these data and report them in the Network Development Plan. The plan will also include an analysis, findings, and recommendations. The plan will include a review of system goals, articulate the priorities for network development, and explain the rationale for the recommended priorities, including priorities and rationale for establishing the priorities for developing community-based alternatives to inpatient care. In addition, the plan will identify regional priorities based upon regional and cultural differences. The priorities will clearly address the mental health and substance use disorder treatment needs of each unique population. The plan will be shared with all constituencies outlined in this response for review and feedback, and will be developed in collaboration with DHH-OBH. Once the final plan and priorities are approved by DHH-OBH, the QIC, and the Executive Team, a Network Development Work Plan will be established to clearly identify objectives, action steps, responsible parties, timelines, and measureable outcomes. The Work Plan will be used to guide and monitor progress in meeting the priorities established through the Network Development Plan.

(d) Assessment of current provider capabilities: We will meet with each major provider of services to build a collaborative working relationship, learn about their business plans, and explore opportunities to expand the availability of community-based alternatives to inpatient care. As part of our Annual Network Plan, we will analyze the current network of providers, obtain details about their service locations,

services provided, staffing patterns, community-based services, specializations, and programs provided. The Cenpatico CEO, COO and Network Management Administrator will meet regularly with providers to explore their interest and capacity to develop new community-based alternatives to inpatient care. We will offer new contracts or amendments to existing providers who express interest, have the financial resources, and demonstrate the capacity and ability to develop and expand community-based alternatives to inpatient care in each region. In addition, we will outreach to peer- and family-run businesses to encourage them to consider developing peer operated community-based services.

(e) Collaboration with DHH-OBH in plan development: We will seek approval of the Network Development Plan from DDH-OBH and make changes and additions based upon requests and recommendations from DDD-OBH. We will develop the Network Development Work Plan in concert with DDH-OB and will meet with DDH-OBH at least quarterly to review the Work Plan. The quarterly meetings will provide a forum to report progress, identify barriers and challenges, discuss changes, brainstorm solutions, and celebrate successes.

2.e. Network Management
xi. Describe how the Proposer will operate and maintain sufficient qualified service providers to ensure culturally-appropriate services, including outreach, engagement, and re-engagement of the Latino, African American, Vietnamese, Native American and other minority populations and delivery of a service array and mix comparable to the majority population within each region.
Suggested number of pages: 3

Using Data to Ensure Network Sufficiency

Cenpatico's credentialing process includes detailed questionnaires providers are required to complete so that we can assess not only their specialties and modalities but also capture their ability to speak languages other than English, including American Sign Language, and determine handicapped accessibility of their service location(s). This enables us to appropriately refer enrollees to the most appropriate provider based on their cultural and linguistic needs. The data we capture through the credentialing process is reportable and included in our provider directory so that enrollees can make the most informed decision when selecting a service provider. Each LGE, HSD/HSA, WAA and CMHC will be required to include a provider roster as part of their credentialing application which includes these data elements.

Understanding the Culture of Diversity

Cenpatico understands that language is only a part of what should be considered when providing services that meet cultural and linguistic needs of the populations we serve. Cenpatico has a robust provider training program that includes required cultural training for all provider staff. These trainings help staff understand the importance of cultural awareness in treatment, including outreach efforts, to bring enrollees into care and to engage them in treatment. When an enrollee is disengaged in their treatment, culturally sensitive re-engagement will ensure their return and success in their treatment program. Although Cenpatico has cultural training that focuses on cultural norms for specific race and ethnic populations, our program includes additional cultural trainings such as LGBTQ (Lesbian, Gay, Bi-sexual, Transgender and Questioning) training, the Culture of Poverty, and training on how to work with those who are blind, deaf or hard of hearing.

Cenpatico expects all provider agencies to do outreach and have engagement and re-engagement activities and protocols, but Cenpatico also has staff that will provide outreach and engagement activities in the communities we serve. We review census information for each community and monitor penetration rates to ensure we are targeting the underserved and most vulnerable populations so they, and the community agencies who work with them, know how to get access to our services. Cenpatico utilizes a multi-prong approach from our staff, and we work with our providers, to use print materials, video, community outreach as well as social media efforts to reach as much of the community as possible. We work to get the message of our services not only to those who need treatment, but to their friends and family members, with information on how to encourage those close to you to seek treatment and who to contact for help.

Our Mental Health First Aid (MHFA) Initiative helps to train community members on how to recognize when a person needs assistance, how to approach them, and the information they can share to get into services. This effort has helped with stigma reduction in many of our other markets, as well as nationally, as reported by the National Council for Community Behavioral Healthcare (http://www.thenationalcouncil.org/).

Cenpatico's member services staff will make presentations throughout the community to explain the MHFA Certification training and discuss how to sign up for training. These presentations are done in a manner that presents MHFA certification similar to CPR, so that the community understands it is training for the layperson on how to recognize symptoms of a mental illness or crisis and what to do once an issue has been identified.

Reaching Out to Louisiana's Diverse Communities

Cenpatico will identify natural supports for the member such as family members, religious and spiritual resources, culturally specific clubs, community organizations, and traditional healers. The purpose would be to promote natural integration into the community, develop relationships with community resources that could actively aide in member's acceptance of appropriate care, and decrease isolative behavior.

Cross-system alliances would also be built where appropriate. For example, relationships with the corrections system and juvenile justice would be fostered in the case of substance abuse disorders or crimes committed through mental illness and/or cultural differences.

Cenpatico recognizes the sub-populations of a culture that warrant special attention. For example, this may be members withdrawn from the community due to trauma and not receiving needed care or members with multiple hospital admissions. In these cases, particular cultural expertise is acquired in greater depth and shared, where appropriate, with the member, the member's family, and the providers. The object is true cultural integration into the health care system in general in order for the member to accept and benefit from treatment.

As an example, we take the Vietnamese population. Non-compliance with treatment could be a misunderstood issue here. We would need to inform providers that psychiatrists are referred to as *bac si tam than* translated literally as "doctors who treat madness." People seeking treatment are considered impulsive, wild, and potentially dangerous. Families can believe that the member is possessed by angry ancestors. They will hide the member and deliberately prevent contact with the outside world. Therefore, culturally sensitive family work would be primary in developing mental health access for the member. Spiritual leaders may be accessed to gain support for treatment. Education for member, provider, and family would be actively pursued by Cenpatico.

Recruiting Minority- and Women-Owned Behavioral Health Providers

Cenpatico has an excellent track record recruiting minority- and women-owned behavioral health **providers.** In Arizona, 50% of our intake provider agencies are minority- and/or women- owned or operated agencies. We have provided technical assistance and support to help each of these organizations to grow and develop. We look for persons representing local minority groups in each local community with experience in delivering behavioral health services and a passion for the care and treatment of persons with behavioral health conditions. We help them develop business plans and find creative mechanisms to fund their expansion. We maintain regular contact with them and provide technical assistance though coaching and mentoring. In Arizona, we hired a Business Coach who provides hands on business coaching to assist people in developing their businesses, market their businesses and meet state requirements.

In Arizona, we have helped three Latino organizations to grow and expand their businesses; including Pinal Hispanic Council, Corazon, and Community Intervention Associates. All three organizations have grown significantly since 2005, expanding into additional counties and opening additional offices. All three have become leaders in the market, being among the first to implement full electronic health records, adopt telemedicine and develop new programming geared toward meeting the needs of Latino families.

We will use similar strategies in Louisiana to effectively increase the numbers and access to qualified service providers who represent members' culture and understand the needs of minority populations. We will actively seek out members' preferences through survey, focus groups, and member meetings to inform our network development plan specifically for opening member access and appointment availability to culturally diverse providers.

2.e. Network Management
xii. Describe the Proposer's plan for implementing a statewide network of crisis response providers to serve people of all ages. Provide an example of the Proposer's success in developing, implementing and managing crisis response network providers. **Suggested number of pages: 4**

New markets offer the opportunity to improve all aspects of behavioral health service delivery. Crisis services and the development of a statewide network of crisis response providers is an important pillar of the continuum of behavioral health care. Offering a wide variety of crisis services, such as 24/7/365 crisis phones, crisis mobile teams, case management and crisis respite helps reduce reliance on expensive levels of care such as emergency room use and inpatient hospitalization.

Our Plan for a Statewide Crisis Response Network

Cenpatico's plan for development and implementation of a statewide network of crisis response providers will be to first familiarize itself with the existing crisis community collaborative that consists of community partners available to support and manage behavioral health crises in the local community and connect with these organizations to join the crisis team. We are aware of the 2008 legislation (Act 447) that requires each DHH region to develop and implement a crisis collaborative and we will work with these coalitions to determine service gaps and identify ways Cenpatico can assist. We recognize that crisis services need to be localized to be effective and that our efforts must complement and support existing crisis responders.

- We will participate in or initiate 1st responder crisis meetings in all major communities and draw up mutually agreed upon protocols
- We will expand the Crisis Network and ensure adequate availability of mobile crisis team providers, and alternative community based crisis intervention services.
- We will train crisis providers about how to maximize community based interventions and reduce the use of Emergency Departments
- We will educate staff, stakeholders and behavioral health providers about how to access crisis services in each community
- Cenpatico's call center will include 24/7 access to clinicians who can assist callers in crisis, deescalate situations and if necessary make contact with local first responders. The call center will maintain up to date listings of local crisis response resources to facilitate rapid response when a crisis emerges as well as tracking and trending regarding crisis incidents
- Cenpatico will provide training in Critical Incident Stress Management (CISM), Danger to Self or Others (DTS/DTO) assessments, community-based resolution strategies, family system interventions and recovery principles to effectively respond to crisis situations. Outpatient providers will be trained on the importance of developing a crisis intervention or wellness plan with consumers from the point of first contact.
- We will monitor the use of mobile team interventions and dispositions, hospitalizations, use of community-based diversions, emergency department usage (as available from the state) for trends and opportunities
- We will establish baseline data to monitor progress and ensure effectiveness of interventions to reduce the use of emergency departments and inpatient settings for behavioral health crises.

For the development and ongoing activities, meetings will be scheduled on a monthly basis (if not already ongoing). Meetings will be held in each major community so that unique local needs are addressed. E-

mail newsletters, flyers, and crisis cards will be handed out at each meeting as well as onsite visits to the various organizations to post flyers and cards. Cenpatico will also coordinate media efforts with local newspapers and radio to support awareness of crisis resources within the community and help avoid unnecessary emergency room usage. This process follows the successful implementation of a crisis response network by Cenpatico of Arizona.

Development and Managing a Crisis Response Network in Arizona

We have successfully implemented community-based crisis intervention services that demonstrate dramatic reductions in emergency department visits and behavioral health inpatient hospitalizations. In Arizona, we have implemented community based crisis intervention services in eight counties. Prior to assuming the management of services in these counties, virtually all after hours crisis services were delivered in emergency departments. In order to transform the system, we engaged NurseWise as our 24/7 crisis line, and contracted with providers to develop community based crisis mobile teams (CMTs). NurseWise triages all calls and dispatches the mobile teams to meet the needs of the callers. NurseWise employs Nurses trained to triage medical conditions and reduce the use of emergency department for non-life threatening conditions. ***Eighty-eight percent of all crisis calls are resolved by NurseWise staff without the need for CMT or emergency department services.*** Community based CMTs are dispatched for 11% of the calls received. Less than 8 calls per thousand result in police involvement and less than 6 calls per thousand result in a referral to an emergency department or hospital. We have trained CMTs to avoid the use of emergency department except when clear life threatening conditions are present. We have trained outpatient behavioral health providers and primary care physicians how to access CMT services and educated them about the merits of using CMTs for behavioral health crises. CMTs respond to crisis situations in emergency departments as well, actively working to make alternative arrangements for members with urgent behavioral health needs and reducing the length of time waiting in emergency rooms. In addition, we expanded the availability of community based crisis services as alternative to emergency departments and inpatient admissions. We also expanded the use of social detoxification centers to provide 24/7 “drop off and walk in centers” for persons with substance use disorders in all major communities. We developed an Assessment and Intervention Center (AIC) for children equipped to address crises and deliver thorough psychological and psychiatric evaluations, complete functional behavioral analyses, and complete a thorough work up of strategies to ensure the child can be returned and maintained in the community. We also developed 24/7 Crisis Brief Intervention (CBI) Programs for children and adults through our residential provider network. These programs provide alternative short term living arrangements for persons in crisis, with the goal of returning them to a community setting as soon as possible. In addition, we developed a 24/7 crisis living room setting for adults which provides a home-like setting for adults in crisis. In order to facilitate all these changes, we participated in or developed local community based 1st responder coordination meetings in each major community. Crisis protocols were developed in concert with first responders in each county. Regular meetings are held with police departments, emergency departments, crisis providers, sheriff departments, county agencies, and court and jail representatives. These meetings have resulted in processes which reduce utilization of EDs, reduce time in EDs, reduce amount and time of police involvement, and improve coordination of care.

Ensuring Adequacy of the Crisis Response Network

Cenpatico will manage and monitor the delivery of all behavioral health crisis services, ensuring the adequacy of treatment access, monitoring crisis response timelines, monitoring the use of emergency rooms, and monitoring the effectiveness of reducing the use of out-of-home placements to address behavioral health crises. The behavioral health network will include crisis stabilization services, and community based alternative services. Our proactive efforts will be aimed at reducing the number of crisis situations by providing access to care in a timely way such that consumers in need of an evaluation or

urgent treatment will be able to immediately access a qualified practitioner. We will evaluate opportunities to enhance the continuum of services by adding Respite or other value added services that can provide alternatives to restrictive levels of care. Our experience in other markets will be brought to bear as we creatively address needs in each service area in partnership with local stakeholders. We believe enhancing mobile interventions will demonstrate immediate positive results as individuals receive timely de-escalation of situations and trips to the inpatient hospital or emergency department are avoided. Each community will have different needs for intervention and we will assess these in collaboration with first responders as well as community partners to determine where gaps exist and generate positive solutions to meet the needs. We will work closely with emergency service providers to ensure they have adequate knowledge of alternatives to hospitalization.

Extensive Training to Crisis Response Providers

We will provide training to emergency service providers, offering training in CISM, DTS/DTO assessments, community based crisis resolution strategies, family system interventions and recovery principles to effectively respond to crisis situations. Outpatient providers will be trained on the importance of developing a crisis intervention plan with members from the point of first contact. Such plans allow members to identify support they find helpful during times of crisis, as well as a list of key triggers and behaviors that have led to a crisis for them in the past. Providers will also be trained in completing Wellness Recovery Action Plans, ensuring that adult members receive the community based crisis services that they want in a crisis situation. All Cenpatico staff has access, through our integrated Case Management System to the member's contact history, crisis plans, WRAP plans, and service plans. This information is invaluable to crisis staff and care managers in assisting members as crises occur and as treatment decisions are made. The clinician can send an electronic reminder to the care coordination team to follow up with the member following the crisis episode.

2.e. Network Management
xiii. Describe the Proposer's provider profiling system proposed for this Contract. List the elements the Proposer will use to profile providers:
Suggested number of pages: 3

The Profiler's System

The Provider Profiling Initiative (PPI) generates quarterly data that identify, at minimum the top 10 inpatient (IP) and top 10 outpatient (OP) providers, as measured by total units of service billed (for all diagnoses, age groups, and service modalities provided). There are actually five (5) reports produced each quarter; one report covers the most recent one-year period for which all needed data (authorizations- and claims-based) are available, and the other four reports are the quarterly breakdowns of the data included in the annual report.

Centelligence™ is our proprietary and comprehensive family of integrated decision support and healthcare informatics solutions. Our Centelligence™ enterprise platform continually integrates and analyzes an enormous amount of transactional data (e.g. claims, pharmacy data and 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. Actionable information used to for profiling and performance improvement includes, but is not limited to, Care Gap and Wellness Alerts, Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population-level health risk stratifications, and standard and ad-hoc desktop reports.

The Profiling Elements

IP: Admission Rates, Average Length of Stay (ALOS), Denial Rates, Readmission Rates, Rates of Outpatient Follow-Up within 7 Days of Discharge from Inpatient Events, Evidence of Utilization of Evidence-Based and/or Empirically-Supported Approaches to Treatment, and Quality Assurance Activities and Reports (number of adverse events, Levels 1-4 Quality of Care Reports and Interventions [including Corrective Action Plans (CAPs), and number of Complaints Received and Resolution].

OP: Average Length of Treatment (ALOT), Evidence of Utilization of Evidence-Based and/or Empirically-Supported Approaches to Treatment, Rates of Outpatient Follow-Up within 7 Days of Discharge from Inpatient Events, and Quality Assurance Activities and Reports (number of adverse events, Levels 1-4 Quality of Care Reports and Interventions [including Corrective Action Plans (CAPs), and number of Complaints Received and Resolution].

(a) Indicate if the profiling elements will differ by provider;

The profiling elements will not differ by provider, but rather by service type (IP or OP).

(b) Describe the process for collecting accurate baseline data that engenders provider confidence and the time table for development of accurate baseline data; and

The process and time table for collecting accurate baseline information will be to compile one full year of data that includes all of the profiling elements listed above. Cenpatico will then calculate an aggregate average performance score for each profiling element, identify upper and lower control limits (where applicable) at no more than three (3) standard deviations above and below the average.
The averages will then be compared to the established Cenpatico Benchmarks (developed in accordance with historical utilization data trends in Louisiana and other markets, accepted standards of care, and that were approved by the Cenpatico Medical Director and Provider Advisory Committee) of: ALOS, 5 days or less for TANF-type populations and 7 days or less for SSI- or ABD-type populations; Denial Rate, < 10% for all populations; and, Readmission Rate, <10% for TANF-type populations and <20% for SSI- or ABD-type populations. Seven-Day (7-Day) Follow-up Benchmarks will align with the accepted HEDIS requirements for the market and populations served.

The use of standardized statistical processes for establishing the baseline will allow Cenpatico to identify the spread of performance across each profiling element, identify outliers, and establish meaningful, provider-specific performance targets. Cenpatico will conduct annual testing for statistical significance in decreases and increases in performance, and will conduct Analysis of Variance (ANOVA) activities to assess variations in provider performance.

Cenpatico will engender provider confidence by training providers on the profiling elements and processes. Training will allow providers to replicate our methodologies if they choose, and thereby conduct internal data validation. Cenpatico will also conduct routine data validation activities on each profiling element, and ensure front-end system edits to maintain consistency and logic for all administratively collected data. Profiling data will be presented to providers in dashboard and scorecard formats for ease of use and comparison. All raw data used in the profiling calculations will be included with the dashboard and scorecards.

Cenpatico developed the ***Preferred Provider*** Program as a means of incentivizing providers to meet or exceed the established benchmarks for the various key indicators. Providers that demonstrate service excellence, as determined by the quarterly PPI reports relative to established benchmarks, are eligible to become Preferred Providers. Inpatient Preferred Providers are authorized an established number of covered days for each behavioral health admission without undergoing the complete Cenpatico medical necessity intake review process; review for Preferred Providers begins only when the requested length of stay for an admission exceeds the established threshold.

In terms of the relevant components of our integrated Management Information System (MIS) that we employ for the systematic collection, validation, integration, management and analysis of requisite data needed for profiling, please see Sections 2.g.iv and 2.g.xii for details on our Centelligence™ data integration, informatics, and reporting platform.

(c) Include a description of the parties who will have access to the provider profile and how the information will be utilized. Describe how the Proposer has used provider profiles for other public sector BH managed care contracts.

The data are utilized to make comparisons from quarter-to-quarter and year-to-year on how providers compare to other like-type providers in the market; and, how those providers respond to quality improvement outreach efforts undertaken as a result of the profiling data. The de-identified data are distributed to each of the profiled providers, and follow-up telephonic and on-site meetings between key provider staff and Cenpatico leadership are convened in order to dialogue with providers on interpretation of the data and how the service delivery network can be improved to enhance service collaboration and improve quality of care. The data are also made available to all relevant Cenpatico staff (e.g., in the departments of Utilization Management, Network Development, Quality Improvement, and Compliance) in order to plan additional targeted outreach and quality improvement activities.

The Profiling data will also be used to engage providers in discussion regarding how their approaches to care and service utilization trends are reflective of, or can help facilitate, a service delivery model that is driven by the needs and priorities identified by the members and/or their families. Cenpatico endorses utilization of a Wraparound approach to treatment that focuses on families' strengths instead of deficits; identifies and enlists all available natural supports within the family and/or community in the development and implementation of an individualized, evolving, and comprehensive array of services tailored to each member's or family's individual needs; and, helps members and their families expand their problem-solving skill sets, their capacities for resiliency in the face of future challenges, and their abilities to achieve a greater sense of self-sufficiency and independence.

Cenpatico will utilize at least three methods of provider monitoring to measure compliance with a service delivery model that is inclusive of input from members and their families/caregivers. The first method is the Utilization Management Department's medical necessity review of Outpatient Treatment Request

forms (OTRs) submitted by providers. All OTRs are reviewed for connectedness between the members' presenting problems (as reported by the member or family/caregiver), the diagnoses, the identified S.M.A.R.T. goals (Specific, Measurable, Attainable, Realistic, and Time-Limited) that will be the focus of treatment, the specific modalities and interventions that will be used to achieve those goals, and the objective criteria that will be used to assess what progress has been made and/or how the approach to care will be modified in order to facilitate progress. Cenpatico will make outreach calls to, and conduct telephonic and on-site trainings with, providers to learn what approaches to care are being utilized, how they align with evidence-based and/or empirically-supported treatment, and how they might be modified to align with a family-driven, outcomes-oriented approach to care.

A second monitoring activity will be on-site chart audits. A standardized tool is used to conduct chart audits, and it includes specific questions regarding whether the provider has identified the member's support systems, has identified the member's strengths, has educated the member about their diagnosis and the ensuing treatment plan, and whether the member and/or family is in agreement with the plan (as evidenced by their signature on the treatment plan).

Another way is to monitor the utilization data for any potential disconnect between a provider's stated approach to treatment and the guidelines for that approach as it relates to frequency of services over the course of treatment. (The National Wraparound Initiative, for instance, publishes *The Wraparound User's Guide: A Handbook for Families*. The Engagement, Planning, Implementation, and Transition phases described in the handbook describe an expected decrease of service frequency over time, a titration of services, leading to discharge.) Providers that purport to use Wraparound principles and treatment guidelines should demonstrate a similar decrease in service frequency over time, which would be reflected in their claims-based utilization data

One example of how Cenpatico has used PPI data to improve services is the Georgia *Strengthening Families Program* (SFP) Pilot Program. Through its PPI efforts, Cenpatico identified numerous community-based services providers in Georgia that were delivering care that did not appear to reflect a consistent and planful approach to treatment. The providers had required continuous “shaping,” feedback, and even medical necessity denials due to inappropriate requests and/or excessive lengths of treatment. In many cases, there was little or no significant amelioration of symptomatology and/or improvement in member functioning. Also, many providers were struggling to generate realistic and measurable community-based treatment goals and discharge criteria, and could not articulate a clear model for their practice.

The over-arching goal of the SFP Pilot was to engage providers in a way that would improve their treatment practices and equip them to deliver evidence-based care. In November 2009, Cenpatico selected three providers in the Georgia market that were utilizing large amounts of community-based services (e.g., in-home community support) with comparatively small amounts of co-occurring behavioral health therapy. Cenpatico contracted with Lutra Group, Inc., the sole authorized source for SFP staff training, to provide a two-day on-site training for SFP service development and delivery to the three identified Pilot providers.

Results from the first Lutra Group SFP Georgia Outcomes Report stated, "The children enrolled in the SFP Pilot at two Atlanta sites had significant behavioral and mental health problems that were almost twice as severe as those children who generally participate in SFP, resulting in a particularly high-risk population and therefore appropriate for the SFP intervention... 100% of the five family change variables were improved significantly." The report also stated, "Hence, it appears that the SFP programs are having a dramatic impact on the overall family environment, beyond that found normally in other SFP sites nationally. This is a very positive effect and a tribute to the Cenpatico strategy."

2.e. Network Management
xiv. Describe at least one (1) goal, measureable outcome and strategy from another client state where improvements in the availability of and member engagement in culturally appropriate services occurred. Also, describe one (1) strategy that did not result in positive change and the Proposer's understanding of why this strategy was not successful. **Suggested number of pages: 3**

Cenpatico has significant experience improving the availability of and member engagement in culturally appropriate services.

Our Goal: Services to American Indian children/youth and families will be tailored to the unique needs of the individual child/youth, family and tribe and provided in the least restrictive environment, in a timely fashion and in accordance with Best Practices, while supporting and respecting the child's and family's cultural heritage.

Measurable Outcome: By the end of the contract year, American Indian children/youth and families will experience an increase in family-based and community services as evidenced by an increase in direct support services provided to American Indian children/youth and families, and American Indian children/youth and families will report satisfaction with family-based and community services.

Our Successful Strategy

In Arizona we implemented a program called "Meet Me Where I Am" (MMWIA). The program provides family-based and community support and rehabilitation services 24/7 to children/youth and families at risk of out-of-home placement. We adapted the program to be more culturally-appropriate to serve the American Indian community and address the unique cultural needs of American Indian children/youth and families in Arizona. About 50% of enrolled American Indian children/youth live on reservation in Arizona. We wanted to help this population receive culturally-appropriate services while remaining within their own community. In addition, we wanted to help children/youth who do not live on reservation be able to connect with their Tribe and their cultural background. We also wanted to make sure we were responsive to the specific cultural diversity present within the Arizona American Indian community. The initiative has focused on expanding the availability of culturally appropriate, family-based and community services for the express purpose of helping American Indian children live successfully in their own communities. The services were designed to be flexibly tailored to the unique needs of each child/youth and family. In addition, we worked with our providers and each local Tribal community to create a tribe-specific, culturally-competent service plan for each child.

Our strategy involved 3 components: 1) Collaborative Provider, Family, Youth, and Tribal Community and Stakeholder Relationships, 2) Transformation through Collaborative Work Plans and Provider Coaching, 3) Monitoring Provider Performance.

Collaborative Provider, Family, Youth, Tribal Community and Tribal Stakeholder Relationships: Implementation of the Meet Me Where I Am (MMWIA) Initiative for the American Indian Community began with the formation of a steering committee to develop the cultural aspects of the initiative. The committee consisted of the Cenpatico Tribal Liaison, provider agency staff, key Tribal system partners (Tribal Behavioral Health, Tribal Child Protective Services, and Tribal Social Services), and Tribal community members. Meetings were held bi-weekly during the initial planning stages. The Tribal Liaison coordinated and facilitated the steering committee, promoting family voice, and working collaboratively to review progress and address challenges. Kick-off events were hosted by Cenpatico to get the initiative underway. Youth, family members, provider agency staff, Tribal and other system partners, Cenpatico leadership, and interested community members attended. These events provided an overview of the vision, goals, and strategies of the initiative, and highlighted the benefits of providing culturally responsive, individualized, and flexible support and rehabilitation services to American Indian children/youth and families.

Transformation through Collaborative Work Plans and Provider Coaching: Each provider was required to develop an implementation plan. We required all provider staff to complete American Indian Cultural Competency training. Training was required regarding *evidence-based treatment and interventions* for American Indian children and their families; including, "White Bison's The Medicine Wheel", and "12 Steps for Native Youth". We also required providers to complete training in coordinating care with Indian Health Services and Tribal 638 facilities. We monitored the completion of the training through our web-based training system, Essential Learning. We also provided ongoing training opportunities to increase the skill and knowledge of provider staff to effectively deliver culturally-responsive behavioral health services. Ongoing training opportunities have included additional Best Practices, including: "American Indian Strengthening Families Program", "Positive Indian Parenting" and "Fatherhood/Motherhood are Sacred". Outcomes were measured through the use of youth/family satisfaction surveys. Our Provider Coaches met at least twice a month with each provider to provide technical assistance.

Monitoring Provider Performance: Our provider coaches and program development staff will be monitoring the initiative through the use of CFT practice reviews, chart audits, program audits and provider performance monitoring. We will monitor the implementation plans monthly. To further ensure integrity to the initiative, we will implement fidelity audits, involving a thorough review of provider agency implementation plans, organizational charts, program descriptions, and job descriptions. The audits will be conducted quarterly, and involved a review of medical records, and interviews with clinical staff, direct support staff and program managers. The Tribal Liaison will work with the Tribal Steering Committee to develop a fidelity audit tool that measured the quality of services, and ensured all cultural elements of the initiative were fully implemented. Providers will be given technical assistance and corrective action letters as appropriate to keep the initiative on track.

Outcomes

Cenpatico has successfully completed the engagement phase of this initiative. Through dialogue and collaboration with tribal leaders and providers, Cenpatico has established Letters of Agreement with all six Tribal Nations in our region. These agreements have enabled Cenpatico providers to deliver services on tribal lands, and increased the amount of services delivered to American Indians. Our engagement efforts have helped providers to more effectively engage tribal members both on and off the reservation. Cenpatico has received positive feedback from various community members and tribal stakeholders that have participated in the development process. The application of project management strategies and ongoing and frequent provider coaching has made the engagement phase of this initiative successful.

Unsuccessful Strategy

Recognizing the importance of service planning in the delivery of culturally-competent services, we embarked on a campaign to improve provider chart audit scores related to culturally-competent behavioral health service planning. Our strategy was to make it a contract requirement that providers reach an 85% acceptable chart audit score, provide specialized training to provider behavioral health professionals, conduct regular chart audits, and provide technical assistance to provider clinical directors regarding internal chart verification processes. We implemented all four strategies over the course of a year and did not see a remarkable improvement in audit scores. The scores failed to improve despite contract requirements, despite completion of training requirements, despite giving providers consistent audit results, and despite assurances from provider clinical directors that processes were in place to improve scores. Youth/family satisfaction surveys also indicated dissatisfaction related to service plans, including cultural-specific activities.

Lessons Learned: What we learned is that a strategy based solely on training, auditing charts, consistently providing audit results and reviewing provider processes will not be successful. It is ineffective to assume providers are appropriately executing processes to ensure the maintenance of quality documentation, even when they express the best of intentions. Without careful monitoring of

provider processes with meaningful consequence, clinical documentation often deteriorates and service planning becomes lax. We have learned that we need to conduct consistent monitoring to ensure providers have procedures, processes and practices in place to consistently monitor the timeliness, accuracy and cultural-competency of service plans. We also learned that since it takes several months to recognize an improvement or recognize deterioration in service planning audit scores, providers must put in place a real time monitoring process to ensure service plans are completed timely and accurately and represent culturally-competent service planning. We now understand that we need to conduct consistent monitoring to ensure providers have appropriate procedures, processes and practices in place to consistently monitor the timeliness, accuracy and cultural-competency of service plans. We have also learned that our monitoring of provider documentation verification and correction processes must include a detailed audit of every step in their process. Failure to complete one step in the verification and correction process results in failing audit scores. As an example, if a provider discovers a service plan is out of date or is not culturally-competent and the issue is brought to the attention of a clinical supervisor and the clinical supervisor fails to appropriately act on the information, the service plan will not be corrected and the provider's verification and correction process will have failed. As a result, we have learned that we must consistently audit every step of provider's verification and correction processes to ensure they are effective. Data obtained in our monitoring process needs to be transparent and shared regularly with providers in order to assist them in making rapid adjustments in their processes as part of an ongoing quality improvement process. We have also learned that we cannot assume that provider processes will remain in place once established. Staff turnover and conflicting provider priorities often interfere with the administration of quality monitoring. We have learned that we need to regularly audit provider internal documentation verification and correction processes to ensure they are in place, operational and effective.

2.e. Network Management
xv. Describe the strategies the Proposer will use to facilitate BH provider, PCP, DCFS, OJJ, DOE and OSH collaboration other than at the individual case level. Describe the Proposer's experience in at least one (1) example of collaboration including the actions and strategies taken and results. **Suggested number of pages: 3**

We have a solid record for developing and maintaining collaborative working relationships with stakeholders and providers. We understand that collaborative relationships with stakeholders and providers are critical to developing and maintaining effective systems of care. We are committed to providing stakeholders, providers, members, and families an equal voice and participation in policy formation and program development. We encourage and facilitate provider and stakeholder involvement through formal meetings, advisory boards and personal interactions. We will establish four advisory boards to advise the company: a Stakeholder Advisory Board, Provider Advisory Board, Youth Advisory Board, and Peer and Family Advisory Board.

Stakeholder and BH Provider Advisory Boards

The Advisory Boards will be co-chaired by the CEO and a Board representative. The Boards will meet quarterly to provide guidance and feedback regarding the SMO and the system in general. We will present aggregate system performance data to the Boards, including network adequacy, access to care, quality measures and outcomes. We will use the meetings to identify barriers and system issues that need to be addressed. We have developed these Boards in other markets. We find they are invaluable to identify barriers and problems early before they become difficult to overcome. The Boards advise us regarding policies, and programs and changes that need to be made in the system. Stakeholder Board Members advise us about State, agency-specific initiatives and opportunities for collaboration. Agendas and minutes of Board meetings are maintained and recommendations are tracked through work plans.

Stakeholders Collaboration

We will recruit and maintain staff to serve as stakeholder liaisons. Liaisons will be assigned to DCFS, OJJ, DOE and OSH. These liaisons will be required to attend regularly scheduled stakeholder meetings, and meet with stakeholders at the State, district and local levels to ensure communication channels are open. The liaisons will be empowered to troubleshoot local and agency-specific concerns. The liaisons will meet with stakeholders to bring issues, barriers, and concerns back to Cenpatico for review and resolution. They will provide training about the BH system to stakeholder staff. This personal touch gives stakeholders someone to call when issues emerge. In Arizona, we developed a Stakeholder Issue Resolution Tracking System (SIRTS), which tracks issues to ensure they are resolved timely and completely. The system tracks the issue until the stakeholder confirms the resolution is complete. When a stakeholder alerts the liaison to an issue, the liaison immediately begins working with the appropriate staff at Cenpatico to facilitate a resolution. All meetings with stakeholder staff culminate in a write up of the content of the meeting, any barriers that need to be addressed, any kudos received or given, and the date and time of the next meeting. This information is added to SIRTS. Cenpatico offers to host most meetings, providing an agenda and meeting minutes, to alleviate the stakeholders of this responsibility. Issues are not considered resolved until the “loop has been closed” and the stakeholder is satisfied with the outcome. System issues are taken to various Cenpatico departments or committees for resolution. System issues often require a root cause analysis and a plan to address the systems issue. Quality checks are then completed to ensure the system issue has been resolved. In a recent Arizona meeting held with Child Protective Services (CPS) , CPS

identified an issue with a provider that was not providing timely clinical information to CPS. The liaison established and facilitated weekly meetings with CPS and the provider to solve the issue by sharing information and discussing other coordination of care issues. Both the provider and CPS reported the meetings were very helpful and resolved the issue. We will bring SIRTS to Louisiana to ensure all stakeholder issues are recorded, tracked, resolved, documented and verified to be completed. Finally, our liaisons and senior leadership will continually review stakeholder initiatives and goals and look for opportunities to collaborate to assist stakeholders in reaching their goals. We have found that working together to help each other reach our individual and collective goals creates efficiencies and synergies that save States money and provide better outcomes for the persons we serve.

Provider Collaboration

Our Provider Coaches will collaborate with providers to help them work effectively in the system. They will make personal visits with provider agencies to troubleshoot issues, provide training, identify barriers and obtain recommendations for system improvements. They will also assist providers in developing processes that ensure they meet contract requirements, are able to bill services appropriately, and overcome barriers. The Coaches will provide hands on support to providers, ensuring collaboration is occurring between Cenpatico and providers. The Coaches track issues and problems through a detailed, individualized Provider Work Plan. The Plan provides a mechanism to identify, track and resolve issues that are brought to the attention of the Cenpatico by providers, stakeholders and Cenpatico staff. The Provider Coaches create regular opportunities for providers to give feedback to Cenpatico and collaborate to create solutions to problems. The individualized Provider Work Plans ensure issues are fully resolved. We have also learned that it is important for the CEO, CMO, COO and CFO to meet regularly with provider agencies. We will conduct monthly Provider CEO Meetings to create opportunities to identify system issues, share information and problem solve issues. We also will host monthly Provider Clinical and Operations teleconferences with providers to keep providers informed about initiatives, training opportunities and provider expectations. We also will use the calls to identify system issues and problems. Our case management (CM) and utilization management (UM) staff build effective relationships with providers to ensure the system is functioning appropriately to ensure people get the services they need. Our CM/UM staff report issues and problems to our Quality Improvement Committee (QIC) Subcommittees for review and resolution. We also will invite providers to sit on our QIC committee and various subcommittees. We have found their participation on these committees is very helpful in discovering the root causes to problems and identifying solutions. We also will conduct periodic statewide Provider Summits to identify challenges and solutions to system issues.

Personal Interactions

We have learned that effective partnerships are built upon establishing trusting relationships. We strive to build effective relationships by meeting with key stakeholder decision-makers and providers on a regular basis. We expect all of our staff to be Cenpatico ambassadors, demonstrating integrity in all human interactions. Our CEO, the senior management staff, department heads and liaisons will build effective working relationships with stakeholders and providers at all levels. We want to ensure stakeholders and providers feel comfortable calling us with any issues, making recommendations, and asking for our assistance. We follow a “No

Wrong Door" approach to collaboration. Wherever an issue is raised or problem identified, we will ensure the issue or problem will be addressed.

PCP Collaboration

Our Community Liaisons will meet with PCPs throughout Louisiana to ensure they know how to access BH services, and facilitate better coordination of care between BH and PH providers. Cenpatico as a Centene subsidiary, is skilled in building and maintaining relationships with medical managed care organizations and physical health providers. In Arizona, we developed a PCP Training Kit for use by all Medicaid Health Plan Contractors. The kit outlines how to initiate a referral for BH services, along with various resources to assist participants that are in crisis, or experiencing specific BH challenges. We also use the kit to train Health Plan trainers. The trainings have served to streamline the referral process to assist PCPs in accessing BH services for members. We also have worked with BH providers to co-locate with PCPs to make it easier to facilitate referrals for BH services. We have also worked with Medicaid Health Plans to reduce the use of EDs for BH issues by developing protocols, educating BH and PH providers about the appropriate use of EDs and educating members about the appropriate use of EDs. We will bring similar solutions to Louisiana. We will work with BH providers, PCPs and Medicaid Health Plans to expand opportunities to engage Medicaid members into BH services and more effectively coordinate BH and PH care.

Additional Examples of Collaboration

- ***Texas Supreme Court Children's Initiative*** The Texas Supreme Court has established a statewide children's commission consisting of child welfare judges from across the state. These judges serve in "cross-over court" and are involved in juvenile justice and drug court programs. Cenpatico's Director of Foster Care sits on the Children's Commission Collaborative Council – the group of community organizations that touch a child's life. Through this forum, judges ask questions about BH services, medications, processes, and treatment modalities. Most recently, this group has formed a psychotropic medication, education, and technology, crossover court subcommittee to address varying aspects of the child welfare service delivery system. Cenpatico' s representation on this committee has helped Judges understand best practice models, trauma informed care, information about medications and general questions about BH as it relates to abused and neglected children.
- At the local level, Cenpatico is a collaborative council member on the ***Travis County Model Court***. This initiative is a national initiative through the Department of Juvenile Justice. There are less than 13 of these model courts across the country. This model court initiative is a pilot program, ongoing for three years, that focuses on integrating the child welfare judges, juvenile justice judges and all corresponding services and programs. Cenpatico has been invited by the New York Model Court Initiative to participate in a cross-site visit with the San Jose Trauma Informed Care Model Court, to discuss how trauma informed care has been infused into the juvenile and child welfare systems. Through this overall effort, joint treatment team planning now occurs where in the past, there would be two parallel treatment plans. The goal is to leverage resources, share information, reduce duplication of effort and increase efficiency and positive outcomes, all working towards goals of overall stability and safety for children. Cenpatico staff across the state participates in a variety of similar local level taskforces, to include the

Harris County Infant and Toddlers Court Initiative, and the West Texas Crisis Consortium.

- Each month, Cenpatico participates in what is called the ***Joint STAR Health Meeting***. STAR Health is the health care program for children in foster care, contracted through the Department of Health and Human Services. Together, HHSC, the Department of Family and Protective Services, health care providers and Cenpatico staff (representing BH) meet to address policy issues, develop programs, and reduce bureaucracy. Over a three-year period, this group has been extremely successful in transforming many of the ingrained cultural and bureaucratic processes that often impede progress for youth.
- In Yuma Arizona, we helped to create a local Crisis Response Coordinating Committee to reduce the use of EDs for BH issues, reduce police involvement in BH crises and reduce the amount of time police officers were “off the street” addressing BH issues. By creating collaborative crisis protocols, and developing alternatives to ED use for BH issues, we were successful in reducing police involvement and ED utilization for BH issues in Yuma.

2.f. Member Rights and Responsibilities
Describe how the Proposer will assure Members understand and know how to exercise their rights. Include a description of how the Proposer will assure members' rights are recognized and supported by employees and providers. **Suggested number of pages: 2**

Cenpatico has developed innovative, timely, and population-appropriate education and outreach techniques to enhance member awareness and understanding of their rights and responsibilities. We design all of our materials and information to ensure that our members understand how to exercise their rights, including requesting assistance, provider changes, and their benefit package and how to file a grievance, appeal or complaint. We ensure that our member materials are provided in an easy-to-read format of a 5th grade reading level, and are culturally and linguistically appropriate, having resources available in English, Spanish and Vietnamese. All materials are made available both in print and on our Cenpatico website. In addition, we will add additional languages to support changing membership demographics as needed. Cenpatico public websites are Section 508 compliant.

Member Welcome Packet. Member rights and responsibilities are communicated initially during Member Orientation through the Member Welcome Packet. Our Member Handbook describes member rights, responsibilities and protections, such as privacy rights and explains helpful information such as how to file a grievance, members' right to a state fair hearing, advance directives and member rights under state law. This information is also available on the Cenpatico website. We distribute the Member Welcome Packet within ten days of being registered or participation in their first covered behavioral health service whichever is first), and when updated in compliance with DHH-OBH requirements. As required by NCQA, member rights and responsibilities are also described, at least annually, in our Member Newsletter. This important information is also included on our website, www.cenpatico.com. We provide printed copies, upon request, for any member who cannot access this information on our website.

Regular Communications and Enhancements. We use every contact to create an educational opportunity with our members and their families. These opportunities include, but are not limited to, each time a member calls our Member Services Call Center, outreach calls made by our Care Coordinators or Care Managers, and community outreach events such as member and family forums. To further aid in understanding, all communications to members involving a Notice of Action, including but not limited to eligibility or service determinations, include information on how to grieve, appeal or file a state fair hearing. In Louisiana we will introduce our secure Member Portal which will include enhanced educational materials and opportunities, and secure messaging. These enhancements will allow us to expand our electronic media educational opportunities beyond what is currently available to our members. As we do in every market, we will grow relationships with community-based organizations and provider partners to promote member and community education. Our market-specific public awareness campaigns enhance not only the health of our members, but also the communities and parishes where our members live.

To ensure that our materials and website are effectively communicating member rights and responsibilities in a method and context that is accessible and understandable to members, Cenpatico periodically conducts advisory groups of members, family members and providers who review our materials and methods for delivery, or try out our website and provide us with feedback. We subsequently use this feedback to continually enhance our member education and outreach through both written materials and our website. Our member usability testing is designed to evaluate how easy it is to use our provider directories, the appropriateness of website font size and reading level, intuitive content organization, and ease of user navigation. Members who participate in website usability testing are provided with a tool that guides them through testing website features and scoring their experience completing the tasks. Members also provide written feedback and suggestions regarding their experiences and improvement opportunities.

Provider Support for Member Rights and Responsibilities. We educate our providers on member rights and protections in the Cenpatico Provider Manual, which is distributed annually and posted on our Provider Portal. Additionally, we provide our Member Handbooks containing member rights and responsibilities information to LGEs, HSD/As, CMHCs, FQHCs, RHCs, WAA, FSOs, and other CSoC system partners to aid in understanding and awareness. In other markets, we have partnered with Medicaid Transportation vendors, who retain copies of our Member Handbook, and carry a copy of our Member Handbook in each vehicle, for reference or for the member's use as they are transported. We will employ this and other similar methods in Louisiana to aid in member awareness.

We monitor for provider understanding through our annual member satisfaction surveys and through regular community forums including our Peer and Family Advisory Council, which reports directly to our Quality Improvement Committee. In this way we continually work to monitor the quality of our system of care, and to help educate members about their role as active participants.

Employee Support for Member Rights and Responsibilities. Cenpatico staff are trained on the principles of the system of care and recovery during employee orientation; included in this training is explanation and discussion of member rights, responsibilities and protections. We then monitor employees' recognition and support of member rights and responsibilities through community forums and satisfaction surveys; however, we are also able to use our Witness Quality Monitoring (Witness QM) call auditing tool to provide employees feedback on their direct interactions with members. Witness QM allows supervisors to audit actual phone calls with members and play back the call to staff during performance evaluations to offer constructive feedback. Additionally, we document all member mailings such as Member Handbook mailings or Notices of Action, which contain information regarding member rights and responsibilities, in the member's TruCare record. Presence of appropriate member notifications and mailings is audited during staff chart audits to ensure quality of service.

To ensure that our materials and website are effectively communicating member rights and responsibilities in a method and context that is accessible and understandable to members, Cenpatico periodically conducts advisory groups of members, family members and providers who review our materials and methods for delivery, or try out our website and provide us with feedback. We subsequently use this feedback to continually enhance our member education and outreach through both written materials and our website. Our member usability testing is designed to evaluate how easy it is to use our provider directories, the appropriateness of website font size and reading level, intuitive content organization, and ease of user navigation. Members who participate in website usability testing are provided with a tool that guides them through testing website features and scoring their experience completing the tasks. Members also provide written feedback and suggestions regarding their experiences and improvement opportunities.

Cenpatico puts members first in behavioral health care and will partner with DHH-OBH, members, families, providers and advocates to support the rights of individuals with mental health or substance abuse conditions.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
i. Describe the Proposer's telephone system capabilities, call center software and operating systems. **Suggested number of pages: 1**

An organization can have the most sophisticated technology available but if it is not intelligently designed for user simplicity, it fails its purpose. Cenpatico's systems support our mission of improving lives for our members, providers or stakeholders working with us, and our own staff. Our goal is ease of use ensuring technology does not become a barrier to access or information.

Member and Provider Services: Telephone Communications. Today, Cenpatico health plans serve our members and providers through state of the art telecommunication services provided by our parent company Centene Corporation (Centene), which will be extended to Cenpatico of Louisiana. Our telecommunications architecture will integrate Cenpatico and all of our Louisiana business units and deliver high availability through redundant hardware, software and voice networking services. Today we use the Avaya IP Telephony platform which provides multiple call path redundancy, automatic call distribution (ACD) and advanced vectoring.

Telecommunications Architecture Designed for 24 by 7 by 365 Operation

Avaya IP Telephony platform resides on Dual S8730 Media Servers in our Centene enterprise data center. These servers are capable of failing over to a redundant pair of Avaya S8730 Enterprise Survivable Servers (ESS). ESS servers are active, redundant systems which are installed at our Secondary Datacenter for back up and disaster recovery. One or more Avaya G450 Media Gateways provide local connectivity at remote offices for analog, digital, and IP endpoints. The G450 Media Gateway also provides ISDN-PRI trunk modules for local access to the Public Switched Telephone Network (PSTN) and has a Local Survivable Processor (LSP) which can process calls in the event that connectivity is lost to the Enterprise network.

Avaya Communication Manager (CM) Version 5.2.1 delivers world class call routing and feature-rich applications. Cenpatico will be supported by automatic call distribution (ACD) and advanced vectoring technology. Avaya CM 5.2.1 provides the ability to support remote IP agents, allowing maximum flexibility for distributing call agent workload as well as supporting disaster contingencies.

Our managed private IP Multiprotocol Layer Switching (MPLS) backbone is deployed in a fully meshed topology with vendor diversity, connecting our health plan offices telephone systems using Voice Over IP (VOIP) technology, and providing multiple routing paths for high volume and emergency conditions. The voice network consists of dedicated local Primary Rate Interfaces (PRIs) and analog lines provided by the Local Exchange Carriers (LECs) and long distance PRIs that carry outbound toll and incoming toll free calls provided by Verizon Business. Call center prompts on the toll-free numbers for member, provider, and case management services will be designed using the Avaya Voice Portal IVR platform. See *Figure 2.g.i.a: Enterprise Telephony Network.*

Please reference table *2.g.i.a* for a list of our telephone system software and a description below of how these systems suit the needs of the contract and how they will be used in service to our members and providers.

Interactive Voice Response. Our Avaya Voice Portal IVR platform with voice recognition capabilities and Avaya Communication Manager (CM) Version 5.2.1, will allow callers (strictly at their option should they choose to not talk with a live operator) to use our automated and secure self-service telephonic features and to select or speak menu choices and identification information, to receive information over the phone via IVR in automated fashion, and/or to direct their call accordingly to the appropriate live person or queue to be answered by qualified staff. In addition to options to directly speak to a staff

representative, our IVR has systematic options for such services as claims status, Third Party Liability, Authorization Request, etc. In this way we blend the speed of automation for those who prefer that to immediate access to a live person.

Avaya Communication Manager (CM) Version 5.2.1 powers our IVR with Virtual Call Center (VCC) capability, delivering world class Automatic Call Distribution (ACD) and advanced vectoring technology. ACD allows call center management to route calls to the least busy, next available, especially skilled or remote IP agents, allowing maximum flexibility for distributing call agent workload. Our VCC also supports our after hours and disaster contingency design, in that calls are easily routed to after hour call lines by Cenpatico staff or remotely by Centene telecommunications staff.

Our phone technology allows warm transfers (with the three parties on the line) to any phone number; thus, Member Service Representatives (MSRs) can connect members directly, even to external organizations such as a Primary Care Physician office, members are not asked to hang up and redial.

Call Tracking. We will document incoming member and provider calls in our Member Relationship Management / Provider Relationship Management (MRM/PRM) System. If calls are referred to a clinician, the call is documented in the nationally recognized care coordination and clinical documentation system, TruCare. TruCare archives all clinical contacts for a given member in a single place. Please reference our response to question 2.g.iv and 2.g.xxv for more information on TruCare.

MemberConnect and ProviderConnect (MRM/PRM). Through our MRM/PRM, we expand the efficiency and extent of member information that we can collect, transmit and display in order to best serve our members. MRM houses easily accessible data and reference materials that enable our call center representatives to quickly search and access information in order to respond to member and provider questions the first time, with no need to look into other systems, or route the call to a particular work group. Additionally, MRM and PRM support inbound campaign management: situations where for example, a member who we have been trying to reach (but have been unable to contact for whatever reason - e.g. incorrect phone number in our records) – calls us for any reason – our Cenpatico Member Support Representatives (MSRs) will be able to address the immediate issue – and address the issue(s) that we have been trying to communicate to that member.

Call Reporting. Avaya IVR, Avaya CM and MRM/PRM provide detailed call center reporting at each step in the process. IVR reports detail what occurred during the IVR interaction, including what path was selected, what voice command was stated, and when the selection was for systematic services, the IVR records the data for the covered individual and provider identification number, when applicable, as well as the date and time of the call. Our CM system records all information for response times, wait times, abandonment rates, call volume, call length, etc. Finally, our MRM/PRM system allows us detailed reporting including the reason for the call, as well as what occurred during the call.

Continuity of Call Center Services to Providers, Members and DHH-OBH. In the event of a natural disaster or pandemic, all business functions that rely on our telecommunications system have *top priority*, specifically our member and provider call centers. If an emergency event were to disable any of our offices, our Business Continuity Plans (BCP) call for phone lines to be transferred to NurseWise, our afterhours call center, to ensure continuity of service. Please see our response to 2.h. for more information on our BCP.

Figure 2.g.i.a: Enterprise Telephony Network.

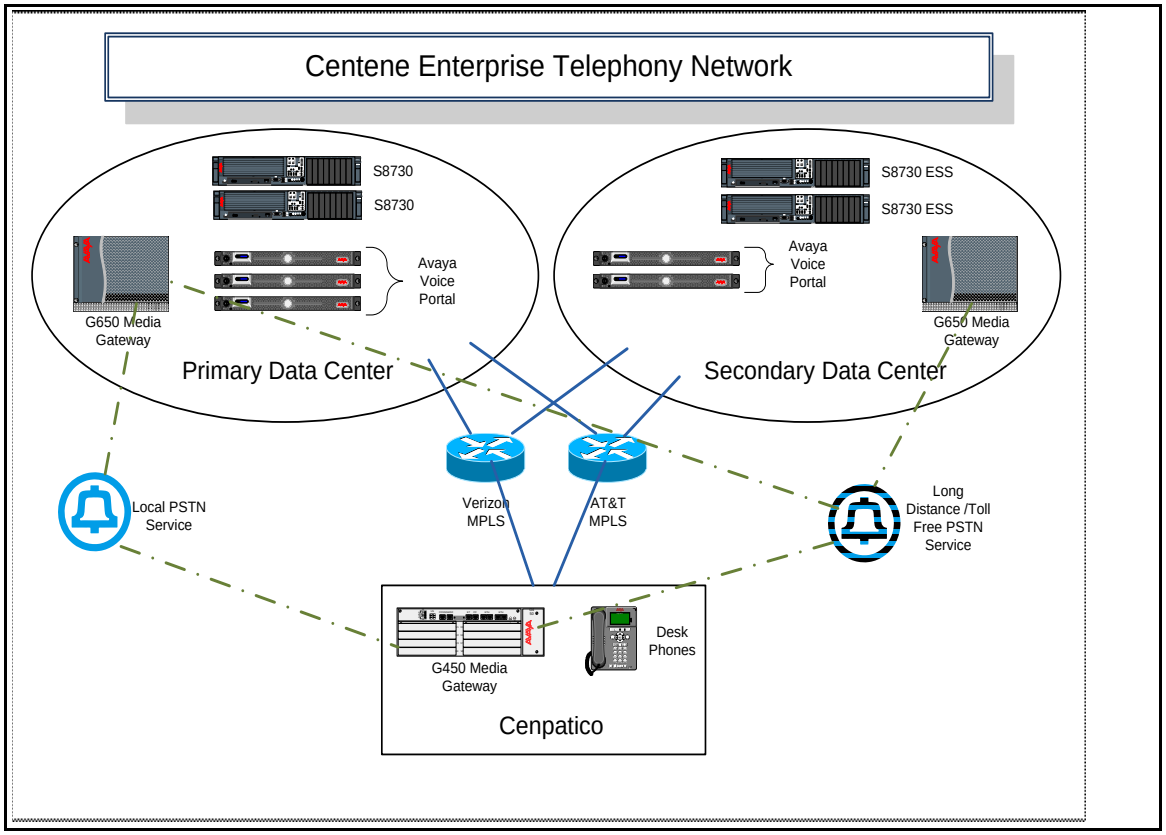


Table *2.g.i.a*

Application	Vendor	Application Description	Current Version	Database	Programming Language
Telecom Services					
Avaya Communication Manager (CM)	Avaya	Delivers world class call routing and feature rich applications	5.2.1	NA	C/C++
Avaya Call Management System (CMS) Supervisor	Avaya	Tracks and reports information processed through the ACD	14	NA	C/C++
Avaya Modular Messaging	Avaya	Multimedia messaging platform - users to respond to messages via voice, fax, text, and file attachments.	5	NA	C/C++
Avaya Voice Portal	Avaya	Speech-Enabled self-service IVR	5.1	Oracle	Java, VXML

2.g. Technical Requirements
ii. Describe how Information Technology (IT) and claims management functions will be organized, including staff that will be Louisiana based and staff available from the Proposer's corporate operations. Provide an organizational chart for IT and claims management that includes position titles, numbers of positions, and reporting relationships. Describe the qualification of staff. **Suggested number of pages: 4 exclusive of organizational chart.**

Centene Corporation (Centene), will manage Information Technology (IT) and claims operations for Cenpatico of Louisiana, as they do for all our health plan subsidiaries. Centralizing IT and claims operations allows us to provide DHH-OBH with enterprise level, state of the art systems and business process expertise focused *exclusively* for Medicaid and other public sector managed care programs that successfully address the Management Information System (MIS) needs of our affiliate plans, state clients, and public sector providers for effective, results-driven health plan administration. In our experience, MIS functions are best centralized to take advantage of the synergies created through combining technical expertise with multi-state/multi-product operations, along with the feasibility of supporting our local operations with large scale computing and associated facility assets (such as fault tolerant, highly available and resilient hardware and software, high performance and high speed bandwidth, etc.). Cenpatico's members, providers, and DHH-OBH will benefit from best practices in information technology and data reporting from across the country. Centene's over 275 experienced IT professionals and 450 claims staff will be supported by the Cenpatico corporate office in Texas for the implementation of our local Cenpatico of Louisiana health plan operation. Today, Centene's MIS organization and Cenpatico support coordinated care for 1.7 million Americans enrolled with our affiliates in 12 states and over 85,000 public sector medical and behavioral providers.

MIS Support

While IT and claims staff supporting Cenpatico's MIS will be located primarily in Centene's corporate headquarters in Missouri, *Cenpatico Louisiana will have business process owners in all key functional areas* ***in Louisiana*** who will work closely with (and as the service customers of) the corresponding Centene IT and Claims staff. This structure enables Cenpatico's members, providers, and DHH-OBH to benefit from *both* centralized MIS best practices and data reporting *and* the Louisiana Behavioral Health Partnership (LBHP) focused knowledge, expertise, and quality of care provided through a strong local presence in Louisiana.

Additionally, Cenpatico Louisiana will have the support of the Cenpatico corporate office in Texas. Since 2007 Cenpatico business management at our corporate headquarters, and our IT and dedicated claims counterparts in Missouri, have successfully implemented or expanded behavioral health plan operations in seven states. This team not only brings their expertise to the implementation process, they will transition the working relationship with IT and dedicated Louisiana Claims processing staff in Missouri to the locally based Louisiana operations team as reflected in Chart 2.g.ii.A, and will continuously support this team throughout our contract with DHH-OBH.

Louisiana IT and Claims Team. Cenpatico will have several locally based MIS and Claims staff supporting Cenpatico local operations, DHH-OBH, other state agencies and our providers. Please reference Chart 2.g.ii.B below. Our Information Systems Administrator will report to Cenpatico's Chief Financial Officer (CFO) and will be responsible for day to day IT coordination with Centene, working directly with providers and Centene to enhance all aspects of IT service delivery, including Electronic Data Interchange (EDI), our provider portal and member website specific to DHH-OBH and the LBHP program. The IS Administrator will also monitor change requests with our Service and EDI Help Desk. The primary focus of the Web Developer and Web Application Developers is to support our provider portal and member web site. Our Data Analysts will analyze business requirements and produce reports for Cenpatico operational and clinical management functions. The IS Liaison, reporting to the Office

Service Manager, will assist local staff with computer related issues and assist the Centene Network Operations Center (NOC) and Systems Administrators with any technical issues at the Cenpatico location. The IS Liaison and Office Services Manager will work closely with Centene's Director of Business Continuity, to create, manage, maintain, oversee, and exercise, with all Louisiana staff emergency management, response, and disaster recovery plans.

The Claims/Encounters Administrator reporting to the CFO, will oversee claims and encounter-related activities and will work with providers on encounters and claims processing requirements specific to DHH-OBH. This individual will also monitor applicable change requests with the Service Desk; supervise the Contract Implementation Specialists (CIS) and support the Claims Specialists, reporting to the Member and Provider Services Administrator. Claims Specialists help and train providers on how to submit accurate and complete claims information. Also reporting to the member and Provider Services Administrator are our Data Services Supervisor, Eligibility Processors and Web Technicians. These positions will directly support the provider community, referral agencies, DHH in areas of enrollment processing, and from a web perspective, ensuring that all authorized providers, state agencies, etc. are provisioned with a provider portal account and support those users with web functions.

IT Organization Focused Exclusively on Public Sector Programs

Please see Charts 2.g.ii.C and 2.g.ii.D and related narrative below for a graphical depiction of Centene's current IT and Claims organizational structure, staffing.. MIS and claims functions are divided into *six major areas* reporting directly to the Chief Information Officer (CIO).

IT Integration. This team focuses on new health plan *implementations*, integrating new business within existing health plans and aligning critical health plan priorities with ongoing IT development activities and release schedules to ensure on time delivery of new features and enhancements. This team will work closely with the Cenpatico Contract Implementation Manager to ensure the implementation of the LBHP business is measurably successful.

Business Operations Systems. Led by the VP of Business Operations Systems, this team maintains our *primary business operations systems*, providing systems leadership and expertise during new program implementations to ensure accurate, complete, and secure flow of data with our business partners, and to ensure that the unique requirements for our state clients' programs are configured and managed comprehensively within our ***core administrative systems***. In the case of the LBHP program, this includes support and implementation of the unique requirements and support of agencies including DHH-OBH, the Office of Juvenile Justice (OJJ); the Department of Education (DOE); and the Department of Children and Family Services (DCFS) and the Wrap Around Agencies (WAA). The Business Operations Systems group includes the following teams: Electronic Data Interchange (EDI); Eligibility/Enrollment; Member and Provider Relationship Management; Claims Adjudication, Payable/Finance and Claims Reporting; Compliance Reporting; Encounters Reporting.

One hundred percent of our 275 IT staff and 450 claims staff and resources are focused exclusively on managing Public Sector programs such as the Louisiana Behavioral Health Partnership: a critical differentiating factor of our organization.

Medical Management Systems. Our Medical Management Systems team will work closely with Cenpatico's Vice President of Clinical Operations and Cenpatico of Louisiana's Chief Medical Officer to configure our integrated Medical Management applications to support all care management activities. This team also maintains our advanced Centelligence™ advanced analytics applications for quality and HEDIS reporting, predictive modeling, assessments and risk profiling, and business intelligence tools to assist in identifying opportunities for care. (See our response to question 2.g.xii). Our External Web Services and Portal teams within the medical management group will maintain our Cenpatico Provider

Centene was recently recognized with the **2010 Gateway Business Innovation Award** for its web-based executive dashboards, which provide real-time intelligence and are updated daily to provide early warning of adverse trends, claims drill-down for a ***quick analysis of clinical, financial or operating issues, and predictive modeling.***

Portal, our Wrap Around Agency Portal and DHH-OBH web portal sites. (See our response to question 2.g.v and 2.g.viii).

Infrastructure Services. Our infrastructure team supports the foundation of our information and telecommunication services ensuring a highly available, secure, and HIPAA compliant MIS environment. This team includes our Business Continuity Team; IT Security; Service Desk; Network Services; Database Services; Information System Operations; and System Services. This team will work closely with the Cenpatico Information Systems Administrator to ensure system performance for Cenpatico Louisiana.

IT Strategy and Service Continuity. This group provides architecture design and capacity management for new business implementations, as well as researching and recommending new and emerging technology solutions that have meaningful application in support of our health plans. This team also evaluates current use of IT services and projects future needs; and oversees release and change management, and IT Disaster Recovery services along with the Infrastructure Services team.

Business Process Optimization (BPO). By using the Six Sigma and Lean Six Sigma methodologies, the BPO team works across all functional areas of the organization, evaluating the interaction of processes to ensure proper alignment with business objectives, performance, and financial outcomes. Where their analysis leads to technology solutions or change, they are an integral part of the IT development team, facilitating requirements gathering, documentation and developing training materials.

Claims Operations Center. The VP of Claims Operations located in St. Louis directs the approximately 350 claims processing staff that receive, process, adjudicate, pay and report on claims for Cenpatico and Cenpatico's affiliates. The Director of Claims Operations in Farmington oversees the Claims Operations Teams and is responsible for ensuring Cenpatico claims are processed accurately and within state and federal regulatory requirements. The dedicated Mail Room Cenpatico Claims Managers' staff located in Farmington, MO, will handle *paper* claims correspondence processes.. Mail Center Supervisors and their staff sort (e.g. by form type) inbound paper claims and correspondence, prepare this paper for scanning (e.g. remove staples) and convert paper to image and data with our Optical Character Recognition (OCR) equipment (see Section 2.g.xxii). Our Mail Center/Claims Correspondence Supervisors oversee the automated production of outbound claims *paper* correspondence (e.g. letters from Centene requesting additional claims information from providers). Vertexer Supervisors and their teams perform quality assurance on 100% of scanned claims to ensure these claims have been accurately scanned. The Cenpatico Claims Manager, Supervisor and staff process all "first time pended claims" that cannot be automatically adjudicated. "First time claims" are claims providers have submitted to Cenpatico for the first time and are not claim adjustment requests or claim resubmissions. The Coordination of Benefit (COB) Claims Analyst Supervisor processes all claims (paper or electronic) that do not automatically adjudicate and that require COB processing (see Section 2.g.xxxiii and xxxiv). Under the Director, Process Engineering, the Cenpatico Contract Implementation Manager (CIM) is responsible for the claims project component of new implementations, such as Cenpatico Louisiana; including business requirements and User Acceptance Testing (see Section 2.g.xxiv). The Manager, Claims Reporting produces daily and monthly reports on metrics such as Turnaround Time, EDI penetration, Auto Adjudication Rates and Performance Standards (see Section xxi and xxiii). The Supervisor, Product Quality conducts root cause analysis for "non systemic" operational issues when needed; oversees claims quality improvement activities; produces work process documentation; and executes claims resolutions

(including MIS system change requests if needed to address root causes). The Director, Process Engineering and Claim Project Analyst are also responsible for subrogation, credit balance and overpayment recoveries; processing/crediting of provider refund checks; initiating and processing overpayment recoveries from providers; and facilitating a reduction in overall interest payments (see Section 2.g.xxxiv). Under the Director, Quality Services, the Quality Review Manager review *100%* of all "high dollar" claims over set dollar thresholds prior to payment. Also under the Director, Quality Services, the Claims Manager processes all claim adjustments. Finally, Cenpatico Contract Implementation Specialists (CIS) review any issues found in a check run review to identify the root cause. When the CIS, or the Cenpatico Claims/Encounter Administrator, submits MIS change requests our IT department, the Claims/Encounter Administrator and the IT Quality Assurance Team execute an established work process to ensure that first time claims are paid correctly. Our Encounter Business Operations (EBO) Manager supports our Cenpatico team and DHH-OBH encounter reporting needs, providing expertise to ensure accurate and timely encounter reporting. The EBO ensures that adjudicated claims result in clean encounter data for accurate financial reconciliation and also identifies improvement initiatives while providing quality oversight for encounter processing through the routine generation and analysis of appropriate dashboard reports and metrics.

Experienced Leadership

The Public Sector MIS experience of our 275 IT professionals 450 Claims Staff and Cenpatico Implementation and Operational Oversight will ensure a smooth introduction of Cenpatico in Louisiana. Below is a brief description of the experience our senior leadership team brings to Cenpatico and DHH-OBH in service of the LBHP program.

Len Whyte, *Cenpatico Chief Operating Officer*

Len Whyte joined Cenpatico in January, 2007 as its Chief Operating Officer in Austin, Texas. In this role, he has responsibility for clinical operations, network management, business operations, project management, Cenpatico of Arizona and the Schools division. Prior to joining Cenpatico, Len served for more than 16 years with PacifiCare Health Systems in a variety of roles. Most notably he spent ten years building PacifiCare's behavioral health business from $6 million to $220 million. Len has more than 25 years of experience in the healthcare industry. His expertise spans areas of operations and finance. Len received his Masters degree in Finance from the Kellogg School of Management, Northwestern University and a Bachelor of Arts degree in Psychology from St. Olaf College.

Donald Imholz, *Executive Vice President, Chief Information Officer*

Donald Imholz has worked in IT for 30 years, the last 3 of those years in healthcare as CIO for Centene. Previous to this appointment, most of Don's career was in Aerospace where he held executive positions in all aspects of Information Technology including CIO for all of Boeing Defense Systems, as well as in other management positions where he was responsible for all application development and support on a global basis. Since joining Centene he has aligned IT with business priorities, implemented best practices in system management, and migrated the organization to an Agile system development process. Don has led the transformation of Centene's system architecture, with virtually every system having been either significantly upgraded or replaced over the past three years. This has resulted in greatly improved scalability and enhanced business processes.

Centene IT has been recognized with several awards, among them, inclusion in the 2010 Information Week 500.

Keith Hibbard, *Vice President, Information Technology, Business Operations Systems*

Keith Hibbard has worked in Information Technology/healthcare field for over 25 years, with 16 years focused on behavioral health. Over the past eight years at Centene, Keith has served as IT director over specialty product lines, Senior Director over IT Operations, and in the most recent two years as Vice President of Information Technology, Business Operations. Over his tenure at Centene, he has led the Information Technology areas related to: Provider Data Management, Business Configuration, Claims Operations, Clinical Data Management, New Business Implementations and EDI. Most recently, Keith has been responsible for the successful implementations of Member/Provider Customer Relations Management (Centene's MRM and PRM systems), HIPAA/NPI compliance, and EDI/X12 5010 compliance planning and execution.

Ed Gallegos, *Vice President, Business Operations*

Ed Gallegos has worked in the healthcare industry for over 20 years; fifteen of those years have been leading and managing large scale claims and call center operations. He initially joined Centene as VP of Operations, which included claims and encounters processing, system configuration, operations training, audit, and quality improvement initiatives. In addition to his extensive operational experience, Ed held various key positions that included VP of Human Resources as well as VP of Diversity and Cultural Competence at Blue Cross and Blue Shield of Florida (BCBSF). His efforts at BCBSF in the latter role led to BCBSF ranking nationally among the top 50 companies for Diversity. He also successfully led BCBSF to national recognition in customer service as measured by J.D. Powers for three consecutive years. Ed is considered an innovative and results oriented individual as proven by his accomplishments over his career. He has broad and deep experience in executing large scale operational efficiencies while focusing on delivering exceptional customer service. His experience in leading national group health plan accounts such as General Motors, Ford, and the Federal Employee Program (FEP) and others resulted in favorable rankings in performance. He has made significant improvement in driving results at Centene since his arrival.

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2.g. Technical Requirements
iii. Describe training for IT and claims staff, including any subcontractors. 5 page suggestion

Having a strong training process is not only critically important for our own staff, which is described below; but training will also be a *key* component of our mentoring process for the LGEs and myriad providers who are not entirely familiar with traditional Medicaid codes and billing processes separate from our typical process trainings.

Training Process Overview

We offer our Information Technology (IT) and claims personnel specific curricula geared toward assisting these professionals with attaining predefined performance metrics. In addition, we will tailor our courses for the specific requirements of Cenpatico and DHH/OBH to ensure staff understanding regarding the specific processes required for our contract. Our training is designed to help learners gain knowledge by actually performing goal-oriented tasks in a safe learning environment. We also recognize that training must be offered in many formats to accommodate widely varying schedules and geographic locations. For this reason, we offer training through regularly scheduled workshops; e-learning, on-the-job training.

IT and Claims Staff Training Approach

Computer Based Training (CBT). For specific courses, Centene invests in CBT providing flexible on-line training for our employees. We purchase CBT and build courses internally using state of the art course development tools. Most of our CBT courses are available to all employees through our intranet site, CNET. Courses include General Information about HR programs as well as mandatory, annual compliance programs which are overseen by our Compliance Department. Mandatory programs include Diversity/Anti Harassment, Compliance, HIPAA Training, Preventing Workplace Violence and Cultural Competency. Our CBT allow us to validate understanding of the material through quizzes, and completion of required courses.

In addition to these required courses, many other subjects are available to all employees and are designed to further industry-wide and company-specific education. For example, courses include: A Day in the Life of a Claim, Corporate Department Overviews, An Introduction to Medical and Behavioral Health Services, What is Managed Care? and Operational Excellence Awareness Training.

Instructor Led. Centene offers classroom training at our corporate headquarters and will hold specific training programs for end users at Cenpatico's Louisiana offices. Also, as appropriate, our I T professionals may enroll in off-site training in their area of expertise. Courses vary from technical to business management. We offer business training through our Centene Leadership Institute (CLI) and Centene Academy for Leadership Excellence (CALE) programs, designed for executives, managers, and supervisors. In addition, Presentation Skills courses are conducted for employees performing on-the-job or standup instruction to other employees or to external customers. We design all our courses using American Society Training and Development (ASTD) design standards and principles to ensure maximum learning results.

Other Training Opportunities. Cenpatico will offer additional training for employees to augment the training solutions described above, such as regularly scheduled Lunch and Learn seminars. Training materials such as videos and presentations from classroom training are also available on-line to all employees.

IT-Specific Employee Training

We tailor our IT training curricula according to individual roles and responsibilities but the common goal is to maintain and expand our staff's knowledge of current technology, systems and process. For example, the management team is required to obtain certification in the *Information Technology*

Infrastructure Library (ITIL). ITIL provides a framework of proven concepts and policies for managing IT services such as continuous improvement. Likewise, all our IT development teams are trained on *Agile Software Development Life Cycle* methodologies; a development framework that has proved very successful with our business partners. We provide training upon initial employment and on an ongoing basis to ensure proficiency, skill building, and employee job satisfaction and retention. In Table 2.g.iii.A, please find a summary list of specialized IT Training available to our staff. Training opportunities encompass the design, development and support of our telecommunications, hardware and network infrastructure, operating and database systems, and application development as well as management and business courses.

Cenpatico and Centene will augment our formalized training with management and employee sessions, as necessary, geared specifically to meet the needs of Cenpatico and DHH/OBH.

Hands-On Training. Although training sessions are a valuable tool in providing our employees with current information, we believe hands-on training, provides a unique opportunity to augment professional skills. Below are some examples of hands-on training provided to IT personnel:

Area	Description
AMISYS Advance Configuration	AMISYS Advance, is our core claims transaction processing application. We provide on the job training for each subsystem within AMISYS Advance : Eligibility, Benefits Management, Capitation Payable, Indemnity Configuration, Claims Processing and Pricing Management.
AMISYS Advance Technical Orientation	Provides the foundation for learning AMISYS Advance software layers and utilities such as Architecture Structure and the UNIX Environment
Portico Core Training and Non-Core Training	Portico, Provider Data Management: provider network management processes and data (credentialing, contracting, provider management); non-core training (provider data support).

Mentoring/Shadowing. Our IT Management ensures that new IT hires are assigned a mentor to answer questions and provide guidance on Centene programs and system configurations. We also pair the new employee with various cross-functional experts to gain a better understanding of specific business processes.

IT Qualifications. We strongly encourage continuing education and certification for our IT department personnel. Our employees take courses and receive certifications for multiple programs including: ITIL; Novell; AMISYS Advance; Microsoft Office Professional and Engineer Certification; Cisco Network and Information Security and Telecommunications; multiple programming languages; Microsoft Office applications and Business Processes.

Claims-Specific Employee Training

Centene has a dedicated claims training team supporting our Claims Operations group. Training includes hands-on computer training, simulated work processes, comprehensive lessons and exercises, and one-on-one assistance designed to ensure *all* students receive a *comprehensive* understanding of claims processing, and that employees are prepared to address the scenarios most commonly presented during claims processing activities. Instructional methods and tools are knowledge based, quality driven, and comprehensive of analytical functions that drive quality improvement and internal customer service. The focus is participant driven involving best practices, current work processes, process bulletins, and insight into system configuration for an improved understanding of how the employees work impacts operations. All training programs are conducted by Claims Trainers, and are supported by solid curriculum and evaluation tools to confirm attainment of skills and quality audits. Please see Table 2.g.iii-B for a list of the core claims training modules plus additional e-learning opportunities.

Progressive Learning. Training encompasses foundational learning that transitions into advanced level training for more complex claims processing functions. In total, an advanced adjuster can receive a

minimum of *14 weeks* of classroom and hands-on training designed to span all aspects of claims processing from fundamental skills to specific elements related to health plan needs. The training encompasses review of the AMISYS Advance application including types of claim pends and related protocols for resolution; claims adjudication modules include review of benefits, pricing, authorization requirements and; the workflow module addresses how to access and view claim images, route claims and correspondence to other internal departments and follow up mechanisms. Training modules for COB/TPL equip the processor with the skills to research and coordinate benefits to ensure accuracy in payment determination. The claim adjustors' curriculum provides them with a comprehensive understanding of the claims adjustment guidelines to effectively process resubmitted claims, identify and report trends in processing deficiencies or errors for specific processors, providers or technologies. All participants are audited throughout the training programs and must demonstrate proficiency to graduate from the programs and begin processing or adjusting claims.

Beyond The Classroom. Training support continues beyond the formal classroom. The Claims Training team holds scheduled learning labs allowing processors individual attention in areas for improvement. Participant(s) can schedule lab time during designated business hours to further their understanding. In-depth training courses range in length from 15-25 days long and are designed to provide hands on intensive training for analysis and processing of claims, processing of coordination of benefits, and processing adjustments. Training success is measured by the participant's ability to hit accuracy and timeliness goals in their claims processing. In addition to the multi-day classes, there are Centene e-learning classes designed to improve knowledge around topics such as guidelines for explanations of benefits (EOB) versus explanations of payment (EOP), how to read and take correction action on results in reports such as the Claims Batch Error Report and the Claims Payable Report. A listing of courses and their descriptions are listed in Table 2.g.iii.B.

Provider Training

In addition to training our IT and Claims staff, we also invest in training our providers, and will also provide training to the Wraparound Agencies (WAA) and Family Support Organizations (FSO) on topics relevant to their role in the process. Please also reference section 2.e.ix for more information on Provider Training. From an IT and claims perspective, we will focus provider training on accurate and complete claims submission, moving from paper claims to electronic claim submissions and how to use our Provider Portal features. We will engineer the content of our provider curricula and provide multiple learning opportunities for our providers, based on their technical expertise. Cenpatico will deliver provider training through a three step process that provides an initial training curriculum, followed by evaluation and retraining as necessary:

- *Train* – We present to providers a curriculum designed for easy understanding with clear objectives and goals regardless whether training is provided in-person or via the web through our Provider Portal.
- *Monitor* – Once we provide initial training, we will monitor providers to ensure concepts are presented are operationalized. We achieve this by focusing on outlier providers; that is: those providers having difficulty with a particular process.
- *Retrain* – Over the course of time a provider may be identified by us in outlier reporting as needing refresher training or focused training on a specific subject. At that point the training process begins again.

Provider Online Training and Technical Assistance. Providers and their staff can will be able to access Centene's policies and procedures regarding data submission and demographic and claims data requirements via Cenpatico's web based Provider Portal. The Portal will offer 24/7 access to supportive educational materials and other information. Other training methods may include.

- E-learning

- Webinars
- Workshops
- Provider Mentor Teams
- Specific Needs Training
- Telephone Support

Provider Office Visits and Outreach. Cenpatico has a strong commitment to partnering with our providers and ensuring their ability to navigate our processes. Cenpatico maintains a local presence in every market to enable face-to-face interaction directly with providers and their office staff. In addition to all the formal training programs identified above, Cenpatico of Louisiana Network staff will identify provider specific training needs and will be able to deliver this training on location in the provider's office. This level of training extends to the WAA and FSO agencies for which Cenpatico has specifically designated one of the provider trainers.

Investing in Training to Serve Our Members. Comprehensive training is *critical* to the successful delivery of care to Louisiana members. Centene and Cenpatico of Louisiana will work to enhance the skills of *everyone* involved in our operations. We have found that relevant and focused training, efficiently delivered, leads to higher quality member care and customer service. Carefully designed training serves as a potent motivating force by empowering Cenpatico, Centene, and provider staff with the tools and skills they need for their job. We provide a diverse set of training classes in various formats, such as instructor-led classes, Computer Based Training (CBT), e-Learning, webinars, and 'Lunch and Learn' seminars to accommodate multiple learning styles.

Table 2.g.iii.A - Specialized IT Training

Area	Description
Avaya - Telecommunications	VoIP in Practice / Trunk and Routing Administration / Quick SIP / Administer Voice Portal / Avaya Voice Portal Installation and Maintenance / Session Manager Technical Overview / System Manager Technical Overview / System Manager Installation and Setup / Session Manager Installation and Setup / Session Manager Administration / Advanced System Manager Administration
Cisco / Juniper – Network	CCNA / 5519N - Cisco Data CTR Unified Computing Implementation / 5281N – Data Center Networking – Cisco Nexus 5000 & 7000 / JNCIS / Citrix Netscaler / Cisco Live conference / Cisco MDS training
NetApp - Storage	Data ONTAP 7-Mode Administration / Operations Manager, Protection Manager, and Provisioning Manager Administration Performance Analysis on Data ONTAP
Programming	837I and 837P / Accelerated SQL / Alchemy Database / Assembler I & II / C and C++ / COBOL I,II,III, IV / DBII / FoxPro / HTML and WEB Programming / Java I & II / Certified Data Base Administrator-IBM / SQL Fundamentals Using Oracle / SQL programming using SQ Server / SQL -RAD Environment Certified/ Oracle Programming using PL/SQL I & II / UNIX 9000 UNIX SQL training /Visimage/Vital Soft Ware /Visual Basic
Microsoft Courses	Design Security for Microsoft Networks Implementing Windows 2008 Security Secure Windows Server Managing Security in Microsoft SQL Server 2008 Windows Server 2008 Active Directory Configuration Planning and Implementing Windows Server 2008 Configuring, Managing, and Maintaining Windows Server 2008 Designing a Network Infrastructure in Windows Server 2008 Microsoft Exchange Server 2010 Configuration Designing and Deploying Messaging Solutions with Microsoft Exchange Server 2010 Administering and Maintaining Windows 7 MS Office Product Suite: Word, Excel, PowerPoint, Visio, Access, Project Microsoft Project Enterprise Administrator and Management Solution
Software	TruCare/CCMS/CICS/Pricing/McKesson Team Track and Team Track Administrator Aternity Service Now Portico AMISYS and MACESS Customer Relationship Management (CRM)

Area	Description
Business Courses	Agile Change Management Methodology Project Management Information Technology Infrastructure Library certification (ICA) International Claim Assoc. (PAHM)Prof. Academy of Healthcare MGMT Business Communications and Centene Supervisor Institute Management Skills for New Managers, Supervisors and Tech. Supervisors Project Management -Understanding the PM Role Myers-Briggs Training and 7 Habits of Effective People Essentials of Credibility HIPAA Parts A,B & C Group Life & Health HSS-Healthcare Software Synergies Provider Contracting & Guidelines Training Sexual Harassment Leadership Training Writing Class AAIM Centene Behavioral Interviewing Signature Service Training Service Desk training Telephone Doctor from Curt to Courteous Telephone Doctor Internal Customer Service Email Effectiveness Training
Operating System	Red Hat System Administration I –III Red Hat Enterprise Virtualization / Linux Troubleshooting Techniques and Tools / Red Hat Cloud Architecture / Red Hat Enterprise Security: Network Services / Deployment and Systems Management / Directory Services and Authentication / Clustering and Storage Management / System Monitoring and Performance Tuning / HP-UX: Core and transition system administration / Hardware and partitioning / High availability, security, performance, & virtualization
Database	Oracle Database: Administration I & II / Performance Tuning Oracle Real Application Clusters Oracle SQL SQL Server: Maintaining a Microsoft SQL Server 2008 Database / Implementing a Microsoft SQL Server 2008 Database / Writing Queries Using Microsoft SQL Server 2008 Transact-SQL

Table 2.g.iii.B - Core Claims Training Modules

Course	Description	Course Quality Expectations
Analyst Basics - 25 day course	Analyst Basics training course is part one of a two-part Analyst 2 program designed as an introduction to medical claims processing. The objectives for the training are to provide participants with the fundamental skills required for accurate analysis and processing of medical claims. Training will focus on the use of AMISYS Advance software applications, medical coding, claim forms, and communications to other departments within Centene to efficiently process provider claims in an appropriate and timely manner ensuring regulatory turnaround times. The course will provide an in-depth look at the work flow application for viewing claims, writing letters, tracking stored information, and routing claims and correspondence to other Centene departments. Participants will gain a	95% Processing 97% Payment 99% Financial

Course	Description	Course Quality Expectations
	detailed review of the AMISYS Advance software as a claims processing database. They will learn to navigate, perform claims payment and denial functions, as well as specifics on routing. In addition, participants will learn to process keying verification, billing issues, duplicate claim pends, prior authorizations, pricing for anesthesia claims, processing newborn member claims, claims pending for possible other insurance, and adjusting claims from Contact Service Forms from Centene state health plans and/or Compliance Coding Management departments. Quality guidelines for participants are measured to industry standard goals to ensure participants can meet quality expectations prior to leaving the training program.	
Analyst Pricing - 15 day course	Analyst Pricing training course is part two of the two-part Analyst 2 program designed to train analysts to manually process claims pending for special pricing. The objectives for the course include detailed pharmaceutical and home health care pricing, pricing for multiple surgical procedures performed in the same operative session, to process claims pending for prior authorization, application of DRG pricing, and provider adjustment functions of previously processed claims requiring PLP review. Participants will learn to manually calculate special pricing and authorization requirements for hospital leveling of care claims, durable medical equipment and supplies. This course builds comprehensively on the Analyst Basics program preparing participants for next level responsibilities. Quality guidelines for participants are measured to industry standard goals to ensure participants can meet quality expectations prior to leaving the training program.	95% Processing 97% Payment 99% Financial
Coordination of Benefits - 15 day course	Coordination of Benefits (COB) training course is an add-on course to the Analyst 2 program that encompasses basic coordination of benefit fundamentals for medical claim processing. The objectives for this course are to equip participants with the tools required for processing claims pending for Third Party coordination. Participants are trained to utilize other insurance Explanation of Benefits to calculate benefits paid to the provider by Centene. Quality guidelines for participants are measured to industry standard goals to ensure participants can meet quality expectations prior to leaving the training program.	95% Processing 97% Payment 99% Financial
Analyst Basics 3 - 15 day course	Analyst 3 Basics training course combines comprehensive knowledge from the Analyst 2 level courses and introduces the challenging application of adjustment requests to previously submitted provider claims. The objectives of this course are to gain a comprehensive understanding of claims adjustment guidelines to effectively process resubmitted claims, the application of interest criteria, determining Centene vs. provider error, and processing adjustment requests from Centene state health plans and/or Compliance Coding Management departments. This course follows the A2 program and requires proven proficiency in Analyst 2 processing. Quality guidelines for participants are measured to industry standard goals to ensure participants can meet quality expectations prior to leaving the training program.	95% Processing 97% Payment 99% Financial

E-learning Opportunities		
Mail Delivery and Premium Sort	Presentation provides basic guidelines to ensure accurate and consistent delivery and preliminary sort procedures. The objectives learned include: mail delivery and mail receiving process, preliminary sort process, behavioral health and medical P.O. boxes.	95% Final Score
EOB vs. EOP	Presentation provides basic guidelines to ensure accurate and consistent identification of an EOB vs. an EOP attachment. The three objectives trained include definitions of EOBs and EOPs, verbiage to consider when determining an EOB/EOP attachment, and letters/forms considered as an EOB attachment.	95% Final Score
Claims Batch Error Report	E-learning course teaches participants to recognize the Batch Error Report, identify the error codes associated with the Batch Error Report, make necessary corrections to remove the claim from the report, document claims with appropriate remarks and file the report for record keeping.	95% Final Score
Claims Payable Report	E-learning course teaches participants to recognize the Claims Payable Report, identify the errors associated with the Claims Payable Report, correct the errors to remove the claim from the report, document claim with appropriate remarks, and file the report for record keeping.	95% Final Score
Claim Duplicates	E-learning course includes information on aiding individuals processing duplicate claims. This will include state specific guidelines as well as tips to ensure participants are thinking outside the box.	95% Final Score

2.g. Requirements
iv. Describe the Proposer's software systems and hardware for managed care and claims payment functions. Include any ancillary modules or systems in use for other related functions (e.g., provider, eligibility, authorizations, data store) and how the systems are interfaced. Please provide a workflow diagram of the process as indicated in the Implementation Planning section of the RFP.
Suggested number of pages: 6

Nationwide Systems Expertise Focused on Local Plan Public Sector Programs

Cenpatico of Louisiana's (Cenpatico's) key Management Information Systems (MIS) resources will be managed by Cenpatico's parent company, Centene Corporation (Centene) and Centene's over 275 experienced MIS professionals working in conjunction with Cenpatico's MIS and operations staff. Since 1984, Centene has focused *exclusively* on Medicaid, CHIP, and other public sector managed care programs, and has successfully addressed the unique functionality, connectivity and data exchange needs that our local plans, state clients and public sector providers need for effective, results-driven health plan administration. The fact that our integrated MIS supports both behavioral health (BH) and medical public sector health programs means that we are well positioned to support the kind of collaborative care support called for in the RFP (Section II.B.4); as well as the emerging world of standards based Electronic Health Record (EHR) systems and Health Information Exchanges (HIE) (see Section 2.g.x of our proposal) for both medical and BH meaningful technology use. We have reviewed all information technology requirements in DHH's Office of Behavioral Health (DHH-OBH) Request for Proposal (including all requirements in Section II.E of the RFP) and are able to fully support all information technology aspects of the Louisiana Behavioral Health Partnership (LBHP) program.

Deploying MIS Resources at Cenpatico of Louisiana

The table below summarizes the MIS capabilities in place today and that we plan for LBHP by the time of contract implementation.

HIT Resources	Timing
MIS Infrastructure - Fault tolerant servers for core applications (referral, enrollment, eligibility, claims and encounter processing, clinical management, websites, reporting) - and *supporting* applications (EDI, image scanning and OCR, Interactive Voice Response (IVR), middleware, data integration subsystems, e-mail and secure e-mail, etc.)	In place now. Please refer section 2.g.iv data archive and retrieval and disaster recovery; and section 2.g.xxxv for details on our hardware infrastructure.
Redundant, highly available **Wide Area Network** (WAN) for data and voice communications.	In place now. Local connections pre-configured local thin client, secure desktop workstations, and telephone system (including IVR) for Cenpatico office will be put in place prior to contract implementation by our Centene MIS department. Please refer to sections 2.g.i for details on our voice communications technology; and section 2.g.xxxvi for information on our network and software components.
HIPAA compliant transaction and codeset translation software, HIPAA compliance checking software, and HIPAA compliant security controls.	Full HIPAA transaction support available now via our EDIFECS EDI system. All HIPAA Security controls in place now. Physical controls based on Centene security standards for Cenpatico office will be put in place prior to contract implementation by our Centene facilities manager and staff. Please see section 2.g.ix describing our HIPAA compliant interface; 2.g.v on our ability to interface with DHH-OBH and other agencies; 2.g.vi regarding our capability to interface with providers; 2.g.xi on our ability to send and receive data; 2.g.xix sending and receiving data from other agencies; 2.g.xi for our support of HIPAA transactions; 2.g.xxvii and 2.g.xxviii for our experience with the HIPAA 270/271, 834 transaction and the 835 remittance transaction, respectively; and question 2.g.xx for our readiness for 5010 and ICD-10 conversion.

HIT Resources	Timing
Integrated core processing applications: including AMISYS Advance claims processing, Automatic Work Distributor (AWD) claims workflow, MACESS document management and Member and Provider Services and master data management support (via our Member Relationship Management (MRM) and Provider Relationship Management (PRM)) systems. MDE xPress Encounter Pro (encounter processing). CaseNet TruCare (TruCare) **clinical management system,**	In place now. These systems and capabilities are described in further detail below. Please also see sections 2.g.xxi – 2.g.xxxiv for more information on our claims processing capability, third party liability and coordination of benefits and waste, fraud and abuse. Please see sections 2.g.v, vi, vii, ix, and x for more information on TruCare.
Centelligence™ Enterprise Data Warehouse (EDW) and Centelligence™ integrated SAP BusinessObjects **reporting software** and Impact Pro Predictive modeling system; MedAssurant Catalyst (HEDIS and clinical quality reporting).	In place now. Please see below and section 2.g.xii for a detailed description of our Centelligence reporting platform.
Secure web based **Provider Portal** (with advanced clinical support).	We will customize a version of our Provider Portal for Cenpatico operations prior to contract implementation. Please see section 2.g.viii for specifics on our Provider Portal.

MIS Software Modules and Components: Functionally Rich Yet Integrated Where Needed

Please refer to Figure 2.g.iv-A below for a diagrammatic overview of our MIS, its integrated components and key data interfaces with DHH-OBH, other state agencies and our providers. Figure 2.g.iv-A shows our communications, functional application and database "layers" and components that represent our MIS in the service of health programs such as LBHP. Our discussion below walks through these components and, along the way, we highlight how these components support our major operations.

Electronic Data Interchange (EDI). Our Coviant Diplomat Transaction Manager (Coviant - item **A** in Figure 2.g.iv-A) handles our automated production of HIPAA and non-HIPAA (state proprietary) EDI file exchanges with our state partners, and our network of almost 60 EDI Trading Partner clearinghouses. We exchange data using Secure FTP (SFTP), but we can support virtually all industry standard secure file exchange protocols. Our EDIFECS integrated modular transaction subsystem (item **B**) provides HIPAA test and production Version 4010A and 5010 compliance checking, automated HIPAA transaction monitoring, and conditional transaction routing driven by transaction specific business rules, ensuring (for example) that a HIPAA *claim* is routed to our AMISYS Advance claim processing system (item **D**). Additionally, providers (such as LGEs) who submit 1,000 or more claims monthly, will want to leverage the on-boarding capability of our EDIFECS Ramp Manager, enabling them to send EDI transactions directly to us via our Provider Portal. Providers can certify their status with us as HIPAA compliant, and they will have the option to submit their production HIPAA 837 claim transactions (and receive HIPAA 835 Remittance Advices) directly with us via our secure, web based Provider Portal. EDIFECS supports a wide range of file transmission and receipt *acknowledgement protocols*, including ANSI standard 997, TA1 ,831, 824, and state proprietary formats. EDIFECS systematically monitors all HIPAA production transactions, and will alert our EDI Operations staff via dashboard functionality if a particular Trading Partner's submission patterns are deviating from normal. We automate processing scheduled runs (e.g. eligibility file receipt and processing , claims data loads) on daily, weekly, or monthly cycles through our TIDAL Enterprise Scheduler (TIDAL) job scheduling software. Our TIBCO software suite (item **C**), provides data validation services, transaction routing and associated middleware workflow support to and from other internal systems.

Eligibility Processing. EDIFECS can receive eligibility files from DHH (and other state agencies - as mentioned on page 1 in the document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11), validate and map each data item to the membership input file format of our Member Relationship Management (MRM) system (item **E**). TIBCO applies edits such as those for duplicate member records, date criteria validity, field data integrity, and valid date spans - all prior to loading into MRM. Once

eligibility data is loaded and processed in MRM, it is systematically promulgated to AMISYS Advance (item D), our claims processing system; our TruCare integrated health services management platform (item F); our paper scanning and Optical Character Recognition (OCR) system (MACESS - item G); our Automatic Work Distribution claims workflow engine (AWD - item H); and our Centelligence™ Enterprise Data Warehouse (EDW) data integration engine (item I) via our Informatica near real time Extract, Transport, and Load (ETL) middleware (J). Through EDW, we also make member eligibility data securely accessible to our members, providers, and state agency users online via our secure Member, Provider and State Agency Portals (K) . Please see Sections 2.a.x, 2.g.vi, and 2.g.viii for additional information on our secured Member, Provider, and State Agency Portals, respectively.

Member Services: The Member Relationship Management System. Our Member Relationship Management system (MRM - item E) will support all aspects of our members' relationship with Cenpatico. Please refer to Figure 2.g.iv-B: MRM, in which the three concentric circles represent multiple types of interactions among: MRM (item 1 in Figure 2.g.iv-B), Cenpatico member services staff (2), and members (item 3). MRM is our integrated repository of "all things member" and has three core integrated components:

- **Member Demographics System** (MDS). MDS is similar in design to a Master Patient Index application in that it employs a Master Data Management (MDM) approach to member data through the use of a Master Member Index (MMI) - an identifier unique to the individual member "person" - that can support multiple current and historic member plan identifiers. Our MDM design provides processes for collecting, aggregating, matching, consolidating, quality-assuring, persisting, and distributing member data throughout our organization to ensure consistency and control in the ongoing maintenance and application use of member data.
- **MemberReach** automates, manages, tracks and reports on our workflows for outbound and outreach member campaigns, as well as targeted outbound interventions (such as engaging high risk members in disease management programs). For example, in the case of the LBHP, we will use MemberReach to issue "annual well care visit" reminders to members (see section g.xi for more information).
- **MemberConnect** is our Customer Relationship Management (CRM) member services application which greatly expands the efficiency and extent of member and caregiver information that we can collect, transmit, display, route and use. MemberConnect also supports inbound campaign management. If a member , family member or other caregiver we have been trying to reach happens to call us for any reason, our Cenpatico MSR's can address the member's immediate issue, then they or a Care Manager can talk to the member about the issue that is the subject of our outreach attempts.

Figure 2.g.iv-C MRM Components: depicts the core technology components of MRM, including MemberReach and MemberConnect. We have built MRM on Microsoft Dynamics MDM (item 1 in Figure 2.g.iv-C) and Customer Relationship Management (CRM - item 2), and Avaya Voice Portal (AVP) Interactive Voice Response (IVR) with Predictive Auto Dialing (PAD) technology (3 - also shown as item AD in Figure 2.g.iv-A). Figure 2.g.iv-A also depicts how, and for what purpose, MRM integrates with the rest of our functional applications.

Provider Services: The Provider Relationship Management System. Our Provider Relationship Management system (PRM - item L in Figure 2.g.iv-A). Figure 2.g.iv-D PRM Components: graphically depicts PRM's four service components:

- **ProviderConnect** (item 1 in Figure 2.g.iv-D) is our application for creating, routing, tracking, managing, and reporting provider (including LGE) inquiries. The main users of ProviderConnect are Provider Service Representatives (PSRs), but PSRs also can send and receive provider inquiry work items to and from any other departments (including MSRs and Care Managers), using ProviderConnect.

- **ProviderReach** is our automated outbound provider campaign management application allowing the efficient and coordinated launch of broad based (Plan level) provider communiqués, notices, and recruitment across multiple communication channels, including telephone, e-mail, fax and web. See item 2 in Figure 2.g.iv-D.
- **Portico** is our provider data management system which integrates provider related information (item 3 and also shown as item **AC** in Figure 2.g.iv-A) across our other MIS components needing to use provider data.
- **Emptoris** is our comprehensive provider contract management software, supporting efficient and collaborative provider contracting, amendment, and re-contracting processes with Cenpatico providers, while ensuring regulatory compliance (item 4 in Figure 2.g.iv-D and also shown as item **AC** in Figure 2.g.iv-A).

We developed PRM (which we began implementing in our affiliate health plans in late 2010) using the *same* Microsoft Dynamics CRM platform (5) we have deployed for MRM, integrated with our Portico enterprise provider data management system (6); our Emptoris enterprise contracting system (7); and the *same* Avaya Voice Portal (8) component used in MRM. As Figure 2.g.iv-D shows, PRM is integrated with our Provider Portal, AMISYS Advance, our Automatic Workflow Distribution (AWD) system, and in the 1st Quarter of 2012, our **Enterprise Content Management (ECM)** system. ECM is our new (in process of deployment in 2011), next generation data capture solution to accelerate the processing of paper and faxed authorization requests, assessments, care plans, survey questionnaires, and other paper based correspondence. ECM is comprised of our integrated RightFax fax communications system and our scanning and Optical Character Recognition (OCR) workflow system on the receiving end and leverages the workflow capabilities of our Microsoft SharePoint collaborative platform to streamline and automate the capture and processing of these documents, and integrates the resulting captured data into the appropriate application (e.g. TruCare for authorization, assessment and Plan of Care data, EDW for survey data). Overall, PRM's modular architecture provides a comprehensive view for our PSRs to address any provider inquiry quickly, and/or to route any provider matter to the appropriate Cenpatico department. AVP's voice recognition technology allows provider IVR users to speak identifying information and menu commands for retrieval of eligibility, claim status, and other information.

Claims Processing. We accept HIPAA 837 EDI electronic claims from almost 60 claims clearinghouses (Item **M**), and beginning in the 3rd Quarter of 2011, *direct* from our providers via our Provider Portal; and we will support direct submission from DOE/LEA for LBHP claims (referred to as "DOE encounters" in the RFP) should that (or any other) state agency wish to use that feature. Today, we also support the online entry of claims via our HIPAA Direct Data Entry (DDE) facility on our Provider Portal and this feature, too, will be available on our State Agency Portal for the LBHP. HIPAA EDI format adherence is verified real-time using our EDIFECS X Engine (**B**). Providers can submit paper claims, which are scanned using Optical Character Recognition (OCR), indexed and converted to machine readable data through MACESS (**G**) (as mentioned above, we are in the process of enhancing our MACESS component to our new ECM). EDI and paper claims are processed thru our EDIFECS and TIBCO software (**C**) to map, translate, and validate the data, ensuring that common edits are consistently applied prior to loading into MRM (**E**). Component **D** is AMISYS Advance, one of the health care industry's premier transaction processing systems and our core processing system, providing HIPAA-compliant claims processing. Our Automatic Work Distribution (AWD) software (**H**) manages workflow of any pended claim in AMISYS Advance in *real time*. If a claim pends in AMISYS Advance, AWD immediately routes an electronic work item to a claims processor skilled to address that type of claim pend. The claim processor can then address the pend issue through AWD, and the appropriate claim change is immediately made in AMISYS Advance. ClaimsXten (**N**) reviews adjudicated claims *prior to payment* for such items as bundling and unbundling of services, incidental services, mutually exclusive

codes, global surgery follow-up days, duplicate claims, invalid procedures, bilateral services, and incorrect age/gender validation. Please see section 2.g.xxxii for more information on our proactive strategies to detect fraud, waste or abuse in claim submissions, including our use of powerful detection services from HCI, Inc. For payment, Cenpatico will offer Electronic Funds Transfer (EFT) and/or Electronic Remittance Advice (ERA) options directly to our providers through a clearinghouse, or through our new (and free to the provider) Payformance or Emdeon capabilities. Explanation of Payment (EOP) information is also available to providers through our secure Provider Portal (**K**). See section 2.g.xxviii for more information.

Encounter Processing: Once AMISYS Advance adjudicates claims to a finalized status, our MDE Xpress Encounter Pro (Encounter Pro) workflow system (**O**) extracts this claims data, prepares and submits the data as encounters to DHH through TIBCO and EDIFECS (for translation to HIPAA 837 format and HIPAA compliance checking).

Clinical Management: Cenpatico clinical staff will use TruCare (**F**). TruCare is our member-centric health management platform for collaborative care coordination and case, disease, and utilization management. TruCare affords users a *member centric* view of clinical cases so that our clinical staff can easily see the entire behavioral (and medical - if available) health status and history of members, and to ensure that coordinated and holistic programs are in place. TruCare's interface capabilities allow it to transmit authorizations in real time to our AMISYS Advance claims subsystem, and TruCare's data granularity allows authorizations to be issued at the procedure code level, enabling the highest level of specificity for subsequent claim adjudication, and enhancing claim payment turnaround times to our providers. Our TruCare system is integrated with McKesson's industry leading InterQual medical necessity criteria (MNC) software.

LVM Telehealth Triage (Telehealth Triage - Item **P**) is our clinical workflow application supporting Cenpatico's NurseWise nurse advice line affiliate. Telehealth Triage enables our NurseWise Registered Nurses (RN's) to answer member health questions, refer symptomatic callers to the appropriate level of care, and support members to make informed decisions about their health.

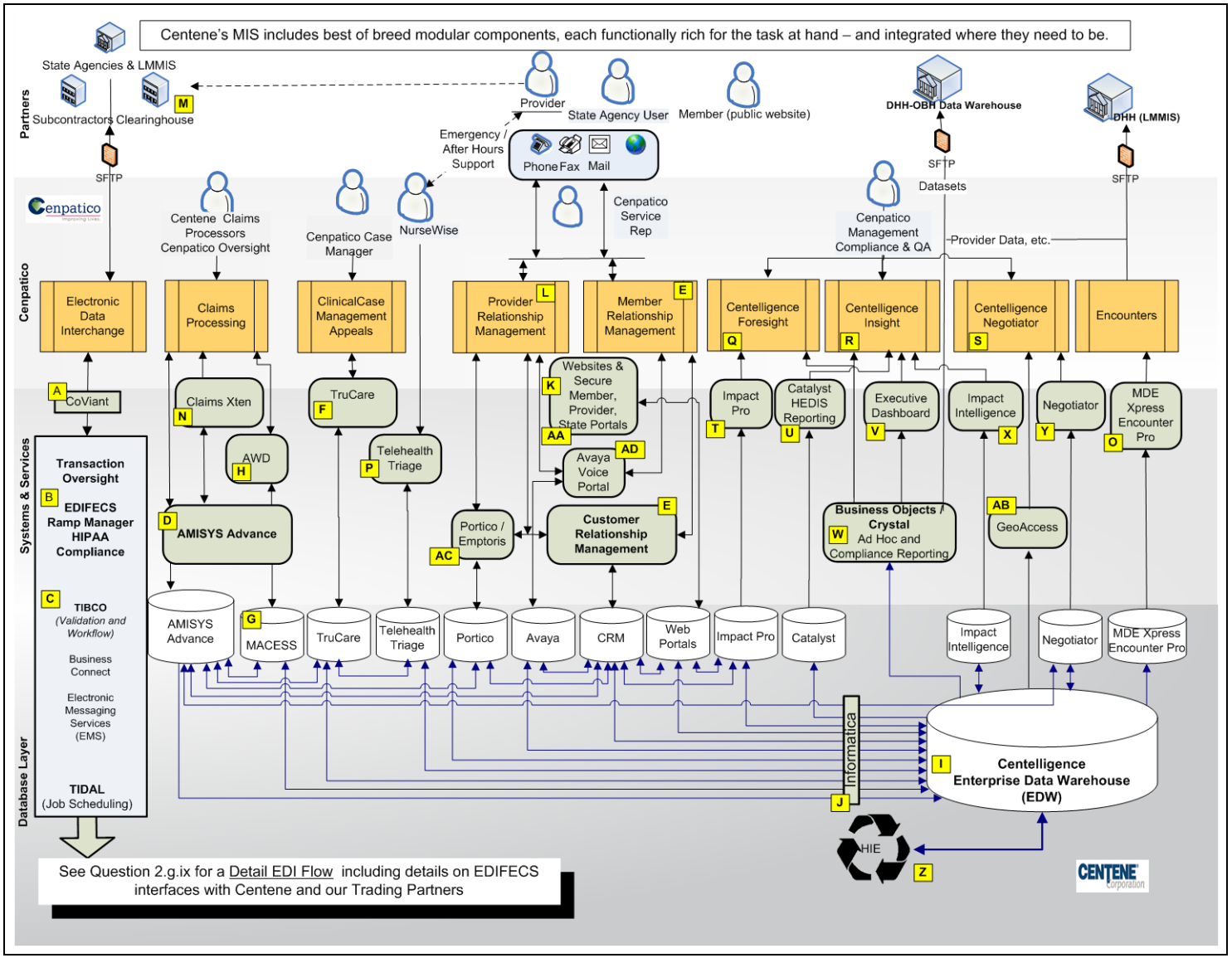
Business Intelligence: Collectively, the integrated items **I**, **Q**, **R**, **S** ,**T**, **U**, **V**,**W**, **X**, **Y**, and **AB** in Figure 2.g.iv-A represent Centelligence™, our proprietary and comprehensive existing and planned family of integrated decision support and health care informatics solutions. Our Centelligence™ enterprise platform integrates data from multiple sources and produces *actionable* information: everything from Care Gap and Wellness Alerts, to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, and standard and ad-hoc desktop reports. Please see Figure 2.g.iv-E: Centelligence. Centelligence™ continually analyzes an enormous amount of transactional data (e.g. claims, lab test results, authorizations), producing "business intelligence" and delivering the right information products to the right person (e.g. Care Manager, MSR, Provider, and WAA,) for the right task (e.g. clinical intervention, internal workload adjustments, client reporting) at the right time (e.g. on schedule, or "in real time"). Please reference question 2.g.xii for more information on our Centelligence™ platform. The Centelligence™ family includes:

- Centene's **Enterprise Data Warehouse** (EDW), which integrates behavioral, medical (if available), pharmacy claims, member and provider demographics, and assessments, into a centralized repository. During 2010, we implemented a *significant* upgrade to our Enterprise Data Warehouse (EDW) with the incorporation of the **Teradata®** Extreme Data Appliance. This major capital investment significantly improves our ability to handle truly large amounts of data in much shorter timeframes.
- **Centelligence™ Insight** - our SAP BusinessObjects based desktop reporting and management KPI Dashboards capability, as well as our integrated incorporation of Ingenix's Impact Intelligence clinical quality and utilization tools. Both of these solutions will afford Cenpatico and our providers (including WAAs) the practice and peer level profiling information.

- **Centelligence™ Foresight** - incorporating our Impact Pro, and Centene proprietary predictive modeling and Care Gap/Health Risk identification applications. Foresight is a multi-dimensional, episode-based predictive modeling and care management analytics tool integrated with our EDW.
- **Centelligence™ Negotiator** – our contract modeling application that leverages historical market information to aid in the analysis of new or modified provider contracts. New contract configurations (fee schedule, etc.) can then be electronically fed to AMISYS Advance to accelerate and simplify the implementation of the contract. GeoAccess (item **AB** in Figure 2.g.iv-A), another component of Centelligence™ Negotiator, is our provider network geographic access analysis software.

Item **Z** in Figure 2.g.iv-A depicts, our ability to exchange standards based data in support of Electronic Health Records (EHR) and Health Information Exchanges (HIE). We support standards such as HL-7, and the XML-based Continuity of Care Document (CCD). Please see section g.x for more information.

Figure 2.g.iv-A



Secure Provider and State Agency Portals: Item **K** in Figure 2.g.iv-A represents our secure web-based Provider and State Agency Portals. Please see our response to section 2.g.viii for more information on our provider portal capability, and section 2.g.v and 2.g.xix for information on how our portal will support Wrap Around Agencies (WAA).

Case Example: Our MIS at Work for the CSoC Program. We would like to summarize key aspects of our MIS by walking through an important **LBHP use case** in cursory fashion. Please refer to Figure 2.g.iv-F: CSoC: Referral & Intake, Assessment, and POC for the following discussion. In Item **A** in Figure 2.g.iv-F, a youth, parent, caregiver, provider (including LGEs and FSOs), WAA, or state agency refers a child to Cenpatico (**B**) for the CSoC program via phone or (in the case of state agency or provider - via the web (**2**)). The caller accesses us through our Avaya Voice Portal (**1**) where they are immediately connected to a Cenpatico Member Services Representative (MSR - **C**). The MSR performs basic intake functions; entering the appropriate information in MRM (**3**), and "warms transfers" the inbound call to a Case Manager (CM - **D**). The CM pulls up the MRM member record and administers a Brief CANS MRM form (item **4**) - and this information, along with the member demographics is posted to TruCare (**5**) in near real time through our SOA. Assuming the child is eligible for CSoC enrollment (e.g. at risk of out-of-home placement), and assuming there is a WAA in this example for this child's service area, the CM approves in TruCare (**5**) 30 days of community services to be coordinated through the "referred to" WAA. These authorizations flow real time to AMISYS Advance for subsequent claims processing, when corresponding claims are filed with us (**6**). Upon CSoC enrollment, MRM will automatically issue a secure e-mail to an Independent Assessor (IA - **E**)- along with a pre-filled Comprehensive CANS PDF. If the IA cannot support receipt of our secure e-mail link, we will also support online entry of the CANS assessment on our Provider Portal, or outbound fax (or certainly regular mail). Meanwhile our Centelligence™ EDW (**7**) is receiving data concerning the child's demographics and enrollment in CSoC via real time updates from MRM and TruCare. As part of the "bi-weekly dataset", EDW sends the child's demographics and CSoC enrollment status to DHH-OBH's data warehouse via (we suggest) an outbound HIPAA 834 (please see our discussion in section g.vii titled *Example 2: Referral - to - Eligibility Record* - for more information on our recommended approach). Once the IA (**E**) has completed the Comprehensive CANS - that data is loaded into to the member's care record in TruCare. The "loading method" depends on *how* the IA has sent us the completed assessment: either direct entry by the IA via the web (Provider Portal); or import of completed CANS assessment from PDF (emailed securely back to us); or OCR of faxed or mailed completed assessment (via our Enterprise Content Management (ECM) system). In any event, the completed Comprehensive CANS will be securely visible to the IA and to the WAA (**F**) via our secure Provider Portal - to help inform the WAAs development of the Plan of Care (POC). The WAA will be able to enter the POC online via our Provider Portal - and (again) this information will be attached to the child's care record in TruCare; and viewable by all authorized direct and extended members of the WAA (e.g. Wraparound Facilitator and the Child & Family Team (**G**), and providers involved with this particular CSoC case (**E**,**G**,**I** and **H**). The latter also might include an LEA (**I**) accessing the child's information via our State Agency Portal; and/or submitting encounters for coordinated services from school employee providers (see our response to g.xxx for more information). Claims are submitted to us for services rendered to the CSoC child via online entry on our Provider Portal (including encounters from LEA over our State Agency Portal); or via paper; or via EDI - and these claims are matched (where appropriate) with authorizations already loaded in AMISYS Advance. Finally, on one of the daily HIPAA 834 files from the LMMIS, we will obtain information assigning the CSoC child to Medicaid, or to some other funding stream, and we will systematically update the child's eligibility in MRM (and thus downstream systems) accordingly.

Figure 2.g.iv-B: MRM

Figure 2.g.iv-B: MRM Centene's **Member Relationship Manager** (MRM) enables Cenpatico to ***identify***, ***engage***, and ***serve*** our members in a holistic and coordinated fashion – across the breadth of their wellness, clinical care, administrative and financial matters related to their benefit plans.

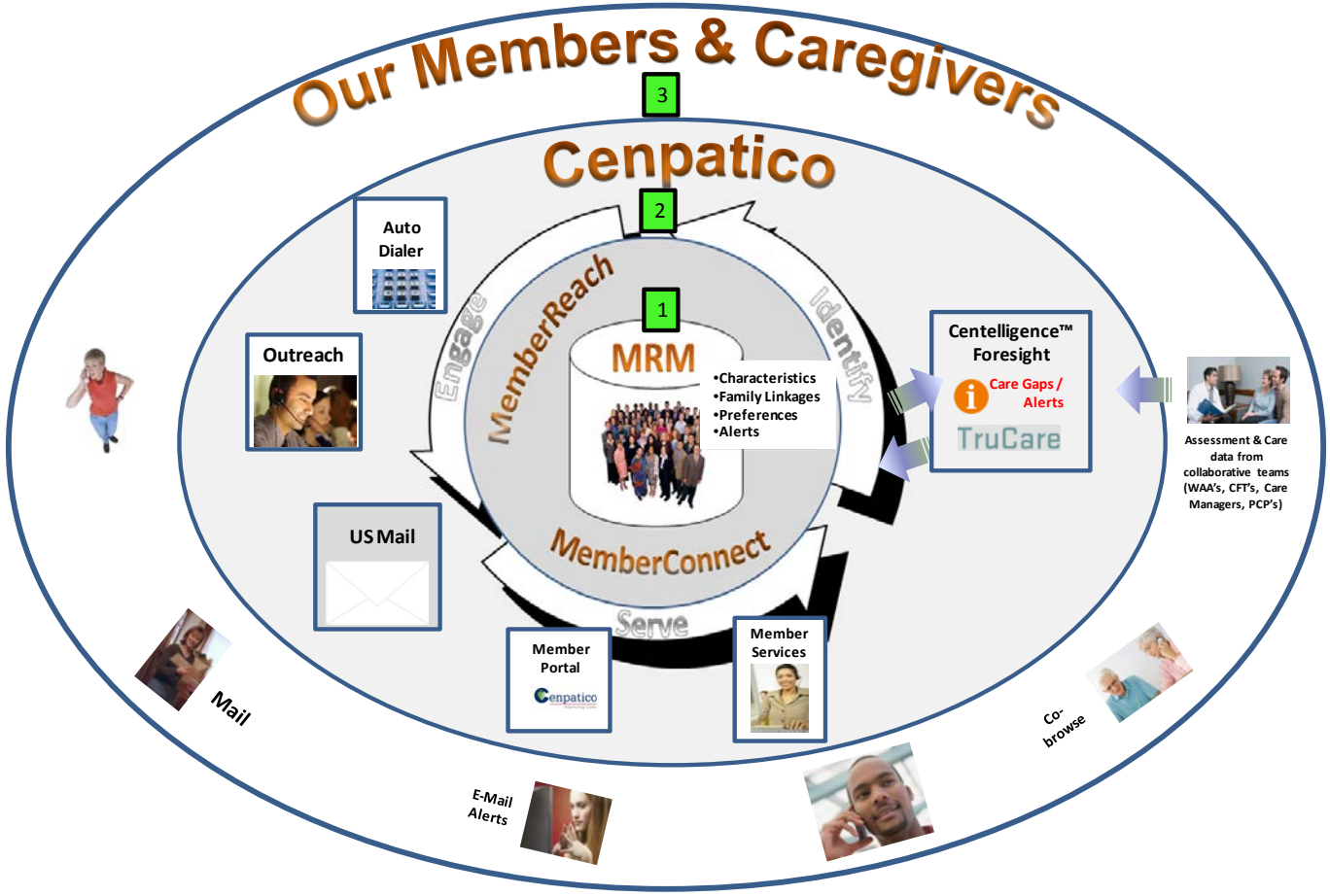


Figure 2.g.iv-C MRM Components

Figure 2.g.iv-C: MRM Components: We have built MRM on best of breed contact relationship management (CRM) and provider data management technologies, customizing service workflow support for our local Plan needs, and integrating with our suite of applications to provide a *holistic service experience* for our providers.

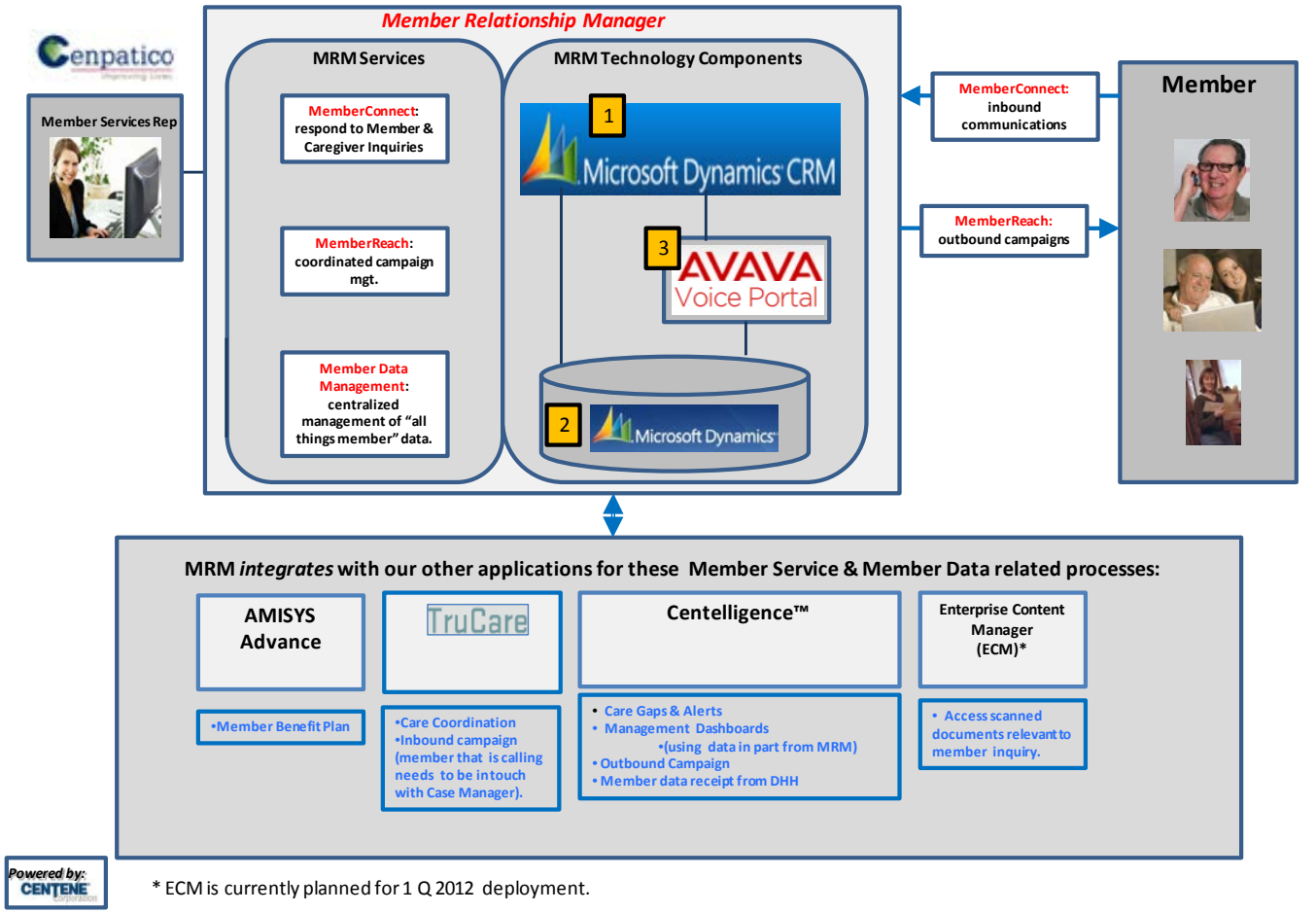


Figure 2.g.iv-D PRM Components

Figure 2.g.iv.D: PRM Components : We have built PRM on best of breed contact relationship management (CRM) and provider data management technologies, customizing service workflow support for our local Plan needs, and integrating with our suite of applications to provide a *holistic service experience* for our providers.

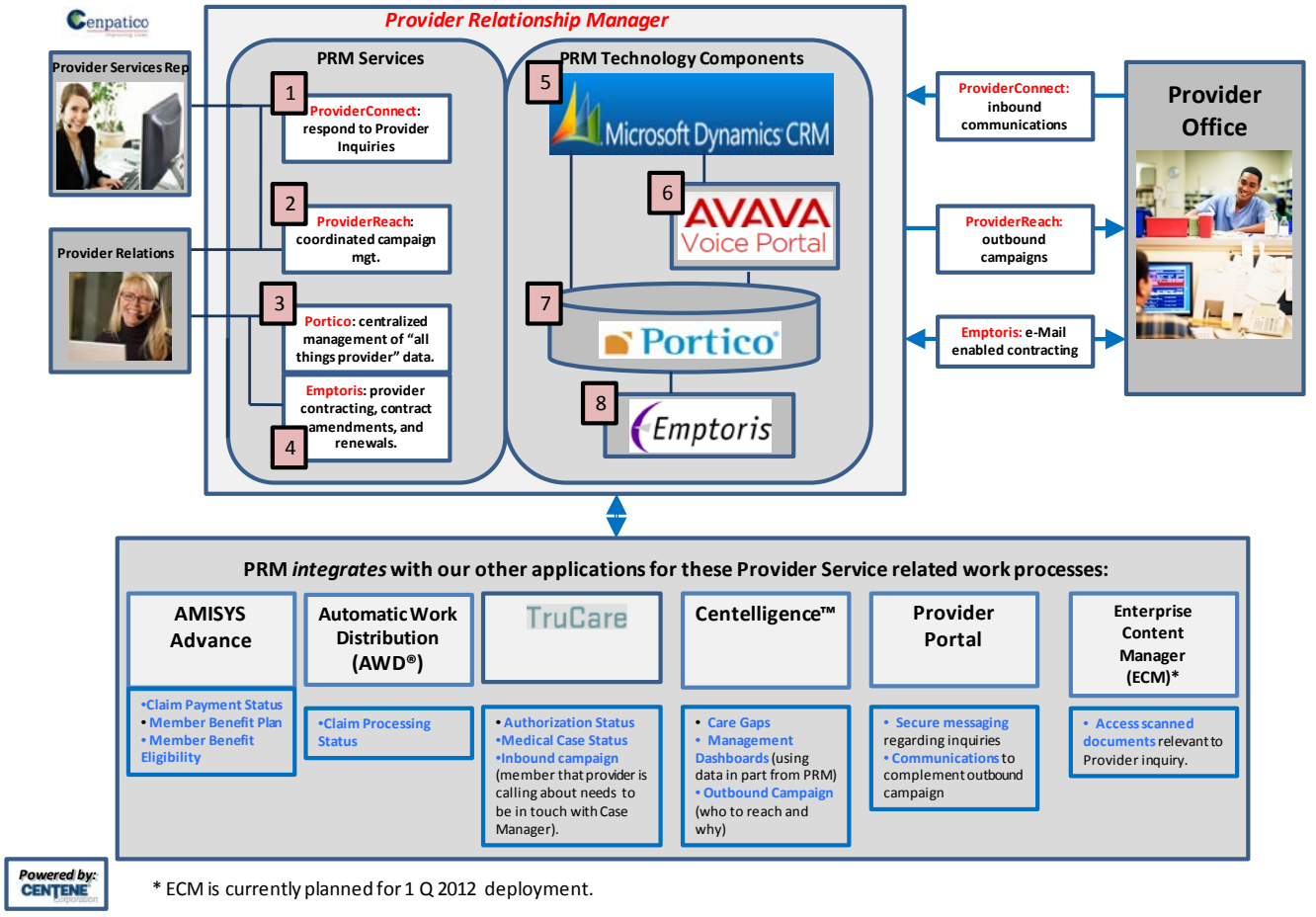


Figure 2.g.iv-E: Centelligence

Figure 2.g.iv.E : Centelligence™

Centelligence™ is Cenpatico's and Centene's trademarked brand name for our existing and *planned* **family** of integrated decision support & healthcare informatics solutions. Our Centelligence™ enterprise platform **integrates data** from multiple sources and produces ***actionable information***: everything from Care Gap and Wellness Alerts, to Key Performance Indicator (KPI) Dashboards, Provider Clinical Profiling analyses, population level health risk stratifications, and standard and ad-hoc desktop reports.

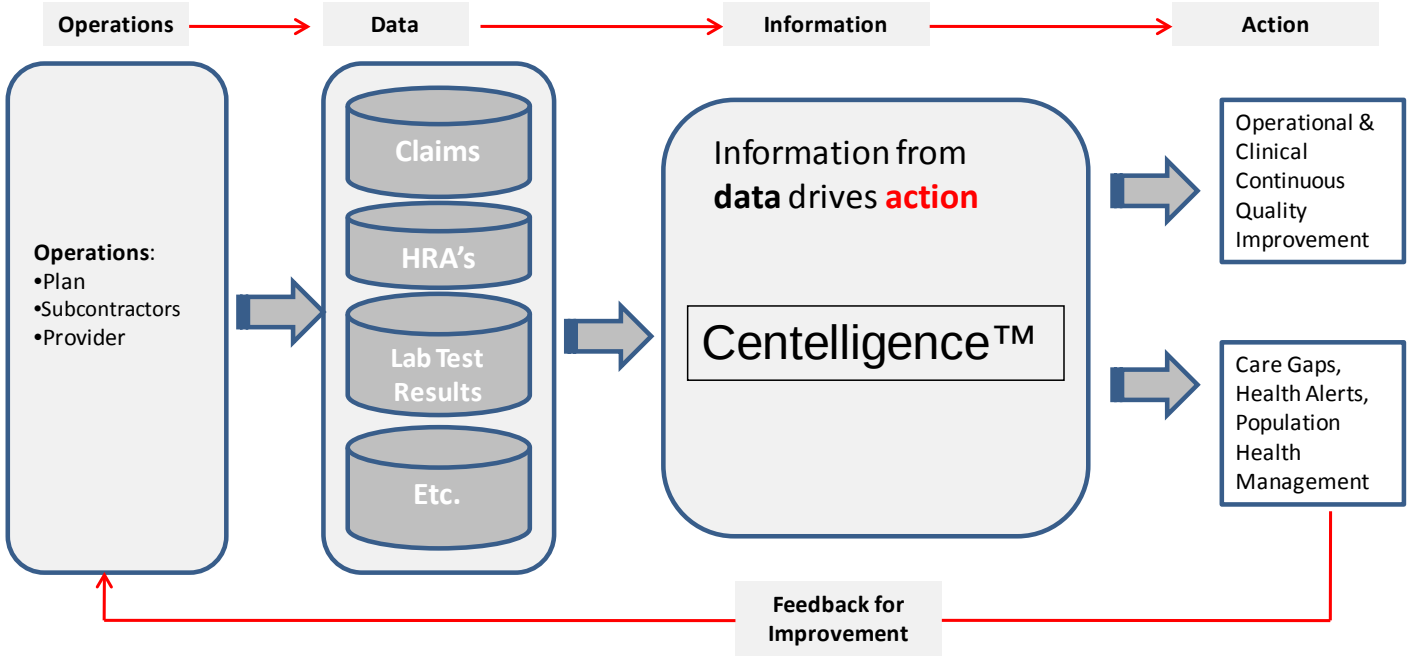
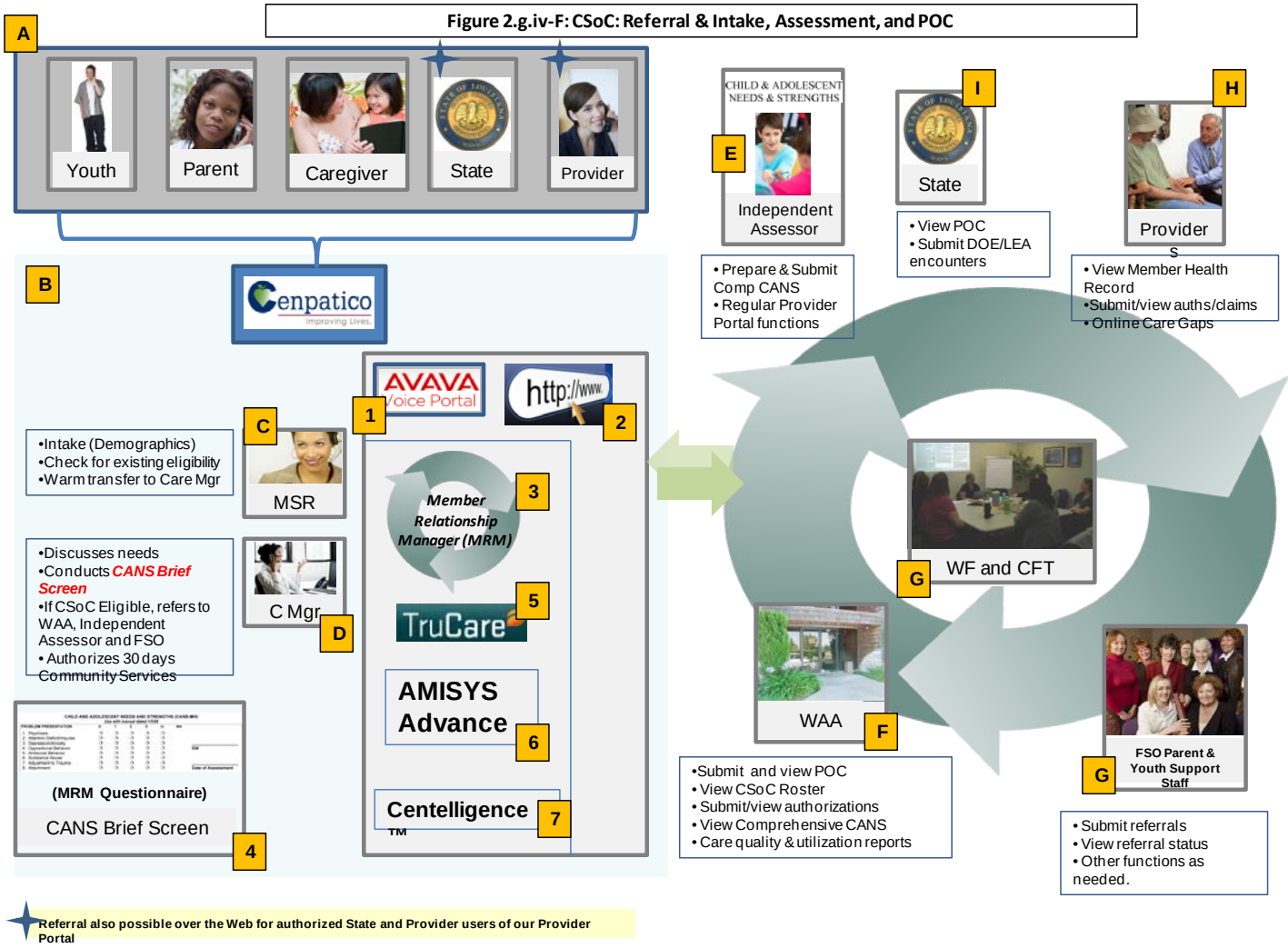


Figure 2.g.iv-F: CSoC: Referral & Intake, Assessment, and POC



2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
v. Describe how the BH MIS will electronically and securely interface with the DHH Medicaid Medical Information System (MMIS) system, the WAAs, the DHH-OBH data warehouse, including the capability of interagency electronic transfer to and from the participating state agencies (DHH, DHH-OSH, DCFS, DOE, & OJJ) as needed to support operations. **Suggested number of pages 3**

Technologies To Support Multiple Interface Needs

With our 27 years public sector health administration experience with complex programs such as the LBHP, Cenpatico and Centene have necessarily architected an MIS that can send and receive (or present online) the right data at the right time to the right state agency, provider entity, or other Trading Partner constituent, with flexibility to support the particular needs or capabilities of that Trading Partner - a particularly important consideration when interfacing with a wide range of providers and agencies (e.g. LGEs, WAAs, FSOs, etc.) across a breadth of urban and rural settings. It is important to note that our integrated MIS supports both behavioral health (BH) and medical programs: although the SMO's responsibilities are focused on BH, the fact that our one unified enterprise MIS supports the entire spectrum of public sector health programs, means that, for example, we can (and do) interface efficiently and reliably with MMIS platforms across 11 states, and that we can receive and process pharmacy and medical claims data.

On the topic of SMO receipt and processing of medical claims data, we carefully reviewed DHH-OBH's document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, and the question and answer at the bottom of page 6 in this document suggests to us that DHH-OBH (perhaps through DHH) will make behavioral (e.g. basic behavioral health services LBHP members receive through the CCNs) ***and*** medical claims data available to the SMO - for all Medicaid funded LBHP members. If this is DHH-OBH's intention, we plan to incorporate (with DHH-OBH's concurrence) this medical utilization data into a number of care coordination and collaboration processes. For example, we will include this medical utilization data in our online Member Health Record (MHR) for our LBHP providers, including LGEs, WAAs and state agency users of our State Agency Portal (please see Section 2.g.x for more information).

For the LBHP program, we will deploy several existing interface capabilities with participating state agencies to support operations; including:

- HIPAA secure EDI file exchanges, including HIPAA Version 5010 compliant transactions, and (where needed) state agency proprietary file formats (e.g. for provider data feeds from us to DHH-OBH data warehouse and to the Louisiana MMIS);
- If desired by DHH-OBH, Extract Transform Load (ETL) processes for "database to database" interfacing between our integrated Enterprise Data Warehouse (EDW) and the DHH-OBH data warehouse for selected datasets;
- Secure online access to our State Agency Portal, allowing authorized state agency users to make referrals to an LBHP program (e.g. CSoC), check existing LBHP eligibility, upload documents (e.g. Individualized Education Plans (IEP) for DOE/LEA users), submit encounters via HIPAA Direct Data Entry compliant online facilities (for DOE/LEA users), and access reports and ad-hoc "data mining" access to our Enterprise Data Warehouse.

Interfacing with the Louisiana MMIS (LMMIS)

Our MIS is fully capable of receiving and processing HIPAA 834 eligibility and enrollment files on a daily update and monthly basis (per RFP Section K). Our COVIANT Diplomat Transaction Manager (COVIANT) handles our automated, scheduled production file exchanges, including the 834, with the MMIS systems we interface with (for both transmission and receipt). We support all standard industry data communication protocols such as Secure FTP–SFTP (SSH), FTPS (TLS/SSL), PGP encryption over the internet or via a Virtual Private Network (VPN). Our integrated EDIFECS EDI subsystem checks for HIPAA compliance, issues ANSI 997 (or 999 for HIPAA 5010) functional acknowledgements back to the MMIS, translates the data and (via our TIBCO middleware) posts the data to our production Member Relationship Management (MRM) system, for use by our integrated core applications (claims, authorizations, care management, etc.). Eligibility data we receive from the MMIS is posted to our production systems within 24 hours of receipt. Please see Section 2.g.xvii for more information on our experience in processing the HIPAA 834.

Per the RFP related document: **LABHSwimLane052711**, page "*Swimlane Resource F: Credentialing, Licensure and Certification*", we will also transmit securely provider network data to the LMMIS per DHH format specifications. We routinely send provider data to the MMIS systems for our health plans, and we send this provider data from our Provider Relationship Management (PRM) system, through our EDW. Please see Section 2.g.iv for more information on PRM.

Our MIS is also capable of processing HIPAA 820 Premium Notice transactions, should DHH make these available; to assist with premium reconciliation processes.

Experience With MMIS Transitions. We realize that, over the course of the SMO contract, DHH intends to replace its existing MMIS. We will comply with any transitional requirements as necessary should DHH implement a new MMIS. We have relevant experience among our other state clients with just this scenario. For example, in 2010, one of our state clients migrated to a new Fiscal Intermediary (FI) and a new MMIS. In anticipation of that cutover, and working with the state and the new FI, we successfully implemented, tested, and deployed changes to support new:.

- Enrollment and eligibility file exchanges
- Encounter and associated file exchanges
- Additional reference file exchanges

We accomplished all of the above, and more, at no cost to our state client or the FI.

Leveraging the Web to Interface with the LGEs, WAAs and other Network Providers

We will deploy our secure web based Provider and Portal to serve not only our LGE and other BH providers, but the Wraparound Agencies (WAAs) as well - for a number of functions:

- **Online support for the referral process** - allowing the LGE, WAA, or other network provider to check LBHP eligibility on a child, refer the child to the CSoC program and receive acknowledgment and check status (please see Section 2.g.vi for additional information).
- **Ability to enter Plans of Care (POC)**. The LGE, WAA or other network provider will be able to either upload a scanned image of the POC, or enter the POC online; allowing our Care Managers to review the POC quickly and authorize 30 days of community care for the child. Our Provider Portal is integrated with our TruCare collaborative care and utilization management platform.
- **Ability to view the TruCare Service Plan**. The LGE, WAA or other network provider will be able to view at any time the ongoing treatment plan (TruCare Service Plan) to help the Wraparound Facilitator (WF) and Child and Family Team (CFT) to collaboratively manage care in coordinated fashion. Please see Section 2.g.x for more information.

- **Ability to view and download the roster of children currently enrolled in the CSoC with the WAA**. In addition, if the WAA is so equipped and desires, we have the ability to issue this roster in HIPAA 834 format securely via https file transfer in our Provider Portal.
- **Ability to view the BH Member Health Record (BH MHR) of the enrolled CSoC child**. Authorized provider users will have access to the Provider Portal BH MHR - which will display summary demographics, BH utilization, and (where we have received from DHH-OBH), medication utilization. Please see Section 2.g.x for more information.

In order to take advantage of the above capabilities, our LGE, WAA and other network providers will need standard internet access, with a reasonably recent version of a web browser (Internet Explorer 7 or above). No significant browser add-in software is needed, aside from Adobe Acrobat (free) for PDF viewing. We will provide all providers (LGEs, WAAs, etc.) with user documentation for the Provider Portal; as well as training prior to 3/1/2012, and ongoing support via our Cenpatico Provider Services department.

Interfacing with the DHH-OBH Warehouse

Should we have the privilege of serving the LBHP program, upon contract award we will immediately meet with DHH-OBH and present interface alternatives for the DHH-OBH warehouse. We can accommodate two broad alternatives for data integration with the DHH-OBH warehouse. Both scenarios involve interfacing with our enterprise scale, Centelligence™ EDW: our Teradata based data warehousing engine that integrates data from our core internal applications (claims, member eligibility, provider, care management, etc.) as well as external sources (pharmacy claims, external prior utilization, etc.) - all in near real time (please see Section 2.g.iv, x, and xii for more information). In terms of interfacing with the DHH-OBH warehouse:

- We can issue batch files for individual data sets. For example: today we issue outbound HIPAA 834 eligibility files for a variety of purposes (e.g. to convey member demographic changes that our members inform us of). We recommend that DHH-OBH consider the use of the HIPAA 834 from us - to support the *referral* - to - *assignment to funding stream* process (see Section 2.g.vii).
- We can also support Extract Transform Load (ETL) processes for a "database to database" (EDW to DHH-OBH warehouse) integration approach.

In reality, the above options are not mutually exclusive; but can be used judiciously depending on the dataset, transmission frequency, and data latency considerations, and we look forward to discussing DHH-OBH's integration needs in more detail.

In addition to the above, we will also enable online access to DHH-OBH and other authorized state agency users to our EDW via our SAP Business Objects interactive reporting toolset. Please see Section 2.g.x and 2.g.vii for more information.

Our MIS is fully capable of supporting the invoicing and supporting data requirements (e.g. spend down and retroactive encounter data for Adult Medicaid) called for in RFP, Section K. We have reviewed the requirements in Section K, and recommend the use of HIPAA 837 formats from us to DHH-OBH or DHH wherever possible to support these processes (e.g. for spend down and retroactive eligible expenditure data from Cenpatico to DHH-OBH and/or DHH). ***Figures 2.g.v-1: Medicaid Related Payment Flow*** and ***2.g.v-1: Non-Medicaid Related Payment Flow*** graphically depict our understanding of the key file exchanges needed between the State Agencies and Cenpatico for the payment, invoicing, and supporting data flows between all parties. In ***Figure 2.g.v-1: Medicaid Related Payment Flow***, we recommend the use of HIPAA 837 formats for items **A3** (Adult Spend Down & Retroactive Eligible payment details) and **B2** (Child Medicaid encounters). In ***Figure 2.g.v-2: Non-Medicaid Related Payment Flow,*** item **E2** symbolizes the data specified in the RFP Section K.13.b (page 164), to substantiate administrative activities performed by the SMO in service of DHH-OBH Non-Medicaid eligible members of the LBHP. For the period (per RFP) that DHH-OBH pays the providers directly, we

will supply the data for E2 from our EDW - which contains all encounter, care management (including authorizations), call related statistics, and other member (client) level activity. In the case of items F2 and G2, we again suggest the use of the HIPAA 837 as most likely the most efficient data interface to support DCFS and OJJ in these processes, but we will, with the cooperation and guidance of DHH-OBH, consult with DCFS and OJJ to determine final specifications.

A State Agency Portal for Supporting LBHP Operations

We will offer access to all authorized users at DOE (and the LEAs), OJJ, DFCS, and DHH-OBH, to our secure, web based State Agency Portal (Portal). Through the Portal, authorized users will be able to:

- **Submit referrals for LBHP programs** (in exactly the same manner as WAAs and other authorized provider users of our Provider Portal), as well as the ability to query eligibility on members.
- **For DOE/LEA: submit IEPs / IHPs** for use by our Care Managers and subsequent authorization of services for LBHP members in our TruCare system.
- **For DOE/LEA BH services delivered by school employee providers: submit encounters** in HIPAA format via our HIPAA DDE compliant claims entry facility, with navigational aids, prompted edits, and contextual help.
- **Online access to our BusinessObjects online reporting tools**.

Upon contract award, and after consultation and guidance from DHH-OBH, we will ask each of the four agencies for a formatted data list of individual users with appropriate identifiers - e.g. "Agency Employee Number", and other identifying demographic information, so that we can provision State Portal accounts for each user. We can also - with approval from DHH-OBH, set/up master user accounts for DHH-OBH and/or each Agency - so that each "master Agency user" can create and maintain State user accounts for their respective Agency.

Secure Online Access. In addition to the above, we can (and do, where needed) securely access interactively designated applications at our state agency clients: for example - in one state our staff access an online agency database for the entry and management of behavioral health grievances and appeals. We support all industry standard methods of access to agency systems, including VPN over the Internet, dedicated lines, Citrix MetaFrame, Microsoft Terminal Services, and of course, Secure Sockets Layer (SSL) and https for access over the Web.

Secure e-Mail. We also support HIPAA compliant secure e-mail communications (e.g. any communication containing Protected Health Information [PHI]) between systems, sites, and/or domains through Transport Layer Security (TLS), an industry standard protocol for securing electronic communication. Our messaging systems also support industry standard protocols such as S/MIME and SSL. GlobalCerts SecureMail gateways at our network perimeter provide seamless gateway-to-gateway encryption with remote SecureMail Gateways using the SecureTier™ certificate management system. For agencies that do not use SecureMail Gateways or support encryption technologies, Cenpatico secures any email communications via the GlobalCerts SecureMessenger service that allows provider users to encrypt messages to any Cenpatico recipient. We also use Vericept's data loss prevention tools to monitor and control PHI data usage, both in motion as well as at rest.

Figure 2.g.v-1: Medicaid Related Payment Flow

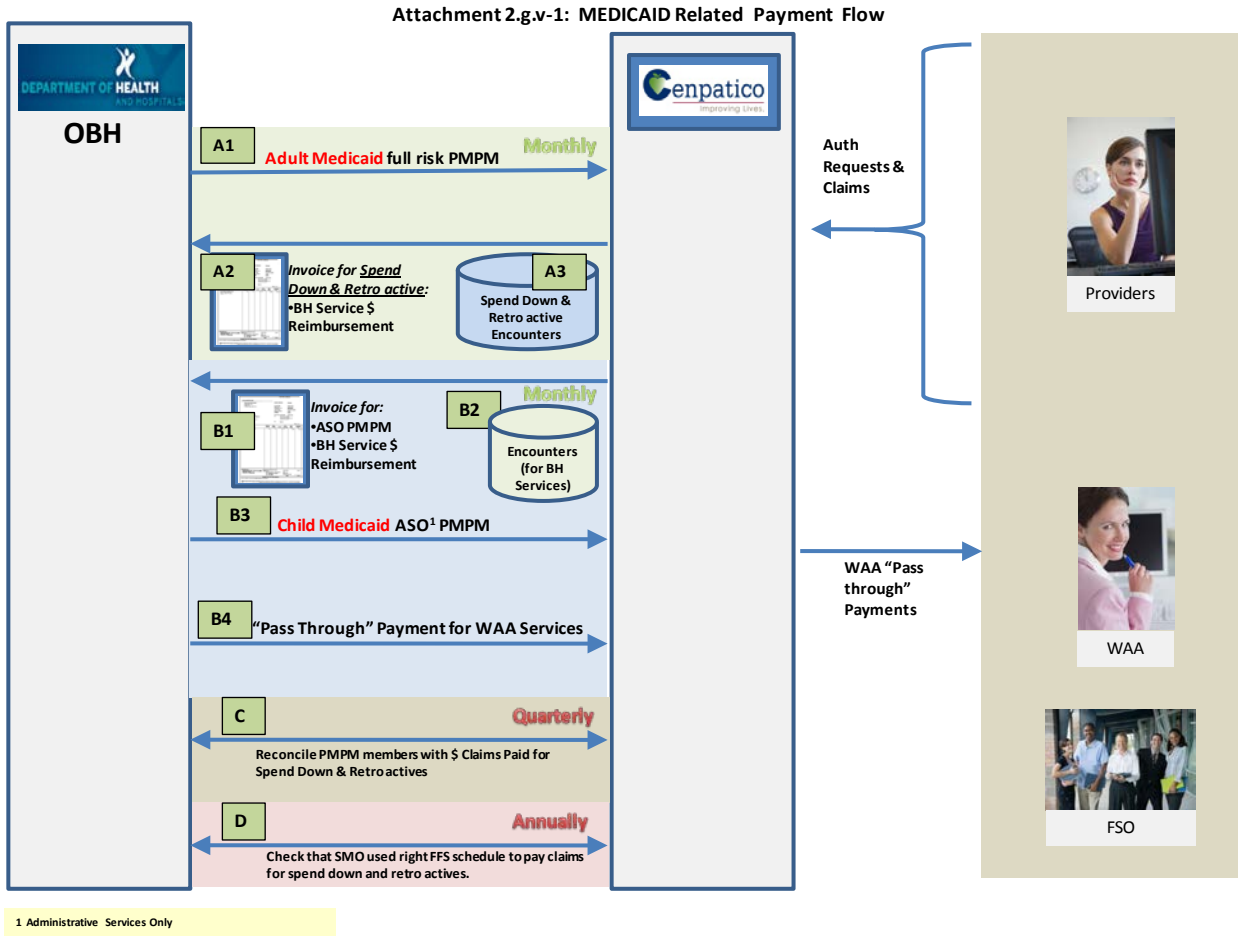
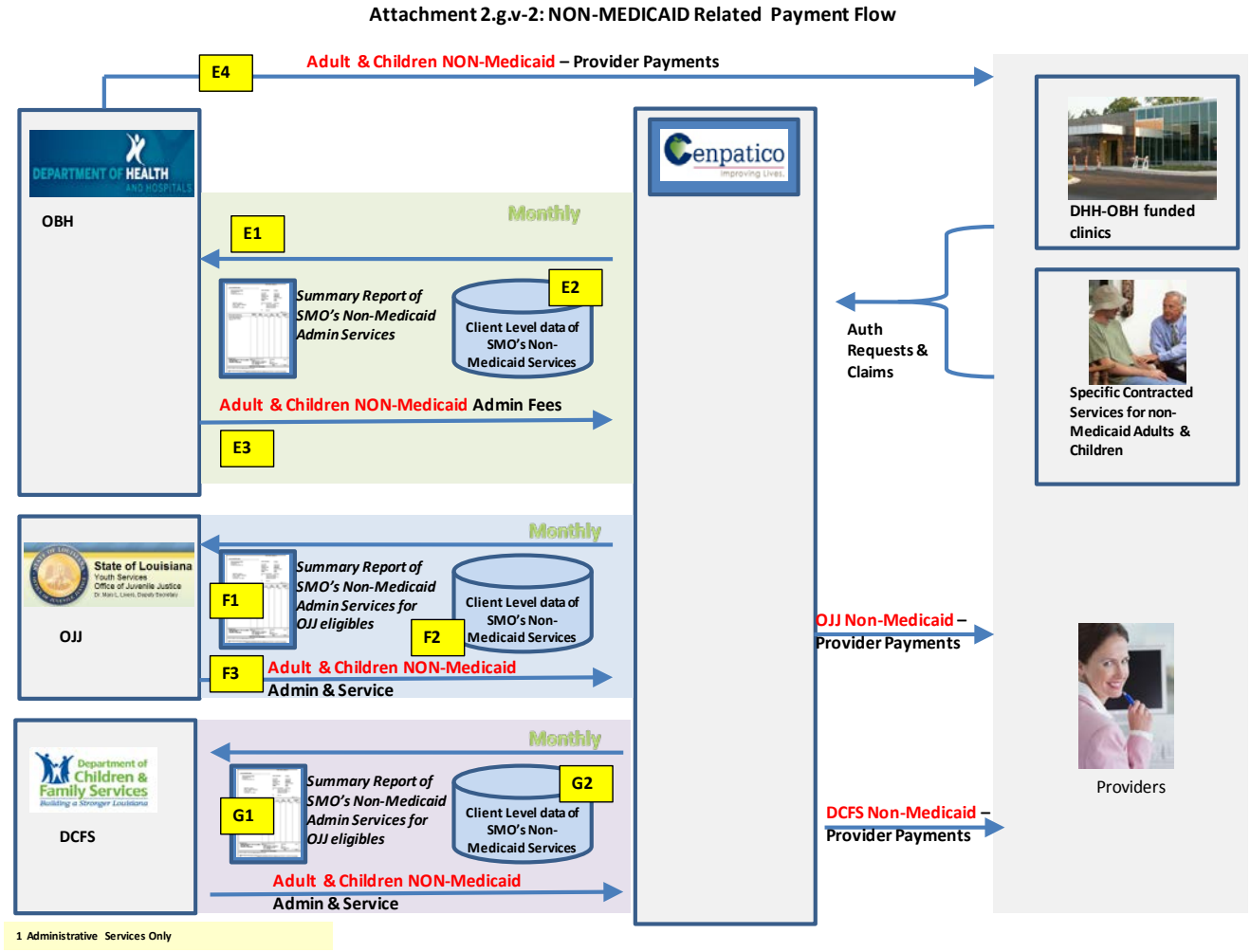


Figure 2.g.v-2: Non-Medicaid Related Payment Flow



2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
vi. Describe Proposer's web-based capabilities to receive and respond to providers and State agencies for referrals and prior authorizations for services. Suggested number of pages 2

Use of the web will be critically important for data management, immediate communications, transparency, and overall efficiencies whether it is daily operations or during critical events. Cenpatico's intelligent design of multiple functions and access points online that are both Section 508 compliant and mobile compatible takes the basic user experience to a different level in preparation for both health reform and disaster responsiveness. Our streamlined tools and processes flag potential fraud and abuse and yet can connect a myriad of stakeholders across agencies, first responders, as well as traditional members and providers with relevant information. Based on discussions with Louisiana providers, Cenpatico has begun creating simplified training modules specifically for regional providers to mentor them on elements such as basic billing to electronic health record best practices.

Support for Secure Web Based Applications & Workflow for Providers and States

Through Centene, Cenpatico offers today a variety of web-based, online behavioral health (BH) administrative and clinical transactions via our secure Provider Portal, including HIPAA compliant online claim submissions, eligibility inquiry, claim status inquiry, authorization submission and more. We are in the process of expanding our Portal functionality across the Centene and Cenpatico nationwide, and have already begun introducing support for direct batch HIPAA 837 claim submissions, support for online attachments (for complex authorization and claim support), online member health records, Service Plans, care gap notifications (driven by systematic predictive modeling analysis), and a growing set of online provider reports. In recent years, as the number of our provider web applications has grown, and as broadband access has become common even in rural areas, the usage of our web-based secure Provider Portal has grown exponentially. For example, from January of 2008 through December of 2010, the number of our medical (PH) ***and*** BH providers registering on our Provider Portal has grown at an average compound growth rate of **180% per year**. We also offer a version of our secure Portal for *State Agencies*, including access to state-specific program data housed in our Teradata-powered Enterprise Data Warehouse (EDW), via our integrated set of SAP Enterprise Business Objects decision support applications.

Web Based Referrals & Authorizations for the Louisiana Behavioral Health Partnership (LBHP)

We propose to configure our secure web portal technology, our enterprise Customer Relationship Management (CRM) system, our secure e-mail workflow capabilities, and our integrated HIPAA EDI applications to systematically support the unique data and workflow needs of the LBHP referral and prior authorization process. Please see ***Figure 2.g.vi.-1: Web Referral Flow*** (Figure), depicting a summary graphic of our proposed configuration for DHH-OBH and for the following discussion.

In item **A** in the Figure, authorized users from DHH-OBH, OJJ, DOE (or an LEA), and DCFS access our LBHP State Portal (item 2). Upon contract award, and after consultation and guidance from DHH-OBH, we will ask each of the four agencies for a formatted data list of individual users with appropriate identifiers - e.g. "Agency Employee Number", and other identifying demographic information, so that we can provision State Portal accounts for each user. We can also - at the option of DHH-OBH, set/up master user accounts for DHH-OBH and/or each Agency - so that this "master Agency user" can create and maintain State user accounts for their respective Agency.

Assisted Data Entry for Referrals. Once the user (**A**) is logged into our State Portal (2), they will be able to enter a referral and/or perform an eligibility search - so that (for example) if the referred person is already present in our Member Relationship Management (MRM - item 3) system, the referral screen in

our State Portal can pre-populate member demographics for the State user. MRM is our enterprise CRM for member service inquiry, associated workflow support, and housing our master member data set - our internal "system of record" for "all things member related". We have built MRM using Microsoft Dynamics, integrated with our Microsoft Exchange messaging platform and with our core applications. MRM has an internal Master Member Index (MMI) which ties together all the relationships we have (or have had) with an individual member or presumptively eligible member.

Using SOA to Manage Data Integrity Efficiently. Proceeding with the flow in the Figure, the State user will complete our online Referral form, indicating the LBHP program they wish to refer the "referred person" to (e.g. CSoC, DHH-OBH Adult). Completion of the referral will automatically kick off appropriate workflow in MRM (3). For example, if the referred person is not in MRM as currently eligible or enrolled in an LBHP program (Medicaid or non-Medicaid funded), MRM will denote that the member is *presumptively eligible* - and immediately promulgate (via our message-based Service Oriented Architecture (SOA: item 4)) that "presumptive eligibility" data to our core systems - including the system most relevant for this discussion: TruCare (5): our collaborative care, service planning, and utilization management platform. Please note that the exact same referral submission process will be available to authorized users of our Provider Portal (6) at Wraparound Agencies (WAAs: item C), Family Support Organizations (FSO: item D), and our network of BH providers (item E). Item E also includes "school based BH providers" that are not school employees (see our response to 2.g.xxx (DOE Encounter Data) for more information).

Driving Referral & Authorization Workflow Systematically Through MRM. In addition to automatically distributing presumptive eligibility data to our core internal systems, MRM also drives other appropriate workflow. For example, in the case of the LBHP program, if the referral from the State Agency or the provider (WAAs, FSOs, BH provider) is for enrollment into the CSoC program, MRM will immediately create a work item for completion by a Cenpatico Care Manager (CM) to contact the member's parent, legal guardian, or caregiver (responsible person) in order to administer a CANS brief assessment, via an online MRM form that the CM will fill out while on the phone with member's responsible person. Once the CANS brief assessment is completed, that data is attached to the members record in MRM, and MRM will automatically notify TruCare (5) that 30 days of community and other basic services (as denoted by the CM in MRM) are authorized for the child (TruCare is our system of record for all pre-authorization data, as well as all other member-level clinical information). TruCare subsequently immediately issues these authorizations to our AMISYS Advance claims processing system (not depicted in the Figure for graphical simplicity).

MRM will also issue, at the direction of the CM, and via MRM's integration with our Microsoft Exchange server, a secure e-mail to an independent assessor (represented as one type of BH provider in E) - asking the assessor to administer a Comprehensive CANS assessment. The secure e-mail will include a PDF attachment: the Comprehensive CANS assessment, pre-populated with the "referred child's" demographics. Once the independent assessor has completed Comprehensive CANS, the assessor can attach the completed PDF to a reply to MRM's secure e-mail, and MRM will systematically place that completed assessment in the appropriate CM work queue. The independent assessor may also fax or mail the completed Comprehensive CANS assessment to us - in which case our integrated MACESS OCR scanning system will index and route the scanned CANS assessment to the appropriate CM TruCare work queue. We will also make the completed Comprehensive CANS assessment available to the appropriate WAA (C) via our Provider Portal (6), so that the WAA-assigned Wraparound Facilitator (WF) at the WAA can use the Comprehensive CANS to facilitate development of the CSoC Plan of Care (POC) with the Child and Family Team (CFT). Note in the Figure that WAAs (C) will also be able to submit CSoC POCs to us securely via the Provider Portal (please see our response to g.iv (Software and Hardware) for more information).

Authorization Submissions via the Web. Today we offer full support for clinical care authorization submission and inquiry on our Provider Portal (6). Authorized Portal users can access (via HIPAA compliant processes) an eligible member's record, and are guided through the auth submission entry. Please see ***Figure 2.g.vi.-2: Web Authorization Submission Sample Screenshot*** for an illustration of our Provider Portal authorization entry screen. We also allow providers to electronically upload any documents or images that may be required for our CM to approve the authorization request. This last capability may prove especially useful in the CSoC scenario, where a WAA has submitted their POC to us via our Provider Portal, and attaches that POC (as PDF) to authorization requests for BH services from our providers (the WAAs themselves will not be delivering direct BH care services).

Our Provider Portal authorization facility ties in directly to our TruCare system (5) in near real time, so that requests are immediately posted to the member record for review by our CM.

Whether our providers enter authorization requests via our Provider Portal, or fax or call those auth requests into us, Provider Portal users can inquire on the status of any auth request.

Referral and Eligibility. To complete "the picture" in ***Figure 2.g.vi.-1: Web Referral Flow***, we will, as part of our bi-weekly dataset transmission to DHH-OBH, send those members who are presumptively eligible (that is: those members for whom we have had a referral request, but who have not been assigned by DHH-OBH to a specific LBHP funding stream). We are assuming, based on our review of the RFP and Library materials (including the Swim Lane Exhibits), that DHH-OBH, in conjunction with BHSF/MVA, will assign the presumptively eligible member that we send to DHH-OBH - as eligible for Medicaid or another State General Fund (SGF) or Block Grant funded program; and that we will receive this "funding stream assignment" information via the daily and monthly HIPAA 834 files that we receive from DHH-OBH (item F). When we receive the confirmation / assignment of a presumptively eligible member via item F - our MRM will immediately update the appropriate eligibility span record for the member, and we will immediately (if needed) assign the member to the appropriate benefit plan (e.g. Medicaid, DHH-OBH non-Medicaid Adult). This information, again, will promulgate systematically from MRM (3) to our other core processing systems via our SOA enterprise data bus (4). Please refer to our response to g.iv (Software and Hardware) for more information.

Figure 2.g.vi.-1: Web Referral Flow

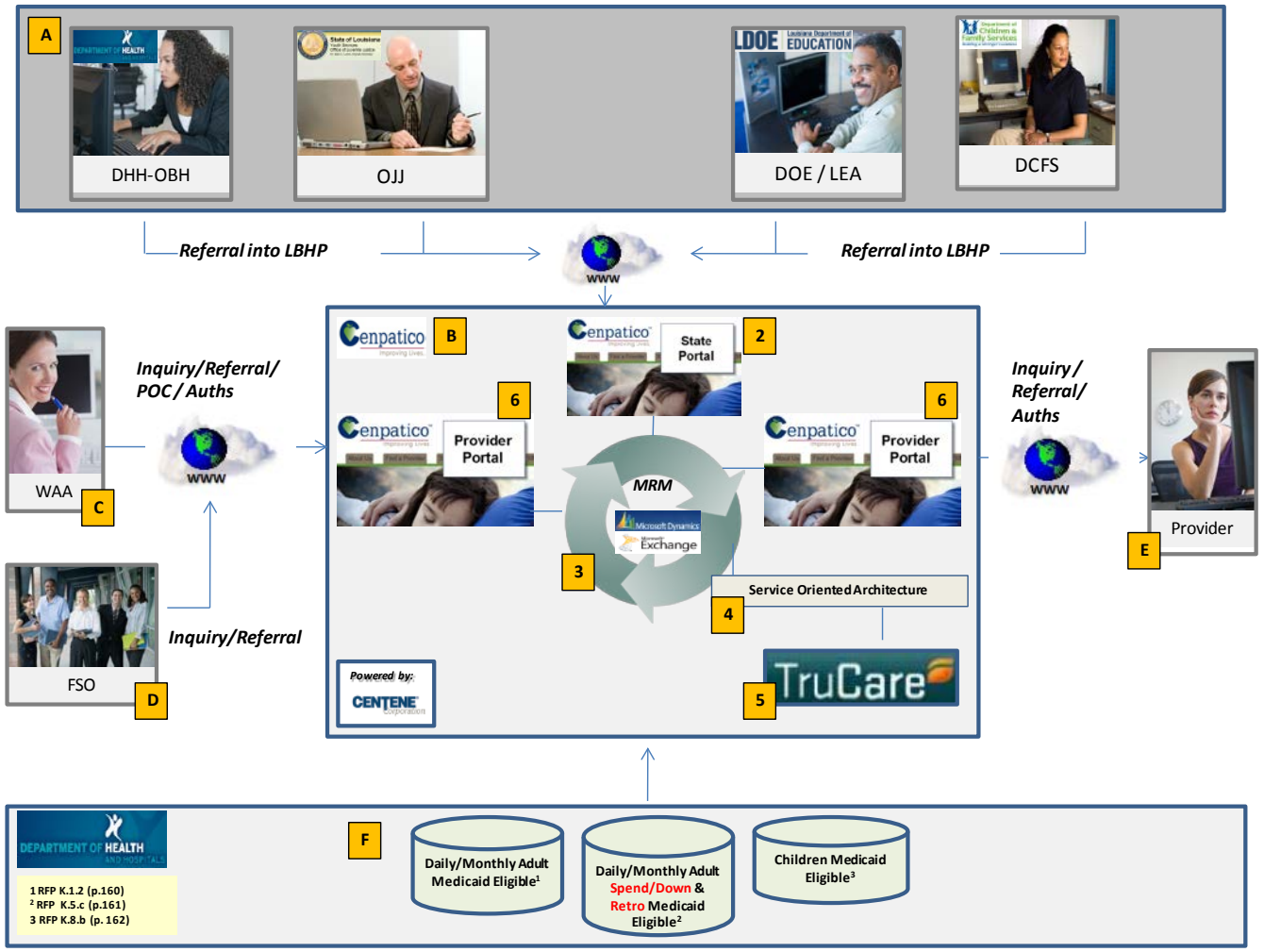
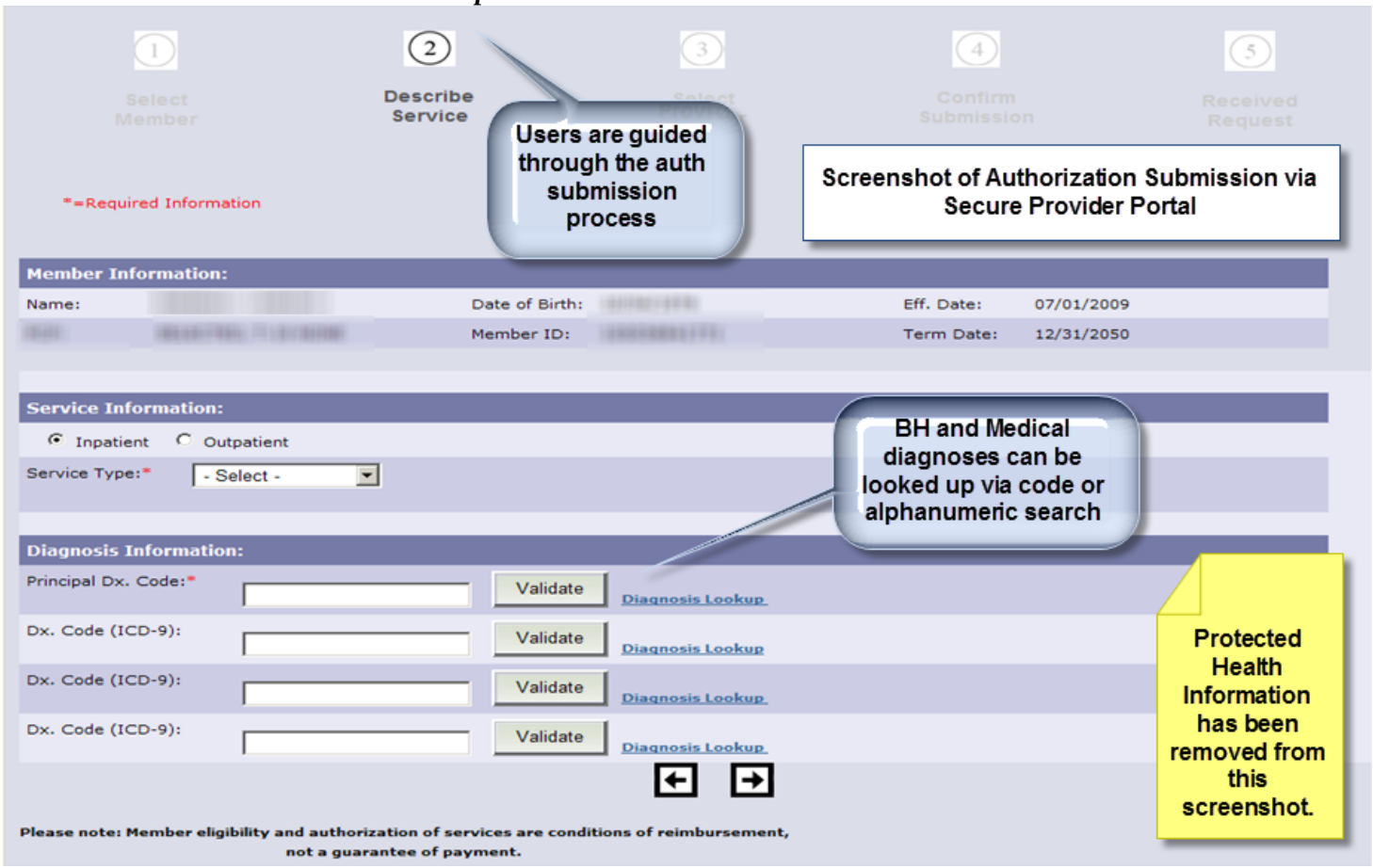


Figure 2.g.vi.-2: Web Authorization Submission Sample Screenshot



2.g. Technical Requirements
vii. Describe how the Proposers BH MIS will meet the requirements for regular (e.g., bi-weekly) electronically transfer client/episode-level recipient, assessment, service, and provider data to the DBH-OBH data warehouse / business intelligence system operated by the State for purposes of state and federal reporting (e.g., SAMHSA National Outcome Measures (NOMS), Treatment Episode Data Sets (TEDS), Government Performance Reporting Act (GPRA,) and for ad hoc reporting as needed by the state for service quality monitoring and performance accountability as outlined in the Quality Management Strategy). Suggested number of pages: 4

National Experience Providing Data To Public Sector State Clients

Through Centene, Cenpatico has over 27 years' experience receiving, processing, reporting, and securely transmitting behavioral health (BH) and medical (PH) client/episode-level recipient, provider, encounter, clinical (including assessment), and other reporting data to our state client agencies, including their Fiscal Intermediaries, for both the direct use of that data by those agencies, as well as reporting for a variety of state and Federal purposes. Today we receive, transmit and supply quality and timely data to state agencies in 11 states (as well as CMS for Medicare) on schedules ranging from daily to annually, depending on the specific information and data product required by our clients. We deliver this data and reporting capability securely and electronically to our state clients via virtually all industry standard protocols.

We have reviewed in detail the requirements in the RFP in Sections II.B.m.iv., II.B.m.vi., II.B.5.k.v.f, II.B.5.k.v.k, II.B.5.k.v.l, II.E.1.n, II.E.5, II.E.6, and II.E.8, and our enterprise, integrated BH MIS can meet all the needs of DHH-OBH's data warehouse / business intelligence system. **In short**, our MIS is able to receive the necessary "input data" from state agencies, providers, WAAs, and members; process that data with complete data integrity; populate our high performance RDBMS data warehouse (EDW - see below); produce the information products and data files needed by DHH-OBH, and transmit that data securely to DHH-OBH's data warehouse using any industry standard communications protocol. We will also enable *online access* to authorized state agency users to our EDW via our SAP Business Objects interactive reporting toolset.

An Engineered Approach to Supplying Accurate and Complete Information

Please refer to ***Figure 2.g.vii.-1: Supporting the DHH-OBH Warehouse*** (Figure) for the following discussion. At the highest level, this Figure depicts the flow of information from the top of the page, from state agencies (item **A**), providers (including LGEs) (**B**), WAAs (**C**), and members (**D**) via electronic data transmissions, secure web portal, telephone, paper mail or fax; to Cenpatico (**E**) - where this data is used for appropriate administrative and clinical purposes (e.g., care and utilization management, claims payment, service authorizations, analytics and reporting); to DHH-OBH and other state agencies (**G**). We ensure the integrity, validity and completeness of the information we send to our state clients through ***four general architectural components*** that make up our integrated Management Information System (MIS). These four categorical components essentially trace the "flow" of data through Cenpatico and to our state client (e.g. DHH-OBH, DCFS, OJJ, and DOE):

1 - External Facing Applications Help to Enforce Data Quality on the Front End. Our "**external facing**" application interfaces and data file upload facilities include all the capabilities and controls we deploy to support data entered by agencies via our State Agency Portal (**1**) and providers (including LGEs, WAAs and FSOs) using our Provider Portal (**2**) and Cenpatico staff using any of our internal business applications. In *particular*, these applications include those that serve as the source of data that will be needed by the DHH-OBH data warehouse in support of the "bi-weekly datasets" referred to in the RFP; including data needed by DHH-OBH in support of NOMS, TEDS, and other federal and state reports:

- **Member Relationship Management** (MRM: (5)) - our member services workflow and master member database: the source of member demographics and current and historic eligibility.
- **AMISYS Advance** (7) - enterprise medical and behavioral claims processing with full support for multiple funding streams; and the source of claims based utilization data.
- **TruCare** (8) - our member-centric BH and medical health management platform for collaborative care coordination and plan of care (including the CSoC plan of care built by the WAA facilitated Child and Family Team (CFT)); and case, disease, and utilization management.
- **Xpress Encounter Pro** (9) - our encounter reporting management and workflow processing system specifically designed for Medicaid and other state funded public sector programs.
- **Provider Relationship Management** (PRM: (10)) - our provider services workflow, contracting, credentialing, and master provider database;
- **Enterprise Content Management** (ECM: (11)) - Our new (in process of deployment in 2011), next generation data capture solution to accelerate the processing of paper and faxed authorization requests, assessments, care plans, survey questionnaires, and other paper based correspondence. ECM is comprised of our integrated RightFax fax communications system and our scanning and Optical Character Recognition (OCR) workflow system on the receiving end and leverages the workflow capabilities of our Microsoft SharePoint collaborative platform to streamline and automate the capture and processing of these documents, and integrates the resulting captured data into the appropriate application (e.g. TruCare for authorization, assessment and Plan of Care data, EDW for survey data).

In the case of our EDI facilities (please see Section 2.g.ix for a detailed diagram of our EDI interfaces), we use EDIFECS and supporting products to apply HIPAA, HL-7, and state specific edits to ensure quality data inbound and outbound exchanges. Please see g.v, g.xi, and g.xix for more information. Please see g.vi for more information on our State Agency Portal; and g.viii for information on our Provider Portal. Much of the data that both external and internal (Cenpatico) users enter into our MIS will eventually be reported by us to DHH-OBH and other agencies either directly or indirectly. Thus it is critical for our "end user facing" applications, such as the online interfaces to our internal applications, and our State Agency and Provider Web Portals, to facilitate the entry of *clean data* by users who are authorized to enter that data. There are **two general sets of controls** we use to ensure that data entered into our MIS has quality and integrity:

- Access Controls. Secure access controls ensuring only authorized users enter data appropriate to their "role". We use network level security, Oracle's Virtual Private Database (VPD), Microsoft Active Directory Application Mode (ADAM), Teradata's Enterprise Security Model, IBM Tivoli Directory Server (TDS), and application level authentication, along with Role Based Access Control (RBAC) to control what applications a user may have access to; what information they can view; and *what data they can view, edit or update.*
- Data Entry Field Level Edits**.** All of our applications - including those on the web, enforce an appropriate degree of field level edits - ranging from simple alphanumeric formats (e.g. HIPAA standard lengths for name fields), to more sophisticated edits (NPI check digit validation), to (wherever possible) the use of drop down lists to prompt valid field data choices, to situational field logical checks (e.g. if user enters a value in one field, this drives the mandatory entry of data in another field). Where possible, our applications pre-populate fields for users: e.g. a provider can look up a member's eligibility on our Portal, and have the resulting demographics pre-populate applicable fields in our online claim form. ***Figure 2.g.vii.-2: Online Claim Entry*** is one example of how our applications help users enter syntactically valid data. This particular example is from our HIPAA Direct Data Entry (DDE) compliant online claim submission application - available to our

network providers on our secure web based Provider Portal. We will use similar data entry aids for the secure **online entry of assessment data** (LOCUS, CALOCUS, Comprehensive CANS, etc.) by providers and agency users through our Provider Portals. Please see ***Figure 2.g.vii.-3: Online Assessment Entry*** for an example of one of the assessment instruments (in this example: the Comprehensive CANS) we will enable for online entry by authorized Portal users (including LGEs, all independent assessors, and any other authorized portal users). Providers performing assessments will also have the option of uploading completed assessment documents via the Provider Portal, or mailing or faxing assessments to us (for subsequent conversion to data via OCR through our ECM - see above).

2- Industry Standard Data Communications Protocols, Controls and Supporting Systems allow us to *send and receive* formatted data (including HIPAA and HL7 transactions, and state proprietary formats) with integrity, confidentiality, reliability, and assured delivery. Please see Sections 2.g.v, ix, xi, and xix for more information on our ability to send and receive production data with DHH-OBH and other state agencies and WAAs using our data communication protocols, EDIFECS EDI processing system and web portals.

3- The Service Oriented Architecture (SOA) design (6) of our interoperable application components, along with our **Master Data Management** (MDM) approach to data storage - persistence, quality assurance and distribution - ensures that our data (once received or entered by us) is represented and stored accurately, completely and uniquely (e.g. no data discrepancies or duplicates). Once validated, "clean" data is received in our MIS (via online entry, online file upload, EDI batch processes, or paper / fax receipt and Optical Character Recognition (OCR) scanning), the data is available to our business applications via our SOA approach to application interoperability. We also ensure data integrity through a Master Data Management (MDM) approach to data stewardship. Please see g.iv for more information on the data interoperability of the application components that comprise our MIS.

4- Our Centelligence™ EDW Data Integration Engine (11), and reporting, informatics and decision support system (12) leverages the SOA services in our architecture, as well as the near real time Change Data Capture (CDC) capabilities of our Informatica middleware (a component of item 6) to *integrate* and *consolidate* data, and to create the information products we supply to our state clients. Once a report or data extract is ready for a state client, Centelligence™ then uses the services of our data and file communications subsystems for reliable transmission to our state clients or their intermediaries (e.g. for scheduled, secure FTP of HIPAA encounter files). EDW integrates medical, behavioral, and pharmacy claims and lab test results, member (including care recipient) and provider demographics, clinical care information (including Plan of Care information), and BH assessment data into a centralized, relational database repository. EDW is essentially the high performance data "junction" in our MIS - the system where operational, transactional data is integrated and consolidated in near real-time - and available for a variety of informatics and reporting applications, including the information we will supply to DHH-OBH's data warehouse. During 2010, we implemented a *significant* upgrade to our EDW with the incorporation of the Teradata® Extreme Data Appliance. This major capital investment significantly improves our ability to handle **truly large amounts of data** (hundred of Terabytes of information) in much shorter timeframes (hundreds of times faster than a traditional DBMS), resulting in more timely data sharing and reporting. Please refer to g.xii for more information on our Centelligence™ reporting capabilities.

Producing and Transferring Data for the DHH-OBH Warehouse: An End-to-End Walkthrough

As depicted in ***Figure 2.g.vii.-1: Supporting the DHH-OBH Warehouse*** (Figure), we can (and will) support all required "data inputs" (e.g. referrals, claims, authorization requests, survey questionnaires) from state agencies, providers (including LGEs), WAAs, members, and our own internal users (e.g., Care

Managers (CM), Provider Network Management staff) using via multiple "data input" modes (online entry, data file upload, EDI, paper, fax, phone), through our integrated MIS; with all these "data entry points" ultimately captured and organized for both member ("client") level and episodic level - as well as aggregate level analysis and reporting - through our EDW (14) - and, from there, via a data transmission method that DHH-OBH specifies, to the DHH-OBH data warehouse (12). On this latter point, we can support a bi-weekly schedule (as postulated in the RFP, Section II.B.m.vi.) or other frequency, including daily, depending on the specific dataset (e.g. DHH-OBH may prefer a daily feed of "new member referral" data from us, to help mitigate data latency issues that might arise from the time a care recipient is referred to us to when that recipient is enrolled in a specific LBHP "funding stream" (e.g. non-Medicaid)). In terms of the dataset formats, we can (and encourage) the use of HIPAA formats where applicable (e.g. new referrals, encounters), and DHH-OBH specified formats where needed (provider network data). Depending on DHH-OBH's needs and preference, we can also support **Extract Transform Load (ETL)** processes for all or some of the datasets required by the DHH-OBH data warehouse. Although there are numerous end-to-end "data flow" permutations depicted in the Figure, we would like to illustrate two examples, to convey some MIS features that support the efficient and accurate collection of data and subsequent transmission to the DHH-OBH data warehouse.

Example 1: Annual Member Survey. Every year, Cenpatico will administer a member survey. LBHP members (D) will have the option of filling out the survey on our website, or by calling our Avaya Voice Portal Interactive Voice Response (IVR) system (which supports voice recognition as well as traditional touch tone data entry) (3). Alternatively, members will also be able to fill in a paper survey (4) and mail or fax to us. Paper responses will be systematically scanned (faxes are in image form already) and our OCR process will capture the survey data and load to our EDW, for subsequent integration with IVR and web-entered survey data, and eventual transmission to the DHH-OBH warehouse.

Example 2: Referral - to - Eligibility Record. In this example, we illustrate data coming into our MIS via State Portal out to the DHH-OBH warehouse, and eventually back to us from DHH (the MMIS). Suppose a DOE/LEA user (A) of our State Portal (1) logs on and enters a referral for a child to the LBHP CSoC program. The user could first attempt to see if we have the child on record in our MRM (5). Suppose there is no record of the child in MRM. The user enters child demographics, and the referral is posted to our MRM (with acknowledgement back to the user). MRM produces an internal Master Member Index (MMI) for the child - a "forever" internal identifier that will capture all relationships Cenpatico may have with the child (e.g. Medicaid, non-Medicaid). MRM then immediately drives workflow at Cenpatico for a CM (F) to call the user (or whomever the user designates) for a Brief CANS screen - the results of which the CM captures in MRM. Of course, several other workflow actions take place (e.g. authorization for 30 days of services issued to the WAA from TruCare - please see g.vi for more information). All this data (auths, screen), along with the new child "presumptive eligibility" record, is fed in near real time to EDW for subsequent transmission to the DHH-OBH warehouse (12). We propose that (as one dataset for DHH-OBH) EDW issue HIPAA 834 formatted records of such "presumptively eligible" members (those members referred to Cenpatico but not yet assigned to an LBHP "funding stream" by DHH) - with the MMI populating the alternate member ID field in the 834 to DHH-OBH. In a subsequent daily EDI feed of HIPAA 834 eligibility data from DHH (from the LMMIS system) to Cenpatico (15) (or from specific other agencies for non-Medicaid - per page 1 in the document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11), we suggest, if possible, that the internal MMI be repeated back to us in the alternate member ID field in the HIPAA 834 (15), with the assigned DHH (or other agency if applicable for non-Medicaid) member ID in the primary ID field in the 834 (or agency-specific format) along with the assigned funding stream (e.g. Medicaid), and any other information DHH wishes to send us (e.g. TPL) - further enhancing the matching of the original record in MRM with the member record sent to us by DHH (A) at the "end" of the process (15). If DHH or other agency cannot send our MMI back as

suggested above, we can work on alternative strategies with DHH and other agencies (reference: page 8 in the document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11).

Figure 2.g.vii.-1: Supporting the DHH-OBH Warehouse

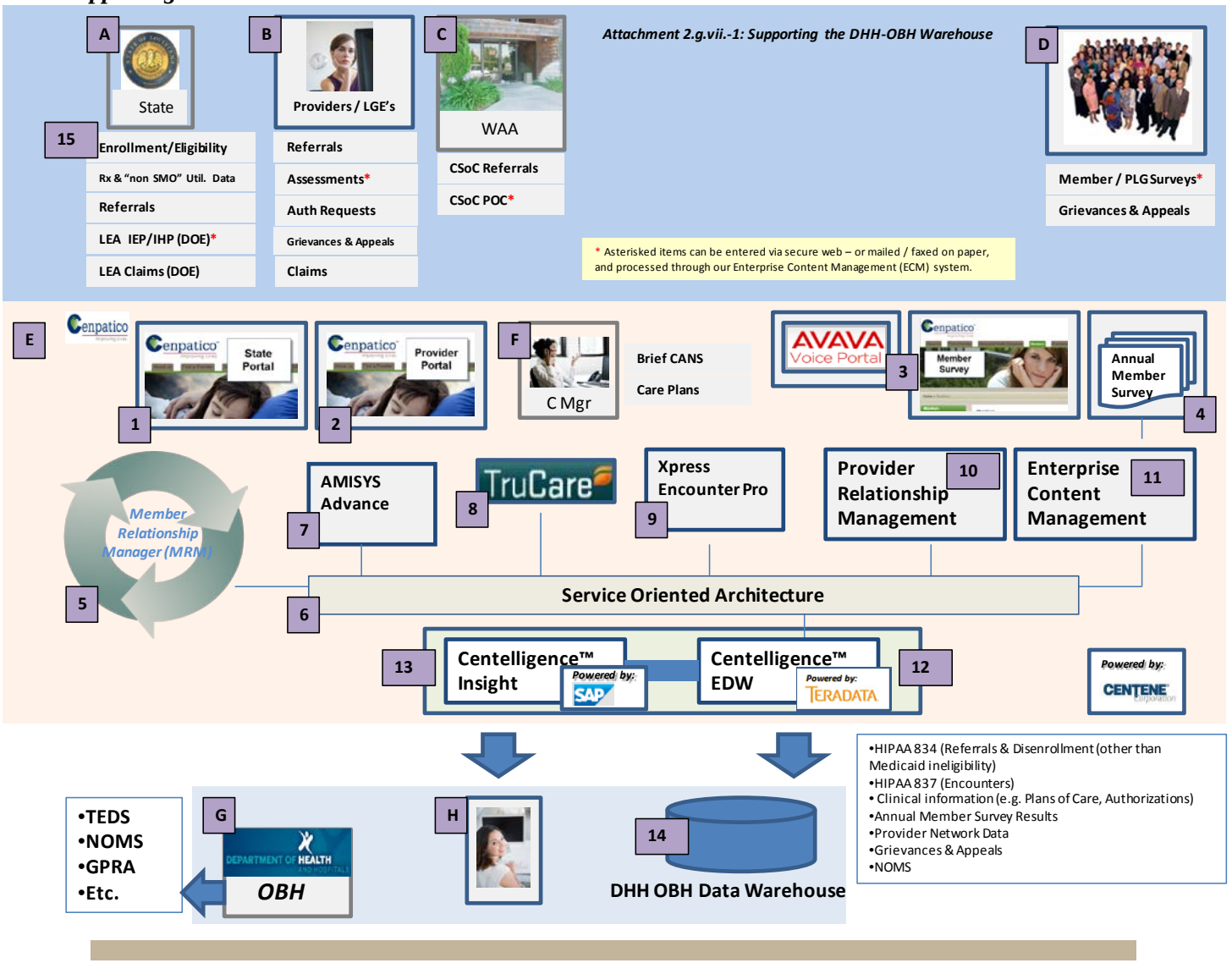


Figure 2.g.vii.-2: Online Claim Entry

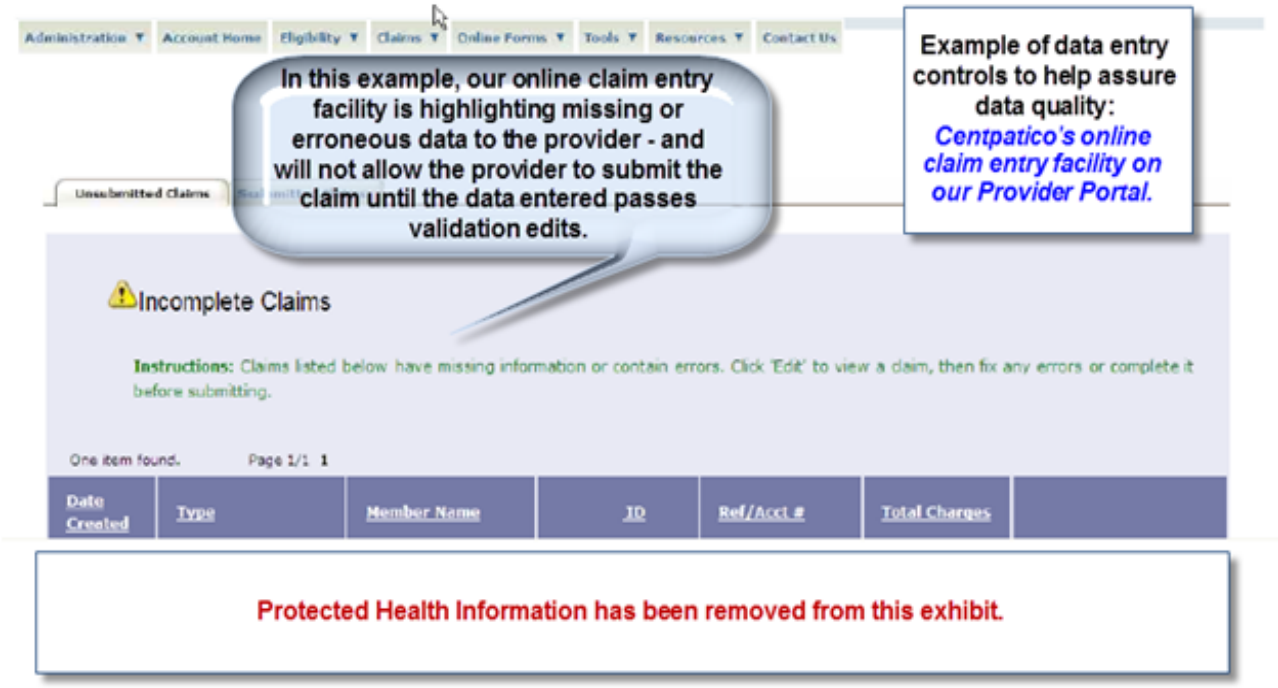


Figure 2.g.vii.-3: Online Assessment Entry

2.g. Technical Requirements
viii. Describe the Proposer's use of Internet website for providers, including any interface with the claims system, eligibility and provider data. Include provider capabilities to use the website to submit authorization requests, claims or inquiries. **Suggested number of pages: 4**

Provider Self Service Capabilities via the Cenpatico Provider Portal

An increasingly important aspect of the Information Technology (IT) support we offer providers is our web based secure Provider Portal, developed (as with all our website applications) on IBM WebSphere technology. Today, our Cenpatico Provider Portals are customized for our local plans, and Louisiana's Provider Portal will feature content, links, and transaction support specific for our behavioral health (BH) providers (including the Local Governing Entities (LGEs)) as well as information and tools to facilitate medical and physical health (PH) integration. Much of our Provider Portal content (such as our online Provider directory) will be available to *any* user (no login required), and we offer a substantial list of provider practice-specific *administrative* and *clinical* functions via the secured part (login required) of our Provider Portal. Please see ***Figure 2.g.viii.A*** for a graphical depiction of the secure interfaces and data content that will support our Provider Portal. At the center of ***Figure 2.g.viii.A*** is a provider landing page (item 1). Item 1 symbolizes a secured Provider Portal session - with access points to other "transactional" information sources and access to other secured sites.

Publicly Available Content. Below, in ***Table 2.g.viii.A***, we have listed the capabilities of the public (no login required) portion of our Provider Portal to be offered in support of the DHH-OBH program, with corresponding itemized references back to ***Figure 2.g.viii.A***, where applicable.

Current Secure Functionality via our Provider Portal. Today our Cenpatico network providers can register online for access to our secure Provider Portal. In ***Table 2.g.viii.B*** we list the secure portal functionality that will be available to our Cenpatico network providers in support of our Cenpatico members and the Louisiana Behavioral Health Partnership (LBHP) program. Please see ***Table 2.g.viii.B*** below for a list of the secure transactional functions our providers perform *today* via the Portal.

Leveraging the Web to Interface with the WAAs and State Agencies

We will deploy specific functionality on our secure web based Provider Portal to support the Wraparound Agencies (WAAs) such as:

- Online support for the referral process
- Ability to enter information for the Plan of Care (POC), or to securely upload the POC as a document or image.
- Ability to view the TruCare Service Plan.
- Ability to view and download the roster of children currently enrolled in the CSoC with the WAA.
- Ability to view the BH Member Health Record (BH MHR) of the enrolled CSoC child.

Additionally, we will also offer access to all authorized users at DOE (and the LEAs), OJJ, DFCS, and DHH-OBH, to our secure, web based State Agency Portal (Portal). Through the Portal, authorized state agency users will be able to:

- Submit referrals for LBHP programs (in exactly the same manner as WAAs and other authorized provider users of our Provider Portal), as well as the ability to query eligibility on members.
- For DOE/LEA: submit IEPs / IHPs for use by our Care Managers and subsequent authorization of services for LBHP members in our TruCare system (note: CMs will regard the IEPs/IHPs from authorized DOE/LEA users as actual care authorizations).

- For DOE/LEA BH services delivered by school employee providers: submit claims and/or encounters in HIPAA format via our HIPAA DDE compliant claims entry facility, with navigational aids, prompted edits, and contextual help.
- Online access to our BusinessObjects online reporting tools for DHH-OBH users (and users DHH-OBH specifies).

Please see Sections 2.g.v, 2.g.xix, and 2.g.xxx for more information.

Figure 2.g.viii.A

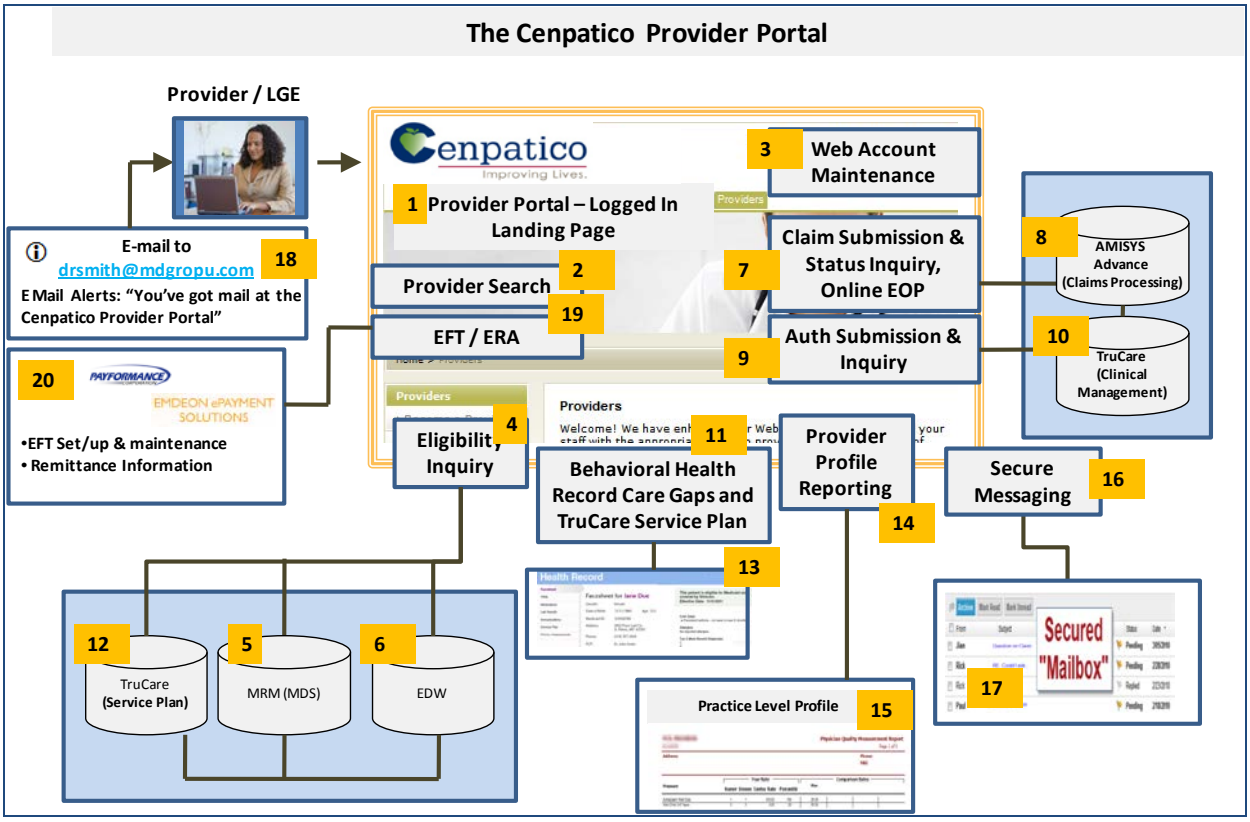


Table 2.g.viii.A

Content	Description
Administrative function	Online registration for a secure login from Cenpatico. We validate providers who apply online with their Tax Identification Numbers (TIN) and National Provider ID (NPI), and other information we have on file for that provider. For state agency users of our State Agency Portal (which has similar functionality to our Provider Portal), we typically use agency Employer IDs supplied to us by the appropriate state agency.
Provider Search (Item 2)	Our provider search capability is integrated with our Provider Relationship Management (PRM) system. The online provider directory will offer multiple search options, including location or name; type; specialty; gender; language spoken; whether accepting new patients; and medical and hospital affiliations.
EDI	Information for providers submitting HIPAA professional, institutional, and encounter transactions electronically to Cenpatico, as well as receiving electronic Explanations of Payment (EOP) from Cenpatico via the HIPAA 835.
Contact Us Form	Allows any user to complete and securely submit an online inquiry form.
Training Information	Training program topics, schedules, and locations.
Provider Manuals	Online Provider Manuals.
Quality standards	Clinical Standards and Practice Guidelines.
Downloadable forms	Forms such as “Prior Authorization Forms,” “Full Panel Adds,” and others.
Links	For LBHP these will be to DHH-OBH, OJJ, WAAs, and other areas that DHH-OBH specifies.
Prior authorization Information	Information on services that require prior authorization (PA) and the process for requesting PAs; as well as PA submission forms.
Claims Dispute resolution information	Process for disputing claims payment.
Appeal process	Process for appealing claims and medical necessity decisions.
HIPAA	HIPAA Policies and Procedures.
Section 508 Compliance (Item 1)	Cenpatico websites for LBHP will be Section 508 compliant. We adhere to web design guidelines that ensure information we present is readily accessible and easy to understand for our user audiences. Our websites and portals are presently available in two languages: English and Spanish, and are designed so that users do not require significant memory or disk resources or special software beyond a web browser.

Table 2.g.viii.B

Content/Function	Description
Web Account Administration (Item 3)	Cenpatico will support the ability for the registered provider practice user (e.g. Billing Manager or Provider - whoever the "lead" user is at the practice or LGE) - to setup and maintain *additional* Provider Portal accounts securely with full adherence to HIPAA regulations. As the functional breadth of our Provider Portal expands, the Portal has become more valuable to more provider staff, and the ability to manage access at the office level is a major benefit.
Enrollee Search (Eligibility Verification) (Item 4)	Our eligibility search will interface with our Member Relationship Management system for Providers to verify member eligibility. Options to search for member by last name, date of birth, date of service; or by member ID and date of service will be available.
Enrollee Benefits coverage inquiry (Items 4 , 5)	Verify benefits coverage online (including whether the member is Medicaid or non-Medicaid), and including Third Party Liability (TPL) information.
Claims status search (Items 7 and 8)	Search for claim status by member information, claim information, and/or provider name.
Online Claims entry (Items 7 and 8)	Submit professional and institutional claims via our Direct Data Entry (DDE) HIPAA compliant online claim form.
Batch claims submission (Items 7 and 8)	Providers submitting more than 1,000 claims a month (such as LGEs) may choose to test and submit their HIPAA 837 claims directly to Cenpatico via our Provider Portal and EDIFECS Ramp Manager tool. We also currently support claim submissions via multiple nationally recognized claims clearinghouses, and will work with any clearinghouse that is able to meet our EDI standards.

Content/Function	Description
Claims Wizard (Items 7 and 8)	To assist smaller providers, we will create a "claims wizard" that will pre-populate data (where possible) in a HIPAA compliant claim form, and allow providers to edit and complete the claim form for services provided. This feature may be particularly useful to LEA providers who do not submit electronic claims via HIPAA EDI to us.
View Claim Adjudication Logic (Item 1)	Ability to view and refer to Cenpatico Claims Adjudication logic in detail - using the Clear Claim Connection tool. Designed by McKesson Information Solutions, Inc. Clear Claim Connection "mirrors" how Cenpatico's claims software evaluates code combinations during the adjudication of a claim. The result: cleaner claim submissions and less chance of misunderstanding between provider and Cenpatico.
Online Explanation of Payment (Items 7 and 8)	Providers can view and download EOP information. For those adjudicated claims that are paid directly by DHH-OBH, we will display the EOP with a specific code, indicating the adjudicated status and that final payment will be made by DHH.
Payment History (Items 7 and 8)	Providers can view and download payment history information.
Claims adjustment submittal (Items 7 and 8)	Submit requests for claim adjustments **online**.
Authorization/referral requests & status inquiry (Items 9 and 10)	We have near real-time integration with TruCare (our care and utilization management system) for authorization submission and inquiry. Providers will be able to submit and search web-submitted authorization requests, and view authorization approvals.
View TruCare Service Plan (Item 11 and 12)	TruCare is our member-centric health services management platform for collaborative behavioral health care coordination and case, and utilization management. Used by Cenpatico's Case Managers (CMs), 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. Please note that (for WAAs), the WAA will submit the CSoC's child Plan of Care (POC) to Cenpatico electronically, and our CMs will review and build the TruCare Service Plan informed by the POC.
Behavioral Health Records (Item 11 and 13)	Behavioral Health Member Health Record (BH MHR) offers a well organized view of a member's utilization, care gaps as well as a cursory clinical "face sheet" for each member for which we have supporting data. We will also have a separate tab for pharmacy utilization based on claims data we receive from DHH-OBH. Our BH MHR will be based on current and historic behavioral health (and medical health - should DHH send us processed medical encounters data) and pharmacy claims information, health risk assessments, and other information systematically received and processed in our Enterprise Data Warehouse (EDW). This feature will be particularly useful for our LGE (due to patient volumes) and WAA users - who are focused on intensive case management for CSoC children.
Online Provider Reports (Item 14 and 15)	Access provider reports to view performance against selected quality measures. We will deliver this capability through our Centelligence™ Insight tool suite including: MedAssurant Catalyst HEDIS and clinical key performance indicator (KPI) software, integrated with our AMISYS Advance claims processing system, our TruCare Care and Utilization Management application, our Enterprise Data Warehouse (EDW), and our Business Objects Enterprise XI R2 Premium tool suite.
Secure Messaging (Items 16 17 and 18)	We are building on our existing online "Contact Us" capability for providers and enabling a secured two-way online communications capability for our Provider Portal users. Cenpatico provider users will be able to sign up for "email alerts" (via our Web Account Administration feature above). If the provider leaves a message for Cenpatico via a secured "Contact Us" web form, Cenpatico will send the provider an e-mail to the address they specified in Web Account Administration (above). This e-mail will NOT contain Protected Health Information (PHI), but will provide a link back to the Provider Portal where the provider can log in and view Cenpatico's response. Further, we are building an "inbox" and "outbox" capability on the Provider Portal so that a provider can securely view messages to and from Cenpatico while logged on to the Portal.

Content/Function	Description
Electronic Funds Transfer (EFT) Payment Support (Items 19 and 20)	Cenpatico will offer several free options for Electronic Funds Transfer (EFT) and/or Electronic Remittance Advice (ERA), either directly from Cenpatico to our providers through ACH direct deposit, through a clearinghouse, or through two additional payment options, **Emdeon ePayment** and **PayFormance**, (without the provider being required to share bank account information with Cenpatico). Providers will be able to review the payment options on our Provider Portal and we will educate our providers on these options and the benefits of each so they can make the best selection for their practice. We believe these features will be of particular benefit to LGEs: • **EMDEON ePayment (ePayment).** Our providers will be able to go to the ePayment site, register, and set up their bank account for EFT. Once set up, the provider can view remittance information online on the ePayment site and/or download a HIPAA 835 ERA for import and processing as payable information into the provider's practice management system. • **PayFormance.** As an alternative, PayFormance offers our providers a comprehensive payment management solution which is "clearinghouse agnostic." PayFormance supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, and provides online capability for viewing detailed remittance information.
Web Browser Compatibility (Item 1 representing all web pages on the Portal)	Our Provider Portal will support Internet Explorer and Firefox browsers. The Provider Portal will also be viewable/usable on reasonably recent versions of Safari, Apple iPhone, and popular Personal Digital Assistants (PDA's).

2.g. Technical Requirements
ix. Describe the Proposer's system's ability to provide an electronic data interface to allow transfer of Health Insurance Portability and Accountability Act- (HIPAA) compliant information from and to WAA, DOE or other agencies. Include the transfer of eligibility and encounter data in the Proposer's response. Suggested number of pages: 2

National Experience Providing Data To Public Sector State Agencies & Constituents.

In addition to sending and receiving protected health information (PHI) with full HIPAA security compliance (with auditable controls for confidentiality, availability, and integrity), Cenpatico and Centene (Cenpatico's parent company) support the transmission *and* receipt of all HIPAA transaction files, including the HIPAA 834 enrollment, eligibility and disenrollment transaction, the HIPAA 837 Professional (P) and Institutional (I) claims transactions, and the production of outbound encounters in HIPAA 837 P and I format. We have over 27 years public sector health program experience in securely receiving and/or transmitting member enrollment, eligibility, provider, claims, encounter, and (since HIPAA's effective date in 2002) other HIPAA compliant information to our state Medicaid agency clients and their intermediaries (e.g. for MMIS data exchanges. Depending on the program we are administering, we exchange HIPAA compliant data with municipalities, health departments, and state agencies focused on matters of child protection, long term care services, housing, welfare, corrections, the courts, and legislative mandates. We exchange HIPAA compliant data with Community Mental Health Centers, and other local behavioral health providers, similar to Louisiana's Local Governing Entities (LGEs) - including the exchange of HIPAA 834 and 837 information. Through our MIS, we receive and transmit timely HIPAA data to state agencies, behavioral and medical providers in 11 states (as well as CMS for Medicare) on schedules ranging from daily to annually, depending on the specific information and data product required by our clients, and using virtually every type of industry standard and HIPAA compliant protocol for file exchanges and/or online, web based portal methods. In some programs (such as our program in Arizona) we receive and send HIPAA 834 and 837 information related to non-Medicaid membership (e.g. for state general fund (SGF) programs) as well as Medicaid, exchanging both types of information with providers and state agencies as applicable, and we process the separation and accounting of non-Medicaid and Medicaid funding. We exchange HIPAA compliant information with state agencies and providers (including provider entities similar to LGEs and WAAs) in four broad manners, depending on the application at hand, and our state agency and provider needs:

- Via HIPAA security compliant EDI: for both HIPAA transaction files and state proprietary files.
- Through our secure web based Provider and State Agency Portals.
- Via our secure access to our state agency online applications where needed (e.g. submission of grievance information, individual eligibility inquiries)
- Via secure e-mail

Establishing EDI Data Interfaces to Suit Our Clients' Needs. Please see ***Figure 2.g.ix.-1: Electronic Data Interfaces*** (Figure) for the following discussion, depicting a graphical summary of the HIPAA EDI compliant data interfaces we have in place today and will deploy for the LBHP. Item **1** in the Figure represents all our Trading Partners for formatted data exchanges (including state agencies, providers, LGEs, the WAA, etc.). From a systems perspective, Cenpatico is represented by MIS components **2**, through **11**. When deploying electronic data interfaces, there are two major considerations: establishment of the telecommunications method, and the data format exchanged. Our goal will be to work with each agency, LGE, and WAA, to assist with infrastructure mentoring where needed if capabilities do not yet exist or updates are needed. Our national expertise with intelligent design for our Trading Partners becomes invaluable during implementation build efforts as we work to create seamless information exchange.

Multiple, Secure and Reliable Telecommunications Methods. Our COVIANT Diplomat Transaction Manager (COVIANT - item 2) handles our automated, scheduled file exchanges (transmission and receipt) with our authorized Trading Partners. We support *all standard industry data communication protocols* such as Secure FTP–SFTP (SSH), FTPS (TLS/SSL), PGP encryption over the internet or via a Virtual Private Network (VPN). COVIANT protects our file exchanges with access control, authentication, and secure configuration features for total data integrity protection during transmission. Note that we also support secure file exchanges via our Provider and State Agency Portals (item 11) via https file transfer (see 2.g.viii and 2.g.vi for more information on our Provider and State Agency Portals, respectively). Our integrated EDIFECS (3) EDI subsystem supports a wide range of file transmission acknowledgement protocols, including proprietary formats as well as ANSI standard 997, 999, TA1, 831, and 824 formats. We encourage the use of acknowledgements for both file transmission and receipts - as a further control for assured delivery, data integrity, and record balancing. We also encourage the use of Public Key Infrastructure (PKI) security implementations not only for encryption but for sender authentication purposes - ensuring not only that the file was transmitted un-tampered, but that the receiver can validate who the sender was as well.

Support for HIPAA Transaction & Codeset, and Proprietary Formats - with HIPAA Security**.** Item 3 in the Figure depicts our integrated EDIFECS EDI subsystem. Among several other EDI functions, EDIFECS applies HIPAA 4010 and 5010 compliance checking, translates inbound and outbound data to/from our internal system formats, and gives our EDI Operations department total control and monitoring of our EDI inbound and outbound traffic and submission patterns in service of all of our Trading Partners. TIBCO (item 4) uses Services Oriented Architecture (SOA) technology to route data in and out of our core business applications (5). Please see 2.g.iv for more information on our SOA and core applications. The table below highlights specific transactions involving HIPAA data and the LBHP, to illustrate how the EDI infrastructure depicted in the Figure can support DHH-OBH's needs:

Information [1]	Description
HIPAA 834 ***from*** Louisiana (LA) MMIS[2] (LMMIS) and/or other agencies	We process daily 834 changes; and we fully support monthly 834 reconciliations. HIPAA 834 transactions will be posted to our Member Relationship Management (MRM) (6) master member system (see 2.g.iv for more information on MRM) within 24 hours of receipt. Also, we can (per RFP Section II.B.10.m) process Third Party Liability (TPL) / Coordination of Benefits (COB) information in the 834. Please see 2.g.xvii and 2.g.xix for more information. We realize, per document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, that we may need to process non-834 files to/from each individual agency for non-Medicaid eligibility and enrollment in a non-Medicaid funded LBHP program, and we can accommodate a scenario such as that, while tying individual recipients to our master member index to insure integrity of a member's eligibility across that member's history with the LBHP (e.g. movement to/from Medicaid and non-Medicaid programs).
HIPAA 834 ***to*** DHH-OBH	We suggest, with DHH-OBH approval, that we transmit "presumptively eligible" member information (for persons referred to us from agencies, providers or WAAs) to DHH-OBH for assignment by DHH-OBH and DHH of that member to the appropriate funding stream (e.g. Medicaid, or OBH or other agency "non Medicaid",). We would subsequently process that validated (or changed) "funding stream assignment" for the member upon receipt of the corresponding member record in the 834 ***from*** the LA MMIS (see transaction above) or other agency, by updating that member's record in our MRM (6). We realize that exact strategies for processes such as member assignment to a funding stream and for a "cross agency eligibility hierarchy" will be specified during implementation - per document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, page 8. Our EDIFECS and TIBCO based EDI subsystem is table driven for configurations such as those called for in the RFP, and we see no significant software programming required on our end, ensuring low project implementation risk.
HIPAA 837 Encounters ***to***	Using our integrated Xpress Encounter Pro system (item 9), designed specifically for

Information [1]	Description
LMMIS and/or DHH-OBH	Medicaid based managed care programs, Centene today processes and submits over 2.2 million encounters per month based on claims we process from over 100,000 medical and Cenpatico behavioral health providers. We realize, per RFP Section K.13 and K.14, that we will need to send client level utilization data to OBH, DCFS, and OJJ for purposes of provider payment (in the case of OBH), and/or in the support of SMO administrative invoicing to the agencies. We can support either HIPAA 837 or agency proprietary formats for these purposes.
HIPAA 837 pre-processed claims ***to*** LA MMIS (for DOE/LEA) or to OBH (for OBH adults)	Per RFP Section II.B.2.xv, we have the ability of adjudicating fee-for-service claims without paying the provider (including LGEs) - but forwarding those claims on to another party (or agency, in the case of the LBHP) for payment. Determination of when a claim is adjudicated but not paid by us can be driven by provider (for example, the DOE/LEA instance of a school employee provider), and/or by the member's assigned funding stream (for example, an OBH non-Medicaid adult). For example in the case of a claim from a DOE/LEA school employee provider, our AMISYS Advance claims system (7) matches claims to pre-authorizations (if required) from our TruCare utilization management system (8), applies appropriate benefit plan (e.g. Medicaid or non-Medicaid), determines the billing provider as DOE/LEA school employee provider, adjudicates the claim and through our EDIFECS system (3), will forward these "adjudicated but unpaid" claims as HIPAA 837 P and I data to the LA MMIS for payment to the DOE/LEA "school employee provider".
Historical Claims Data ***from*** DHH-OBH or DHH	Per RFP Section II.E.4, and pages 6 and 9 in the document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11 we can (and do today) receive historic utilization data as proprietary or HIPAA 837 files - (via HIPAA compliant security), via our EDIFECS system (3) for processing in our Centelligence™ Enterprise Data Warehouse (EDW - item 10).
NCPDP Pharmacy Claims Data ***from*** DHH-OBH	Per RFP Section II.E.3, we can (and do today) receive pharmacy claims data via HIPAA NCPDP or proprietary (via HIPAA compliant security), via our EDIFECS system (3) for processing in our Centelligence™ Enterprise Data Warehouse (EDW - item 10).
Roster data ***to*** WAA	If the Wraparound Agency (WAA) can support the HIPAA 834, we can issue outbound 834 files with member roster information. In the case of the WAA, this would include children under the WAAs coordinated care in the CSoC program. If this is not possible from the WAA's perspective, we will develop a proprietary method (12).
Other Proprietary Formats	We can (and do) support other state agency or other Trading Partner proprietary formats via the EDI infrastructure depicted in the Figure, using HIPAA compliant security methods (13). In the particular case of the LBHP program, examples of such data exchanges could include submission from Cenpatico to DHH-OBH of TPL/COB information (RFP II.B.2.m), and/or submission of CSoC Plan of Care information from WAA's, and datasets (aside from HIPAA 834 and HIPAA 837 data) from Cenpatico to the DHH-OBH data warehouse (per RFP Section II.E.5. and II.E.6.), as well as reporting data to DOE (RFP Section II.B.2.r. xvii.) through our EDW (10) along with the other components under Cenpatico's span of control depicted in the Figure. Please see 2.g.v and 2.g.vii for more information.

[1] We currently support the HIPAA 4010 transaction set, and we are on target to support HIPAA 5010 beginning 1/1/2012 (see 2.g.xx for more information).

[2] We realize (per RFP Library Document LABHSwimLaneDRAFT052711), that decisions are still pending on whether all agency member eligibility will be conveyed via an MMIS monthly feed to the SMO.

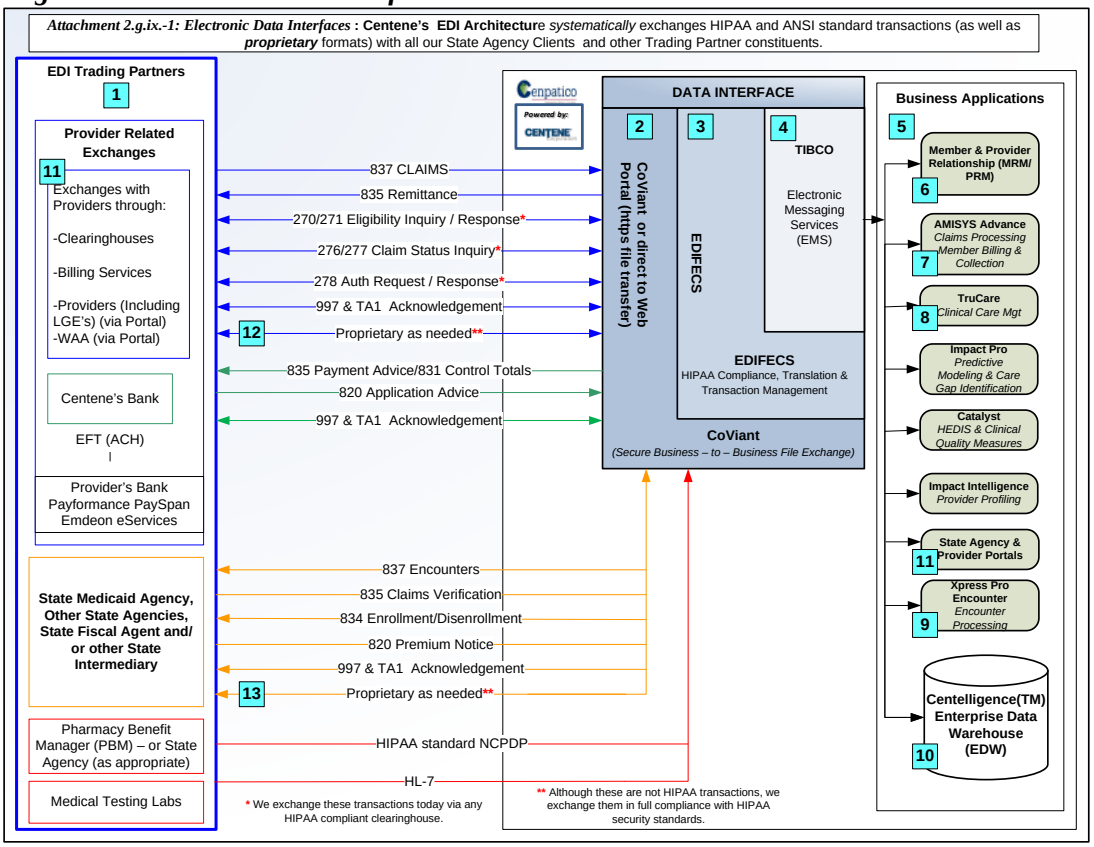
Provider and State Agency Portal We can (and do today) exchange a wide variety of HIPAA compliant transactional data via our web based secure Portals. Please see 2.g.viii and 2.g.vi for more information on our Provider and State Agency Portals, respectively. We will offer access to our Portals to all our providers, including LGEs, WAAs, and the FSOs; and to state agencies.

Secure Online Access. We provide HIPAA compliant secure online access to our desktop reporting and decision support tools for our State Agency clients who require that functionality. In addition, we can (and do, where needed) securely access interactively designated applications at our state agency clients:

for example - in one state our staff access an online agency database for the entry and management of behavioral health grievances and appeals. We support all industry standard methods of access to agency systems, including VPN over the Internet, dedicated lines, Citrix Metaframe, Microsoft Terminal Services, and of course, Secure Sockets Layer (SSL) and https for access over the Web.

Secure e-Mail. We support HIPAA compliant secure e-mail communications (e.g. any communication containing Protected Health Information [PHI]) between systems, sites, and/or domains through Transport Layer Security (TLS), an industry standard protocol for securing electronic communication. Our messaging systems also support industry standard protocols such as S/MIME and SSL. GlobalCerts SecureMail gateways at our network perimeter provide seamless gateway-to-gateway encryption with remote SecureMail Gateways using the SecureTierTM certificate management system. For agencies or WAAs that do not use SecureMail Gateways or support encryption technologies, Cenpatico secures any email communications via the GlobalCerts SecureMessenger service that allows provider users to encrypt messages to any Cenpatico recipient. We also use Vericept's data loss prevention tools to monitor and control PHI data usage, both in motion as well as at rest.

Figure 2.g.ix.-1: Electronic Data Interfaces



2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
x. Describe the Proposer's experience and capabilities in using, creating, and sharing data and maintaining electronic health records. Suggested number of pages:2

A History of Supporting Clinical Information and EHR Use by Providers

Centene and Cenpatico operate numerous managed medical and behavioral health (BH) Medicaid, CHIP, and other state funded programs where we have found that a *critical* success factor in effective care coordination is the appropriate and timely sharing of relevant medical and behavioral clinical information between and among our health plan, network providers, and state agencies. We have continuously sought new ways for the efficient, accurate, secure, and timely exchange of pertinent health information with our providers for *meaningful*, impactful purposes: to facilitate care coordination, to supply vital information when needed by providers at the point of care, and to foster collaboration between our Care Managers (CM) and network providers.

Online Health Record in Texas Supports Medical and Behavioral Health Collaboration

For example, Centene and Cenpatico, working with the Cerner Corporation (Cerner) and our Texas affiliate health plan (Superior Health Plan Network), successfully designed, developed, deployed, and now operate our secure web-based Texas Community Health Record (CHR). This CHR is built on our Service Oriented Architecture (SOA) and has been in operation since 2007 supporting the Texas Foster Care program. Our CHR benefits more than 30,000 children across a broad expanse of rural geographies and is used securely by over 7,700 medical and behavioral providers and over 2,200 Texas state agency users focused on the well-being and health of one of Texas' most vulnerable child populations. Our CHR organizes member records from HIPAA compliant medical and behavioral claims, demographics, data, and lab results that we obtain via HL7 interface with our lab providers; immunization data from Texas' IMMTRAC Immunization Registry, and other information. Our Texas CHR offers online access to member demographics, vital information and history, medications, allergies, lab test results, immunizations, treatment plans and other clinical data. This aggregated electronic health record helps our collaborative team of care managers, state agencies, providers and member caregivers to coordinate care, enhance care quality, and reduce redundant health care services and costs as a patient traverses our provider network. The Texas providers who currently use our CHR have identified the ability to view a snapshot of the member's history and the issues covered with past providers and therapist(s) as one of our CHR's most *helpful* features. Providers also have reported that reviewing the medication history is a useful tool in identifying previous treatment successes and failures.

Online Member Health Records Give Providers Access to Clinical Data

Building upon our experience in Texas, Centene is developing for deployment in early 2012, an online Member Health Record (MHR) for access by all authorized medical home users of our secure web based Provider Portal. Please see ***Figure 2.g.x.-1: Online Member Health Record*** for a sample screenshot. The MHR presents member demographic, behavioral, medical, pharmacy, and assessment information in a familiar clinical "facesheet" fashion with tabbed access to categorical details. Our Centelligence™ Enterprise Data Warehouse (EDW - the same proven "engine" that powers our CHR above) integrates internal data (e.g. authorizations, care plans) and available external data (medical, pharmacy and behavioral claims; lab test results; health risk assessments), along with "care gaps" and health risks systematically identified by our Centelligence™ Foresight predictive modeling system - and supplies this information to the medical home provider.

Customizing the MHR for the LBHP Program. For the LBHP program, we will deploy a *BH version* of our MHR, allowing our authorized provider and WAA users to view member demographics, BH utilization (from our behavioral health claims data as well as BH utilization data supplied to us by DHH-OBH (per RFP Section II.B.4.u.ii.r, page 84 - for BH services obtained by the member outside of the LBHP, e.g. the CCN program). We will also house and display pharmacy claims information received by us from DHH-OBH (per RFP Section II.B.4.u.ii.p, page 84) and we will use that data to also systematically identify potential medication related risks. We will use our Centelligence™ Foresight system to identify and display as a health risk any potential polypharmacy related risks. There are several care coordination "use cases" where our BH MHR will be invaluable. For example: a BH provider who has prescribed psychotropic medications for her patient will be able to view empirical evidence (via the medications tab in the BH MHR) whether the prescribed medications have actually been *dispensed*. This function alone reduces inappropriate use and abuse as well as medication compliance.
We carefully reviewed DHH-OBH's document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, and the question and answer at the bottom of page 6 in this document suggests to us that DHH-OBH (perhaps through DHH) will make behavioral (e.g. basic behavioral health services LBHP members receive through the CCN's) ***and*** medical claims data available to the SMO - for all Medicaid funded LBHP members. If this is DHH-OBH's intention, we plan to incorporate (with DHH-OBH's concurrence) this medical utilization data into our MHR for our LBHP providers, including authorized WAA's and state agency users of our State Agency Portal. Inclusion of medical utilization information in our tabbed MHR format will lead to the same level of collaborative success amongst LGE's, our other network providers, state agencies, families and our Care Managers that we have experienced in Texas.

Our BH MHR affords our LGE and other providers an "electronic health record" (EHR) that many BH providers cannot obtain through CMS' EHR incentive program, due to funding restrictions stemming from the American Recovery and Reinvestment Act (ARRA), which largely excluded behavioral health practitioners from the list of "eligible professionals" under the EHR incentive program. In addition, our MHR will allow our LGE and other providers (including state agency users) to download the MHR from our Portal in Continuity of Care Document (CCD) or Continuity of Care Record (CCR) format for subsequent import into a standards based EHR system, should the provider have an EHR capable of this function (see the callout balloon at the bottom of ***Figure 2.g.x.-1: Online Member Health Record***).

Sharing Care Plans Online with Our Providers

We can also share care plan data with our LGE and other network providers (including FSO's) and WAA's, and state agency users, using the TruCare component of our MIS. TruCare is our member-centric health management platform for collaborative care coordination; and case, disease, and utilization management. Using our Service Oriented Architecture (SOA), TruCare allows authorized Provider and State Agency Portal users to view the care plan via the web. Please see ***Figure 2.g.x.-2: TruCare Service Plan*** for an illustration of this capability, with actual screen snapshots. TruCare will also be used internally by Louisiana Healthcare Connections, one of the CCN awardees.

Working with Health Information Exchanges (HIE's) to Share Clinical Data.

Cenpatico's parent, Centene, continues to work with HIE's in Arizona, Texas, and (most recently) Kentucky in a variety of capacities to further the efforts of these collaboratives. From an MIS perspective, the heart of our HIE interface capabilities stem from the data integration and standards based capabilities of our EDW. We support standards such as HL-7, and the XML-based Continuity of Care Document (CCD) as called for in *45 CFR Part 170 Health Information Technology: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, Interim Final Rule*, published in July of 2010 by the US Department of Health and Human Services . Cenpatico's affiliate (and Centene subsidiary), Bridgeway Health Solutions, participates in the Health Information Network of Arizona (HINAz), a collaborative HIE effort among Arizona health plans, hospitals, large group practices, business leadership, consumers and local administrations.

In Kentucky, Cenpatico's affiliate (and Centene subsidiary) Kentucky Spirit is working with the Kentucky Health Information Exchange (KHIE) - where we are developing Structured Object Access Protocol (SOAP) and WS security standard web services for the transmission and retrieval of CCD information from and to EDW.
Finally, and most recently, Cenpatico's affiliate (and Centene subsidiary) Louisiana Healthcare Connections, plans to pilot the exchange of CCR data with selected Louisiana Federally Qualified Health Centers (FQHC's) in the New Orleans area in 2012. These FQHC's are NCQA certified Medical Homes, and are deploying HHS certified Electronic Health Record (EHR) systems. Together with these FQHC's, and working collaboratively with the Louisiana Health Information Technology (LHIT) Resource Center, we hope to forcefully demonstrate the real value of meaningful use of EHR technology for CCN-P Medical Homes and uncover tactical considerations and implementation insight, which is virtually impossible to uncover otherwise.

We hope to leverage our clinical data sharing experience and capabilities to further strengthen our partnership with our Louisiana BH providers in the service of the LBHP program.

Figure 2.g.x.-1: Online Member Health Record

Our online ***Member Health Record*** (MHR) allows authorized providers who do not have an Electronic Medical Record system, or do not have Health Information Exchange (HIE) connectivity, to access all pertinent health information that we have securely housed on our members. The MHR is one of several capabilities designed with clinical care coordination in mind, and available on our Provider Portal for providers and our State Agency Portal for authorized users.

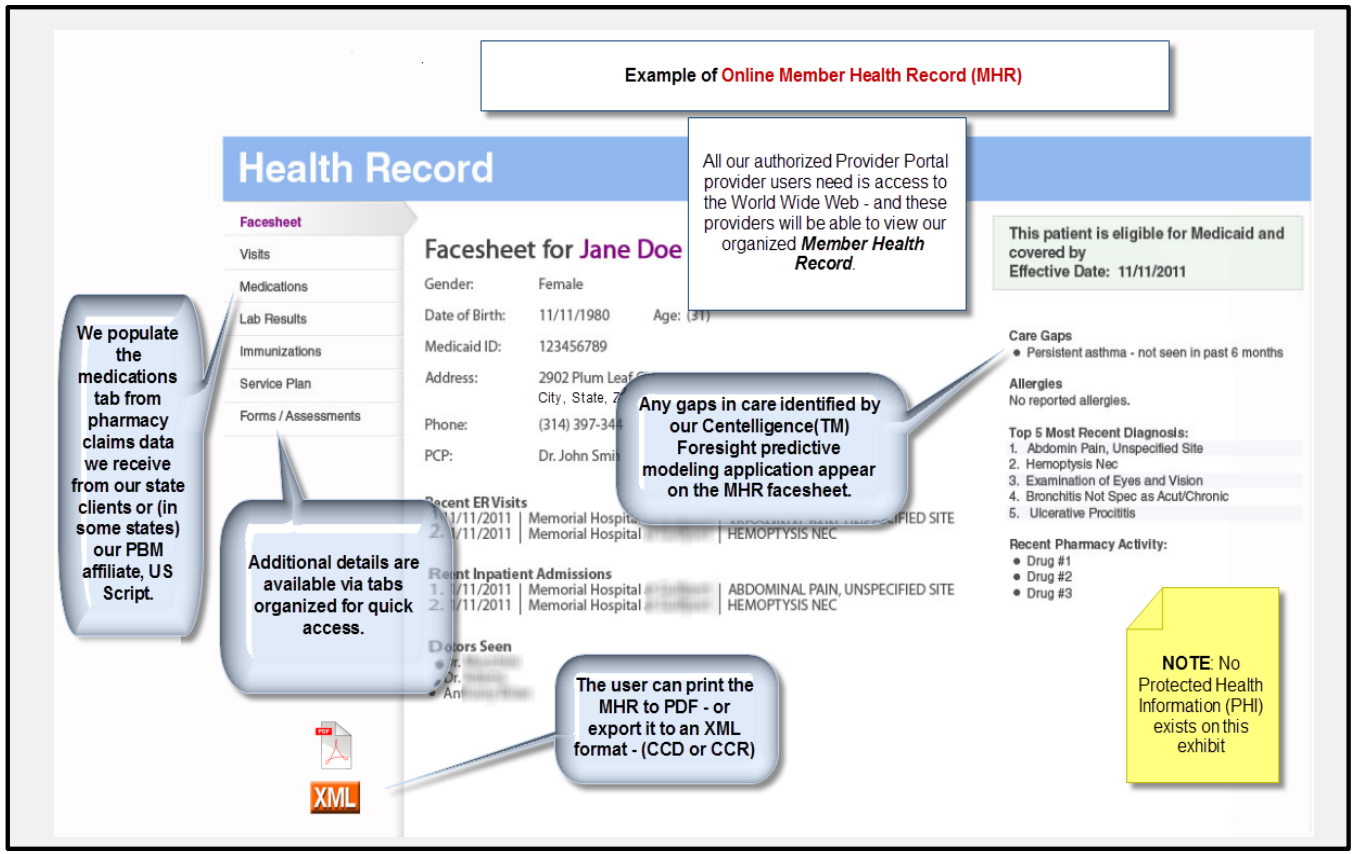
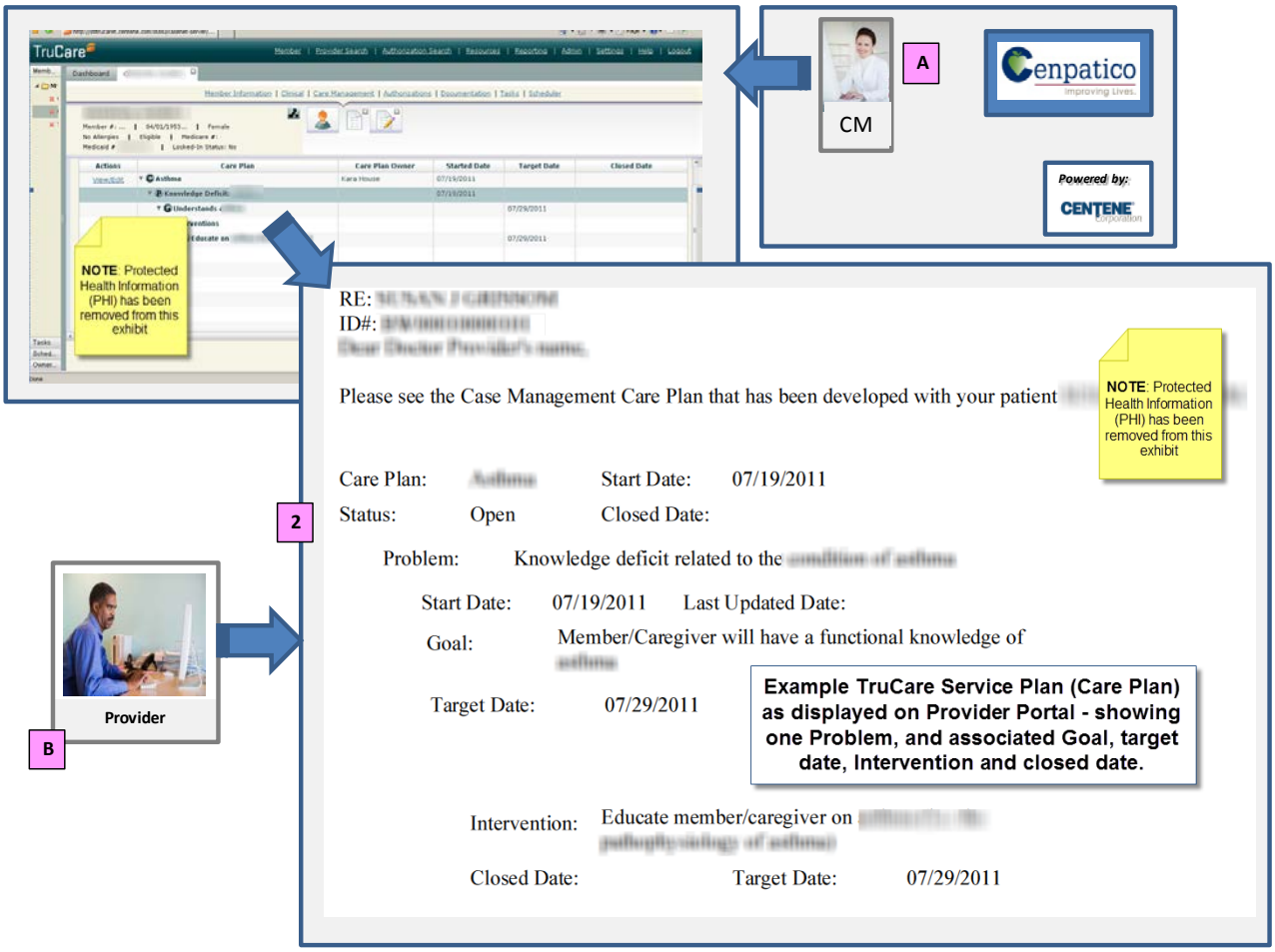


Figure 2.g.x.-2: TruCare Service Plan

Cenpatico's TruCare collaborative care management platform 1 allows our Care Managers A to share care plans 2 with our providers B



2.g. Technical Requirements
xi. Describe the Proposer's system's ability to send and receive data from other agencies consistent with the collaboration requirement in the Scope of Work. **Suggested number of pages: 3**

Experience in Sending and Receiving Data with Multiple Agencies

Today Cenpatico works directly and exchanges information with local school boards and the department of education in Arizona where we operate private day treatment schools (K-12) for children with behavioral disorders. We also work directly and exchange information with the department of criminal justice, local police departments, etc. there operating a community re-entry program. In Texas, Cenpatico's teams work daily with the Department of Family and Protective Services as the behavioral health vendor for the state's 30,000 foster care children. We have direct experience working across multiple agencies and funding streams to provide behavioral health expertise and customized technologies that facilitate transparency through relevant, useful information exchange. We believe Cenpatico is the *only BH-MCO* with this **direct service experience** across these and other agencies. It is this unique experience that has informed our systems and process designs for data exchange *beyond* traditional managed care organizations.

System Ability for Sending and Receiving Formatted Data Exchanges to Range of Agencies

Today, through Centene's secure EDI subsystem, based on Coviant, EDIFECS, and TIBCO technology (see Section 2.g.ix for information), Cenpatico can send and receive administrative, clinical, and reporting data and information via all industry standard methods, with any appropriate state and provider agency. We support the exchange of all transactions noted below today; and can fully support exchanges with the Louisiana MMIS (LMMIS) and with any state agency (or provider agency, including WAAs, where applicable) that can support these transactions. **We can, and do, also accommodate proprietary (e.g. "agency specific") formats, if needed**:

- **EDI -** all HIPAA Transaction formats, including the
  - **HIPAA 834 Enrollment / Disenrollment / Eligibility.** We both receive and send HIPAA 834 transaction files (and we process TPL and PCP information within those 834 transmissions) and can support this exchange with the LMMIS and or any agency for daily, weekly and/or monthly exchanges (per RFP Section II.K, and in the document: SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, particularly on pages 2 and 9). We realize that OBH, OJJ, and DCFS may have a need to support a non-834 format, for non-Medicaid members, and we will work with those agencies to accommodate their needs. Please see Sections g.xvii and g.xix for more information.
  - **HIPAA 837 Professional and Institutional transaction files**. We both receive HIPAA 837 claims and encounters from behavioral as well as medical providers (via any of over 60 claims clearinghouses, as well as direct submissions from the provider to us); and we send HIPAA 837 encounter data to state agencies in 11 states as well as Medicare for some of our Medicare Special Needs Plans (SNPs). Our system can also issue HIPAA 837 claims that are adjudicated by us but NOT paid by us (e.g. for claims we receive from LEA school based providers) - allowing the LMMIS to pay those providers. Our EDI subsystem can also support a similar process for OBH non-Medicaid adults in care, and we realize that OBH may not wish to support a HIPAA 837 format for that purpose. We will work with OBH to put in place a proprietary format for claims for non-Medicaid adults in an OBH program, should OBH desire. Since this transaction (an "adjudicated but not paid claim") is from an OBH business associate (Cenpatico) in this scenario, the electronic format of this file does not have to necessarily be a HIPAA 837 format.
  - **HIPAA 835 Remittance Advice**. We issue HIPAA 835's to providers and also we receive HIPAA 835's from state agencies as a functional business process confirmation and results set of

HIPAA 837 encounter submissions we submit to those agencies. However, per page 9 in the document: SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, we can (and do) support state specific proprietary encounter response files and can accommodate the LMMIS in this manner. Please see Section g.xviii for more information on our support of the HIPAA 835.

- **HIPAA NCPDP formatted pharmacy claims.** We receive processed pharmacy claims both directly from Pharmacy Benefits Managers (PBMs) as well from state agencies. We also support proprietary processed pharmacy claims data. We can receive pharmacy claims data on a daily or less frequent basis - and certainly on a weekly basis (per page 7 in the document: SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11).
- **HIPAA 820 Premium Notice.** We support the receipt of the 820 from our state agency clients, and (in one state) we support the transmission of the 820 for premium refund applications. We realize that the LMMIS does support 820 production today, and we can support that transaction should DHH-OBH request that of us.
- **HIPAA 270/271 Eligibility Inquiry and Response**. Please see Section g.xvii for more information.
- **HIPAA 276/277 Claim Status Inquiry and Response**.
- **HIPAA 278 Request for Authorization**.
- **HL-7** - today we support the receipt or transmission of HL-7 data, particularly for the sending or receiving of clinical lab test results.

- **Proprietary state batch file formats.** We support the transmission and receipt of any proprietary state agency format required by our state agency clients, including formats for provider data, Third Party Liability (TPL) information (we realize that DHH will issue TPL information in the COB loop of the 834, but if other agencies wish to support TPL data exchanges related to non-Medicaid members, we can support that as well), financial reporting data, provider profiling reports (to providers as well as to state agencies), quality management reports and data, and other specialized reports and data.
- We can also exchange data via Extract, Transform and Load (ETL) processes.

To exchange the above datasets, we support all standard industry data communication protocols such as Secure FTP–SFTP (SSH), FTPS (TLS/SSL), PGP encryption over the internet or via a Virtual Private Network (VPN). We can support different approaches for each Louisiana State Agency (OBH, OJJ, DCFS, DOE/LEA, the LMMIS) and we use the COVIANT Diplomat Transaction Manager system component of our MIS to protect our file exchanges with access control, authentication, and secure configuration features for total data integrity protection during transmission. Please see Section g.ix for more information.

System Ability for Web Based Data Exchanges to Range of Agencies

We also support a rapidly expanding list of online transactional data and report capabilities for providers and provider agencies via our online web based Provider Portal, and (for LBHP) our State Agency Portal (a version of our Provider Portal). Some of these capabilities of particular relevance for the LBHP program include online support for both our providers and State Agency Portal users (at OJJ, OBH, DCFS, DOE/LEA):

- Eligibility Inquiry - with full demographic support, PCP and TPL information.
- Authorization Submission, Status, and Response.
- Plan of Care information (viewing and submission).
- Referral submission (see Section g.vi for more information).

- HIPAA compliant Direct Data Entry (DDE) of claims (see Section g.xxx for more information - including the use of this feature as one method to support submission of DOE/LEA encounter information (e.g. per page 3 in the document: SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11).
- Online assessment entry (e.g. LOCUS, CALOCUS, CASI, CANS Comprehensive).
- Secure uploading of attachments (e.g. Word Documents, PDFs, scanned images) that can be systematically indexed to member or claims records (e.g. handwritten assessments, attestations for authorization requests or claim submissions).
- Online Care Gap Notifications (OCGN). Authorized users are presented with any potential gaps in care or health risks when viewing member records via this feature. OCGN is powered by our Centelligence™ Foresight predictive modeling system, which scans behavioral, medical and pharmacy claims data (if available to us), as well as other clinical and demographic information we have on the member; and presents the care gaps or health risks in succinct format (with prompt for additional information) for the Provider Portal or State Agency Portal user.
- Online member rosters. This list of assigned members can be viewed online or downloaded securely into Microsoft Excel; and will be particularly useful as a registry for our LGE providers, and WAAs for their CSoC assigned children.
- Quality and Utilization Reports for our LGE providers and for agencies such as the WAA. These reports assist the provider in getting a holistic "care picture" of the cost and quality of care of their assigned member roster.

Our Provider and State Agency Portals also have a number of other relevant features to support the collaborative philosophy of the LBHP, including online provider directories, and program specific reference information, including clinical practice guidelines, provider and agency manuals, and more. Through the Portals Cenpatico will make these data sets available to all DHH-OBH authorized agencies (OBH, OAAS, OJJ, OMH, DCFS, OPH, et al.). Please see g.viii for more information.

Supporting Collaboration Between LBHP Constituents, Medical Providers, and CCNs

The RFP, in Section II.B.4, outlines a number of requirements for the collaboration among LBHP constituents (the SMO, BH providers, WAAs, state agencies) and medical providers. Our MIS, through our Provider and State Agency Portals, and our Centelligence™ enterprise analytics and data integration engine, can provide the kind of systems support to foster this collaboration.

Identifying the PCP. We fully support the import and use of PCP information present on inbound HIPAA 834 transactions (or - if available and applicable, from non-834 proprietary formats from other agencies besides DHH). The Member Relationship Management (MRM) component of our MIS loads the member's PCP information as present in Loop 2310 of the HIPAA 834 from our state agency client MMIS; into the appropriate member record in MRM, and this information is systematically propagated in near real time to TruCare. MRM is our member services workflow and master member database: the source of member demographic information and current and historic eligibility for all of our core production systems (see Section g.iv and g.vii for more information). TruCare is our member-centric BH and medical health (PH) management platform for collaborative care coordination and plan of care (including the CSoC plan of care built by the WAA and Child and Family Team (CFT)); and case, disease, and utilization management. PCP information (including contact information, if included on the 834) is then available for viewing by our Care Manager (CM). If our CM sees that a member in BH treatment has no assigned PCP on record, we will refer the member to their CCN (and assist the member in making that connection if needed) so that a PCP can be assigned. We will follow/up with the member to ensure a PCP is assigned. We will consult with DHH-OBH on whether subsequent 834 updates we

receive from the LMMIS on the member will have PCP assignment information (that is: from CCN to LMMIS to SMO via the 834 process).

Monitoring Medications. We will import the pharmacy utilization data we receive from DHH-OBH (RFP Section II.B.4.u.ii.p, page 84 and page 7 in the document: SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11) into our Centelligence™ Enterprise Data Warehouse (EDW), where our Centelligence™ Foresight (Foresight) system will identify potential adverse drug interactions, potential member adherence issues, and indications of prescription abuse. Foresight is a multi-dimensional, episode-based predictive modeling and care management analytics tool integrated with our EDW. Our Provider Portal and State Agency Portal (Portals) displays selected member level medication related issues to providers via our OCGN facility (see discussion above).

Our Portals also displays medication related OCGN information on the summary face sheet of our online Member Health Record (MHR). For the LBHP program, we will configure our Behavioral Health (BH) version of our MHR (BH MHR) for our Portals (see Section g.x for more information). In addition, we will make all pharmacy utilization data we receive from DHH-OBH accessible via the medications tab in our BH MHR, to allow our BH providers to view any potential polypharmacy issues, and/or to see if psychotropic medications they have prescribed for a member are actually being filled, or simply to see if - and what - medications are being prescribed for their patient from other providers (including medical providers). If a provider (including an LEA school based provider) using our Portal and viewing the medications tab in our BH MHR, sees an issue, they will be able to submit a targeted alert to Cenpatico securely while viewing the medications list. The alert will systematically post to the member's care record in our TruCare system, where it will prompt the appropriate Cenpatico Care Manager for appropriate follow/up action.

Tracking Annual Well Care Visits. Per page 6 in the document: SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, we will receive claims data from DHH-OBH and import this data into our EDW. Our Foresight system will then be able to systematically scan this data and determine if a member's well visit occurred and when; and alert via MRM, TruCare, and OCGN - (see above) our Member Services Reps, Care Managers and Portal users, respectively. If we do not have data on a member's well visit, as part of our systematic screening of members for special needs (RFP, Section II.B.4.s) we will ask members or their caregivers if and when an annual well care visit has been scheduled. We will capture this information in our MRM system, and MRM will (at the option of the member or their caregiver), give the member a reminder call prior to the scheduled well care visit, via the predictive auto dialing (PAD) capabilities of our integrated Avaya Voice Portal (AVP) telecommunications platform. The reminder call will offer to connect the member or caregiver to a Cenpatico Care Manager if they like, and also prompt the member if they would like another reminder call closer to the scheduled well care visit date. If the member has difficulty scheduling their well care visit, we will ensure the member (or their caregiver) is successfully connected to their CCN plan, or (at minimum), we will make the member's CCN plan aware of the issue.

Integrating with PCPs. We propose to solicit cooperation from the Louisiana CCNs and seek identification data on PCP's in their network. If we receive that data, we will provision Provider Portal accounts for PCP's. When we screen members to identify special needs members, or when a member enters treatment through the LBHP program (e.g. a referral to the CSoC program), as part of that screen or intake, we will seek authorization from the member or caregiver to coordinate care with the PCP, and record the fact that we have signature on file in our MRM. MRM will then systematically allow the PCP to view (via the PCP's provisioned Provider Portal account) clinical information and POC information on the member.

Finally, we would note that while we will work to establish connectivity, et.al. with all CCNs, Centene's physical health plan – the Louisiana Healthcare Connections – statewide network of providers will already be loaded and available in our systems on Day One.

2.g. Technical Requirements
xii. Describe the Proposer's reporting capabilities. Include the reporting functionality, where the reporting is performed (e.g., online or separate database) with how current data is for reporting. Describe ad hoc reporting capabilities and who can perform them. Provide a listing of system reports and their frequency. **Suggested number of pages: 5**

An MIS Architected for Timely and Accurate Reporting

Cenpatico's Management Information Systems (MIS) stores and processes data in all areas necessary to support Louisiana Behavioral Health Partnership (LBHP) operations, including, but not limited to, eligibility, claims and encounters, payment by funding stream, assessments, authorizations, utilization, grievances, and appeals. Reporting data is housed in our relational database management system (RDBMS) information architecture, and will be available for reporting and analysis using SQL based comprehensive reporting tools described below, in full compliance with DHH-OBH and federal guidelines. In support of DHH-OBH efforts to oversee the LBHP Program, Cenpatico will supply DHH-OBH, and other agencies as required by DHH-OBH with timely, accurate, and detailed data. We have the demonstrated capabilities to fulfill reporting requirements through our operation of full risk Medicaid, "state only" and CHIP programs in 12 states today (soon to be 13 by 4Q 2011) with a catalog of over 12,000 reports; and including the unique multi-agency reporting requirements for encounters and multiple funding stream accounting, as required for the LBHP. This latter reporting category is very similar to our existing reporting support at our Cenpatico of Arizona plan. As we do with for all our reporting commitments, we will use our Compliance 360 workflow compliance system to systematically track our adherence to DHH-OBH reporting requirements and deliverable schedules. Compliance 360 utilizes updated databases of both federal and state regulatory and contract-specific requirements that we use to monitor internal activities for auditable, transparent contractual compliance.

We have reviewed in detail the RFP sections related to reporting, and in particular Section II.E.6.d.v, as well as the document: *Quality strategy for the Louisiana Behavioral Healthcare Prepaid Inpatient Healthcare Plan Waiver* (dated 7/7/11); and our MIS can meet all LBHP reporting requirements. In addition, as required by DHH-OBH and in accordance with 42 CFR §438.604(a) and (b), and 42 CFR §438.606, Cenpatico will ensure all data and reporting is certified for accuracy, completeness and truthfulness by Cenpatico's Chief Executive Officer, Chief Financial Officer, or delegated entity when determined and communicated by Cenpatico.

Centelligence™ - Producing Information from Data: Powerful and Intuitive Reporting Tools

Centelligence™ is our award-winning proprietary and comprehensive family of integrated decision support, reporting, and health care informatics solutions. Our Centelligence™ enterprise platform integrates data from multiple sources and produces *actionable* information and reports: everything from care gaps to key performance indicator (KPI) dashboards, provider clinical profiling analyses, population level health risk stratifications, and over 12,000 unique operational and state compliance reports. Centene received two awards in 2009 from Informatica, Inc.: the *Business and Technology Enablement Award*, and the *Vertical Industry Award* for healthcare, both in recognition of our ability to provide compelling information products from integrated transactional data. Please see ***Figure 2.g.xii-A – Centelligence™ Components***. The Centelligence™ family includes:

- ***Enterprise Data Warehouse (EDW)*** – our integrated EDW is a centralized data repository integrated near real time with our core transactional systems for comprehensive reporting capability. During 2010, we implemented a *significant* upgrade to our Enterprise Data Warehouse (EDW) with the incorporation of the Teradata® Extreme Data Appliance. This major capital investment significantly improves our ability to handle **truly large amounts of data** in much shorter timeframes, resulting in more timely reports, Care Alerts, Dashboards, and other informatics and support for both standard and ad-hoc reporting.

- ***Centelligence™ Insight*** – Includes our SAP Business Objects' premium tool reporting suite; our web-based reporting and management Key Performance Indicators (KPI) Dashboards capability. and our integrated Impact Intelligence and MedAssurant Catalyst QSI HEDIS reporting system. Centene recently received the *2010 Information Week 500 Award* for the overall capability of our Centelligence™ Insight analytics. The recent integration of Centelligence™ Insight (Insight) with Impact Intelligence from Ingenix will afford Cenpatico and our providers the practice and peer level profiling information needed for continuous clinical quality improvement. For example, we will provide the WAA's with care quality and cost reports on CSoC children managed through the WAA - enabling Wraparound Facilitators and other members of the Child and Family Team (CFT) to get a holistic picture of all aspects of the behavioral care of their CSoC program children. We carefully reviewed DHH-OBH's document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, and the question and answer at the bottom of page 6 in this document suggests to us that DHH-OBH (perhaps through DHH) will make behavioral (e.g. basic behavioral health services LBHP members receive through the CCN's) ***and*** medical claims data available to the SMO - for all Medicaid funded LBHP members. If this is DHH-OBH's intention, we plan to incorporate (with DHH-OBH's concurrence) this medical utilization data into our EDW for a variety of supporting informatics and reporting purposes, including the augmenting of quality and cost reporting for our authorized WAA, LGE, and state agencies.

Centelligence™ continually analyzes an enormous amount of transactional data - claims, health assessments, and service authorizations - to produce "business intelligence" and deliver the ***right*** information products to the ***right*** person (e.g., State Clients, Case Manager, Member Service Representative (MSR), providers) for the ***right*** task (e.g., clinical intervention, internal workload adjustments, client reporting) at the ***right*** time (e.g., on schedule, or "in real time").

- ***Centelligence™ Foresight*** - Combines Ingenix Impact Pro (Impact Pro) and Centene proprietary predictive modeling and Care Gap/Health Risk identification applications to identify and report potentially significant health risks at various population, provider, and member levels. Related to the discussion immediately above, we plan to incorporate (with DHH-OBH concurrence) any medical uitlization data we receive for use by our Foresight system to augment our ability to identify and proactively report on care gaps (e.g. missing well care visits) and health risks.
- ***Centelligence™ Negotiator*** – our proprietary contract modeling capability that leverages historical market information to aid in the analysis of new or modified provider contracts. New contract configurations (fee schedule, etc.) can then be electronically fed to AMISYS Advance to accelerate and simplify the implementation of the contract. Please reference our response in Section 2.q.iv, for more information on our Centelligence™ Negotiator tool.

Enterprise Data Warehouse - The Engine Behind our Reporting and Data Analytic Capabilities. Our EDW, powered by Teradata®'s Extreme Data Appliance, enables Centene to house, manage and analyze enormous amounts of data. Teradata enterprise technology has been recognized across the IT industry as a "best of breed" data access performance and scalability solution. Teradata provides Cenpatico with the ability to access and perform analytics across large, rapidly expanding data sets, and drastically improves the response time in processing report and system queries, while enabling strategic development of new and creative knowledge-mining tools.

Near Real Time Data Availability. A key design point of our MIS is the transaction-driven, **near *real-time*** integration of our production applications with our Centelligence™'s EDW business intelligence

platform. For example, when a claim is finalized in our AMISYS Advance claims processing system, that "event" posts to our Centelligence™'s Enterprise Data Warehouse (EDW) in *near real time* using our Centelligence™ Data Service Bus (Data Service Bus) – a unique, open architected data replication layer. The Data Service Bus connects our EDW with our key production integrated behavioral health applications, including AMISYS Advance, our TruCare care management application, and our Member and Provider Relationship Management systems (MRM and PRM, respectively). The result: data is available in EDW for subsequent standard and ad-hoc reporting in the quickest practical timeframe. See Section 2.g.iv for more information on this Service Oriented Architecture approach to data integration.

Pharmacy Data. We can (and do) receive pharmacy utilization data today, including processed pharmacy claims data from Pharmacy Benefits Managers (PBM's) as well as state agencies - in HIPAA NCPDP format as well as proprietary formats. We will load pharmacy data from the DHH MMIS (LMMIS) into EDW- and use our Centelligence™ Insight module Impact Intelligence, as well as other reporting and analytic capabilities in Insight, described below, to produce utilization and provider prescriber pattern reports. We will also use the pharmacy data with Centelligence™ Foresight - to identify potential care gaps and/or health risks that the member might have - and these "online care gap notifications" will be presented to providers using our Provider Portal - when they do an eligiblity inquiry. Finally, we will make all pharmacy utilization data we receive from DHH - viewable to provider on our medications tab in our Behavioral Health Member Health Record (BH MHR). Please see Sections 2.g.viii and x and for more information on our BH MHR.

Utilization Data from DHH. We receive BH and medical utilization data from our state clients and their Fiscal Intermediaries today. We can accept HIPAA 837 or proprietary formats and we will, per page 9 of DHH-OBH's document SMORFPQsandAs72911.xls, issued by DHH-OBH on 7/29/11, support the LMMIS proprietary format. We will load this utilization data into EDW, and link the utilization records to other utilization history we may have on the member. Once in EDW, the utilization data we receivve from DHH is available along with all other data we may have on the member, for analysis using Centelligence™ Insight as well as Centelligence™ Foresight (to help us systematically identify health risks and/or potential care gaps). We will make the utilization data available for viewing (along with all other data we have on the member) via our online BH MHR, available to all providers (including LGE's) and Wraparound Agencies (WAAs) using our Provider Portal. See Section 2.g.x for more information.

Powerful Standard and Ad-Hoc Reporting Capabilities. Standard and ad-hoc reports are delivered through our SAP Business Objects Enterprise XI R2 Premium tool suite, including Crystal Reports XI and Web Intelligence XI for reporting and ad hoc query and analysis. Our Ad Hoc solution supports *drill-down capability*, allowing our users to rapidly see details behind summary statistics and key performance indicators. Reports can be exported in several popular formats, such as Microsoft Excel, Microsoft Word, and Adobe Acrobat PDF, for DHH-OBH use. Business Objects provides end users with a web-based analytical reporting tool through a user-friendly interface. Local Cenpatico users will be trained to drill down and view different levels of detail to support decision making. The result is a powerful and intuitive graphical interface "experience" that identifies data in business terms, without the need to learn coding or query language. Business Objects enables end users to clearly understand and answer relevant business questions. This intuitive interface contributes to the accessibility of the information and fosters a broad user community of base users, "power users", and Centene IT professionals.

Our Centelligence™ Insight BusinessObjects tools allows users to query and report on *any* data element housed in EDW (assuming the user has appropriate authorization to access the data in question) to support special requests and studies required by DHH-OBH or other authorized state or federal entities. Once designed, such ad hoc reports can be saved and used on a regularly recurring basis. Centene uses Business Objects *scheduling tools* to deliver hundreds of such standard reports defined by business and state compliance needs to each health plan and/or corporate support staff, and will do the same for Cenpatico.

Today, we support over 2,700 unique Business Object users, representing all internal local plan departments (medical management, clinical operations, member and provider services, provider network management, finance, executive management, compliance) as well as Cenpatico and Centene corporate users, and external state agency users. These users receive *standard reports* with actionable information for daily use and have *full ad hoc* reporting capability based on role based security (please see Section 2.g.vii for more information on our role based access controls). As of this writing, Centene has more than 12,000 unique reports across all of our health plans that exist in Business Objects and that are used for various regulatory filings and decision support and specific to each plan.

The more than 12,000 reports currently supported by Centene inform users on all aspects of health plan operations, service and clinical care quality. Cenpatico staff will have the ability to add their reports to this number and the EDW architecture is fully extensible to support many times these report counts – both in terms of storage of report and query designs; and in terms of production capacity – thanks again to our Teradata Extreme Data Appliance.

Please see Table 2.g.xii-A for a list of reports we anticipate providing to DHH-OBH or utilizing for operational oversight. Centelligence™ reports span:

- ***Provider Management*** **-** including access and network status, provider profiling, Provider Directory.
- ***Quality Improvement*** **-** covering a spectrum of quality indicators, including HEDIS, as well as Member and Provider satisfaction survey reports.
- ***Utilization*** **-** covering essentially the dollars, days, and health care units used by our membership; inpatient admissions; ER visits; condition; usage of therapeutically related drugs and services; clinical outcomes; cost outliers, out-of-network utilization; pharmacy-claims summary by pharmacy, by drug, top 100 drugs dispensed, and other reports and metrics.
- ***Medical Management Reports*** **-** covering a wide array of activities from outstanding authorizations management, follow up and visit history to summary reports on health status of our membership,
- ***Grievances and Appeals*** **-** description, type, and status of open or new grievances or complaints and trends.
- ***Operational Reports*** **-** for decision support in all areas of health plan operations such as claims, enrollment, call center, MIS, coordination of benefits, cost avoidance, and others.
- ***Compliance Reports*** **-** including reports to states Medicaid agencies, fiscal intermediaries, enrollment brokers, federal agencies, and other authorized parties.

Secure Direct Reporting Access for DHH-OBH Authorized Staff. In addition to sending required data to DHH-OBH from our EDW (please see Section 2.g.vii for more information on our support of the DHH-OBH data warehouse), if desired, we will provide DHH-OBH and any DHH-OBH-delegated agency online direct access (e.g. authorized users at OJJ, DOE, DCFS) to data and reporting tools in a secure yet efficient manner. We currently support online access to this reporting capability via secure connectivity, using Citrix MetaFrame technology, to our SAP BusinessObjects decision support system. We will schedule customized training sessions for authorized DHH-OBH personnel to educate them about how to effectively navigate the tremendous amounts of data and information available through our Centelligence™ platform. DHH-OBH users will be required to provide two-factor authentication to connect to our Citrix MetaFrame environment. Once logged into the BusinessObjects environment, access will be strictly limited to Cenpatico data relevant to the LBHP contract.

Centelligence™ Insight. Centene and Cenpatico will use BusinessObjects, to extract meaningful and timely information out of the Enterprise Data Warehouse (EDW) for compliance reporting and decision support. We have the ability to report on all data sets in our Centelligence™ platform that may be required under the contract, including HEDIS measures, financial reports based on the different funding sources, and reports related to utilization, pharmacy, etc. Three important Insight applications include our Impact Intelligence and MedAssurant Catalyst QSI (QSI) systems:

Impact Intelligence. Together with TruCare (our clinical care management platform) and Centelligence™ Insight, Impact Intelligence will allow Cenpatico to produce targeted, *risk-adjusted* clinical quality performance information for our BH providers, including LGE's, and WAA's (for the CSoC program).

QSI. A key component in managing better health outcomes at lower costs is our ability to continually evaluate performance against specific, measurable outcomes. Cenpatico's Quality Improvement (QI) Department will work closely with Cenpatico's Integrated Care Teams (ICT) to define measures that are aligned with ICT clinical program objectives. To evaluate and report on our performance, Cenpatico QI staff will work with Centene's Health Economics and IT Departments utilizing NCQA Certified, MedAssurant Catalyst Quality Spectrum Insight (QSI) software in conjunction with our EDW and BusinessObjects software for analysis and reporting. A combination of these tools will provide Cenpatico and DHH-OBH with comprehensive metrics for HEDIS, provider profiling, and Cenpatico- and DHH-OBH specific quality improvement projects.

The Executive Dashboard: Affording Cenpatico Leadership a Consolidated View of Operations. Building on our investment in EDW and BusinessObjects technology, our *executive dashboard* will collect daily and monthly Cenpatico data to create a self-service executive view. The Dashboard will also permit Cenpatico management to perform drill-down analysis, creating an environment in which summarized metrics can be broken down into detail level data. All metrics are calculated and stored for historical analysis and trending.

In 2010, Centene was recognized with the **2010 Gateway Business Innovation Award** for its web-based executive dashboards, which provide real-time intelligence and are updated daily to provide early warning of adverse trends, claims drill-down for a quick analysis of clinical, financial or operating issues, and predictive modeling

Centelligence™ Foresight. Centelligence™ Foresight gives users the capability to anticipate health risks and care needs with an eye towards outreach, intervention, and health issue avoidance. Centelligence™ Foresight incorporates our Impact Pro and Centene proprietary, predictive modeling and Care Gap/Health Risk identification applications. This integrated suite of applications allows us to identify and report potentially significant health risks at various population, provider, and member levels *beforehand*, so we can initiate appropriate care management activities. Our Centelligence™ Foresight suite includes ***Impact Pro,*** a multi-dimensional, episode-based predictive modeling and care management analytics tool that will allow Cenpatico to use clinical, risk, and administrative profile information, and provide more targeted health care services to our members. In particular, we will use Centelligence™ Foresight tools to identify issues with drug-drug interaction and pharmacy treatment regimen adherence for our LBHP members. Impact Pro intervention opportunities are electronically fed back into EDW for import into our TruCare clinical care management system; our Member Relationship Management (MRM) system (as gaps in care messages); and our Provider Portal, triggering subsequent action by relevant case managers, or providers. Please also see the section below, "Using The Web to Deliver Clinically Oriented Reporting and Functionality to Providers", for an explanation of how care gaps will be displayed to our providers on our Cenpatico Provider Portal.

Supplemental Online Reporting. While our Centelligence™ reporting platform and EDW provide our "plan wide" operational and compliance reports, our integrated core systems also offer on-line reporting for application specific departmental operations (e.g. call center operations). For example, our MRM/PRM platform provides real time dashboard metrics, and a built-in query tool for instant operational reporting for Call Center management staff. Call center management staff utilize the Call Type by Subcategory Report (e.g. claims, member materials request, case management, authorization, etc) to review the types of calls received in a given day, or over a period of time. This information provides insight for staffing, education, or "real time" shifts in workloads, etc. The Frequent Caller report provides insight into members and providers who frequently call, and the nature of the call, which help our staff determine a need for personal outreach and educational opportunities. The Queue Aging report helps manage open items for follow up by the various call queues configured in the system. For example, the call service representative may have referred a call for further follow up to the claims processing queue. The queue aging report shows a count of all items in the queue for that business unit in various buckets of days since the item was created. Reports can be scheduled or on-demand and set within certain parameters.

Providing Reporting Data to DHH-OBH. Our EDW integrates data from external sources (e.g. provider supplied assessments, claim submissions, authorization requests; state agency referrals) along with data from our core applications (TruCare care management, AMISYS Advance claims processing, MRM and PRM, etc.), processes this data in near real-time, and can provide the DHH-OBH data warehouse with reporting data OBH needs for requirements such as SAMSHA's National Outcomes Measures (NOMS) and Treatment Episode Data Set (TEDS). For example, refer to the table below, illustrating the four broad prerequisite "data types" endemic to NOMS, and the "source system" within our integrated MIS supplying that requisite subject area to EDW in near real time. EDW will then issue this data electronically to the DHH-OBH data warehouse (see Section 2.g.vii for more information).

Subject Area Data for NOMS Reporting	*Cenpatico Source System Feeding EDW in Near Real Time*
Member demographics (address, gender, ethnicity, DOB)	MRM
Assessment data (e.g. living situation, employment status)	TruCare
Utilization of IP and OP services, by funding streams	AMISYS Advance
Member Satisfaction Surveys	Website, or Paper/Fax (to OCR), or IVR (Avaya Voice Portal)
Member engagement in programs	TruCare

Using The Web to Deliver Reporting to Providers. In recent years, as the number of our provider web applications has grown, and as broadband access has become common even in rural areas, the usage of our web-based secure Provider Portal has grown exponentially. For example, from January of 2008 through December of 2010, the number of our providers registering on our Provider Portal has grown at an average compound growth rate of **180% per year**. The internet and the web are rapidly becoming the single most important day-to-day two-way information "conduit" with our providers for the distribution of reference material (e.g., Provider Manuals, Clinical Practice Guidelines) and self-service administrative functions (e.g., eligibility inquiry, claim submission and status, service authorization requests). Among other functions we have offered on the web, we are providing more and more Centelligence™ reports and interactive information products to our providers and state agency users over the web via our secure Provider Portal.

Reports for All of Our Network Providers. Administrative Reports. To help deliver services as efficiently as possible, we encourage our providers to use our Provider Portal to access normal administrative reports. These same reports are also available to our Provider Services team, through our PRM suite, and can be printed and mailed to providers if they do not have access to the internet. For LBHP, any provider will be able to view their submitted and paid claims history, including paid amounts and explanations, as

well as history of Authorization or Referral requests, with current status. Clinical Quality Reporting for Network Providers. We can deliver monthly risk-adjusted, practice-level clinical quality and reporting information, expressly for our BH network providers, including LGE's and WAA's. Our Centelligence™ Insight reporting system produces the information for these reports powered by Centene proprietary software, integrated with our Impact Intelligence clinical quality reporting system, and using clinical data (behavioral, pharmacy claims, and other data) housed in our Teradata Enterprise Data Warehouse (EDW). We will also make these reports available to the Wraparound Agencies (WAAs) and LGE's (as well as internal Cenpatico Provider Network Management staff). BH and Pharmacy Utilization Record. Our online BH MHR available to all providers and WAA using our Provider Portal, will have three main components: A summary Face Sheet (demographics, care gaps); Pharmacy Utilization tab, based on data from DHH-OBH; and a behavioral health utilization tab, based on Cenpatico claims and DHH-OBH prior history utilization data, if available. A unique feature of our BH MHR will include an alert to warn Case Managers and Providers of potential pharmacy issues (e.g. drug interactions, prescription abuse, or non-adherence to regimen).

Figure 2.g.xii-A – Centelligence™Components

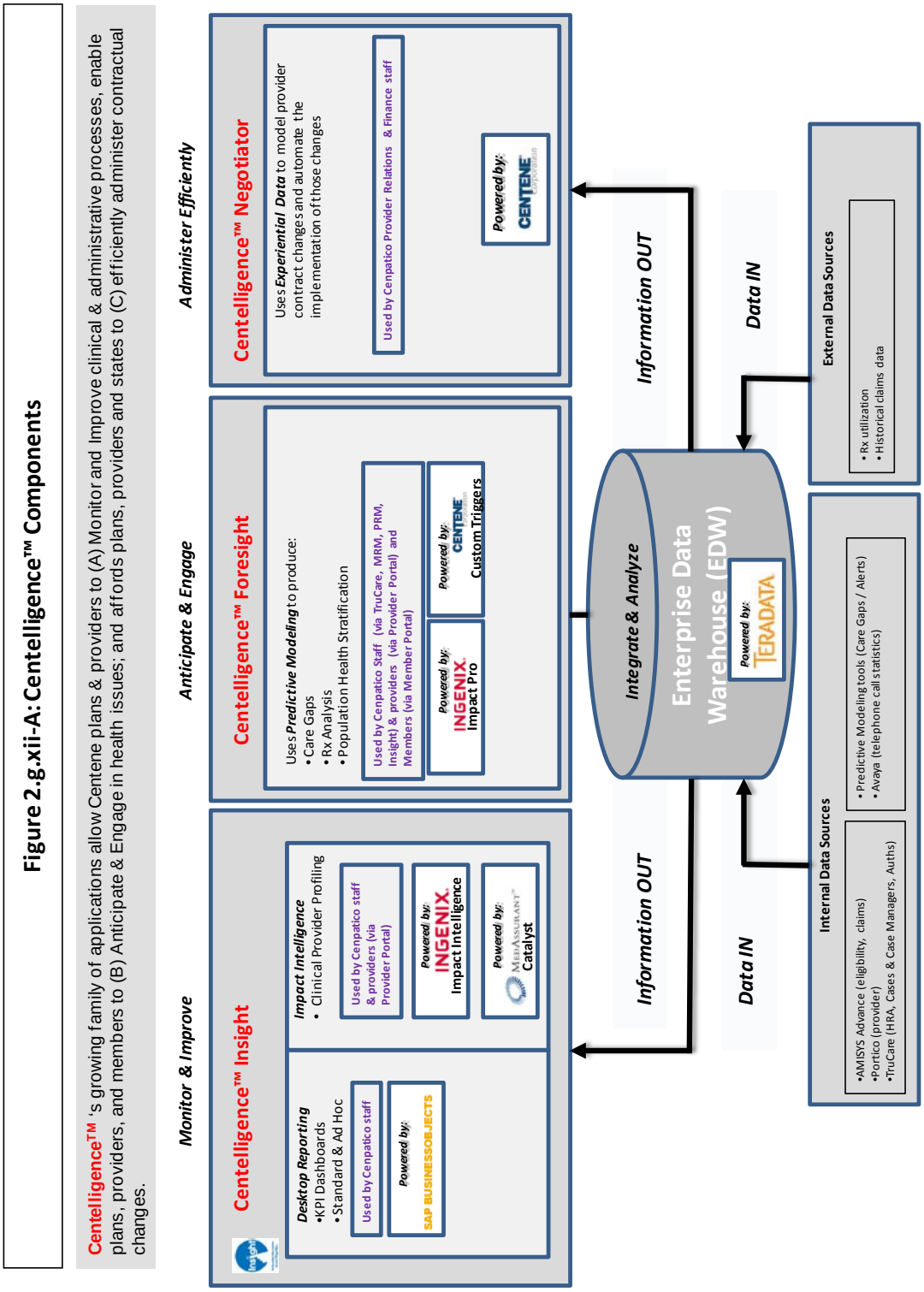


Table 2.g.xii.A – Sample List of Reports

Name of Report	Description	Frequency
Annual Audit		Annually
Provider Complaint		Quarterly
Member Complaint		Quarterly
Timely Access Data		
Cenpatico Waste, Abuse and Fraud (WAF) Tracking Log	Track cases of suspected WAF. This includes any cases referred to or received from DHH-OBH.	Monthly
SIU WAF Summary	Summary of open WAF cases under review by Special Investigations Unit (SIU)	Quarterly
Unaudited Financial Statement	Generally accepted accounting principles in preparing the unaudited quarterly financial statements	No later than 60 days after each calendar quarter
Quarterly written network status	Format approved by DHH-OBH	Due date
		10/15/2011
		1/15/2011
		4/15/2011
		7/15/2011
Contractor's Quarterly Network Status	Reports shall include separate sections reporting changes by qualified service providers (organized by provider type), WAA and FSOs by zip code with DHH-OBH region and for CSoC, by zip code within Act 122 Regions. Each section shall include the following elements for providers lost and gained, prescribers lost and gained and prescriber sufficiency analysis, the name and address of each provider, provider type, contracted capacity, provider identification number, populations served, and an analysis of the effect on network sufficiency	At the time Cenpatico enters into a contract with the State.
		At any time there has been a significant change (defined as more than 1% change in the Cenpatico's network) in Cenpatico's Louisiana operations that would affect adequate capacity and services, and also including-- Changes in services, benefits, geographic service area or payments, or Enrollment of a new population in the Contractor.
		Annually, to demonstrate that Cenpatico Louisiana offers an appropriate range of preventive, primary care and specialty services that is adequate for the anticipated number of Members for the service area and that our network of providers is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Members in the service area.

Name of Report	Description	Frequency
COB Cost Avoidance/Cost Savings	Summary of COB - show total number of claims impacted and total number of dollars paid by TPL	Monthly/quarterly or annually, depending on contract with the state
Lag Report	Claims Paid Lag Report	Monthly
Income Statement	Monthly Financial Income Statement	Monthly
Utilization Report	Mental Health Utilization Reports	Monthly
Denial and Appeal Report	Denials and appeals by type and level of care	Monthly
Appeal tracking log	Standard and expedited appeals, outcomes, timeframes	Monthly or Quarterly
Utilization Metrics/Datasheet	Listing of all levels of utilization activity, raw data, data/1000, percentages	Monthly
IP Diversion	Services offered in lieu of IP hospitalization	Quarterly
7 Day Follow Up	Eligible discharges, number and percentages of those who attended a f/u within 7 days post discharge - HEDIS measure	Monthly
UM Decision Timeliness	All authorization requests and timeframes to render decisions	Monthly
Community Outreach	Listing of all community/provider engagement and outreach efforts	Monthly
Single Case Agreement (SCA)	List of non-contracted providers/facilities for which SCA's were completed	Monthly
Care Coordination/Care Mgmt. Referrals	Number of referrals, dispostion of referral and outcome	Monthly
Case Management	Number of referrals, open cases and closed cases by reason	Monthly
Case Management Outcomes	30, 60 and 90 day pre and post analysis of community tenure, utilization and medical costs for those engaged in ICM	Quarterly
Case Management Satisfaction Survey Results	Scores of responses from ICM satisfaction survey. Identify opportunities for improvement based on member feedback.	Quarterly
Inter-rater Reliability	Analysis of concordance among UM reviewers - Ensure consistence with application of medical necessity.	Annually
Health Plan Quarterly Report	Longtitudinal analysis of utilization, case management and initiatives	Quarterly
Program Eligibility	Listing of members screened for and those found eligible for contract programs, treatment plans developed and service packages authorized - Monitor program eligibility and access.	Monthly
CSoC Performance Measures	Performance monitoring	Monthly
MSIP	Number of assessments given and outcome - Survey based outcomes monitoring.	Monthly
YSS-F Parent Survey	Number of assessments given and outcome.	Monthly

Name of Report	Description	Frequency
	Survey based outcomes monitoring.	
Telesage Outcome Measurement System (TOMS)	Number of assessments given and outcome	Monthly
Client Behavioral Checklist	Number of assessments given and outcome	Monthly
CANS	Number of assessments given and outcome	Monthly
LOCUS	Number of assessments given and outcome	Monthly
Screening/Assessment Report	Number of successful and unsuccessful screening and assessment attempts and outcomes	Monthly
Treatment Planning Report	Volume of treatment plans reviewed and services rendered as a result	Monthly
Credentialing/Recredentialing Report	Listing of all providers with demographic information which also includes specialties. To demonstrate number of providers credentialed and recredentialed on a monthly basis.	Monthly
Provider Roster	Listing of all credentialed and contracted providers. This will include the provider demographics, age restrictions, language and specialties. To demonstrate the "provider network" on a quarterly basis.	Quarterly
Credentialing Activity Report	Report broken down my month demonstrating the number of providers credentialed, recredentialed, termed and sanctioned. This will also include average turn around time to process application. To show the #s/breakdown of all cred activity.	Quarterly
Pended claims	Internal Report - List of pended claims and reason for pend - monitor aging claims.	Daily
Trial Check Run	Internal Report - Claim detail on claims ready to be sent to providers. Identify claims that are paying or denying incorrectly so that they can be reworked before going to the provider -- Internal report only	Prior to each check run -- weekly
Check Run Summary	Internal Report - Summarize metrics from each check run - monitor system functionality, provider education opportunities.	Weekly
Rejection rate	Internal Report - identify % of claims, paper and electronic, that reject. Monitor system functionality, provider education opportunities.	Daily/Weekly
Claims performance	Internal Report - Summary of claim metrics by market - monitor system functionality.	Monthly

2.g. Technical Requirements
xiii. Provide a detailed description of scheduled and unscheduled system downtime for the past 12 months for all government contracts. **Suggested number of pages: 2**

Scheduled and Unscheduled System Downtime

Figure g.xiii-A depicts, for the period June, 2010 through June 2011, the percentage availability of our core integrated business applications - including:

- Our Microsoft Dynamics based Customer Relationship Management (CRM) system which powers our Member Relationship Management (MRM) system, for enrollment and eligibility processing, member master data management, member services, and member campaign management. CRM also powers our integrated provider services system: ProviderConnect. Please see Section. g.iv for more information. Please note that our CRM (including MRM and ProviderConnect) was deployed in the fourth quarter 2010.
- AMISYS Advance, our integrated behavioral and medical claims processing application.
- MACESS document scanning, indexing and associated workflow management subsystem.
- TruCare, our member-centric behavioral and medical health management platform for collaborative care coordination; and case, disease, and utilization management.
- EDIFECS, Coviant, and TIBCO powered Electronic Data Interchange (EDI) subsystem.
- Microsoft Exchange based messaging (e-mail).
- Data communications networking subsystems.

Figure g.xiii-A.

	CRM	AMISYS	MACESS	Trucare	EDI	Messaging	Network
Available	99.95%	99.73%	99.81%	99.90%	99.97%	99.75%	99.98%
Scheduled %	0.05%	0.25%	0.02%	0.10%	0.00%	0.18%	0.01%
Unscheduled %	0.00%	0.02%	0.17%	0.00%	0.03%	0.07%	0.01%

Note in ***Figure g.xiii-A*** that our data communications network was available for over 99% of scheduled availability time for this period.

Detailed List of Scheduled and Unscheduled Downtime

Table g.xiii-A below is a detailed list of the scheduled and unscheduled downtime of our core systems. The unscheduled Wide Area Network (WAN) outage in Arizona was a localized event and did not affect our nationwide network, nor did it materially impact our operations in Arizona.

Table g.xiii-A.

Unscheduled Outage		Total Downtime/Hours
8/26/2010	Network WAN circuits - Yuma, AZ	13.83
8/12/2010	Network outage - AUX Data Center	0.08
2/3/2011	Network Cisco Bug	1.25
2/16/2011	DNS work was performed that impacted Amisys	0.63
2/19/2011	Amisys - Blade Chassis maintenance	0.33
2/21/2011	Trucare - Unplanned outage during maintenance	0.42
3/14/2011	Amisys - Database Down	0.42
	Macess - Locks	9.00
3/15/2011	Tibco - Blade Chassis maintenance	0.55
3/24/2011	Email - Mailbox server - all email	0.08
	Microsoft	0.08
4/1/2011	Macess - Server Outage	6.00
5/10/2011	Tibco - Intermittent DB Connectivity	2.00
5/15/2011	Tibco - Intermittent DB Connectivity	0.17
5/21/2011	Email - Outbound internet Email	2.00
Scheduled Downtime		
6/18/2010	Macess - App Patch	1.00
6/19/2010	Macess - Network Config	0.50
8/8/2010	Macess - Security Updates	0.25
1/7/2011	CRM - Database Alignment	1.00
	Miscelaneous patches	2.00
1/8/2011	Email Patching	0.08
1/9/2011	Amisys - Install New Hardware	4.00
1/10/2011	Trucare - Logging Level	0.50
1/13/2011	CRM - Add resources	0.50
1/15/2011	Email - Exchange Update	0.08
2/1/2011	Trucare Hotfix	1.00
2/6/2011	Amisys - Install patch	8.00
3/1/2011	CRM - Config Change	0.25
3/25/2011	Email Reboot and failback	0.08
4/1/2011	CRM - Add resources	0.50
	Email - Microsoft Patching	0.08
4/8/2011	Trucare - Product Upgrade	7.00
4/9/2011	Amisys - Upgrade Database	10.00
4/18/2011	CRM - Config Change	0.25
4/19/2011	Trucare Hotfix	0.25
5/5/2011	Email Microsoft Patching	0.08
5/15/2011	Network Install Jumbo Frames	0.50

A Fault Tolerant System Architecture Minimizes Operational Downtime

The high system availability reported above is due to the fact that Centene and Cenpatico *engineer* the hardware, software, communications and processes in our MIS to ensure that our applications are available with the least possible processing. Our MIS leverages virtualized operating systems, redundant telecommunication networks and carriers, high performance RAID storage area networks (SAN), multiple and automated system and environmental monitoring and alert controls, clustered application and database servers, rigid and auditable change management procedures, 24 by 7 end user technical support, and (beginning in the 4th quarter of 2011), a second enterprise datacenter with "hot site" back/up capabilities, allowing critical applications to recover nearly immediately in the event of a datacenter disabling event. This combination of technology and processes assures the lowest practical level of system downtime in the industry. Please see Sections g.xv, g.xxxv, and g.xxxvi for more information on our fault tolerant architecture and end-user support.

Web and IVR Availability

Today our Avaya Voice Portal (AVP) Interactive Voice Response Unit (IVR) and all of our external internet websites, including our secure Member and Provider Portals, are available 24/7 and we will maintain this level of service for the Louisiana Behavioral Health Partnership (LBHP). Should we identify a need to schedule unavailability of these systems, the Cenpatico Information Systems Administrator will consult with DHH-OBH and only implement scheduled unavailability with DHH-OBH's agreement.

Other System Availability

Outside of our IVR, internet websites, and email system, our other MIS functions are scheduled available for online use from 7AM to 7PM, Central Time, Monday through Friday. In fact, availability is typically well beyond these hours depending on night production batch cycle loads and system maintenance.

2. g. Technical Requirements
xiv. Describe the Proposer's system data archive and retrieval system including disaster recovery procedures, including loss of the Proposer's main site or computer systems. Indicate when the disaster recovery was last used or tested and describe the outcome. **Suggested number of pages: 4**

Centene Corporation (Centene) will manage the Management Information System (MIS) on behalf of Cenpatico. Centene engineers the hardware, software, communications, and processes in our MIS to ensure our applications are available for our internal staff, providers, members, and state partners including DHH-OBH and other agencies with the least possible disruption. We maintain and continually enhance the availability of our MIS related capabilities through the design of redundancy we factor into the hardware, software, and networking components of our MIS architecture, mitigating the likelihood of system outages. All of the MIS infrastructure technologies, MIS service management strategies, Incident Management, Business Continuity and Disaster Recovery policies, procedures, and processes supporting our MIS offering to DHH are *in place today*, serving nearly 1.7 million members in full-risk managed care programs in Centene's 12 affiliated health plans across the United States. For more information on our architecture, please reference our response to question 2.g.xxxv.

By Q4 2011, Centene will also complete construction of our new, fully-functional, Tier 3, 19,000 square foot production datacenter, with capacity for over 165 IT racks; 6,000 square feet of datacenter floor; and fully redundant environmental, power, and network connectivity systems. This new datacenter will provide us with *full redundant* capability, with our current datacenter serving as our failover operation, reducing our recovery capability from hours to minutes in most cases. For large-scale MIS events, *Centene targets to restore all centralized MIS operations within **12 hours** of the declared disaster*. Further, our telecommunications architecture is engineered so that *mission critical phone communications* remain available at all local sites.

Protecting DHH-OBH Data Records - Systems Archive and Retrieval.

Starting in Q3 of 2011, all Tier 1 and 2 data will be ***continuously replicated*** from our primary corporate datacenter to our secondary datacenter for the purposes of high-speed disaster recovery. Tier 1 and 2 data is defined by the business and consists of all data produced by our core transaction processing systems, Member and Provider Relationship Management (MRM/PRM); AMISYS Advance claims processing; TruCare case and utilization management; Member and Provider Portals, etc. For routine data recovery, system backups are performed on all Centene servers using an Enterprise class backup software package from IBM, called Tivoli Storage Manager (TSM). All database transactions are logged and written to high-speed media several times per day. All data is written to a tapeless environment using a pair of backup storage devices (EMC DD880). One device serves as the primary device and the second device is replicated to the secondary datacenter facility. Daily backups are retained for 30 to 60 days following the original backup. In addition, a backup archive is generated and maintained once per month, according to HIPAA regulations, using traditional tape backup. These tapes are sent offsite to a secure, climate controlled, fireproof facility. Access to offsite tape media is limited to key Centene employees and is strictly enforced by our Tape Management vendor. Centene's Enterprise backup strategy enables us to provide business continuity and a robust backup capability with virtually no chance of data loss. Our new dual datacenter, described below, will be available in Q4 of 2011 to support replicated data on a near real-time basis for our tier 1 databases and applications. This will provide additional recovery points that create more depth of recovery and a more agile recovery environment. Please see Figure 2.g.xiv-A: Data Storage Architecture

While the necessity of a good backup solution is obvious, the whole intent of the backup strategy is to manage a recovery scenario in the most efficient way possible. This includes file recovery, database recovery, or even a full data center recovery due to an unexpected disaster. A summary of the key features available with our backup solutions include:

- Automated, operator-less backups and restores
- Fast online backups to high-speed media backup storage device (EMC DD880) and monthly tapes
- Fast single file, database or full system recovery
- Robust Tape Management facility to manage the location and protection of all tape media
- Complete catalog containing a history of all backup data at its location on media
- Replicated backup storage device and automated tape copies for offsite storage and Disaster Recovery needs.

Emergency Response and Disaster Recovery - A Proactive, Organized Response.

When any Centene region or business operation, including Cenpatico Louisiana, is affected by an emergency, **the entire company, *as defined in our Business Continuity Plans,*** is placed on alert. Pre-identified teams, including the Executive Team (Management Team), Business Continuity Management Team (Steering Committee), Centene Corporate Crisis Management Team, Cenpatico Corporate Office Team, ***Cenpatico Louisiana Local Response Team (LRT)***, and other Support Teams and Business Units (such as our Corporate Operations and Specialty Companies) might be engaged to respond. We call the combined response team the Crisis Management Team (CMT). This leadership and the supporting teams are collectively responsible for ensuring that critical local health plan and Centene business functions (particularly call center functions for communicating with members and providers) remain operational under emergency and post-emergency conditions including, but not limited to a natural emergency /disaster, manmade emergency, or epidemic (pandemic). Business Continuity Plans covering Crisis Management, Business Continuity, and Disaster Recovery exist for *all* Centene locations. These are created and maintained by the business leaders themselves, under the guidance of our experienced Business Continuity Planning/Program (BCP) team. We will create Business Continuity Plans for our Cenpatico Louisiana offices and integrate these into our overall Business Continuity Program. For more information on our BCP and Emergency Planning, see our response to section 2.h.

Continuity of Call Center Services to Providers, Members and DHH-OBH. In the event of a natural disaster or pandemic, all business functions that rely on our telecommunications system have *top priority,* specifically our member and provider call centers. We have engineered several levels of *redundancy* in our phone system hardware, software, and networking, with automated rerouting of inbound calls to other Centene call centers in the event of a communications failure for any one of our call centers. If an emergency event were to disable any of our offices, including Cenpatico Louisiana offices, our Business Continuity Plans (BCP) call for phone lines to be transferred to NurseWise, our afterhours call center, to ensure continuity of service. NurseWise staffing needs at the call center are reviewed at the time of the emergency and, if needed, additional staff are called in to address any increase in call volumes. In 2010 and through Q2 of 2011, we addressed all incidents that threatened our telephone-based functions without any material impact on operations. This includes severe winter weather that took down telephone lines and transformers in the Southeastern and Eastern regions; rolling power outages that impacted our Texas locations: potential tornados and flooding affecting our offices in Mississippi; and several other less dramatic events.

Information Systems Monitoring - Tools and Resources; Continuous Testing of All Applicable System Functions. Centene maintains a centralized approach to managing system capacity, availability, and performance. Our Network Operations Center (NOC) located in St. Louis, Missouri, monitors *all* production systems and *remote* offices 24/7/365 for service availability, system performance, and capacity utilization. Centene's NOC staff are dedicated to monitoring business critical applications, employing an Information Technology Infrastructure Library (ITIL)-based Incident Management Process enabled by industry-leading incident management and system monitoring tools, such as Hewlett-Packards OpenView Operations®, Solarwinds, Cascade, and Fluke's Visual Performance Monitor.

If the NOC were to identify an issue that impacts business operations at Cenpatico Louisiana , the NOC would alert the Centene Service Desk who is responsible for initiating a virtual Emergency Management Team call line. All on-call staff and our Business Continuity Team participate in these calls, along with the Local Response Team lead. Our CMT has well defined protocol for managing the CMT call line, allowing them to quickly assess the issue, engage the appropriate staff, ensure notification to the state on a timely basis, and provide communication to all appropriate parties. Status updates for all Crisis Management Team calls are provided to senior management on a periodic basis until the issue is resolved. Our Information Technology staff can access all of Centene's systems remotely using Citrix. Staff can quickly and securely resolve issues any time and from any place with access to an Internet connection, cellular network, or telephone line. See Figure 2.g.xiv-B: Centene Event Monitoring Architecture and Section 2.g.xv for more information on our Help Desk.

Information Systems Disaster Recovery. If an emergency event disables our primary datacenter, for any reason, we will invoke pre-established recovery procedures. Restoration of all critical business functions then begins at our alternate data facility.

Centene's New Datacenter. Centene's datacenters are designed to be fully HIPAA-compliant and provide state of the art security measures. In the 1st Quarter of 2012, we will operate our two fully-redundant enterprise datacenters as mutual "*hot site*" backups. Each datacenter will have the capacity to assume operation of all **business critical** production systems if the other datacenter is rendered inoperable. Please see Figure 2.g.xiv-C: Centene Data Center Reference Architecture.

Features include:

- *Scalability and Growth* - designed for a 20-year growth plan.
- *Datacenter Hardening* - designed to withstand penetration due to natural or other security threats.
- *Fire Protection System* - advanced fire detection and alert systems.
- *Network Access* - designed with fully redundant networking infrastructure and network circuits.
- *Electrical Plant* - constructed for reliability, performance, and fault tolerance.
- *Mechanical Plant* - high performing and highly efficient cooling system

Louisiana Business Continuity and Work Area Recovery. If a disaster is limited to a local office (such as Cenpatico Louisiana office), the Local Response Team would work with Centene's Corporate Crisis Management Team to execute the business continuity plan. In the event the local office is inaccessible or destroyed, work area recovery services will be initiated at a SunGard Recovery facility, which provides for desktop computers, telephones and connectivity to our systems at Centene's data center so staff can resume activities quickly. Per the BCP, within minutes, member and provider calls will be re-routed to pre-designated Centene operations in other areas, and systems and servers will be gracefully shut down through remote controls except for environmental monitoring systems. A Crisis Command Center would be established and displaced employees would be reassigned to designated areas and able to log on to our systems and continue to support the needs of our members and providers remotely. Reference Figure 2.g.xiv-D: Centene Business Continuity / Disaster Recovery Scenarios.

Communication with DHH. Local Cenpatico plan management will be responsible for notifying DHH-OBH of any event that will or may potentially impede our ability to service our members, providers and DHH-OBH.

Annual Business Continuity Planning Review and Exercise. Our entire BC program undergoes a formal review on an annual basis and the Cenpatico team in Louisiana will go through the planning and annual review process as do all our locations. All departments and Senior Management participate in these reviews which include a read through of our current plan, an update of all materials, and a read through of the final plan after all changes have been made. Following this, we conduct a scenario-based exercise to

ensure the plan addresses all factors related to both short- and long-term emergencies that could cause an interruption in the flow of our operations. Additional BCP changes are made based on the scenario exercise to ensure the plan reflects the ideal response to an event. These activities are overseen by our Corporate Business Continuity Department which is staffed by a team of credentialed Business Continuity Planners with multiple years of experience in planning, maintenance and methodology who oversee and manage the tools for documentation and our contracts for recovery.

Corporate Information Technology Disaster Recovery Exercising. In addition to the annual refresh and testing of Business Continuity Plans, Centene conducts annual full-scale testing of our recovery capabilities by simulating the complete destruction of Centene's primary data center. As part of this exercise, we perform an annual "Hot-Site" information technology test, also known as a disaster recovery (DR) exercise.

Historically, Centene has tested its ability to recover critical Management Information System (MIS) capabilities by conducting a full scale planned exercise using our third party vendor, SunGard. Having successfully completed these exercises for multiple years, we chose to evolve our approach in 2010, exercising our ability to respond to an unannounced "mock event."

Using an "earthquake mock event" as the trigger, Centene Corporation conducted its annual exercise beginning on Tuesday, November 02, 2010. With the exception of the CIO and a few Senior IT Directors, no one on the recovery team was aware of the event. Beginning at 4:00 AM CST, notifications were sent and IT Infrastructure Management joined a bridge call by 4:15 AM where they were instructed to identify and contact primary resources asking them to assemble at 7:30 AM to receive the scope of the exercise --- or impact of the earthquake. With only access to our emergency online documentation repository, but no access to anything within the primary data center, or other resources, a team of 23 MIS professionals were asked to restore critical IT functions.

The Emergency Command Center was invoked using our third party notification service, NotiFind, which provides the ability to send out messages to multiple people and contact devices simultaneously without requiring Centene's corporate Data Center be operational (i.e., phone or e-mail systems). Crisp communication inside the command center with external users and management was controlled through the following methods:

- Deployment of a dedicated Crisis Manager.
- An open 24x7 pre-established IT conference bridge where technical resources could join together to resolve issues throughout the exercise.
- A periodic management conference bridge to facilitate communication between the DR recovery facility and remote recovery management personnel.
- An on-site IT Service Desk was established to document problem tickets and track them through completion as they do in our production environment.

In the last stages of the exercise we were able to *successfully* validate critical services and business processes were functionally restored. Significant examples include:

- Eligibility and Claims Processing
- Secure Provider Portal Services
- Medical Management Systems

We make the results of our Disaster Recovery exercise available to each of our health plan compliance officers and to our state partners on request.

Figure 2.g.xiv-A: Data Storage Architecture

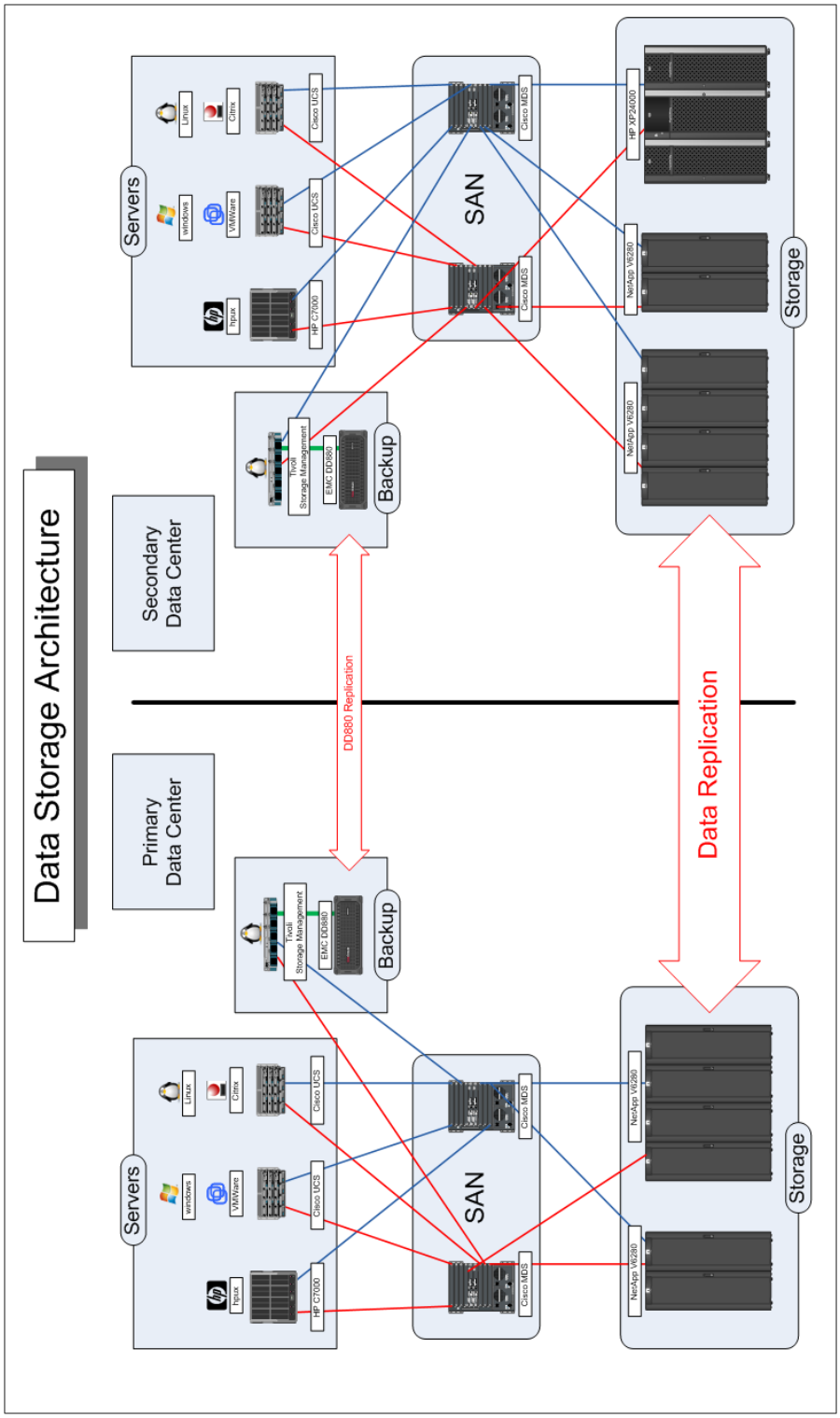


Figure 2.g.xiv-B: Centene Event Monitoring Architecture.

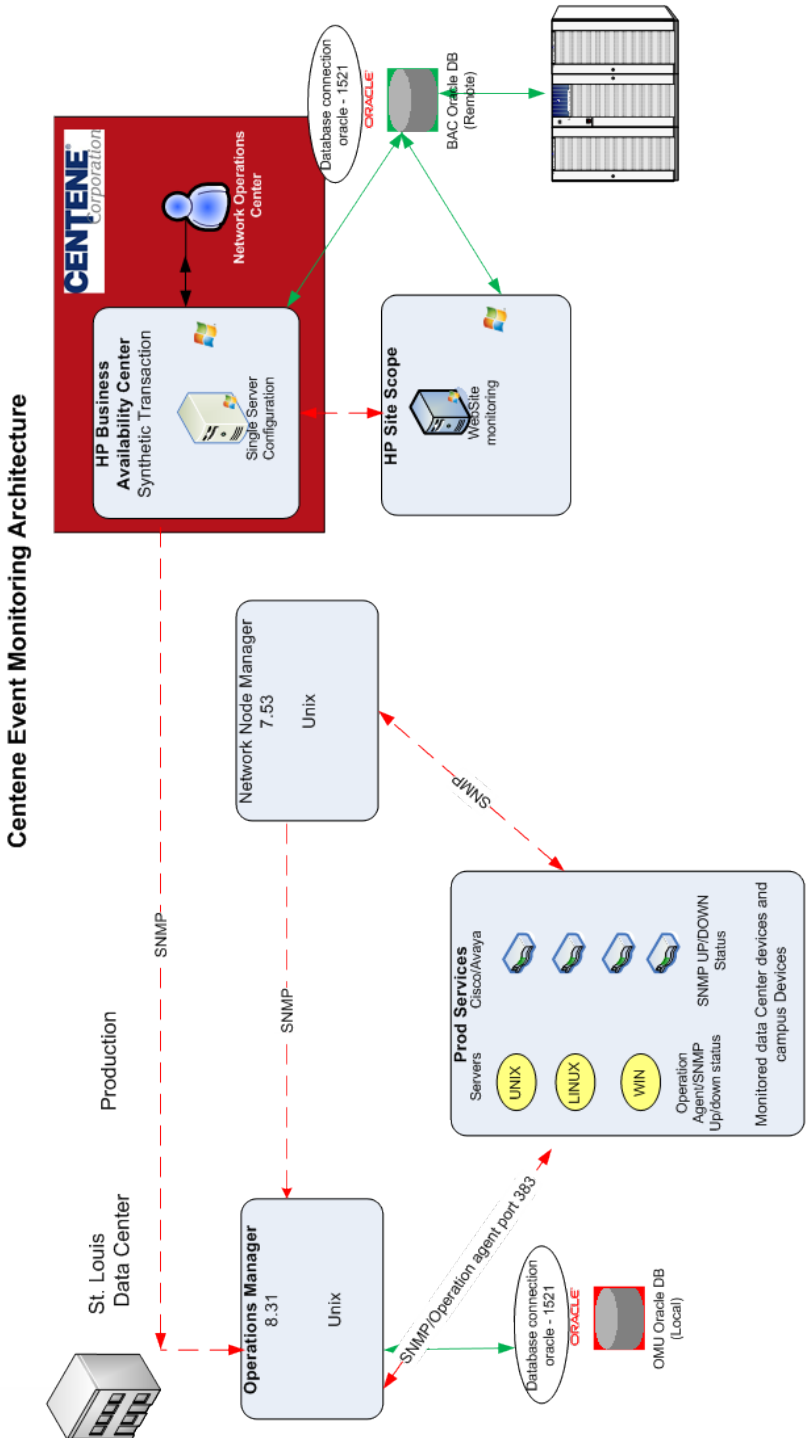


Figure 2.g.xiv-C: Centene Data Center Reference Architecture

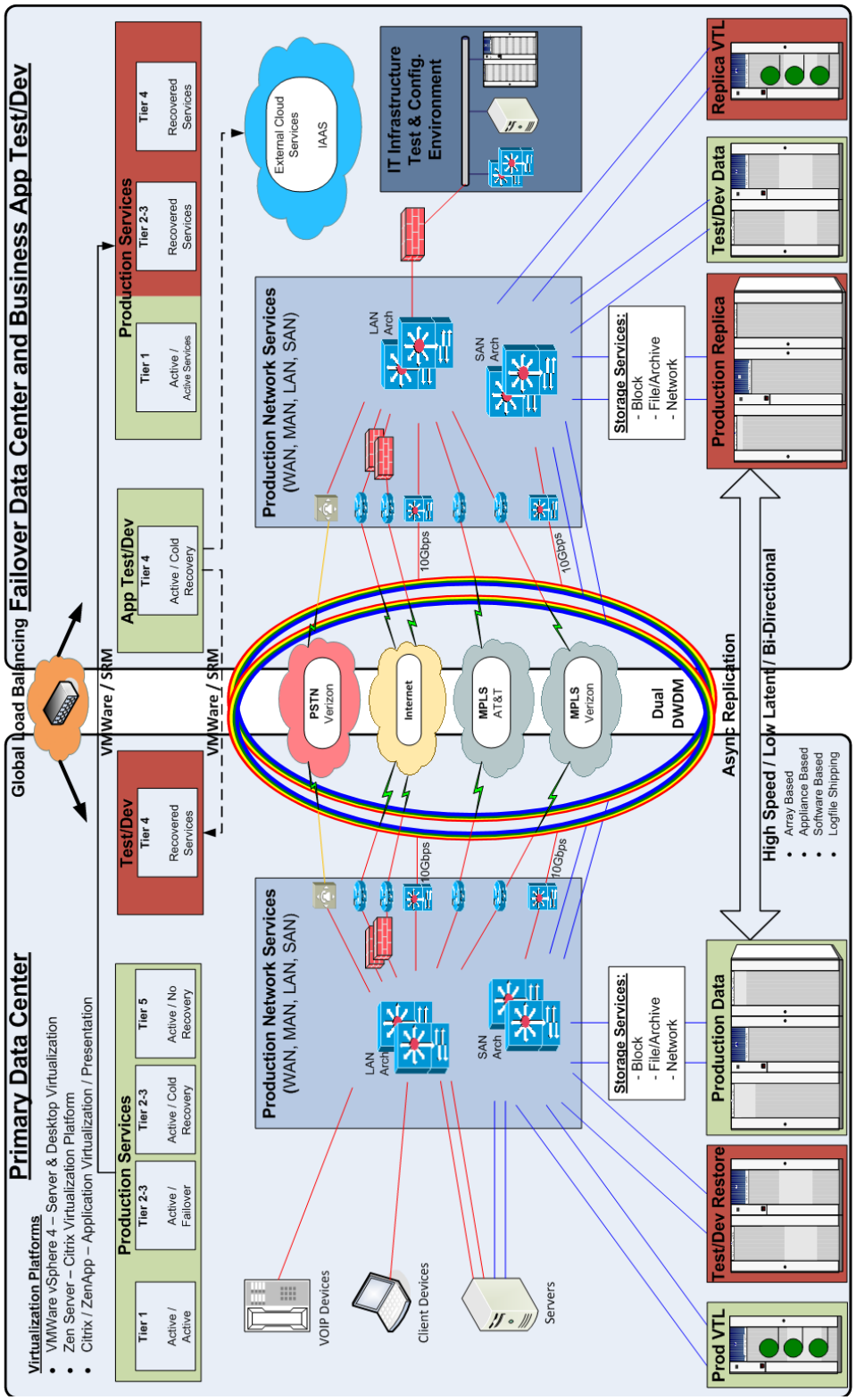
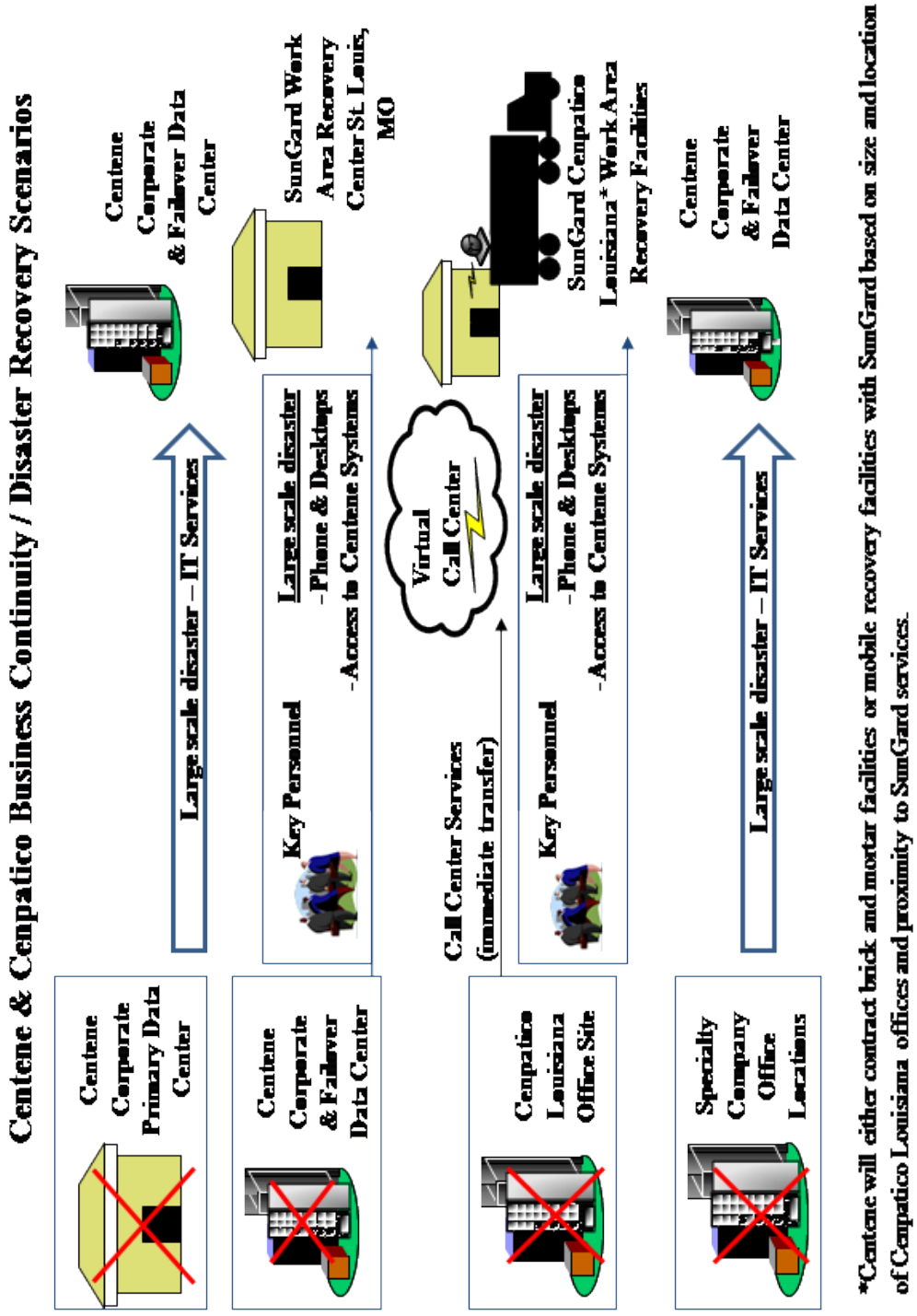


Figure 2.g.xiv-D: Centene Business Continuity / Disaster Recovery Scenarios



2.g.xv. Describe the Proposer's technical support or "help desk" services available to front-end users of your information systems. **Suggested number of pages: 2**

Supporting Cenpatico's Internal Front Line Users

Centene will support local Cenpatico staff in Louisiana with a fully staffed technical support Help Desk, which we refer to as our Service Desk, located at Centene headquarters in St. Louis, Missouri. The Service Desk will be available to Cenpatico front line users *24/7* through a dedicated toll-free number, or internally through a five digit extension. The Service Desk is staffed by a minimum of two agents from 6:00 a.m. to 7:00 p.m. Central Time, Monday through Friday, with on call staff available after hours and on weekends.

Cenpatico's Louisiana based Information Systems (IS) Administrator and IS Liaison will assist in the *coordination, management and tracking* of all Cenpatico open requests related to applications, hardware and business data analysis and reporting. Cenpatico's IS Administrator and/or Liaison, will also participate in monthly technical meetings and weekly WebEx calls with the Centene Service Desk to coordinate support activities, as do the IS Liaisons from all Centene health plans.

Experts on the Front Line. Centene's Service Desk employs a "one call and done" approach to user calls whenever possible. Centene trains Service Desk representatives in a wide variety of systems, services and applications to ensure that calls and emails sent to the Service Desk are handled efficiently by the Service Desk agent themselves without escalation. Service Desk employees and all local IS Liaison, such as Cenpatico's IS Liaison in Louisiana and IT staff are required to attend periodic training courses and seminars related to improving customer satisfaction, diplomacy and call center techniques. Service Desk technicians also receive a minimum of two weeks intensive training at the Centene Datacenter in St. Louis, Missouri, with technical, in depth topics ranging from PC hardware troubleshooting to AMISYS Advance (our claims processing system) to report creation. In addition, we offer our Service Desk representatives the latest Computer Based Training (CBT) courses such as Microsoft A+, N+, Server+ and the Microsoft Certified Professional curriculum. As front line support, the Service Desk is also at the center of crisis management and coordinates with our Network Operations Center (NOC) and key crisis management staff. A core team of systems support analysts, engineers and management are on stand-by 24/7 to respond to any crisis call initiated by the Service Desk.

Service Support Automation. Our Service Desk uses ServiceNow (on-demand IT Service Management tool) as an integrated incident support management solution to submit, monitor and manage calls and change requests from front line users through to completion. Service Desk staff document all calls and requests into ServiceNow where a unique ticket number is assigned. ServiceNow then issues a notification email to the Centene or Cenpatico user who contacted the Service Desk. This email contains the ticket number and a summary of the user's issue or request. Once the user receives an email with a ServiceNow ticket number, they can log into ServiceNow through CNET (our intranet) to view their tickets and the status of each.

ServiceNow is also used by our Network Operations Center (NOC). When our NOC detects an issue, the NOC staff log an alert to a central console. Depending on the severity of the issue, ServiceNow may issue a ticket and notify our on-call technical staff. ServiceNow categorizes incidents and problems by type of service and location to allow us to streamline tracking and reporting, so that we can spot any trends in the issues our front line users are experiencing, and develop action plans to eliminate any systemic issues. Cenpatico's IS Administrator will be able to enter and view tickets online via ServiceNow to track their status and ensure successful resolution. ServiceNow is Information Technology Infrastructure Library (ITIL) driven and provides *automatic escalation* of trouble tickets to the appropriate Centene or Cenpatico staff, based on customizable metrics such as length of time a ticket is open; knowledge base resolution and activity reporting; keyword and full-text searching against the knowledgebase; integrated problem management to assess whether a ticket is a one-time trouble-ticket or an indicator of systemic,

longer-term performance and system problems; change and risk management planning with an automated approval process; asset management tracking from purchase, implementation, decommission through disposal; software license compliance tracking; and Service-Level Agreement (SLA) administration. In other words: ServiceNow automatically helps our Service Desk route front line user requests or issues to the appropriate Centene or Cenpatico department.

Service Desk Response Standards. Our Service Desk staff classify incidents reported to the Service Desk by severity (SEV) level. If an incident is extremely serious, such as a significant network problem or a loss of service for one of our production applications, we consider this a SEV 1 incident, and the Service Desk responds immediately. If the incident involves a loss of service for portions of an application, or where a specific group of users are impacted, we categorize this as a SEV 2 incident but our Service Desk *still* responds *immediately*. SEV 1 and SEV 2 incidents must be escalated from the Service Desk or the NOC to an Incident Manager, who initiates a Hotline conference call bringing together Crisis Management Team members to communicate the issues related to the SEV1/SEV 2 incident. When a SEV 1/SEV 2 incident occurs, the On Call Support Resources convene to begin troubleshooting the issue until it is resolved; system vendors are called in to assist when necessary. Once we resolve the SEV1/SEV2 incident, we document the root cause and solution into the ServiceNow system so that we can develop an action plan to eliminate such issues in the future and/or use as a reference in future incident troubleshooting and analysis. As outlined in our response to question 2.g.xiv, we will notify DHH-OBH of any event that will or may potentially impede our ability to service our members, providers and DHH-OBH.

While our Service Desk responds immediately to SEV 1 and 2 incidents, SEV 3 and 4 incidents are addressed as quickly and efficiently as possible, but no later than two and seven business days, respectively, after the SEV 3 or SEV 4 issue is logged into SreviceNow. An example of a SEV 3 incident would be interruption of service to a single user; while adding a non-standard software package (like Microsoft Visio) is an example of a SEV 4 incident.

Tiered Support Ensures Immediate and Appropriate Response. Centene assigns support roles into "tiers" to manage front line user incident resolution, and we mobilize resources from these tiers into the issue resolution process based on the issue severity. A Tier 1 role (Service Desk or NOC staff) initially identifies an incident and the Incident Manager is accountable for following a SEV 1 incident through to resolution. The SWAT role is an on-call support resource team on heightened alert who may be convened when SEV 1/SEV 2 incidents arise. Tier 3 roles are higher management and/or system or network vendors to whom SWATs can escalate.

Helping to Maintain IT Security. The Service Desk plays an important role in helping to maintain a secure workstation environment. All users (front line and support staff) are instructed to contact the Service Desk when they suspect a virus or other malicious activity, such as an unidentified or strange file received through email. The Service Desk will direct the appropriate process to resolve the issue.

Monitoring Front Line User Satisfaction. The Service Desk sends satisfaction surveys to all users. If a user files an unsatisfactory report, the Service Desk supervisor follows-up directly with the user to determine the issue and identify how service could be improved going forward. The supervisor reviews the report with the Service Desk technician as part of our continuous performance improvement process.

Provider and DHH-OBH Support

Cenpatico views not only our own staff as front line users, but also we recognize our Providers and DHH-OBH as front line users of our MIS. Our MIS and claims technical support is grounded on a two prong strategy: a) thorough *training* delivered in multiple venues and on "provider friendly" schedules; and b) in-person and phone based support. Please see our response to question 2.g.iii for more information on Provider Training and 2.g.xii for training DHH-OBH to utilize our reporting tools for the purpose of data mining.

Cenpatico Provides Local Support to Our Providers. Cenpatico providers will be able to call our Provider Services call line for first line of support. If the Provider Service Representative is not able to assist the Provider with a technical question, that call will be routed to the appropriate staff, such as the Data Services or Claims Specialists to discuss any issues or questions related to their IT operations, such as the submission of claims data; and/or simply accessing and using our provider portal. In some instances, telephone support is not enough, so our local IT staff will go directly to the provider's location and provide hands on assistance and guidance. When Cenpatico contracts with a new provider, or an existing Cenpatico provider hires new staff responsible for IT operations, our IT team, with support from Centene, will train and test data exchanges with the new provider or new provider staff.

Provider Claims Support/EDI Help Desk. In addition to the above, Centene will offer their Electronic Data Interchange (EDI) Help Desk to support Providers Monday through Friday, from 8:00 a.m. to 5:00 p.m. Central Time. Centene's EDI technicians communicate directly with providers, clearinghouses, as well as all internal users who may experience issues or have questions about electronic submissions. The EDI Help Desk technicians will reach out and work directly with providers who submit electronic claims and have high rejection rates and help resolve any issues that cause claim rejections. In conjunction with Cenpatico's Data Services Supervisor, the EDI Help Desk will also offer training or technical expertise to encourage EDI submissions from providers who submit paper claims. EDI Help Desk staff respond to all voice messages and emails within 24 hours, and they will be available to participate in conference calls with providers, software vendors, plans and clearinghouses as needed.

General Provider Telephone Support. Cenpatico providers and their staff will also be able to contact our Customer Service Center where they can access knowledgeable Customer Service Representatives experienced in claims, enrollment/disenrollment and the submission of demographic data.

2.g. Technical Requirements
xvi. Describe the Proposer's ability to access the system for end users not working in the office. **Suggested number of pages: 2**

Hardware

We configure, provision, and use a standardized desktop environment for all Centene and health plan staff with operating systems that include Windows Win 7, Office 2010 SP1, Rightfax 9.4, McAfee Virus Scan 8.8, Latest Microsoft Updates for laptops.

Encryption Software. All Centene laptops and portable communication devices utilize MacAfee's Safeboot encryption software (our thin client desktops have no hard drive and no stored data). In addition, all mobile devices are equipped with Absolute tracking software so that a device (e.g. laptop or PDA) can be physically located when connected to a network. In order to prevent disclosure of PHI, if a device is lost or stolen, access to that device (laptop, Blackberry, etc.) is systematically revoked, the device is locked, and authorized MIS staff remotely delete all information on the device.

Secure Remote Access

Two Factor Authentication. As a part of our commitment to the comprehensive implementation of information security best-practices, Centene and Cenpatico will utilize award winning SecureAuth® *Identity Enforcement Platform (IEP)* software to provide secure multifactor authentication for Cenpatico employees and partners, including DHH-OBH designated users that require remote access to Centene information systems.
IEP will be one of the core components on our defense-in-depth strategy ensuring that only authorized individuals are allowed remote access into our Cisco VPN, Microsoft Outlook Web Access, and Citrix published applications. In addition, the extensible and flexible nature of the IEP software allows it to be quickly integrated to protect any other applications that might be deployed in the service of Cenpatico's Louisiana Behavioral Health Partnership program.

Access to Systems. Remote access to Centene's internal network is available to authorized users via two solutions. Our preferred method for providing remote access is via encrypted sessions using our Citrix Secure Access Gateways together with multi-factor authentication. This method provides the highest degree of both data and device security while ensuring that no data leaves the corporate datacenter. For those instances when remote access via Citrix does not provide sufficient utility, we also provide a secure Virtual Private Network (VPN) using Cisco's VPN 3000 Concentrator and multifactor authentication. Centene's IT Security department has implemented in-depth access control procedures and audits to ensure that all forms of systems access, including remote access, are strictly controlled and limited to those authorized users with a demonstrated need for such access. These policies are set and reviewed by our Chief Information Security Officer (CISO).

Presentation Layer. Our corporate datacenter in St. Louis, Missouri, will centrally run and maintain all Cenpatico programs, applications, processes, and data. With Internet connection, any laptop user can access systems and data through Citrix Secure Access Gateways. Once connected, our virtual desktop allows remote users to access systems and data through an engaging, intuitive, and responsive interface, while the enterprise servers house our high transaction, critical business applications and data in a safe and reliable computing environment. Like our thin client approach, discussed in our response to question 2.g.xxxv, Citrix virtual environment provides the following benefits:

- Data Integrity. Because Protected Health Information (PHI) and Cenpatico's core applications and operational data will be housed in our central datacenter, Cenpatico will benefit from all the infrastructure support of our corporate datacenter including our data integrity controls, data loss prevention, back-up capabilities, audit trails, and help desk support.

- Business Continuity and Confidentiality. With centralized data, information is safe in the event a laptop is lost, stolen or damaged in some manner. Protected Health Information (PHI) is better protected because it is not stored on the virtual desktop; it is only accessed through the virtual desktop. Our encrypted laptop drives also contribute to data confidentiality and secure operations.
- Protection from viruses**.** By having our core transactional data and applications centrally housed and by running enterprise anti-malware protection on our centralized systems, we mitigate the exposure to viruses or malware that might otherwise impact operational data, such as member, provider, claims, care management, and other business critical information.

2.g. Technical Requirements
xvii. Describe the Proposer's experience with the 270/271 Eligibility Request/Response transactions as well as submitting and receiving 834 Enrollment/Disenrollment transaction sets. **Suggested number of pages: 3**

National Experience Exchanging Data with States and Their Intermediaries

Centene Corporation (Centene) will operate and manage the data exchange and processing requirements for Cenpatico. Centene has over 27 years of experience processing eligibility/enrollment two-way exchanges (data to/from our state clients and provider support) for public sector health care programs in 11 states, and on behalf of over 1.6 million members and a nationwide network of over 100,000 physicians, specialists, hospitals, behavioral health clinicians, and ancillary providers. Today, we support all HIPAA transaction formats, including those pertaining to eligibility/enrollment with our state clients or their intermediaries.

Current Experience Processing Data

HIPAA 270/271 Processing. We are operationally compliant and support the HIPAA 270/271 transaction in *all* our markets today through a growing number of Trading Partners. Providers can also use our HIPAA Direct Data Entry (DDE) compliant eligibility inquiry and response function available on our secure Provider Portal. Please see our response to section 2.g.viii for more information on our Provider Portal. In addition, we continue working with CAQH and our EDI Trading Partners in supporting the implementation of Committee on Operating Rules for Information Exchange (CORE®) for the HIPAA 270/271 transaction; enabling an enhanced level of benefit eligibility data exchange - a particularly important consideration with the LBHP program, with its multiple benefit plans, spend down criteria, and funding streams.

HIPAA 834 Processing. Centene currently receives processes and updates enrollment/eligibility data in each of the states in which we operate a health plan. As described below, we utilize a standard HIPAA 834 file to load and update member enrollment and eligibility data into our MIS. In certain situations, we also utilize supplemental, proprietary data files to incorporate state-specific information necessary for the management of the program. In all cases, we meet or exceed local state technology and business requirements and compliance guidelines to utilize data in a consistent, accurate and effective manner.

A key differentiator for Centene is our organizational focus on public sector healthcare programs. The administration and use of Medicaid and CHIP enrollment/eligibility data differs significantly from private or commercial health insurance programs. Over the years, Centene has developed specific business processes, controls and technologies designed *specifically* and *exclusively* for the continued successful processing of state Medicaid and CHIP data. What this means for DHH-OBH is a successful history of data processing capabilities maintained over an extended period of time, inclusive of the many changes necessitated by federal or state requirements. In the table below we summarize this experience.

Centene Operated Plan	[1]Utilization of HIPAA 834?	[2]HIPAA Level	First Year of Operation
Wisconsin	Yes	1	1984
Indiana	Yes	1	1994
Texas	Yes	4	1999
Ohio	Yes	1	2004
Arizona	Yes	1	2006
Georgia	Yes	4	2006
South Carolina	Yes	1	2007
Florida	Yes	1	2007
Massachusetts	Yes	1	2009
Mississippi	Yes	1	2011
Illinois	Yes	1	2011

[1] We have been exchanging HIPAA 834 transactions with all our plans since 2003.
[2] Please note that HIPAA Compliance Levels listed in this column are the Compliance Levels requested by our state clients or their enrollment brokers. We can support a broad variety of formats and HIPAA-compliant standards, and for our largest markets we have encouraged and requested a higher HIPAA compliance level to improve our ability to automate eligibility processing (Texas and Georgia).

Receiving, Processing and Updating Eligibility and Enrollment Data

As part of our normal business support capabilities, Centene successfully receives, processes, acknowledges, updates, and transmits formatted data to and from our integrated Management Information System (MIS) from a wide variety of Trading Partners (state agencies, fiscal intermediaries, enrollment brokers, claims clearinghouses, providers, etc.) through all industry standard methods (VPN, Secure FTP, https, etc.).

Eligibility and Enrollment Data. Today we process inbound HIPAA 834 transactions on a daily, semi-monthly, and monthly basis from *all* our state clients or their Fiscal Intermediaries (FI) or Enrollment Broker (EB), and in accordance with companion guide specifications per state, FI or EB. We can accommodate *any* 834 transaction schedule desired by DHH-OBH. We receive and transmit HIPAA 834 transaction files via our secure file exchange management system, Coviant Diplomat (Coviant). Our TIDAL job scheduling software manages member load processes for overall process integrity. Inbound 834 files are automatically processed through our EDIFECS EDI system for HIPAA 4010A and 5010 compliance validation and translation. EDIFECS, in conjunction with our TIBCO middleware also edits for duplicate member records, date criteria validity, field data integrity, and valid date spans. Any member records that trigger edits default into an Exception Report where they are systematically corrected using data correction routines prior to subsequent processing.

We will process HIPAA 834 files received via DHH or DHH's FI through our EDIFECS system using HIPAA 5010 compliance checks (for go-live on 3/1/12), and load this data into our Member Relationship Management (MRM) member data management system through Add, Delete, and Modify transactions with accurate begin and end dates - all within 24 hours of receiving the HIPAA 834 from the DHH FI. This 24 hour processing turnaround time has and remains our normal mode of operations across our health plans. MRM is our "system of record" and master data store for "all things member" related - including demographic (member identifiers, address and contact information, confirmed or potential family linkages, special needs, and numerous other attributes), administrative, member preferences (e.g. communication options such as e-mail, phone, mail) - along with history for these attributes.

MRM also houses our master member index (MMI) - an internal global member identifier, similar to a master patient index, to tie together alternate or historic member identifiers. MRM allows us to systematically link information about the member across that member's relationships with us or DHH, or prior health coverage spans (where we have such history). Once member data populates MRM, it is systematically promulgated to our other systems including (via TIBCO middleware) AMISYS Advance, our core claims processing system; our TruCare integrated health services management platform; our MACESS EXP paper scanning and MACESS FormWorks Optical Character Recognition (OCR) system; our Automatic Work Distributor (AWD) claims workflow engine; and our Enterprise Data Warehouse (EDW) data integration engine via our Informatica near real-time Extract, Transport, and Load (ETL) middleware. Through EDW, we also make member eligibility data securely accessible to our providers online via our Provider Portal. Our MRM can maintain Cenpatico's member historical data indefinitely, subject to DHH-OBH retention requirements.

Based on Centene's experiences with our affiliate health plans, below are some example scenarios where we would work with DHH-OBH to address specific enrollment and eligibility file issues (we will, of course, work out specifics in consultation with DHH-OBH):

Identifying Duplicate Enrollment/Eligibility Records. During the initial load process referenced above, using EDIFECS and TIBCO, we identify duplicate eligibility and enrollment records in a particular HIPAA 834 load file. These duplicate records are output on a load report and are worked by our Eligibility Specialists. If we confirm that the records are duplicates, we will report this fact in the manner prescribed by DHH-OBH.

Member on DHH file, not Active with Cenpatico. The Cenpatico Eligibility Specialist will work with DHH-OBH to validate member additions if not flagged as such on the DHH file prior to adding to the Membership Subsystem.

Member Information Inconsistent with DHH File. (Date of birth, category of aid, address, phone number). The Eligibility Specialist will work with DHH-OBH and have Member Services staff contact the member to ask that they update address and phone changes with the appropriate county office.

Member not Reported on DHH File. The Eligibility Specialist will work with DHH-OBH to confirm eligibility or termination. Our Integrated Care Teams will work with the Eligibility Specialist when a member is identified as requiring a service, verified by the state verification system as eligible but not present on the enrollment file, to resolve membership conflicts.

Multiple Identifiers for Same Person. When we load processed member records into MDS (MDS is our Member Demographics System - MRM's central relational database), we identify any potential duplicate members "at the person level" - meaning the system looks for members (perhaps with different identifiers) who potentially may be the same person. Our Eligibility Specialists work these records as well and once we confirm with the state the correct identifier and demographics for a member, MDS distributes that information to all our internal systems so that we systematically link claim records, clinical case management records, member service records, etc. to the corrected member identifier.

For example, should our Eligibility Specialist identify two records with two different eligibility spans, and two different Medicaid ID numbers, but where it is possible that the two records apply to the same person (e.g. name, address, date of birth), our Eligibility Specialist will validate this fact by working with DHH-OBH and other records we may have on the member, and possibly contact the member directly to confirm that the multiple records are - in fact - one person. If we confirm that the records are for one person, we link those records to our master member index for that member in MDS, allowing us to consolidate history (e.g. claims) at the person level.

Member Referrals

For someone who is referred to us for enrollment in an LBHP program, and for whom we have no existing member record, we will consider them “presumptively” eligible in an LBHP program and create a contingency eligibility record in MRM with an MMI. This process is similar to what we do today for enrollment in our Arizona behavioral health plan. We will send this contingency enrollment information, including this number to DHH-OBH for enrollment in the LBHP plan in a HIPPA 834 transaction. Once DHH-OBH reviews these records, and if the individual is enrolled in the LBHP program, DHH-OBH can return (via DHH and the MMIS) the member record, with the Enrollees Medicaid ID number and our MMI within the HIPAA 834 transaction (in the alternate member ID field) for systematic identification and matching of the presumptive eligible record with the HIPAA 834 record we receive from DHH-OBH (via the MMIS). With or without the MMI, we will be able to match records in our MRM utilizing the algorithms defined for finding existing members (e.g. a combination of member attributes, name, address, birth date, etc).

Sharing Member Data

Today, we support the ability to transmit member demographic changes, such as changes in address or telephone number, to any of our state clients who request this information. We support HIPAA 834 formats for this purpose; and can also accommodate a state or FI proprietary format as may be specified by DHH. To capture member "self reported" changes, we efficiently capture member demographic

changes via our MemberConnect contact relationship management (CRM) system. Our Member Services Representatives (MSR's) can enter new member contact information in fields that do not overwrite the information we have received via DHH, or their FI so that we can maintain data integrity - keeping data issued to us by the state separate from self-reported information from the member. We then extract and send this updated data to the state or state designated entity. For additional information on our eligibility and enrollment data - including how we utilize this information across our MIS - please see our response to 2.g.iv.

Best Practice and Implementation

Looking back at the 27 years of implementations we have performed alongside our state clients, we have come to learn that it is necessary, to share clearly documented data interface specifications amongst Trading Partners, and rigorously vet, discuss and paraphrase via both written formal documentation, and meetings with small working groups to ensure understanding of the requirements and that all possible scenarios and workflows are identified. Following this, we have learned that it is important to thoroughly test these scenarios with data as close to production like as possible. We look forward to meeting and closely working with DDH-OBH should we be awarded the opportunity to serve the LBHP program.

2.g. Technical Requirements
xviii. Describe the Proposer's experience with the HIPAA 835 and electronic funds transfer. **Suggested number of pages: 2**

Centene and Cenpatico know from our claims processing reporting and analytics that an electronically filed claim results in a faster, more accurate process; allows us to utilize the information sooner in care of our members; and is better for our environment. Our experiential data shows that when providers prepare claims electronically, the time from service to submission to Centene is abbreviated by more than *half* the time compared to claims submitted on paper. This means that we obtain the data earlier, our Case Managers can utilize the information sooner in the care of our members; we can process and pay the claim faster and issue an electronic remittance (HIPAA 835) or paper explanation of payment (EOP) to the provider; and we can display the information sooner to our providers via our secure Cenpatico Behavioral Health Member Health Record. Please reference our response to 2.g.viii for more information on our Provider Portal capability.

In addition to the benefits listed above, for our providers, Electronic Funds Transfer (EFT) and Electronic Remittance Advice HIPAA 835 (ERA) afford administrative and financial efficiencies such as:

- ***Improved cash flow*** – Electronic payments can mean faster payments, leading to improvements in cash flow.
- ***Maintain control over bank accounts*** – the provider keeps TOTAL control over the destination of claim payment funds. Multiple practices and accounts are supported.
- ***Match payments to advices quickly*** – Provider can associate electronic payments with electronic remittance advices quickly and easily.

For all these reasons, we aggressively educate and support our providers across all Centene health plans on the benefits and methods of Electronic Data Interchange (EDI) claim submission and EFT and HIPAA 835 Remittance Advice. For example, between June 1, 2010, and June 1, 2011, approximately 86% of all behavioral health claims were submitted electronically to Cenpatico and approximately 65% of our behavioral health providers in Texas received payment by Electronic Funds Transfer over the same time period.

Whether a provider submits a claim electronically, or via paper, providers can view an online, detailed status of all of their claims through our Provider Portal. We include ERA or Explanation of Payments (EOPs) for all methods of payment and provide an accounting of claims adjudicated. EOPs are available on Centene's Provider Portal and providers are also offered the option of receiving the HIPAA 835 Electronic Remittance Advice (ERA) in lieu of paper EOPs. EOP's and ERA's include data elements such as:

- *the amount billed and paid*
- *application of third party liability, if applicable*
- *the reason and adequate description of all denials, partial payments and adjustments*
- *the provider's rights and instructions for dispute*

We can tailor remittance advice to include specific information required by DHH-OBH.

We aggressively educate and support our providers on the benefits and methods we offer for Electronic Data Interchange (EDI) claim submission, Electronic Funds Trans and HIPAA 835 Remittance Advice.

Enabling Electronic Funds Transfer

We actively encourage our providers to sign up for one of the three EFT options we offer:

1. ***EMDEON ePayment (ePayment).*** Our providers will be able to go to the ePayment site, register, and set up their bank account for EFT. Once set up, the provider can view remittance information online on the ePayment site and/or download a HIPAA 835 ERA transaction file for import and processing as detailed information into the provider's practice management system and/or financial system, to support the provider's accounts receivable processing. Providers who use EMDEON's practice management hosted service or submit their claims to us via EMDEON, will also be able to take advantage of the "integration" efficiencies ePayment supports.
2. ***PayFormance.*** PayFormance by Payspan offers our providers a comprehensive payment management solution which is "clearinghouse agnostic". PayFormance supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, and provides online capability for viewing detailed remittance information, as well as the ability to download HIPAA 835 electronic remittance files directly to the provider's HIPAA compliant practice management system and/or patient accounting system eliminating the need for manual re-keying (as above).
3. ***Cenpatico Direct Electronic Funds Transfer.*** To initiate EFT directly with Cenpatico, all a provider will have to do is complete a Cenpatico EFT Agreement. Upon acceptance, Cenpatico will deposit payment for claims directly into the provider's bank account.

Electronic Remittance Advice (ERA)

Through Trading Partners. Centene supports ERA through our trading partners. Following each weekly payment cycle,

Cenpatico Provider Portal. Providers can view explanation of payment (EOP) through our Provider Portal and can request a printed version of their electronic remittance advice.

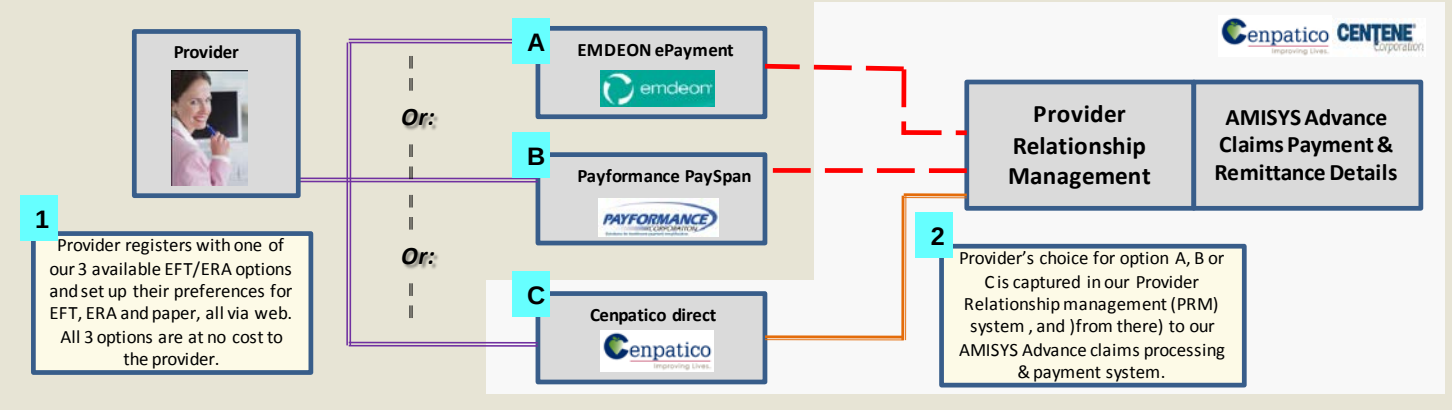
Enlisting, Training, and Supporting Providers

Cenpatico realizes that technology only partially addresses the effort to encourage EDI submission of claims and Electronic Funds Transfer and Remittance Advise. We will therefore supplement our technology options with active and aggressive provider education, one-on-one assistance, and other training methods to motivate a wide audience. Below we list some of the methods that have helped us to achieve high rates of EDI claim submission and providers registered for EFT and Electronic Remittance services. We will utilize these in Louisiana to encourage our providers to go paperless.

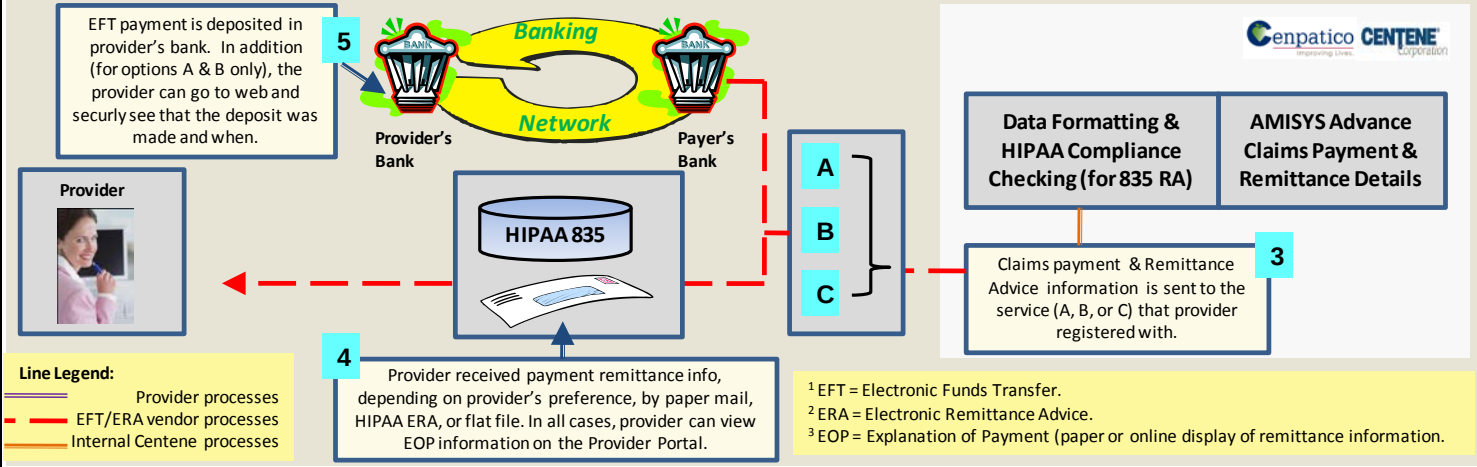
- Our Cenpatico Claims Liaisons will be well trained in our electronic submission offerings and will work with the provider community directly to facilitate enrollment; walk them through the Portal submission options, in training sessions or through web-ex type sessions; and generally be available to support providers with any issues or barriers they have regarding EDI and EFT.
- We will organize outbound campaigns using our ***Provider Relationship Management (PRM)***. We will leverage this tool when appropriate to communicate with providers, such as to recruit providers, to exchange EDI with us and to make them aware of our EFT capabilities. *Please reference 2.g.iv for more information on our PRM system.*
- We will send **EOP stuffers** containing the benefits of filing electronically, EFT payment and Remittance advice options.
- **Provider Newsletters** sent to specialist and PCP office locations geared toward billing and coding staff within a practice or facility and emphasizing EDI and EFT.

Figure 2.g.xviii.: EFT and ERA Options

SET-UP: We orient the provider to our 3 supported EFT[1] & ERA[2] options. The provider then registers (or changes when needed) for EFT with their designated bank and their chosen method to receive paper EOP[3], ERA, as well as online presentation of remittance details.



OPERATIONS: Provider receives EFT payments in the bank they designated in SET-UP; and receives payment remittance information via HIPAA 835 Remittance Advice, or other "flat file" format (at their option), or as paper EOP, and (in all cases) displayed online.



[1] EFT = Electronic Funds Transfer.
[2] ERA = Electronic Remittance Advice.
[3] EOP = Explanation of Payment (paper or online display of remittance information.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xix. Describe the Proposer's system's ability to send and receive data from other agencies such as eligibility (HIPAA 834) and member's plan of care data consistent with the collaboration requirement in the Scope of Work. **Suggested number of pages: 3**

Experience and System Ability for Sending and Receiving Data to Range of Agencies

Cenpatico understands that a successful public sector managed care health plan has to collaborate with not only state Medicaid agencies, but also with municipalities, health departments, judicial and educational systems and other public and private agencies focused on matters of child protection, long term care services, housing, welfare, corrections, the courts, and legislative mandates. Through its parent Centene, Cenpatico successfully supports electronic data exchanges and a variety of connectivity options with our state agency clients, their Fiscal Intermediaries (FI), and provider and human service agencies through a combination of open data interfaces and expanded use of web and e-mail based technologies, all backed up with *training* and *support*. Most BH-MCOs work peripherally with these groups through their Medicaid contracts whereas Cenpatico has direct experience contracting and partnering with agencies outside traditional Medicaid. That experience has shaped technology nuances that foster greater usability and transparency across our enterprise currently. In this arena, we will be introducing best practices based on *actual* experience and lessons learned.

Multiple Applications of the HIPAA 834

Our MIS supports the transmission *and* receipt of all HIPAA transaction files, including the HIPAA 834 enrollment, eligibility and disenrollment transaction, the HIPAA 837 Professional (P) and Institutional (I) claims transactions, and the production of outbound encounters in HIPAA 837 P and I format. We support the receipt and functional acknowledgment (ANSI 997 or ANSI 999 for HIPAA 5010) of the 834 from Medicaid agencies, and post daily updates we receive from our agency clients to our production Member Relationship Management (MRM) system within 24 hours of receipt. MRM is our member services workflow and master member database: the source of member demographic information and current and historic eligibility for all of our core production systems (see Section 2.g.iv and 2.g.vii for more information). We also can issue *outbound* HIPAA 834 transaction file to state agency clients (if they desire) of any demographic changes in member information that we learn of in our interactions with the member or their parent, legal guardian, or caregiver. For one of our behavioral health plans, we also receive HIPAA 834 files from *provider agencies* via secure FTP; containing "enrollment in care" information; information that we process and issue out to our state agency client as a HIPAA 834 "presumptive eligiblity" roster, so that the state Medicaid agency in this case can determine Medicaid or other State General Fund (SGF) or block grant program eligibility. The state Medicaid agency in this case then sends us back (via a regular daily process) the "presumptively eligible" member's record with the final determination of the member's funding benefit plan (e.g. Medicaid), which we then post to our production systems (member data management, claims, care management, etc.).

We support the receipt and processing of member ***other insurance*** (OI) information via the 834 - for purposes of Third Party Liability (TPL) and Coordination of Benefits (COB) application in our claims processing. We also support the inclusion of OI that we discover (e.g. through our TPL/COB service provider (HMS)) in outbound 834's to our state agency clients, if they desire.

Cenpatico also fully supports the import and use of PCP information present on inbound HIPAA 834 transactions. Our MRM loads the member's PCP information as present in Loop 2310 of the HIPAA 834 in the appropriate member record, and this information is systematically propagated in near real time to TruCare. TruCare is our member-centric BH and medical health management platform for collaborative

care coordination and plan of care (including the CSoC plan of care built by the WAA and Child and Family Team (CFT)); and case, disease, and utilization management. PCP information (including contact information, if included on the 834) is then available for viewing by our Care Manager (CM). If our CM sees that a member in BH treatment has no assigned PCP on record, we will refer the member to their CCN (and assist the member in making that connection if needed) so that a PCP can be assigned. Further, we will follow/up with the member to ensure a PCP is assigned. We will consult with DHH-OBH on whether subsequent 834 updates we receive on the member will have PCP assignment information (that is: from CCN to LMMIS to SMO via the 834 process).

Using the Web to Support Collaborative Development and Sharing of the Plan of Care

Our web based Provider Portal will be available to all authorized BH providers and WAA's. Among several important clinical features of our Provider Portal (via its integration with TruCare) is its support for web entry of Plan of Care information. We will configure our Provider Portal and TruCare for the LBHP so that providers (or WAA's in the instance of CSoC cases) can enter (via the web) Plan of Care (POC) information. This resulting information is systematically loaded into TruCare, where it can then be reviewed by our CM's, and viewed by all authorized Provider Portal users. Our CM's can then review services on the POC that require prior authorization, and the CM can then enter those authorizations in TruCare for subsequent use in claims processing, tracking, and reporting.

If the WAA or provider cannot or will not (for whatever reason) wish to use our Provider Portal for POC entry, we will allow the provider to fill out a paper POC form and fax or mail to us, and we will process that completed POC using our Enterprise Content Management (ECM) system. ECM is our new (in process of deployment in 2011), next generation data capture solution to accelerate the processing of paper and faxed authorization requests, assessments, care plans, survey questionnaires, and other paper based correspondence. ECM is comprised of our integrated RightFax fax communications system and our scanning and Optical Character Recognition (OCR) workflow system on the receiving end and leverages the workflow capabilities of our Microsoft SharePoint collaborative platform to streamline and automate the capture and processing of these documents, and integrates the resulting captured data into the appropriate application (e.g. TruCare for authorization, assessment and Plan of Care data, EDW for survey data).

In many situations, we will engage the member's PCP for collaborative participation in the development of the POC (as describe in the RFP, Section II.B.4.t, page 79). We propose to solicit cooperation from the Louisiana CCN's and seek identification data on PCP's in their network. If we receive that data, we will provision Provider Portal accounts for PCP's. When we screen members to identify special needs enrollees, or when a member enters treatment through the LBHP program (e.g. a referral to the CSoC program), as part of that screen or intake, we will seek authorization from the member or caregiver - to coordinate care with the PCP, and record the fact that we have signature on file in our MRM. MRM will then systematically allow the PCP to view (via the PCP's provisioned Provider Portal account) clinical information and POC information on the member. In other words (and using the example of the CSoC program): our Provider Portal will be available for collaborative clinical data sharing among the Wraparound Agency (WAA), our CM (via TruCare), authorized participants in the Child and Family Team (CFT), including other providers such as the PCP and independent assessor (provider administering the Comprehensive CANS assessment).

In some cases (e.g. for non CSoC cases) the Plan of Care may be developed by our CM. In this case, again, the POC built in TruCare will be visible to authorized users of our Provider Portal - and State Agency Portal.

Other Data Exchanges with Agencies

Our MIS has the capability to send and receive information needed for the collaborative care delivery central to the LBHP program. Key examples of these capabilities are:

- Assessments: users of our Provider Portal will be able to enter LOCUS, CALOCUS, CASI, Comprehensive CANS and other assessments securely online. This data will then immediately populate the member's care record in TruCare, and be integrated all other member information (e.g. claims utilization, demographics) in our Centelligence Enterprise Data Warehouse - our Teradata powered data integration engine. Providers will also have the option of faxing or mailing completed assessment to our ECM system, where the paper form will be systematically converted to data and (again) populate the member's care record.
- IEP/IHP: DOE/LEA's will be able to enter online - or upload completed Individualized Education Plans (IEP) or Individualized Health Plans (IHP) (e.g. as scanned images or PDF documents) to us via the State Agency Portal, and this information will be used by our Care Managers to create prior authorizations for services for the corresponding members.
- Referrals: Authorized users of our State Agency Portal (at DHH-OBH, DOE/LEA's, OJJ, and DCFS) and our Provider Portal (WAA's and other network providers) will be able to make referrals to an LBHP program (e.g. CSoC) securely via the web. Please see Section 2.g.vi for more information.
- DOE Encounters: DOE/LEA school based employee providers will be able to submit encounters online via our HIPAA Direct Data Entry (DDE) compliant claims entry facility, with contextual help, entry edits, and prompted navigation (see Section 2.g.xxx for more information).
- All state agency users of our State Agency Portal will be able to access LBHP data housed in our EDW, using our BusinessObjects suite of business intelligence tools.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xx. Describe The Proposer's current status of implementing the HIPAA ANSI 5010 formats and preparation for the ICD-10 implementation. **Suggested number of pages: 3**

Preparing for the Use of HIPAA Version 5010 (HIPAA 5010).

Centene began HIPAA 5010 planning and gap analysis activities in 2008 under the direction of our Manager of EDI Services. We initiated these activities in anticipation of the Final Rule, which was issued by the US Department of Health and Human Services (HHS) in the Federal Register on January 16, 2009, mandating compliance for covered entities of Centene's size on or before January 1, 2012. We implemented the HIPAA 5010 compliant version of our core eligibility and claims processing subsystems (AMISYS Advance Release 4) in Q4 2009, and completed our internal gap assessment in early 2010 for other impacts to our IT environment. We completed integrated system Level I (internal) HIPAA 5010 testing in early 2011, and we began Level 2 (external) HIPAA 5010 testing during the first quarter of 2011 with providers that were ready to test with us. We have already implemented the 5010 version for the HIPAA 834 and 820 transactions for one of our state clients and we are in production with those transactions for that client. *We remain solidly on target to meet the HIPAA 5010 mandate (errata version) and deadline*. Please see ***Figure 2.g.xx.A: HIPAA 5010 Compliance Plan*** at the end of this question, for a summary of our compliance milestones by transaction type.

Implementation Flexibility. Our entire EDI system, including EDIFECS and our TIBCO system, allows us to support both the HIPAA 4010A1 and 5010 transaction standards as our providers and trading partners transition to the new EDI standard according to their own timeline. To further support our providers' move toward 5010 compliance, our secure Provider Portal offers users a HIPAA compliant Direct Data Entry (DDE) option, enabling them to conduct HIPAA 4010A transactions today, and 5010 transactions effective January 1, 2012.

Preparing to Support and Use the ICD-10.

In 2010, we instituted our inter-departmental, enterprise level ICD-10 compliance initiative led by our Chief Technology Officer (CTO), who reports to our Executive ICD-10 Steering Committee. The Committee is comprised of business leadership from all departments affected by the US Department of Health and Human Services (HHS) Final Rule published on January 16, 2009, and modifying 45 CFR Part 162 to mandate the use of ICD-10 CM and ICD-10 PCS (ICD-10) codesets in HIPAA transactions effective October 1, 2013. In late 2012 or early 2013, we will upgrade our AMISYS Advance system to its ICD-10 compliant version, along with requisite upgrades to our TruCare health services management platform; Centelligence™ reporting and decision support system; and MDE Xpress Encounter Pro system, in coordination with DHH-OBH. We anticipate completing Level 1 testing by the end of 2012, and Level 2 testing by mid 2013.

Utilizing HIPAA 5010 and ICD-10. We intend to fully capitalize on the additional analytic support capabilities delivered by the ICD-10 codeset. ICD-10 offers over 5 times more diagnoses codes than the ICD-9, covering more illnesses with greater granularity. This will allow us to better identify members with specific conditions that will benefit from tailored care management programs, as well as allow us to refine the selectivity in our predictive modeling applications.

We also look forward to capitalizing on the expanded amount of eligibility information that the HIPAA 5010 will provide via the HIPAA 270/271 transaction, as well as other "downstream" processes reliant on eligibility, such as authorization requests and claim submissions.

Continually Monitoring and Anticipating Future Federal Mandates.

Cenpatico's Compliance Department and Centene's Legal and IT Security Departments will work closely together to monitor relevant announced federal mandates *at large* (e.g. published in the Federal Register), IT mandates related to security, and federal mandates relevant to our contracts with DHH-OBH and other Louisiana state agencies. We use our Compliance 360 corporate governance, risk management, and compliance system to organize, manage (among other functions), and document our compliance with specific federal mandates. Our Security Committee, chaired by our Legal Department and comprised of representatives from our Compliance, Internal Audit, Risk Management, Human Resources, IT Security and Physical Security departments, meets monthly and discusses new regulations or rules as they arise. Our Director of IT Security reports to our CISO and is a member of the Information Systems Audit and Control Association (ISACA). ISACA provides our IT Security Director with information and notifications on changes and new regulations and rules at the federal level and provides guidance on evidence required for demonstrating compliance with new and existing regulations or rules.

Figure 2.g.xx.A: HIPAA 5010 Compliance Plan

Centene 5010 Compliancy Plan

Transaction Description	Claim		ERA		Control Totals		Premium Payment		Eligibility		Eligibility Inquiry		Claim Status Inquiry		Authorization	
x12 Transaction(s)	837I, 837P		835		997, 999, TA1		820[1]		834[1]		270/271		276/277/277U		278	
	Start	End	Start	End	Start	End	Start	End	Start	End	Start	End	Start	End	Start	End
Internal Systems & Trading Partner Conversion																
Internal Gap Assessment	Nov-09	Mar-10	Nov-09	Mar-10	Sep-09	Mar-10	Sep-09	Mar-10	Sep-09	Mar-10	Nov-09	Mar-10	Nov-09	Mar-10	Nov-09	May-10
Remediation and 5010 Software Upgrades	Mar-10	Aug-10	Mar-10	Aug-10	Mar-10	Aug-10	Mar-10	Aug-10	Mar-10	Aug-10	Mar-10	Aug-10	Mar-10	Aug-10	May-10	Aug-10
Publish 5010 Companion Guides	Dec-10	Jun-11	Dec-10	Jun-11	Dec-10	Jun-11	Dec-10	Jun-11	Dec-10	Jun-11	Dec-10	Jun-11	Dec-10	Jun-11	Dec-10	Jun-11
Internal System Testing of 5010 Transaction	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11
Implement 5010 Maps in EDIFECS platform[2]																
Partner Test Platform	Dec-10	Mar-11	Dec-10	Mar-11	Dec-10	Mar-11	Dec-10	Mar-11	Dec-10	Mar-11	Dec-10	Mar-11	Dec-10	Mar-11	Dec-10	Mar-11
Production Platform	Mar-11	Jun-11	Mar-11	Jun-11	Mar-11	Jun-11	Mar-11	Jun-11	Mar-11	Jun-11	Mar-11	Jun-11	Mar-11	Jun-11	Mar-11	Jun-11
Partner Testing and Certification[2]	Jul-11	Dec-11	Jul-11	Dec-11	Jul-11	Dec-11	Jul-11	Dec-11	Jul-11	Dec-11	Jul-11	Dec-11	Jul-11	Dec-11	Jul-11	Dec-11
Partners Moved to Full Production[3]	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12
Conduct conversion barrier survey with remaining 4010 submitters	Jun-11	Sep-11	Jun-11	Sep-11	Jun-11	Sep-11	Jun-11	Sep-11	Jun-11	Sep-11	Jun-11	Sep-11	Jun-11	Sep-11	Jun-11	Sep-11
Conversion options/assistance to 4010 submitters	Aug-11	Dec-11	Aug-11	Dec-11	Aug-11	Dec-11	Aug-11	Dec-11	Aug-11	Dec-11	Aug-11	Dec-11	Aug-11	Dec-11	Aug-11	Dec-11
Begin rejecting 4010 submissions[4]	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12	Jan-12

Encounter Conversion

5010 Claim to 4010 Encounter	Start	End	Start	End	Start	End
Analyze 5010 transaction vs. 4010 encounter edits	Apr-11	Jul-11	Apr-11	Jul-11	Apr-11	Jul-11
Design Remediation (if necessary)	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11
Test 5010 Claims Submission vs 4010 Encounter	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11
Analyze State 5010 Encounter Companion Guide	May-11	Jul-11	May-11	Jul-11	May-11	Jul-11
Convert Encounter Map to 5010	Jul-11	Aug-11	Jul-11	Aug-11	Jul-11	Aug-11
5010 Claim to 5010 Encounter						
Test 5010 Claims Submission vs 5010 Encounter	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11
4010 Claim to 5010 Encounter (should not be necessary if 4010 claim runout complete)						
Analyze 4010 transaction vs. 5010 encounter edits	Apr-11	Jul-11	Apr-11	Jul-11	Apr-11	Jul-11
Design Remediation	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11	Jul-11
Test 4010 Claims Submission vs 5010 Encounter	Aug-10	May-11	Aug-10	May-11	Aug-10	May-11

NA

Footnotes

[1] Centene is currently in production with HIPAA 5010 Versions of the 820 Premium Payment and 834 Benefit Enrollment & Maintenance Transaction Sets in the service of one State. Dates listed for the 820 and 834 are "latest" dates for all Centene Plans

[2] To assist our Trading Partners with test and certificaiton of HIPAA 5010 transactions implemented according to our Companiong Guides, we are deploying EDIFECS' Ramp Manager for direct and interactive testing of Trading Partners with Centene. Ramp Manager will provide full EDI diagnostics so that Trading Partners can quickly identify and remediate any issues with their HIPAA 5010 test transaction submissions.

[3] The dates listed here are "no later than" dates. In some cases, we will support the movement to HIPAA 5010 earlier than the date listed. For example - see Footnote #1.

[4] In other words: HIPAA transactions with dates of service prior to 1/1/12 - but submitted to Centene on 1/1/12 or later - must be in HIPAA 5010 format.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxi. Provide claim submission statistics as directed below for the most recently completed month overall for your current clients, for electronic and paper submissions. All formats, including proprietary formats, should be included.

Claim Type	Number Received
CMS UB 04 (paper)	_____
CMS 1500 (paper)	_____
HIPAA 8371 (Institutional)	_____
HIPAA 837P (Professional)	_____
NCPDP	_____
Other (please list)	_____

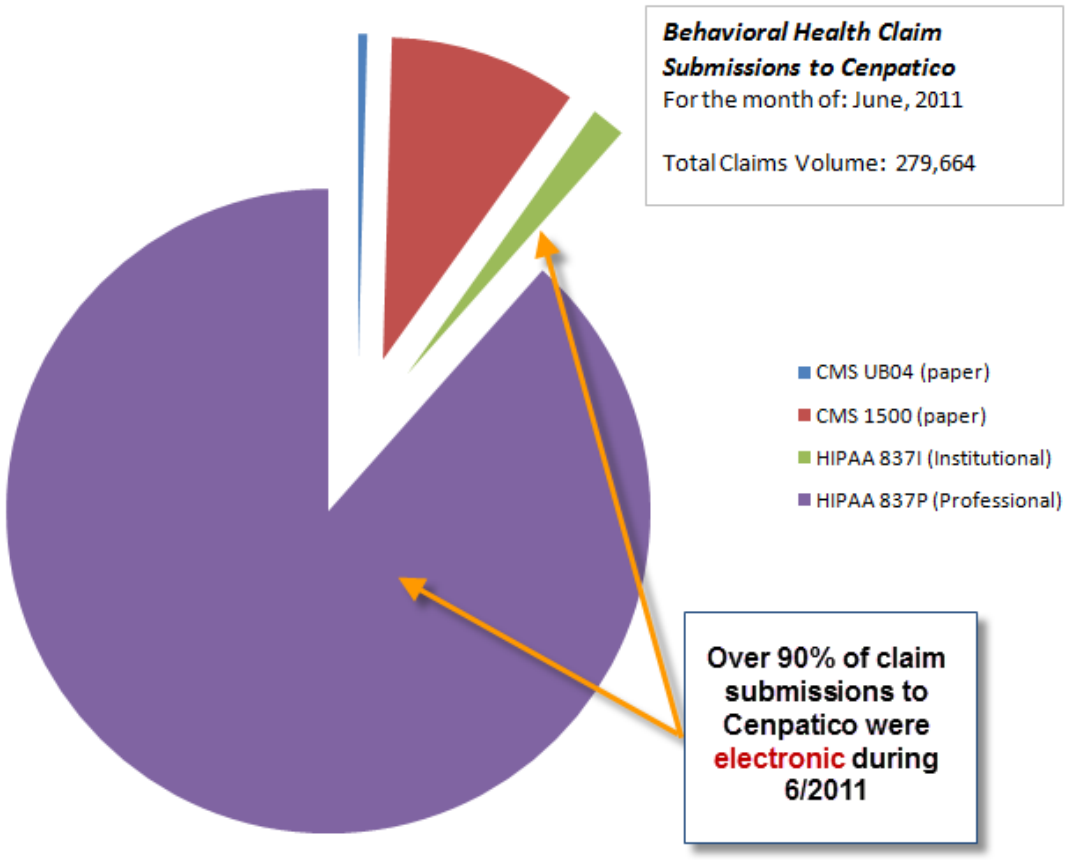
Claim Submission Statistics

For the month of ***June, 2011***, Cenpatico received the following claim volumes from providers:
Table 2.g.xxi: June 2011 Claim Submissions.

Claim Type	Number Received
CMS UB04 (paper)	1,239
CMS 1500 (paper)	26,348
HIPAA 837I (Institutional)	4,760
HIPAA 837P (Professional)	247,317
TOTAL Claims Submitted to Cenpatico:	**279,664**
NCPDP[1]	584,403
Other (please list)	N/A

[1] Pharmacy claims submitted to Cenpatico's affiliate (and Centene subsidiary): US Script.

A Unified MIS Architecture Processing Behavioral and Medical Claims.
During June, 2011, Centene received 1,745,854 medical and behavioral health (BH) claims of which 279,664 were for Cenpatico. All claims were processed through our enterprise MIS (please see Section 2.g.iv for more information). In addition, **US Script**, Centene's pharmacy management company, processed over 580,000 claims encompassing both medical and behavioral drug claims. We house all processed claims (including pharmacy claims) in our Centelligence™ Enterprise Data Warehouse (EDW), where EDW integrates that data and where it is used for a variety of care management, health informatics, reporting, viewing, and analytical purposes (see Section 2.g.xii for more information).
Provider Training and Support Leads to Standardized Claim Submission Formats.Because of our ongoing provider orientation, training, online tools and claims support - all supplied by a coordinated combination of our web based secure Provider Portal, Provider Services Representatives and EDI Operations Helpdesk, - we did ***not*** receive any claims in "non standard" format: all submissions were either HIPAA standard transaction formats or CMS standard paper formats.
Electronic Submissions Represent a Large Percentage of Overall Claims. Please see ***Figure 2.g.xxi-B*** below for a graphical breakdown of the behavioral health claims tabulated in ***Table 2.g.xxi***. As the Figure illustrates, the majority of our claims submissions during June, 2011 were via standardized electronic means. Our over 90% electronic claim penetration rate in June was by no means atypical; for example, over all of 2010 our EDI penetration rate was over 85% nationwide, and in our plan in Arizona (a plan similar to LBHP in several ways), our penetration rate was over 97% over the year 2010.
Figure 2.g.xxi-B.



Much of our success with fostering electronic claim submission - is through our multiple electronic options for providers; including:

- Our support of HIPAA EDI submissions through a network of over 60 Trading Partner clearinghouses, including the largest such services such as Emdeon, Inc., and Availity.
- Our Provider Portal - which allows providers to enter claims directly online in HIPAA Direct Data Entry (EDI). We introduced this capability approximately two years ago, and in that time we have seen volumes increase to our current average of 35,000 BH claims per month entered electronically in this manner.
- The introduction in 2011 of allowing providers to submit HIPAA EDI files to us directly and securely through our Provider Portal (allowing the provider the option of using a clearinghouse or not).
- Our support for multiple provider electronic payment options; which further incents our providers to switch to electronic claim submissions. For example, in Cenpatico's Texas plan, we paid 68% of our BH providers via electronic funds transfer (EFT).

Disciplined Claims System Configuration & Processes Leads to Quality Performance.Of the BH claims volume listed in ***Table 2.g.xxi***., 93% were automatically adjudicated, and fully 98% were processed within 14 days with 99% processed within 21 days. Our efficient pended claim processing procedures have also minimized pended claims inventory: from June 2010 through June 2011, our pended claims inventory, as a percentage of monthly claim receipts, averaged only 0.5%. Finally, our careful attention to continuous claims auditing, benefit plan configuration, coupled with quality processes in handling member and provider data; leads to claims processing accuracy: for example, during the first quarter of 2011, Cenpatico achieved 100% financial claim payment accuracy.

2.g. Technical Requirements
xxii. Describe the Proposer's process for receipt, storage, and data entry of provider paper format billings. **Suggested number of pages: 2**

Inbound Paper Claims – Process Overview

Cenpatico Louisiana providers will be instructed to submit paper claims to a dedicated P.O. Box located at the Centene Claims Processing Center in Farmington, MO. Once the claim arrives at the mail center, there are two distinct flows related to processing paper claims:

- Claim Preparation and Scanning
- Claim Keying and Vertexing

Claim Preparation and Scanning. On receipt of claim correspondence, our mail center opens and reviews the contents of each envelope to prepare the claim for the keying process. The claims are inspected and prepared as follows:

- Staples are removed.
- Cuts and tears are taped if repairable. If not, a photocopy is made for scanning. The original document is stored with the photocopy.
- If the characters and print are too light or too dark an adjusted photocopy is made for scanning. Again, the original document is stored with the photocopy.
- In cases when there is a letter included in the envelope and there are multiple claims, the letter is copied and attached to each claim for scanning.
- If "continued" is typed in Box 28 on the claim, this indicates a multiple page claim. The Mail Center Specialist will review the next page to verify that it is continued based on charges and other documents received. All pages remain together in case of a multiple page claim.

On occasion we receive a claim from the post office that is damaged beyond repair. When this occurs, the claim and envelope are placed in a "Provider Issues" bin in the mail center. Periodically through the day, our mail room supervisor or designee will clear the issues bin by preparing a letter for the provider advising them that the claim was damaged on receipt and to please recreate and resubmit the claim again (Mail Return Letter). On occasion we also receive claims in a format that is no longer accepted. For these cases, our mail center will issue a letter asking the provider to resubmit the claim on a HIPAA compliant form (old form not accepted letter). These letters are standardized for easy administration.
Once the claims are prepped, they are sorted into document types so that claims can be processed in batch according to the vertex templates that we have created. Templates exist for the following:

- CMS1500 professional claim form
- CMS1450 ("UB04") claim forms
- General Correspondence

Once sorted, the documents are scanned using our MACESS FormWorks Optical Character Recognition (OCR) system. For first time claims, MACESS assigns each document (claim) a unique claim number. The above process is generally completed within 24 hours from receipt of a paper claim.

Claim Keying Process. Once scanned, all first time claims (those that are not a claim adjustment or correspondence) are staged for Key Form Image (KFI) workers for vertexing. During the vertex process, KFI workers will look up the member and provider based on information on the claim and validate that the patient on the claim is a valid member within our system, and that the diagnosis codes exist in our tables, among other criteria. We can and do reject claims during this process, if for example, patient is not a valid member, key data is missing, such as provider NPI, Member ID, etc. KFI also compare the vertex template to the image within MACESS, to ensure that the OCR captured the text correctly and if not, KFI correct the data for processing. KFI will also manually key more difficult claims that OCR cannot read.

Once paper claims successfully complete this process, they are moved to a completed status and are ready for export through Coviant and our Tibco data translation and pre-adjudication tool for processing and loading into AMISYS Advance our core claims processing system and our Automated Work Distributor (AWD) claims workflow tool. For more information on our claims processing capability, please see our response to questions 2.g.iv and 2.g.xxiii through 2.g.xxxiv.

All claims that have either been rejected by MACESS or manually routed to the reject queue will have letters sent to the provider with an explanation of rejection.

Claim adjustments and all correspondence are scanned and staged for follow up by the Correspondence Claim (CC) department. Each correspondence receives an index number and is routed to the appropriate member and provider folder within MACESS. During vertexing of correspondence documents are categorized to route within AWD/MACESS for follow up by a claims processor. Our CC department will issue standard acknowledgement letters for all appeals received, then routes the correspondence within AWD for follow up by a claims processor.

Mail Department Audit

Our Vertex auditor conducts a daily quality audit on a 3% random sample from each KFI worker (manual) and automatically processed claims. A Correspondence Coordinator Auditor conducts daily quality audit on 3% random sample on all correspondence documents. Correspondence vertexing is audited to confirm images are filed to correct member/provider folders. A 100% review of all form letters generated for return to providers is performed on a daily basis prior to folding and stuffing into envelopes. The audit includes determination of proper letterhead and general typing errors in address header, checking if complete claim reference information is included and when applicable, verifying if the copy of claim image being returned is incorporated and correct. A minimum 2% audit is performed on all other correspondence job functions, including appeal acknowledgement letters, appeals and remarks that are created and made in AMISYS Advance, and routing of documents within AWD for processing.

Physical Security

Centene physically protects all documents containing PHI with limited and strictly controlled access. We secure all our Centene corporate, health plan and claims processing facilities via proximity card access on all external doors, elevators, and the internal entry doors on each floor. The card access system records all access attempts/card swipes whether successful or not. Additional physical security controls include digital security cameras and panic switches installed at each reception desk. Our receptionists require that all visitors sign in and out at the front desk; are issued a temporary badge; and are accompanied by an employee when visiting a Centene facility, including our Claims Processing Center in Farmington, MO.

We will provide escorted access to our claims processing unit to authorized DHH-OBH or Federal representatives, when requested, or provide access by other means, such as secure WebEx, to inspect the quality, appropriateness, and timeliness of services performed by Cenpatico. Each month, the Manager of Centene Claims Processing Center reviews the sign in log to ensure that only appropriate physical access requests are approved.

All claims are received in a secure room to which only employees with appropriate authorization have access. After scanning and vertex processing, claims are boxed and labeled and are transported to an on-site storage room where they are stored for 3 weeks. Access to this facility is also restricted to specific employees. Following the 3 weeks on-site storage, Star Business Solutions (SBS), Centene's business partner for offsite storage of sensitive documents, picks up the boxes and delivers them to a secure storage facility. Paper documents are retained according to retention policy and are then shredded. Scanned Digital images are kept according to the retention specifications for each of our state clients.

All SBS procedures for handling records are compliant with the standards set forth by HIPAA. Centene's records and documents are transported in a secured vehicle. SBS's facilities are secured and controlled by

video monitoring 24/7. Visitors are required to sign a visitor log and are escorted by SBS management at all times. The storage facility is also monitored for protection against fire 24/7 and it features a "zone activated" fire suppression system. The site is maintained in such a way to keep it free from vermin. Finally, although the facility is not in a flood plain or a flood prone area, all records are warehoused in such a way to eliminate any potential flood damage. Star Business Solutions also assures that the personnel handling sensitive information is tied to adequate regulations. All of their employees are required to pass a full background check before employment. They also sign "non-disclosure" agreements with SBS to assure confidentiality.

Encouraging Electronic Submission of Claims

Cenpatico and Centene know from our claims processing reporting and analytics that when a provider files claims electronically, the entire process is faster, more accurate, allows us to utilize the information sooner in care of our members, and is better for our environment. We have evidence that when providers prepare claims electronically, the time from service to submission to Centene is abbreviated by more than *half* the time compared to claims submitted on paper. However, we also recognize that provider capabilities related to submitting electronic claims and receiving payment through Electronic Funds Transfer (EFT) vary significantly based on a provider's technological support and expertise. That is why we support a growing variety of online, Electronic Data Interchange (EDI) and EFT options so each provider can select the best approach for their practice. We then actively work with the provider to facilitate participation. Please refer to question 2.g.xi (sending and receiving data from other agencies); 2.g.xxxviii (experience with HIPAA 835) and 2.g.viii (for administrative services available through our Provider Portal).

2.g. Technical Requirements

xxiii. Describe the Proposer's internal claims audit including percent of claims audited. Provide a sample of the reports used in this process. **Suggested number of pages: 5**

Claims accuracy is a primary goal of Centene and Cenpatico. Processing claims correctly the first time reduces costs and increases provider satisfaction. Claims are audited at several stages to ensure accuracy and to identify any system issues that maybe prohibiting correct auto adjudication. We have a dedicated team of behavioral health claims specialists, who are familiar with processing claims for standard behavioral health/substance abuse services including use of a typical provider and/or non Medicaid funding streams.

We conduct 360 degree evaluations of the claims life cycle by establishing a tiered approach to audit that evaluates all claim functions from the mailroom or EDI receipt to payment disposition:

- **Staff Audits:** which evaluate the performance of all staff involved in claims processing before claims are paid and ensures staff adherence to job specific guidelines.
- **Claims Run Review Audits:** which are a final review of claims ready to be released to the provider. Both Claims Run and Staff Audits are conducted prior to releasing claim payments to the provider.
- **Department Audits:** are conducted by our *Internal Audit and Compliance* department and are performed on a sample of adjudicated claims. This audit encompasses all aspects of claim entry, adjudication, enrollment and benefit and payment determinations. In order to ensure audit integrity, the reporting structure of the Internal Audit and Compliance department is *completely independent* of our Claims department.

In addition to these ongoing audits, Centene's external auditors conduct **Sarbanes – Oxley** section 404 audits (**SOX)** and **SAS/70 Type II** audits to validate the effectiveness of the internal claims controls.

Staff Audits

Although frequency, function and methods of staff audits differ along each step in the claims life cycle, our approach to all of our staff audits focuses on determining if staff:

- Have successfully completed applicable training
- Know the performance benchmarks for their position and the role audit plays in performance achievements
- Are familiar with their job function
- Know how their job as Processor impacts the entire claim life cycle.

Our internal Quality Review Team (QRT) analysts are Claims Subject Matter Experts (SME's) with extensive claims administration experience, and many have held operational positions in the functional areas they now audit as part of the QRT. The QRT audits each Claims Processor (processor) with a frequency and sample volumes appropriate to that processor's experience level and recent quality performance. The QRT staff use that sample to review all processor adjudication actions to confirm whether processors adhere to Centene and Cenpatico policies and procedures and whether the processor is correctly using our workflow tools. QRT auditors also confirm that the processor is correctly coordinating and communicating with other departments and following up on work items per Centene and Cenpatico policies and standards. When the QRT auditor completes their audit report, they and/or the processor's supervisor meet with the processor to discuss audit results and review each error in depth to determine if additional training is required. If necessary, the QRT auditor or supervisor may implement a follow up targeted audit to confirm whether processor has a clear understanding of the proper handling of the erred claim situation.

Claims Run Review

Cenpatico, with the ultimate responsibility for claims accuracy, will also audit claims processed for the LBHP program on a weekly basis, as we do for all states in which we operate. Cenpatico Contract Implementation Specialists (CIS) review a detailed list of all the claims scheduled for payment release for each weekly payment cycle. The list will contain service line level detail so that every date of service or procedure contained on one claim can be reviewed. The percent of service lines that are reviewed weekly varies depending on the operational age of the program (e.g. LBHP). In a new program, or when several pricing or benefit changes have been made, the CIS will review between 50-100% of the service lines. Anything identified as not paying correctly is marked for manual reprocessing and is sent back to the claims processing team with the desired outcome described. This process reduces the possibility a provider will receive an incorrect claim payment or denial. Additionally, for new programs, after the weekly claims run has been released, the CIS or the Cenpatico Claims/Encounter Administrator will investigate any system issue that might have occurred, causing claims to initially process incorrectly. The Claims/Encounter Administrator will work with the behavioral health dedicated system configuration team to fix any configuration issues to ensure correct auto-adjudication.

For new implementations a claims review typically includes a review of all paid service lines to verify by contract, provider type, procedure code and funding stream that the actual or allowed payments are correct. "Paid" in a claims run includes fee-for-service claims resulting in an actual check for the provider as well as claims that register the allowed amount against a block payment but do not result in a check being released to the provider. The ability to still process the claim without actually sending out a payment is how Cenpatico will accommodate those services where the state will actually directly pay the provider (e.g. OBH non-Medicaid Adults, or services provided by DOE/LEA school employee providers). We will also audit a sample of service lines with denial codes to check for accuracy. Denial codes commonly reviewed are: authorization denials, incorrect service location, missing or incorrect modifiers, member eligibility, non-covered benefit denials, and provider ineligible to perform service denials. An additional advantage to this audit step is that providers with consistent errors can be flagged and contacted by our provider relations team for training opportunities.

When accuracy levels consistently above 95% are reached, the percent of service lines reviewed is reduced to around 5-10% weekly. Below please see summary recent results of Claims Run Review audit.

Sample Claims Run Review Audit Results – May 2011

State		5/6/11	5/13/11	5/20/11	5/27/11
Georgia					
	% Service Lines Reviewed	4.5%	6.7%	6.2%	11.7%
	% Accurate	98.8%	97.6%	97.4%	99.6%
	# service lines corrected	30	33	54	7
Indiana					
	% Service Lines Reviewed	83.6%	86.8%	79.0%	84.6%
	% Accurate	99.0%	99.3%	99.2%	98.5%
	# service lines corrected	64	26	51	62
Massachusetts					
	% Service Lines Reviewed	12.8%	16.6%	8.6%	11.3%
	% Accurate	98.6%	96.6%	98.8%	98.8%
	# service lines corrected	23	20	17	17

Please find below an example of a recent detail sample of audited service lines with payment/denial ("EX") codes to check for adjudication accuracy.

Example of service lines flagged for rework

Service Number	ICD9	Pro-cedure Code	Mod-ifier	Paid	EX Code	Code Description	Release	Comment
K15M88	3094	90806		0	DZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	N	No auth needed. This is the 5th of the initial visits.
K17M11	31401	90811		0	A1	DENY: AUTHORIZATION NOT ON FILE	N	ALLOW TO PAY-NO AUTH REQ
K06M20	30500	H0004	HF	46.52	92	PAID ACCORDING TO CONTRACT / PROCESSING GUIDELINES	N	S/P 47.00
K16M85	31401	90806		0	DZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	N	No auth needed. This is the 7th of the initial visits.
K19M39	30420	H0005	HF	31.68	92	PAID ACCORDING TO CONTRACT / PROCESSING GUIDELINES	N	S/P 32.00
K16M35	30420	H0004	HF	46.52	92	PAID ACCORDING TO CONTRACT / PROCESSING GUIDELINES	N	S/P 47.00

Finally, after the changes are validated, the CIS will give final approval to Centene for payment release. This review targets areas of *contractual compliance* rather than processing accuracy.

Targeted Audits. QRAs conduct *targeted audits* to confirm that a processor understands a specific process. For example, should a processor's production reflect a high rate of claim denials, the QRA may conduct an audit to confirm the appropriateness and accuracy of their actions. QRAs also conduct high dollar threshold audits of professional claims in excess of $5,000 and facility claims in excess of $10,000 on a *daily basis* to review any high dollar payments prior to the check cycle.

Department Audits

The last layer for claims specific audit is conducted by our Internal Audit and Compliance Department (IA&C). The claims processing subsystem of AMISYS Advance provides our IA&C department with a comprehensive audit function with definable parameters to track all changes to a claim. AMISYS Advance creates a unique auditing record for every modification, including adjustments, to create a complete historical account of all claim changes. The system retains associated audit records for a claim or service for 90 days after resolution, and these records can be readily accessed and used by IA&C for auditing, tracking and reporting.

IA&C audits random samples of claims selected immediately following the weekly claims run cycle. They independently sample both manually adjudicated claims and systematically adjudicated ("auto adjudicated") claims for paid, denied and adjusted dispositions. This statistically valid sample size is informed by industry experts such as KPMG, and Ik-Whan Kwon, Ph.D (author of *Statistical Decision Theory with Applications to Business and Economics – Bayesian Approach*) and in literature, such as in

Essentials of Managed Health Care Fifth Edition by Peter R. Kongstvedt, and provides a 99% confidence level with a quarterly average precision of +/- 2.5%

If a claims error is identified by the IA&C department, it is sent to our claims department for review. Our claims department can refute the error and provide documentation to validate the claim processed correctly or if our claims department agrees that an error occurred, our claims department must identify the root cause and provide the IA&C department with the action taken to correct the situation.

Cenpatico Audit for LBHP. Cenpatico will adhere to DHH-OBH financial payment accuracy standard of 97% and procedural accuracy of 99% and will audit 2% of claims for each claims processing day (Monday through Friday). We will document findings according to DHH-OBH specifications as outlined in the Request for Proposal. Please see figure 2.g.xxiii-A below for the sample Audit Report we propose for DHH-OBH. We perform similar audits today for each of our health plans, and we use a similar report in our other markets.

At minimum, we will review at minimum the following in our LBHP audits:

- *Data Validation*: Check **accuracy of OCR** by comparing scanned claim image to AMISYS Advance to detect discrepancies (Claim data correctly entered into the claims processing system with an assigned transaction number).
- *Provider Eligibility*: Confirm accuracy of **provider** selection and provider network enrollment dates (Claim is associated with the correct provider & Proper coding consistent with the provider's credentials)
- *Authorizations*: Confirm the accuracy of **authorization selection** and application of limits and date spans (Service obtained the proper authorization & Authorization limits are not exceeded)
- *Recipient Eligibility*: Validate accuracy of **recipient** selection and enrollment dates (member eligibility at processing date correctly applied).
- *Claims final adjudication processing*: Validate the computation of **allowed charge and payment accuracy** for each service in the claim and the application of appropriate remark/denial codes after claim adjudication (Allowed payment amount agrees with contracted rate & Denial reason applied appropriately).
- **Duplicate claim** submissions were identified and denied *(duplicate payment of the same claim has not occurred)*
- *Modifier Codes*: Validate accuracy of actions in response to **Reference edits (**Effect of modifier codes correctly applied)
- *Claims Resubmission and Adjustment processing*: Confirm that the intended **resubmission and adjustment** are processed as intended. (Adjustments to claims are properly made with supporting documentation).
- *Third Party Liability Edits*: Check **accuracy of TPL determination** and application of primary payments, if applicable and confirm accuracy of Coordination of Benefit (**COB**) calculation. (Co-payment application considered and applied & payment is coordinated properly when other insurance is applicable).

Reporting

As mentioned above, all our Audit Teams produce reports using the Claims Audit Report Database and supporting information from AMISYS Advance and related systems and will work with DHH-OBH to define a suitable format for these reports. This report would also include number of claims audited, number of errors, and the dollars associated with those errors. Below is a sample report we use for other health plans.

Figure 2.g.xxiii-A Sample Report - Accuracy Statistics

Total Quality Summary

	Financial Acc. ***	Procedural Acc. ****
2nd Q '10	99.4%	99.5%
3rd Q '10	99.4%	99.1%
4th Q '10	99.6%	99.3%
1st Q '11	99.3%	98.9%
Average	**99.3%**	**99.1%**

*** Financial Accuracy: Total **DOLLAR VALUE** of errors to the total **DOLLARS** paid
= 1-((Overpaid + Underpaid)/(Paid))

**** Payment Accuracy: **NUMBER** of claims with financial errors to the total **NUMBER** of claims audited
(# of Claims Audited - # of Claims with Payment Errors)/# of Claims Audited

Industry standards for claim quality based on *Essentials of Managed Health Care*

	Good	Excellent
Payment	97%	99%
Financial	99%	99%

Failure to meet any industry standard level

Meets or exceeds "acceptable" industry standard level

To identify progress, 97%-99% financial accuracy

Meets or exceeds "good" industry standard level

Correction Methods

Education and Retraining. Claims processing issues related to claims staff performance or provider billing errors are typically remediated through education and retraining. QRAs or IA&C communicate all staff deficiencies to the immediate Supervisor who establishes a retraining plan. Upon completion of training, the QRA or Supervisor may implement a targeted audit to confirm that additional training or action is not warranted. QRAs will communicate all provider billing problems to Cenpatico's Provider Services Department where outreach and education can be arranged and conducted by their Provider Relations Specialist.

Change Request (CR). If it is determined that the error is due to configuration, our Cenpatico Claims Liaison and our Configuration team will review the logic causing the error to determine where the issue lies and will put in a CR to have the configuration changed accordingly. All CRs go through testing, validation that the correct outcome was achieved, User Acceptance Testing and finally, are promoted to production when these steps are completed.

Process Modification. Upon identification of a potential systemic process deficiency**,** our QRA or IA&C staff notify Centene's Process Quality Department, who will employ tools such as Lean Six Sigma to determine root cause. Through analysis and cross-functional dialogue with all affected departments, this team evaluates and recommends process improvement plans.

Provider Specific Monitoring and Audits. Centene and Cenpatico are committed to ensuring that providers have the tools and support systems in place to ensure claim timeliness, accuracy and completeness of data submitted. We conduct a number of claim audits on submitted claims and, where

necessary, root cause analyses to identify system or coding problems, and initiate outreach and education to targeted provider billing staff to provide guidance and instruction as necessary. For Cenpatico, this outreach will be conducted in person, via email or telephonically. Our Cenpatico Claims Liaison and Provider Claims Educator (Cenpatico Claims Team) will also attend large group orientations, training sessions and workshops to provide the claims expertise necessary to respond to specific questions raised by providers and their billing staff.

Outlined below are several of the monitoring and audit activities that will be conducted by or in conjunction with Cenpatico Claims Team. These are best practices gleaned from our experience with our affiliate Medicaid managed health plans:

Quarterly Key Provider Claim Reviews. The local Cenpatico Claims Liaison will review the top twenty claim submitting providers or *key provider group* claims quarterly and provide scoreboard results to Cenpatico's Contracting and Network staff for HEDIS scoring and Pay for Performance results. Cenpatico's Provider Relations staff will also evaluate top denials and intervene with providers if billing patterns reveal potential errors.

EDI Claims Submission Analysis. In conjunction with Centene's Electronic Data Interchange (EDI) Help Desk, the local Cenpatico Claims Team will collaborate to identify and educate providers who submit paper claims and attempt to encourage electronic submissions via our Provider Portal or EDI clearinghouses. Please refer to Section R, question 13 for more information on our efforts to encourage the use of EDI and Electronic Fund Transfer (EFT) by our providers.

90 day Implementation Claim Audits. We will conduct claim audits for 90 days for all new providers to assist in identifying any configuration or billing issues. Early outreach and education promotes good relationships with providers and fosters long standing business relationships.

Program Modification Audits. With the introduction of any program changes, such as a change in state reimbursement rates, our Cenpatico Claims Team will review claim outcomes to ensure complete compliance with state, federal and DHH-OBH compliance requirements. Even before those changes are put into effect, Centene and Cenpatico Finance Team will use Centelligence™ Negotiator system to simulate the impact of rate changes, in terms of which providers are impacted by the change and the overall likely effect on provider payments based on historical claims history. We can then implement those rate changes automatically in our AMISYS Advance claims processing system; allowing us to deploy rate changes smoothly, quickly - and accurately.

Claims Xten® Reviews. The Cenpatico claims team will review the results of the Claims Xten® edits to determine if a provider is consistently billing with unbundled, incidental or retired codes. If identified, the Provider Claims Educator will outreach and educate the provider's office.

Addressing Provider Non Compliance

Our routine audit activities allow for the early identification of possible billing or coding issues. When issues are identified, Cenpatico staff will work with providers to educate them via new provider orientations; phone calls to the provider's office; and during onsite visits. If trend analysis identifies a provider who is failing to adhere to billing and coding requirements, the Provider Services Representative or local Claims Team member will refer their findings to Cenpatico's Provider Network Team for further action. A Provider Relations Specialist from the Provider Network Team will immediately contact the provider, provide education on contractual requirements and administrative requirements, and offer the local Cenpatico Claims Team, our EDI specialists or other relevant department to conduct retraining in person if necessary. The Cenpatico staff will document all activities and trend follow up behaviors to determine if issues have been corrected. For continued billing or coding issues, the Provider Network Team may refer the provider to the Credentialing Committee and Clinical and Service Quality

Improvement Committee (CASQIC) for consideration of additional action, including sanctions and possible consideration of continued network status.

Should any Cenpatico staff member suspect a provider of potentially fraudulent billing, they will immediately engage Centene's Billing, Errors, Abuse, and Fraud (BEAF) department who provides oversight and guidance for the prevention, detection, and resolution of billing misconduct including inappropriate billing and coding.

2.g. Technical Requirements
xxiv. Explain the Proposer's high-level testing process to fulfill the claims testing processes requirements.

Centene and Cenpatico will provide local and enterprise level, claims processing expertise to ensure the successful implementation and ongoing operation of all claims processing functions for the Louisiana Behavioral Health Partnership (LBHP). We have in place the processes and teams, both internal as well as external auditing firms, to monitor and assess the overall quality of our operations, and to assist us in achieving internal as well as state contract objectives. We continuously and systematically evaluate our performance and implement measures, where necessary, to introduce controls to reduce risk and implement change to ensure high quality systems and business processes, and industry best practice. We also see DHH-OBH as a critical member of our team and look forward to establishing a strong working relationship with DHH-OBH as a partner in our effort to achieve continuous quality improvement.

Cenpatico Audit for LBHP

As described in section 2.g.xxiii, in addition to our routine audit processes, we will conduct a specific claims audit for DHH-OBH. Cenpatico will adhere to DHH-OBH financial payment accuracy standard of 97% and procedural accuracy of 99% and will audit/test 2% of claims for each claims processing day (Monday through Friday). We will document findings according to DHH-OBH specifications as outlined in the Request for Proposal (RFP, Section II.E.17 and 18) . At minimum, we will review the following:

- *Data Validation*: Check **accuracy of OCR** by comparing scanned claim image to AMISYS Advance to detect discrepancies (Claim data correctly entered into the claims processing system with an assigned transaction number).
- *Provider Eligibility*: Confirm accuracy of **provider** selection and provider network enrollment dates (Claim is associated with the correct provider & Proper coding consistent with the provider's credentials)
- *Authorizations*: Confirm the accuracy of **authorization selection** and application of limits and date spans (Service obtained the proper authorization & Authorization limits are not exceeded)
- *Recipient Eligibility*: Validate accuracy of **recipient** selection and enrollment dates (Member eligibility at processing date correctly applied).
- *Claims final adjudication processing*: Validate the computation of **allowed charge and payment accuracy** for each service in the claim and the application of appropriate remark/denial codes after claim adjudication (Allowed payment amount agrees with contracted rate & Denial reason applied appropriately).
- Duplicate claim submissions were identified and denied *(duplicate payment of the same claim has not occurred)*
- *Modifier Codes*: Validate accuracy of actions in response to **Reference edits (**Effect of modifier codes correctly applied)
- *Claims Resubmission and Adjustment processing*: Confirm that the intended **resubmission and adjustment** are processed as intended. (Adjustments to claims are properly made with supporting documentation).
- *Third Party Liability Edits*: Check **accuracy of TPL determination** and application of primary payments, if applicable and confirm accuracy of Coordination of Benefit (**COB**) calculation. (Co-payment application considered and applied & payment is coordinated properly when other insurance is applicable).

Claims Processing Implementation Approach

Our dedicated **Claims Configuration** implementation team, led by our Cenpatico Louisiana Contract Implementation Specialist (CIS), will focus on the analysis and documentation of all configuration requirements for the LBHP program to ensure accurate and timely claims processing for our members, providers and DHH-OBH. The CIS will work cross functionally with *all* teams involved in the claims processing function, including Provider Network Management, Medical Management, and our Finance Department. A best practice and a critical activity towards successful implementations has been our "pricing summit" which we like to conduct for all new implementations as soon as possible after contract award. This summit brings together Claims Configuration, Contracting, and our CIS to ensure that all key individuals are at the table when defining and documenting the pricing rules that must be configured in our AMISYS Advance system so that claims will be processed correctly and in a timely manner. Additionally, we work with our senior executives and, when possible, a representative from the state to facilitate the finalization of business decisions around areas of ambiguity in pricing.

Accurate Configuration. The Claims Configuration team remains connected through daily tag meetings and a weekly reprioritization meeting throughout the implementation and post-implementation phases. The activities for this team focus on configuration and setup of our claims processing applications which include: EDIFECS HIPAA compliance checking software for the electronic receipt of claims; MACESS EXP Formworks for receipt and processing of paper claims; Our TIBCO software suite which provides data validation services, transaction routing and finally, AMISYS Advance our core claims processing system. In addition, this team will establish appropriate work processes for claims processors.

Outlined below are the critical path objectives of this team:

AMISYS Advance.

- *Basic AMISYS Advance Set-Up*: The basic code sets, procedure code detail, age/gender edits, and other relevant information are configured as first priority.
- *Creating Payclass Shells*: The objective here is to ensure that payclass shells are set up in AMISYS Advance and are available to attach to provider records in our Provider Relationship Management system, as provider contracts are received. This step assists us in our ability to meet network adequacy needs and to produce provider directories.
- *Loading of Fee Schedules*: Based on the guidelines in the contract, the appropriate fee schedules will be identified by our CIS and then downloaded, formatted, and loaded into AMISYS Advance.
- *Configuration of Benefits*: Cenpatico's CIS will create a detailed benefit grid that encompasses all the different products and member groups in Louisiana's behavioral health delivery system. Upon completion of the Benefit Grid, the benefits will be configured in AMISYS Advance.
- *Configuration of Authorizations*: Our CIS will coordinate with Medical Management to finalize all authorization rules. Upon approval from senior management, the CIS will create a comprehensive authorizations grid, which details the exact specifications for authorizations. Upon completion of benefit configuration and upon receipt of the authorization grid, authorizations are configured within AMISYS Advance so that in most cases, AMISYS Advance will be able to systematically match the authorization decision from TruCare with the claim.
- *AMISYS Advance Six Steps of Adjudication*: Through the completion of the actions listed above, the six steps of adjudication within AMISYS Advance are configured for the specific business rules of DHH-OBH and Cenpatico.
- *Third Party Liability*: Compliance coding for the specific TPL rules and exceptions needed for the LBHP Program are specifically configured for the processing rules of DHH-OBH and Cenpatico.

Configuration of Payment Arrangements (payclasses): Prior to contracting or as needed, the CIS will create payment guides, which will guide the configuration of the payment arrangements in Centelligence™ Negotiator and AMISYS Advance. Centelligence™ Negotiator (Negotiator) has both

contract simulation capabilities and allows us to configure and systematically load complex contract fee schedules directly into AMISYS Advance. The simulation capabilities of Negotiator will allow our provider network professionals to refine and predict the effect of the total reimbursement schedule we develop with our network providers. Negotiator will help us ensure that we compensate and incent our providers (including LGEs) to deliver coordinated, quality care, without exposing our providers to unacceptable levels of risk and that, as we progress through the contract and as we track quality and coordinated care measures, we are able to refine and adjust our reimbursement strategy for ever continuing quality of care delivered. In this latter scenario, Negotiator is indispensable to our Provider Network staff - again to help us ensure that any fee changes will lead to the desired incentives. We will also use Negotiator to partly inform our annual expenditure projections (per RFP Section II.B.10.f, page 128), based on empirically driven (e.g. prior claims data) simulations we run using Negotiator.

Our ability to implement new fee schedules with Negotiator will be particularly important with the reimbursement arrangements we have with our providers, with the emphasis on care quality and coordinated care performance. That is, as we move through the contract, we will be tracking quality and coordination measures jointly with our providers, and we will jointly be adjusting our total reimbursement program with these providers (in compliance with reimbursement requirements mandated in the RFP), with approval from DHH-OBH, so it will be critical to be able to implement new and complex fee arrangements to complement our quality incentives with our providers .

By utilizing a combination of benefit configuration and payclass configuration, Cenpatico will be able to identify services that are to be pre-paid by Cenpatico and then submitted to DHH-OBH for reimbursement, services that are to be adjudicated but submitted DHH-OBH for direct payment to providers, and services to be funded by Cenpatico.

Automated Work Distributor (AWD). We will configure our AWD software for the specific workflow rules required by Cenpatico, such that a claim that pends due to a Third Party Liability (TPL) issue, for example, would route to one of our claims analysts skilled in TPL processing and resolution. Likewise, in order to meet the TAT processing requirements, we will configure AWD to appropriately escalate pended claims to ensure visibility so they can be adjudicated within the required timelines.

Claims Xten and HCI. These tools are delivered with industry standard claims edits based on nationally recognized guidelines, such as the National Correct Coding Initiative (NCCI) for professional and outpatient services. However, we can customize the rules in our ClaimsXten software for the specific coding, reimbursement policies, and benefit criteria for the various Louisiana Behavioral Health Programs. Finally, we will communicate any specific coding requirements to HCI for fraud, waste, and abuse detection.

Provider Relationship Management. We will configure our Provider Relationship Management system for all provider related data necessary to ensure accurate claims payment, including the provider’s financial affiliation(s), license status, specialty/practice type, and payclass (which includes factors that represent the provider’s contractual relationship with Cenpatico).

TruCare**.** For service authorization, Cenpatico will utilize TruCare, our care management and utilization software system. TruCare utilizes rule-based architecture, which allows customized clinical workflow related to clinical decision support criteria, prior authorization, and medical necessity review. TruCare's interface capabilities allow it to transmit authorizations in real time to our AMISYS Advance claims subsystem, and TruCare's data granularity allows authorizations to be issued at the procedure code level, enabling the highest level of specificity for subsequent claim adjudication, and enhancing claim payment turnaround times to our providers. TruCare is integrated with McKesson's InterQual medical necessity criteria software, which gives us evidence-based criteria providing a consistent guideline to help our staff determine the medical necessity and the appropriateness of covered services requiring prior authorization.

TruCare is scalable and fully customizable to exceed DHH-OBH's requirements surrounding service authorization. TruCare's customizable capabilities empower our licensed clinical staff to reduce duplicative or unnecessary services. AMISYS Advance is configured to look for service authorizations, where required, will access the authorization file to obtain the authorization number for the service, and return it to the claim entry screen. If no authorization is found, or if the authorization does not match, the system assigns a deny code. For more information please reference our response to questions 2.g.iv, 2.g.xxv, and 2.g.xxvii.

Thorough and Rigorous Testing

All configuration and coding within our systems to meet the specific needs for the Louisiana Behavioral Health Programs go through a ***rigorous testing and promotion process***. All new configuration is first built in our development environment and is unit tested to ensure accuracy. Once unit tests pass, configuration is promoted to our testing environment for integrated testing. This vigorous testing anticipates all significant processing scenarios. Any issues are immediately communicated to our configuration and/or development team and addressed. Once any issue has been resolved, the configuration moves back to integrated testing and is fully tested again. Upon successful passage through integrated testing, the configuration moves to user acceptance testing (UAT). In UAT, the tester will review the integrated testing results and run 'real life' scenarios through the system and review the results for accuracy. Upon passage of UAT, the configuration is moved to production. Our implementation scheduled is designed so that *at least 30 days pre go-live*, the claims operations and IT staff are able to jointly test hundreds of claim scenarios using mocked up claims, existing claims from another market converted to match Louisiana benefit "like data", as well as partner with our contracted providers in the Louisiana market. We share the results of these tests with these providers to ensure our reimbursement and denials are in line with their expectations. Throughout the process, we conduct joint meetings, which include staff from the claims implementation team, contracting, configuration, and provider data management. Extensive testing and broad review of the results, even with external parties, ensures that the final outcomes of service authorization and claims processing are correct. Partnering with providers helps to build confidence in the provider community that Cenpatico is ready to process claims correctly and timely.

Comprehensive Training

All claims staff attend rigorous training to ensure understanding of the claims process and, where necessary, these training programs will be tailored for the specific requirements of DHH-OBH. Cenaptico's Implementation team will assist with the creation of Louisiana-specific claim training tools for the dedicated Claims Training team as well as provide training for associated staff such as the call center so that good provider service can be guaranteed.

Cenpatico will create a *designated* team of highly trained claims analysts, who will dedicate their efforts to understanding the requirements of Cenpatico and DHH-OBH and who will work with the implementation team and the Claims and Encounters Administrator to ensure all DHH-OBH requirements are understood and implemented correctly.

All claims training programs are created and refined by Centene, leveraging our experience in claims processing activities. Each training module offers a variety of approaches and techniques to address all steps of claims processing. All training programs are conducted by Claims Trainers, and are supported by solid curriculum and evaluation tools to confirm attainment of skills and quality audits. Computer-based training, lesson plans, e-learning, work processes, exercises/assessments, and workbooks are resources in all modules.

Our training programs provide a progressive curriculum that encompasses foundational learning that transitions into advanced level training for more complex claims processing functions. In total, an advanced adjuster generally receive a minimum of 14 weeks of classroom and hands-on training designed to span all aspects of claims processing from fundamental skills to specific elements related to health plan needs. The training encompasses: a review of the AMISYS Advance application including types of claim pends and related protocols for resolution; claims adjudication modules include review of benefits, pricing, and authorization requirements; and the workflow module addresses how to access and view claim images, route claims and correspondence to other internal departments, and follow-up mechanisms. Training modules for COB/TPL equip the processor with the skills to research and coordinate benefits to ensure accuracy in payment determination. The claim adjustors' curriculum provides them with a comprehensive understanding of the claims adjustment guidelines to effectively process resubmitted claims, identify, and report trends in processing deficiencies or errors for specific processors, providers, or technologies. All participants are audited throughout the training programs and must demonstrate proficiency to graduate from the programs and begin processing or adjusting claims.

Claims Training is dedicated to ensuring all students receive a comprehensive understanding of claims processing. This is achieved by use of instructional methods and tools to provide courses that are knowledge based, quality driven, and comprehensive of analytical functions that drive quality improvement and internal customer service. Training support continues beyond the formal classroom. The Claims Training team holds scheduled learning labs allowing processors to receive individual attention in areas for improvement. This environment provides an outlet for support beyond the operation floor and training classroom. The program allows all participants to schedule lab time during designated business hours to practice lessons learned. The focus is *participant driven* involving best practices, current work processes, process bulletins, and insight into system configuration for an improved understanding of how individual claims processors impact overall operations.

Provider Training. In addition to staff training, we will also design our provider training strategy and tools to ensure they are well prepared to file claims according to DHH-OBH and Cenpatico rules as quickly as possible.

It is through our comprehensive training process we ensure that all our claims staff are knowledgeable in claims processes, that there is on-going training, and succession planning in place. It is because of this training and our highly qualified and experienced staff, in combination with our claims processing system functionality, that we can assure DHH-OBH of our ability to meet and exceed requirements.

Policies and Procedures and Compliance Monitoring

Concurrent to system configuration and training, we will be reviewing our standard policies and procedures, updating these according to DHH-OBH specifications and inputting them into our Compliance 360 system for on-going contract monitoring. Our Compliance 360 system allows our Centene and Cenpatico compliance professionals to systematically track our adherence to our state client's contracts, via auditable workflow tools.

Sign off during Readiness Review with DHH-OBH (at appropriate point)

During readiness reviews, we will prepare all documentation, policies, and procedures as required by DHH-OBH. Further, we will demonstrate our ability to process all claims, including those with authorizations, to the satisfaction of our internal management as well as to DHH-OBH. We anticipate that DHH-OBH will "approve" or sign-off on our efforts at the appropriate time, allowing us, with all internal approvals, to move our configuration into production.

Implementation Focused on Operational Excellence

Centene and Cenpatico are committed to achieving ***full operational excellence***. As such, before go-live, two local CIS will be assigned to the Cenpatico Claims and Encounter Administrator. These individuals will work closely with the CIS to evaluate all claims before they are finalized so as to identify any system issues immediately. This hands-on transition with the implementation team, and on-the-job training, ensures that the local Cenpatico CIS will be equipped to monitor claims processes and address claims issues moving forward into full operation. The CIS will continue to support the Claims Encounter Administrator and their staff in the management of claims configuration and pricing post go-live for approximately *six to nine months*, and will work with all areas affecting claims processing, including Provider Contracting and our Medical Management team, for service authorizations to ensure swift and accurate adjudication of claims. Once assured of successful operations, the implementation team transitions work to specific operational areas of expertise; claims configuration and maintenance of Centelligence™ Negotiator and AMISYS Advance will be completely transitioned to the Claims and Encounter Administrator and the Information System Administrator; and maintenance of provider contracts and fee schedules will be transition to the Provider Network Management operational team. Specific disengagement metrics will be established that may include the following and more:

- Claims TAT meets or exceeds the requirements of DHH-OBH.
- Submitted configuration request (CR) volumes are consistently low.
- Auto-adjudication rate is at or above 85% and EDI submission rate reaches 80%.
- Claim accuracy percentage is at minimum an acceptable level.

Wherever possible, members of the implementation team become a part of the ongoing operations staff. If we hire new staff for our Cenpatico implementation, where it makes sense, we will attempt to bring them into the claims implementation portion of our overall implementation project plan. Either way, we have and will modify, as necessary, our detailed transition plan and timeline to ensure that the local Cenpatico claims management staff is trained and equipped to resolve claims issues and lead on-going claims processing improvement efforts.

Our claims operations and configuration team continue to partner to identify ways to prevent manual intervention and increase the auto-adjudication rate. We continually monitor this process through our end-to-end claims processing oversight to ensure quality in each step of the process. Our target goal is to have an 85% auto-adjudication rate, or higher. First-time claim auto-adjudication rate for established Cenpatico markets ranges from 89-93%.

Cenpatico's Support Services Manager monitors daily the electronic and paper claim receipt rejection rates to quickly identify any issues, be they systematic or provider specific, and to coordinate any necessary investigation, correction or provider outreach. The Support Services Manager works directly with Centene's EDI team, Encounters team and Claims Processing team to ensure all aspects of claims receipts, rejections, processing, adjustments, etc. are working properly.

Centene has a dedicated Encounters team who will program and monitor edits required by DHH-OBH for all the distinctive different programs under this contract.

On-going Process Monitoring and Controls

Centene employs multiple methods of controls and auditing to ensure we continuously meet and often exceed state requirements and federal mandates. These efforts include, but are not limited to the following:

Continuous Quality Improvement and Claims Monitoring

We continuously monitor claims volume, claims TAT, and electronic claims submission penetration via our Centelligence™ Insight Dashboards. Below is an example of our dashboard capability for claims Key

Performance Indicators for financial, payment, and processing accuracy. These are monitored both at the plan level and by Centene corporate to identify areas of concern or for possible improvement.

Provider Satisfaction Surveys

In addition to regular face-to-face interaction with our network team, we will outreach to our providers through satisfaction surveys and in the course of relationship building to ensure that we are listening to their concerns and address any issues as they relate to claims processing. Through these outreach activities, we will determine the need to provide training, targeted outreach, etc., to assist our providers in understanding DHH-OBH and Cenpatico rules for processing claims, the benefit of filing claims electronically, or other specific areas of concern.

Provider Administrative Scorecard

We are developing a provider scorecard that will compare a provider's pattern of paper versus electronic claims and reimbursements against all contracted providers. The report will be available via PRM to internal staff who work directly with providers, such as Network Managers, Provider Service Representatives, and Case Managers. The data in this report will demonstrate the connection between a provider's claims submission practice and the impact on their business in terms of claims accuracy and reimbursement turnaround. By pulling the data together and presenting it in this format, Cenpatico staff will be equipped with powerful and easy-to-understand information that will resonate with providers as we work together to improve EDI participation and claims accuracy and reduce administrative costs. See Section 2.g.xxii for how we will encourage and support electronic submissions of claims.

Ongoing Claims Audits

Our Quality Review team performs continuous quality improvement audits on our processes, people, and controls to ensure the highest level of claims accuracy. Please reference our response to question 2.g.xxiii.

Annual SAS 70 Type II Audit. KPMG, LLP performs this annual audit for Centene to test the design of controls over Claims Processing and Datacenter Operations and the operating effectiveness of such controls, including those related to MIS availability, security, and data integrity. In its most recent SAS 70 Type II audit (2010), *Centene received an unqualified opinion from KPMG, LLP* (that is: KPMG did not discover any material adverse findings).

Sarbanes Oxley Management Report on Internal Controls over Financial Reporting. Each year, management conducts evaluations of the effectiveness of internal controls over financial reporting according to Sarbanes-Oxley Section 404 (SOX) regulations. Our Internal Audit Department and Ernst & Young, LLP conducted our most recent audit of these controls for the period ending December 31, 2010, and concluded that Centene's internal controls over financial reporting were effective. Centene's **assessment** of the effectiveness of internal controls, which includes controls for claims processing, for the period ending December 31, 2010, was audited by KPMG, LLP, another public accounting firm. *No significant deficiencies or material weaknesses were identified.*

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxv. Describe the Proposer's process of paying claims and ensuring prior authorization has been obtained. Include the process or system functions that ensure only the number of services authorized are paid. **Suggested number of pages: 3**

Service Authorizations – An Integrated Solution

Cenpatico will provide local and enterprise level, claims processing expertise to ensure the successful implementation and on-going operation of all claims processing functions for the Louisiana Behavioral Health Partnership (LBHP), including those related to prior authorization for services. Cenpatico's Medical Management team is responsible for the detailed analysis and creation of an Authorizations Grid documenting the exact specifications for authorizations. Authorization requirements (ARQ) are then configured in TruCare, our care management and utilization software system and AMISYS Advance, our core claim processing system. Each application, TruCare and AMISYS Advance, is functionally rich for the job they are designed for, yet we have integrated these two systems where they need to be integrated to assure efficient, quality care operations.

TruCare utilizes rule-based architecture which allows customized clinical workflow related to clinical decision support criteria, prior authorization, and medical necessity review. TruCare's interface capabilities allow it to transmit authorizations in real time to our AMISYS Advance claims subsystem, and TruCare's data granularity allows authorizations to be issued at the procedure code level, enabling the highest level of specificity for subsequent claim adjudication, and enhancing claim payment turnaround times to our providers. TruCare is integrated with McKesson's industry leading InterQual evidence based Behavioral Health Criteria to automate all workflow related to level-of-care and continued stay decisions. InterQual criteria allow our UM and Case Management (CM) staff to consider the severity of the illness and episode-specific variables and match the level of care appropriately and in a consistent and objective manner. TruCare is scalable and fully customizable to exceed DHH-OBH Program requirements surrounding service authorization. AMISYS Advance, is configured to look for service authorizations, and where required, will access the authorization file to obtain the authorization number for the service, and return it to the claim entry screen as described in the adjudication process below.

We will also inform our providers about those services requiring prior authorization in the provider manual, and on our Provider Portal. Additionally, Our Clear Claim Connection tool, also on our Provider Portal, will give providers the ability to view and refer to Cenpatico Claims Adjudication logic in detail. Designed by McKesson Information Solutions, Inc. Clear Claim Connection "mirrors" how Cenpatico's claims software evaluates code combinations during the adjudication of a claim resulting in cleaner claim submissions and less chance of misunderstanding between our Providers and Cenpatico. Please refer to question 2.g.viii for more information on our Provider Portal.

Authorization Process. After the Cenpatico reviewer completes their evaluation of an authorization request and updates necessary administrative and clinical information in TruCare, the authorization, if granted downloads from True Care into AMISYS Advance. On receipt of a clean claim, AMISYS Advance follows a six (6) step process of adjudication during which all programmed parameters for authorization (among other criteria) are checked and validated. Please see question 2.g.xxxi for a detailed description of the claim edits performed during the Six Steps of Adjudication process. Briefly, these six steps are:

AMISYS Advance Six Steps of Adjudication.

Step 1: Field and General Edits. AMISYS Advance determines if claim fields are consistent with state standards and federal regulations, as well as age, sex, DRG, duplicate and consistency edits.

Step 2: Member Eligibility. The system verifies eligibility for service dates and coverage type when applicable. Louisiana Behavioral Health Partnership eligibility is based on eligibility files we receive from the state. Members identified as eligible for state or grant funded programs will be enrolled.

Step 3: Provider Eligibility and Status. The submitting Provider's status for the dates of service is verified by a combination of the Medicaid certified provider's NPI and the tax identification number. Except in cases of emergency, the system will only reimburse Medicaid certified providers.

Step 4: Authorization. AMISYS Advance verifies preauthorization, when applicable.

Step 5: Covered Services/Benefits. The system determines covered services by applying configured eligibility, provider, and benefits management rules, along with tables of valid procedure codes/ranges; diagnosis codes (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range; provider type; service location; and benefit limitations to define exactly which services are covered and at what levels.

Step 6: Pricing. AMISYS Advance prices the claim by applying any member third party liability (TPL) or coordination of benefits (COB) information, co-payments or deductible amounts, and Cenpatico's specific contractual and financial agreements.

ARQ's are programmed in a hierarchy from specific to general, ensuring that claims meeting very specific requirements hit against ARQs detailing whether or not an authorization is required. Claims that do not match to specific criteria drop through to more generic filters. ARQ criteria can be created from any combination of the following variables:

Variable	Options	Description
Claim Type	Inpatient or Outpatient	Outpatient claims includes facility outpatient as well as professional claims
Service Location	Select single, multiple or all locations	Nationally defined place of service codes
Treatment Type	Select none, single or multiple treatment types	Pre-programmed clusters of similar codes into categories for ease of selecting a large number of codes quickly
Procedure Codes	Select single, multiple or all codes	Nationally defined Revenue Codes, CPT codes or HCPCS codes. DRGs may also be used.
Diagnoses	Select single, multiple or all diagnoses	ICD9 codes or their successor
Provider	Select single, multiple or all providers	Identify authorization criteria specific to individual providers by using their Cenpatico provider ID in the ARQ
Member	Select single, multiple or all members	Utilizing member demographic groupings such as identified risk populations, gender, age, benefit, program, or division to identify authorization requirements by member
Provider specialty	Select single, multiple or all specialties	Create authorization criteria for specific provider types

Variable	Options	Description
Provider status		Create authorization criteria for participating versus nonparticipating providers
Date of Service	Create date ranges when authorization rules are active	

When the claim reaches the fourth step of adjudication (Authorization) within AMISYS Advance, AMISYS Advance uses the member information validated in step two and the provider information validated in step three along with procedure code, service location and other information on the claim to identify if the claim meets programmed criteria to require authorization. At this point, if an authorization is required, AMISYS Advance will search the open authorizations file for the member and provider as indicated on the submitted claim. If there is a match, the authorization number will automatically attach to the claim record at the service line level; which enables a provider to bill different outpatient services on one claim and have multiple authorization numbers correctly attach to the claim. Cenpatico is also able to link providers into their respective groups, or on-call coverage, so that "linked" providers can perform services on behalf of another provider, given all other criteria (provider eligibility valid on date of service, etc.) is met. In this manner, the administrative burden for provider groups or clinics is minimized. Providers can track their authorizations at the member level and will not be required to obtain additional, possibly duplicative, authorizations under another provider in the group if more than one provider is included in the member's treatment plan.

Counters are set up automatically with each authorization. After the authorization attaches to the service line on the claim, the counter is triggered to recognize that a service has been used and to reduce the number of available authorized services by the total number of units or by the number of visits, depending on the coding and benefit rules for the service.

In the event the authorization rules are more complex than the criteria identified above, AMISYS Advance has the option to move through adjudication step four (authorizations) and create even more detailed requirements in the fifth step of adjudication (benefits). A good example of this is Cenpatico's general policy to allow participating practitioners to perform an evaluation and a series of follow up outpatient therapy visits without first receiving authorization. After the preset number of visits without authorization have been reached, an authorization is required. This criteria of "number of visits per member per provider without authorization" is more complex than the authorization step of adjudication can handle. Therefore, an authorization requirement with the known criteria, in this case participating provider for outpatient therapy codes in an outpatient service location, is created but instead of indicating that "Yes" an authorization is always required or "No" an authorization is never required, AMISYS Advance is programmed to require neither so that claims matching those criteria are simply moved through to the benefits stage of adjudication. In benefits, every possible scenario for claims meeting the criteria is programmed in detail. To continue the example above, the following scenarios would be created in benefits:

Scenario	Outcome
Participating provider or nonparticipating provider for outpatient therapy in an outpatient location with an authorization	Pay contracted rate
Participating provider for outpatient therapy in an outpatient location without an authorization	If number of visits without auth have not been exceeded, add count to the "without auth visits" counter and pay claim. If number of visits without auth have been exceeded, deny claim
Nonparticipating provider for outpatient therapy in an outpatient location without an authorization	Authorization required, deny

The last step of adjudication is pricing. In this step, each service line is routed through Pay Service Qualifier (PSQ) filters. These filters, much like the authorization filters, use criteria such as the provider specialty, participation status, service location, member benefit program, as well as the contract type to direct the claim to a fee schedule. AMISYS Advance will calculate the amount to pay based on the number of units and the rate on the fee schedule. Cenpatico has the ability to load provider specific rates in the event payment is something other than the base state rate.

2.g. Technical Requirements
xxvi. Describe the fields utilized in the exact duplicate match. **Suggested number of pages: 1**

Correctly identifying when a claim is a duplicate submission versus an adjustment or resubmission is very important for claims accuracy and for overall provider satisfaction. Cenpatico uses two different processes to review and validate whether or not a claim is a duplicate submission.
First, duplicate logic is defined into a market-specific table in Amisys. This enables Cenpatico to customize duplication logic as needed to meet the needs of each product. In addition to the date of service, Amisys has 8 variables that can be programmed into the duplication:

1. Provider is the same
2. Amount charged is the same
3. Procedure/Drug codes are equal
4. Diagnosis codes are equal out to the number of specified digits
5. Modifiers are the same (valid for professional services only)
6. Claim type (institutional versus medical) is the same
7. Mouth location/tooth surfaces are the same
8. Claim numbers are the same

Any combination of 6 utilizing the variables above, plus date of service, can be programmed to flag an incoming claim as a duplicate. Depending on the combination, we can set the claim to auto-adjudicate as a duplicate, thus streamlining the process, or we can set the claim to pend as a potential duplicate claim for manual review by an experienced claims processor.

If a claim is pended for manual review, it will be systematically routed to a claims processor utilizing our Automtic Work Distributor (AWD) tool. Our AWD software will manage Cenpatico's workflow of any pended claim in AMISYS Advance in *real time*. If a claim pends for possible duplicate in AMISYS Advance, AWD will immediately route an electronic work item to a claims processor skilled to address this type of claim pend. The claim processor can then address the pend issue within AWD, and the appropriate claim change is immediately made in AMISYS Advance, with a full audit trail of the change and all other financial transaction activity. AWD also provides processors with immediate access to claim images (including attachments) and supports the communication and routing between departments to resolve a claim pend.

The claims processor will follow defined policy & procedures that detail the review steps. If quality reviews or audits identify that a duplicate claim was paid, Cenpatico recoups the payment from the provider.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxvii. Describe the process for determining covered service payments that may not require an authorization.
Suggested number of pages: 2

Cenpatico's Contract Implementation Manager will review all of the LBHP information plus any additional information about non-Medicaid funded services and will create a benefit summary document detailing all of the different requirements by program and provider type. This summary is then reviewed by the Medical Management team. The Medical Management team will assess the benefit model against the medical model that has been designed specifically for the LBHP program. The Medical Management team will identify services that are associated with best practice models. These services will require authorization to ensure the providers are utilizing best practice opportunities in their treatment plans. Other factors contributing to assessing the need to require authorization can include whether or not the member needs to meet certain medical necessity criteria to make service appropriate, e.g. acute level services, whether or not a service lends itself easily to excessive utilization, whether or not the service already has a prescribed daily, monthly or annual limit, etc.

The evaluation of authorization requirements also includes consideration of services that are standard good practice. Services that should happen as part of a standard treatment plan are often given a waiver on authorization requirements. For example, when a member first presents, a WAA provider will need to do a diagnostic evaluation. After the evaluation, creation of goals and a treatment plan, a few follow up therapy visits would be needed to address the member's situation. Since this series of initial visits would be authorized as basic member services, Cenpatico does not require the WAA providers to receive authorization for an initial evaluation and a set number of follow up outpatient therapy visits. Other consideration is given to providers who show an excellence in treatment planning and outcomes measurements. Providers who follow evidence based practices and meet Cenpatico's criteria can be given a "preferred provider status." This status grants the provider an authorization waiver for select services based on where their area of expertise is. Providers given preferred status are monitored periodically for continued adherence to best practices. Allowing initial visits and also awarding good providers with authorization waivers serves to reduce administrative cost for both Cenpatico and the provider while still maintaining resource management and excellent member outcomes. First and foremost, Cenpatico's aim is to provide excellent treatment for the member population while being fiscally responsible with resources. Cenpatico has a proven record of modifying practice behaviors to offer members the most effective, evidence based treatment that results in better outcomes in a shorter timeframe. Over time this results in Medicaid dollars being allocated to more appropriate services and a reduction in high cost, low outcome services.

Once the Medical Management team identifies services that will or will not require authorization, or any particular provider authorization waivers, the Contract Implementation Manager creates the detailed specifications and monitors the system build to ensure accuracy. As described in the response to question 2.g.xxv, criteria will be programmed to match the claim to authorization requirements. Step four of the adjudication process (authorization) is used not only to define which procedures require authorization but also which procedures do not need authorization. When a claim matches against programmed authorization criteria defined as not needing authorization, the claim will move through the adjudication process directly to the benefits step without looking for authorization. As mentioned in the response to 2.g.xxv, all adjudication steps are at a service line level so a claim with multiple services can have some service lines that requiring authorization and other service lines that do not.

These processes will be continually monitored throughout the course of the contract as the community based infrastructure grows and processes (automation) as well as relationships become more familiar, Cenpatico will adjust accordingly, which is one of our key differentiators. The strength of our relationships with our providers is evidenced in our other markets through their persistent involvement with us even in difficult times due to funding changes or when catastrophic events occur. The flexibility of our systems to grow as our programs grow engenders trust.

2.g. Technical Requirements
xxviii. Describe the process of ensuring that paid claims are for providers that are credentialed to perform the specific service rendered. **Suggested number of pages: 2**

Provider Credentialing and Data Management

Cenpatico is responsible for Provider Credentialing and Data Management and will maintain all information related to our providers in our Provider Relationship Management (PRM) system. PRM is our next generation provider services inquiry and provider data management application, powered by Microsoft Dynamics contact relationship management (aka "CRM") software and our *Portico* a best-in-class, end-to-end data management solution that focuses on provider prospecting, enrollment, credentialing, and provider data management, as well as our Emptoris enterprise contracting system. PRM is integrated with our Provider Portal, our Electronic Data Interchange suite, including Tibco and Edifecs; Amisys Advance our claims processing system; TruCare case management system; MACESS image retrieval system; and our Automatic Workflow Distribution (AWD) system.

Thorough Data Collection. As part of the provider contracting process, Cenpatico will enter detailed information into our PRM (specifically Portico), including but not limited to National Provider Identifier (NPI), provider name, group name, W-9's containing the legal entity name and tax identification number (TIN), address, effective date, end date, ***taxonomy***, ***provider specialty***, and other credentialing information. If a Cenpatico member obtains services from an out-of-network provider who is not housed in our system, the provider's data will be added to Emptoris/Portico as a *non-participating* (non-par) provider.

Systematically Cross Referencing Providers' Standing from Multiple Sources. During the contracting process, Cenpatico will collect and ***validate*** information related to a provider, including but not limited to, NPI, demographics, education, government program participation, licensure, accreditation, malpractice insurance, taxonomy code, specialty and hospital privileges. Our credentialing process includes primary source verification as well as systematic scans for reported, sanctionable actions. Please see our response to question 2.g.xxix for more information on provider data and sanctions.

In 2011, we are augmenting our provider data management operations by integrating our Provider Relationship Management (PRM) system with data and interface services from ***Enclarity, Inc*** (Enclarity). Enclarity is the nation's leading commercial provider data supplier, a recognized expert in sourcing, maintaining, and validating provider demographic, specialty, licensure, and sanction information. Through a singular focus on "all things provider", Enclarity maintains a storehouse of correct, current, and comprehensive information by continually reviewing the most trusted sources of data in the industry, a "universe" of provider information representing over 140 million records: all synchronized and normalized in Enclarity's Master Provider Referential Database (MPRD). Through both "on demand" real time and scheduled batch provider data interfaces with our PRM. Enclarity ensures on a regular basis that *the provider data we house in PRM is accurate across all provider informational dimensions*. Every quarter, Enclarity electronically sends us a validation file for all records housed in PRM's Portico database. Portico can then update any information from this Enclarity "synchronization file".

Benefit and Payment Configuration

To ensure that we accurately pay providers based on the services for which they are ***credentialed to perform***, we configure both our benefits and payment arrangements (or pay classes) in AMISYS Advance, our core claims processing system, to ***identify*** the provider specialty codes that are authorized to perform the specific benefit (service). Specifically, we will configure the following systems:

- Provider Relationship Management. We will configure our Provider Relationship Management system for all provider related data necessary to ensure accurate claims payment, including the

provider's financial affiliation(s), license status, ***specialty/practice type***, and pay class (which include factors that represent the provider's contractual relationship with Cenpatico). This information is systematically updated into AMISYS Advance in near real time.

- Configuration of Benefits: Cenpatico's Contract Implementation Specialist (CIM) will create a detailed Benefit Grid that encompasses all the different products and member groups in Louisiana's behavioral health delivery system. Upon completion of the Benefit Grid, the benefits will be configured in AMISYS Advance. Benefits will be configured for the provider ***specialty code*** authorized to perform the specific benefit (service).
- Configuration of Authorizations: Our CIM will also coordinate with Medical Management to create a comprehensive Authorizations Grid, which details the exact specifications for authorizations, including any authorization rules related to provider specialty. Upon completion of benefit configuration and upon receipt of the authorization grid, authorizations are configured in AMISYS Advance so that in most cases, AMISYS Advance will be able to systematically match the authorization decision from TruCare, our care and utilization management system, with the claim. TruCare is fully integrated with AMISYS Advance, so that once approved in TruCare, authorization data is sent to AMISYS Advance, in near real time.

By utilizing a combination of benefit configuration, pay class, and authorization criteria, on receipt of a claim, AMISYS Advance will systematically check the benefit and specialty codes associated with the benefit during the adjudication process (please see 2.g.xxxi and 2.g.xxv responses for more information on AMISYS Advance, Six Steps of Adjudication). *Specifically*, AMISYS Advance will be configured to check the specialty code(s) associated with the benefit to the specialty code(s) assigned to the provider in our PRM based on the NPI submitted on the claim. AMISYS Advance will then check for any authorizations on file in the system, if required.

If the extending provider has the correct specialty code assigned in PRM/AMISYS Advance to perform the service, and the authorization, if applicable, is available in the system, and provided the claim passes all other steps of adjudication, AMISYS Advance will adjudicate the claim for payment. If these criteria are not met, AMISYS Advance will deny the claim and an Explanation of Payment / Electronic Remittance Advice will be sent to the Provider indicating the reason why the claim was denied. Please refer to the response in 2.g.xxxi for examples of the edit codes the provider will receive indicating ineligibility to perform service.

Provider Payment. AMISYS Advance prices claims by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and provider specific contractual and financial agreements. This step also applies DHH-OBH reimbursement rules. The pricing step of adjudication links the claim to the rates allowed for the provider via a Pay Service Qualifier (PSQ). The PSQ uses filters, such as provider status (participating or nonparticipating) and provider specialty, to link the claim to the specific fee schedule for that provider type. In this manner ***there is a double protection*** – benefits and pricing – ***to ensure that only providers eligible to perform select services are paid claims for those services***.

2.g. Technical Requirements
xxix. Describe the Proposer's storage of and use of national provider identification (NPI) numbers. **Suggested number of pages: 2**

The SMO's ability to capture, track, reconcile and apply provider identifiers (including NPI) for network management, claims payment and reporting, monitoring external quality and fraud alerts, and a variety of other applications is critical to ensuring appropriate service delivery across the care continuum and ultimately for introducing structured payments, preferred provider status, etc. Having systems designed exclusively for Medicaid and non-Medicaid public sector provider data administration (including wraparound providers) offers LBHP a customized solution that does not need to be retro-fitted but is Day 1 Ready.

Provider Data Management

Cenpatico is responsible for Provider Data Management and will maintain all information (including NPI) related to providers in our Provider Relationship Management (PRM) system. PRM is our next generation provider services inquiry and provider data management application, powered by Microsoft Dynamics contact relationship management (aka "CRM") software and our *Portico* a best-in-class, end-to-end data management solution that focuses on provider prospecting, enrollment, credentialing, and provider data management, as well as our Emptoris enterprise contracting system. PRM is integrated with our Provider Portal; our Electronic Data Interchange suite, including Tibco and EDIFECS; AMISYS Advance (our claims processing system); TruCare care management system; MACESS image retrieval system; and our Automatic Workflow Distribution (AWD) system. The ***primary key*** and unique identifier for providers across all these platforms is the National Provider Identifier (NPI).

NPI Compliance. Centene has been in compliance with the Center for Medicare & Medicaid Services (CMS) NPI requirement since CMS' compliance effective date of May 23, 2008. Centene requires all subcontractors and subsidiary organizations, including Cenpatico, to comply with Centene corporate data standards and protocols, and adherence to all federal, state, and HIPAA mandates, including use of the NPI. Cenpatico requires all providers to have an NPI and will require providers to provide/submit their NPI to process any transaction or correspondence with our provider network management department (such as change of address requests, group linkages, direct deposit, and any other correspondence) or Claims Processing function which mirrors the principles of the Louisiana *Making Medicaid Better* program.

Thorough Data Collection. As part of the provider contracting process, Cenpatico will collect and enter detailed information into our PRM (specifically Portico), including but not limited to NPI, provider name, group name, W-9's containing the legal entity name and tax identification number (TIN), taxonomy code, address, effective date, end date, primary specialty, and credentialing information. If a Cenpatico member obtains services from an out-of-network provider who is not housed in our system, the provider's data will be added to Emptoris/Portico as a *non-participating* (non-par) provider. At minimum, we require the NPI, TIN, provider name and address to enter a record into Portico. Portico utilizes sophisticated edits to ensure the validity of an NPI (including NPI check digit validation) and ensures the NPI is unique in our system ***before*** provider data is promulgated to our downstream systems.

Once provider data is entered into Portico, it is integrated across our systems and ***only*** in the system of record (in this case Portico) can that data be altered - an approach that ensures the highest possible level of integrity for downstream reporting and information support.

Claims Processing and NPI. Our integrated Electronic Data Interchange (EDI) infrastructure, including our TIBCO EDI translation software and our EDIFECS HIPAA compliance checker, all fully support NPI processing, and leverage full compliance with the NPI mandate to ensure proper format and check-digit on all claims received electronically. If a claim filed by a provider does not include an NPI, these are set

to deny (per HIPAA transaction and codeset regulations) and a detailed reason is sent to the provider (using standard HIPAA denial and/or remark codes) so that the claim can be corrected and resubmitted.

Once loaded into AMISYS Advance, our core claims processing system, AMISYS Advance accommodates the NPI thru total integration of this ID in all appropriate database fields and relationships, and within data entry and viewing fields with appropriate validation controls to ensure NPI data integrity in all claims processes.

Systematically Cross Referencing Providers' Standing from Multiple Sources. Cenpatico's process for contracting and credentialing providers includes collection and verification of many data elements to ensure qualifications for network participation, including but not limited to: federal and state identification numbers such as the NPI, demographics, education, government program participation, licensure, accreditation, malpractice insurance, specialty and hospital privileges. Our credentialing process includes primary source verification of these data elements, as well as systematic scans for reported, sanctionable actions through the use of data from the Council for Affordable Quality Healthcare® (CAQH), the Center of Medicare and Medicaid Services (CMS) Office of Inspector General (OIG) and available State databases. Centene and Cenpatico will have the capability to obtain sanction-related information through a nightly interface with our Portico application and CAQH. Providers excluded from participation with CMS, or without an NPI will not be eligible to participate with Cenpatico.

Continuously Enhancing Provider Data Integrity. In 2011, we are augmenting our provider data management operations by integrating our Provider Relationship Management (PRM) system with data and interface services from ***Enclarity, Inc*** (Enclarity). Enclarity is the nation's leading commercial provider data supplier, a recognized expert in sourcing, maintaining, and validating provider demographic, specialty, licensure, and sanction information; including systematic synchronization with CMS' National Plan and Provider Enumeration System (NPPES). Through a singular focus on "all things provider", Enclarity maintains a storehouse of correct, current, and comprehensive information by continually reviewing the most trusted sources of data in the industry, a "universe" of provider information representing over 140 million records: all synchronized and normalized in Enclarity's Master Provider Referential Database (MPRD). Through both "on demand" real time and scheduled batch provider data interfaces with our PRM, Enclarity will enable Cenpatico to recruit, contract, administer, and manage the ongoing quality of our provider data and network with enhanced accuracy and responsiveness. For example, Enclarity ensures on a regular basis that the provider data we house in PRM is accurate across all provider informational dimensions. Every quarter, Enclarity electronically sends us a validation file for all records housed in PRM's Portico database. Portico can then update any information from this Enclarity "synchronization file".

Preventing Payment to Excluded Providers. If Cenpatico becomes aware that a provider is excluded from Medicaid based on information received from federal or Louisiana state agency, the provider's status is updated in Portico and is promulgated to all systems in near real time, via our Service Oriented Architecture (SOA - please see Section 2.g.iv for more information). AMISYS Advance flags the provider and sets all non-emergency claims submitted by the excluded provider to deny. A detailed explanation is on the remittance to indicate the denial reason.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxx. Describe the process for capturing DOE data as encounters. **Suggested number of pages: 2**

Adhering to HIPAA Processes for DOE data

We have reviewed **Section II.B.2.r, items v. through xvii** in the RFP, pertaining to behavioral health services delivered in coordination with DOE and the Local Education Agencies (LEA's). In coordination and consultation with DOE, we will offer LEA's access to our secure web based State Agency Portal (Agency Portal) to allow authorized LEA users to enter dates, service provided, type of service (individual or group), frequency, provider name, and service goals - for behavioral health (BH) services rendered by school employees to our SMO members. LEA users will have access to a customized version of our existing HIPAA compliant Direct Data Entry (DDE) online claim submission facility (DDE). Our online DDE features pre-populated fields (where possible), field edits (e.g. drop-down procedure and diagnosis codes, with full language descriptions), contextual help, and a prompted "wizard" for step by procedural step to guide the user through the claim entry process. We will also offer LEA's the option of mailing or faxing short encounter forms (in other words, a paper equivalent of our DDE online feature). Whether the LEA submits DOE encounter data via our DDE or via paper; that data will follow the same systematic HIPAA compliant member, provider, and data validation procedures within our applications.

DOE Data: End to End

For a more detailed discussion of the above process, and in the context of an *end-to-end* flow, please refer to ***Figure 2.g.xxx.-1: DOE Encounter & School Based Provider Claim Flow***. In this Figure, a DOE or LEA user (Item **A**) of our State Agency Portal (**B**) enters an online referral (**1**) to Cenpatico. In this particular example, the referral results in enrollment of the child in the LMHP (and possibly in the CSoC program within the LMHP), and the child's member record is systematically built in our Member Relationship Management member eligibility system (MRM: item **C**), which seamlessly promulgates in near real time that member record data via our *System Oriented Architected (SOA)* "enterprise data bus" to our core processing applications:

- TruCare (**D**) - our collaborative care, service planning, and utilization management platform)
- Provider Relationship Management (PRM: **I**) - our integrated Provider data management, contracting, and service system
- AMISYS Advance (**J**) - our enterprise claims processing and payment system,
- Centelligence™ Enterprise Data Warehouse (EDW) (**K**) - Centene's behavioral and medical decision support, reporting and data integration engine, powered by Teradata's Extreme Data appliance

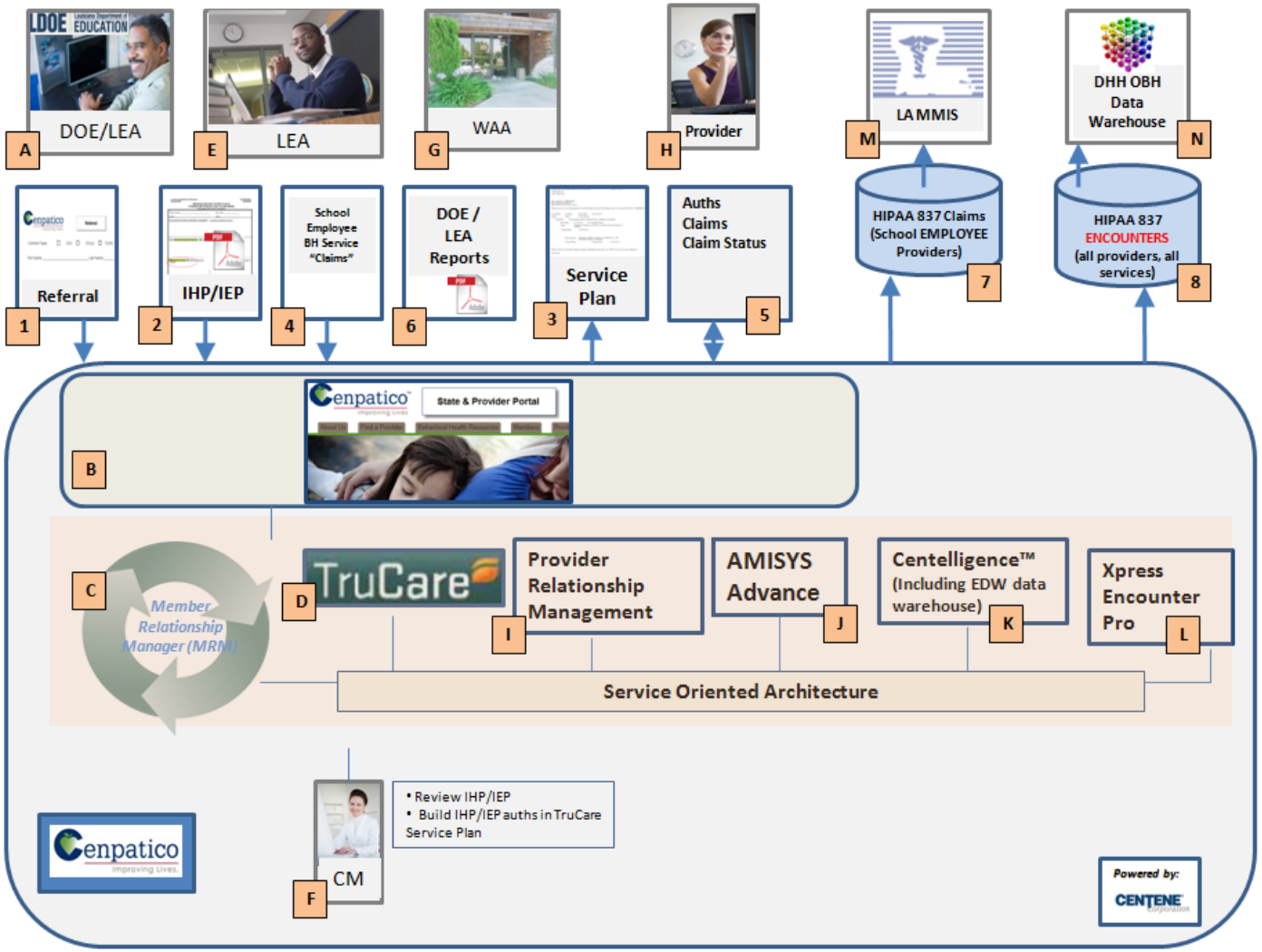
Please see Section 2.g.vifor more information on our State Agency Portal and the referral process. Subsequent to the child's referral and enrollment, an authorized LEA user (**E**) of our Agency Portal will be able to upload a DOE Individualized Healthcare Plan (IHP) or Individualized Education Plan (IEP) (**2**) as a PDF attachment, which our Agency Portal (**B**) will attach to our Member Record in TruCare, systematically invoking an action workflow item in TruCare (**D**) for the responsible Cenpatico Care Manager (CM: **F**) to review the IHP/IEP and create the necessary authorizations in TruCare. The CM will also build the online TruCare Service Plan (**3**) based on information in the IHP/IEP, and this TruCare Service Plan is then available for viewing online by any authorized user of our State or Provider Portal - including DOE and authorized LEA users (**A** and **B**); the WAA (**G**), if this is a CSoC case, and appropriate network providers (**H**) participating in the treatment of the child. Item **H** also represents "school based providers" in our network who are not school employees, and these providers will submit

authorizations (as necessary) and submit HIPAA compliant claims (5) for services rendered to the child. The appropriate LEA authorized user will submit HIPAA compliant claims (4) (as discussed above) either via paper or through our DDE feature. Note that our PRM (I) will house information on all our providers - including "LEA school employee providers"(essentially represented by E), "school based" network providers, and (of course) all of our network providers (H). PRM systematically feeds provider data to AMISYS Advance (J), so that, when a claim is submitted - however it is submitted, AMISYS Advance can match the member, the provider (including the "LEA school employee provider"), with the appropriate benefit plan (e.g. Medicaid, CSOC/Medicaid, non-Medicaid), appropriate authorizations (fed in near real time from TruCare (I)), and the claim's "dates of service" with appropriate eligibility span in the member record (fed to AMISYS Advance by MRM (D). Thus, AMISYS Advance can process a claim from a "LEA school employee provider" (4), and ***not*** pay the claim directly to the LEA, but - instead - produce that claim as a HIPAA 837 encounter with appropriate instructions to pay or not (depending on validation of provider, member, and authorization from the IHP/IEP). AMISYS Advance will output these "school employee provider" adjudicated claims to our Centelligence EDW (K), where our Xpress Encounter Pro system (L) will produce a HIPAA 837 Claims file for payment, as appropriate, by the Louisiana MMIS (M: per RFP requirements) to the LEA.

School based and other Cenpatico network providers (H) who submit claims for the child, will be paid by Cenpatico. For these claims, AMISYS Advance will (again) adjudicate against the member, provider, benefit plan (as determined by the eligibility span dates and dates of service on the claim), and authorizations if required. We will not send these claims to the MMIS (7). However, we *will* send HIPAA 837 encounters of these paid claims (8) to the DHH-OBH Data Warehouse (N). Unless otherwise specified by DHH-OBH, in item 8 we will plan to include *all* encounter data in the encounter data portion of our bi-weekly dataset feed to DHH-OBH (including the data we send to the MMIS in item 7).

Finally, per RFP requirement Section II.B.2.r.xvii., we will produce applicable utilization data for DOE and the LEA's (6). We will create these reports using the Centelligence™ Insight (Insight) module of our EDW. Insight is powered by our Enterprise Business Objects decision support suite of integrated business intelligence applications. Please see our Section 2.g.xxii (Reporting) for more information on our Centelligence™ based reporting capabilities. The reports depicted in item 6 are possible because our EDW data integration engine will house (or have near real-time SOA message based access to) member, provider (including network, WAA, FSO, and "LEA school employee provider"), claims, and clinical data (including authorization data).

Figure 2.g.xxx.-1: DOE Encounter & School Based Provider Claim Flow



2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxxi. Provide a list of the system edits and their description to be used when processing the medical claims.
Suggested number of pages: 8

Cenpatico and our parent company Centene Corporation have developed comprehensive clinical and data related edits that may be triggered at varying stages of the claims adjudication process. Each of these stages is supported by various technologies that offer flexible, adaptable, and dynamic configuration rules, allowing us to incorporate DHH-OBH specific policies regarding claims submission, adjudication and payment. These technologies integrate Cenpatico and Centene policies and procedures, and are kept current with nationally recognized claim coding guidelines. Below is a description of each edit phase in the cycle, and a general description and specific examples of the edits a claim may experience.

HIPAA Electronic Data Interchange (EDI) Edits

Electronically submitted claims data are validated on all inbound and outbound EDI transactions, including the 837P and 837I claims transactions, using Edifecs XEngine (XEngine) software. XEngine supports HIPAA testing standards as defined by the Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP), and allows us to configure edits, or testing, for our specific business rules. XEngine edits validate data against X12 syntax and rules for data structure; test to ensure conditional rules requiring secondary fields are completed accurately and completely; and ensure all data is in compliance with Cenpatico Companion guides. These upfront edits not only ensure that transactions are compliant with federal mandates and state rules but they allow us to be more efficient in our processing by recognizing and rejecting problematic transactions in the earliest stage of the process, and sending notification to our trading partners through the TA1/997 Acknowledgement transaction. This rapid turnaround allows our providers to correct and resubmit these claims as quickly as possible for adjudication and payment. We currently validate claims transactions through SNIP Level 4 on our inbound claims and are working toward Level 5 SNIP testing leveraging Edifecs XEngine and Ramp Manager tools. These levels include ***Level 1:*** Integrity Testing: general testing of the X12 syntax and rules; ***Level 2:*** Requirement Testing: testing for the HIPAA implementation guide's specific requirements; ***Level 3:*** Balancing: testing for balanced amount fields, etc; ***Level 4:*** Situational Testing: testing of specific segment situations (if A occurs then B is required); and ***Level 5:*** Code Set Testing.

HIPAA EDI Compliance. HIPAA format adherence is verified real-time using our EDIFECS X-Engine compliance software which improves our claim auto-adjudication rate and the quality of the downstream encounter data we process and submit to our state clients, such as DHH-OBH. X-Engine validates data against X12 syntax and rules for data structure; tests to ensure conditional rules requiring secondary fields are completed accurately and completely; and ensures all data is in compliance with our HIPAA Transaction Companion Guides. These upfront edits not only ensure that transactions are compliant with Federal mandates and DHH-OBH rules, but they improve processing efficiency by recognizing and rejecting problematic transactions in the earliest stage of the process, and sending notification to our trading partners and providers through the ANSI TA1/997 Functional Acknowledgment (FA). This rapid turnaround allows providers to correct and resubmit non HIPAA compliant claims as quickly as possible for adjudication and payment.

Pre-adjudication Edits. EDI and paper claims data are processed through our EDIFECS and TIBCO middleware , to map, translate, and validate the data, ensuring that common edits are consistently applied. We configure TIBCO to validate certain claim data elements, including member, billing and rendering provider and other data elements against data we currently have in AMISYS Advance. If a transaction is rejected for any of the specific reasons configured in TIBCO, an ANSI 277 Unsolicited (277U) notification is systematically sent to the EDI trading partner or submitting provider, conveying the

specific DHH-OBH-approved edit that did not pass our upfront validation processing. Examples of pre-adjudication edits include:

- Member Validation– confirms presence of member record in our systems.
- Validate Dates of Service – confirms that the claim date of service is valid and does not contain future date or a date outside of the member's eligibility span
- Diagnosis Code Validation/ICD9 tables – confirms the presence and accuracy of ICD9 and procedure codes, and all HIPAA codesets.

Six Steps of Adjudication. All claims that successfully pass the pre-processing edits are loaded for adjudication into AMISYS Advance, our core claims processing system. AMISYS Advance accepts the Julian time stamps, for both paper and electronic claims, indicating when the claim was received. This "date stamp" is part of the control number used to identify each unique claim, allowing us to link together all available information surrounding a claim and to track our adherence to claims processing timeliness standards. AMISYS Advance's audit trails retain snapshots of all transactions for current and historic activity. This audit function includes date span logic, historical claims tracking, operator ID stamping, and accommodates the setting of different audit parameters

AMISYS Advance performs *six primary steps of adjudication* that a claim must successfully pass through in logical succession to reach a paid, denied, or internally pended status. These steps are listed below along with a brief description of each and specific examples of edits that will be configured within each step for DHH-OBH claims.

Step 1: Field and General Edits. AMISYS Advance determines the presence and validity of required claim data such as CPT/ICD9 codes and whether the fields are consistent with the business rules outlined by DHH-OBH and federal regulations; as well as age, gender, duplicate, and timely filing edits. Example edits include:

- Procedure Code/ICD9 Code inconsistent with member gender
- Procedure Diagnosis Code deleted, incomplete or invalid
- Invalid Type of Bill

Step 2: Member Eligibility. The system verifies eligibility for service dates and coverage type, and existence of Other Insurance (OI).

- Verifies that a member is eligible during the dates of service indicated on the claim.
- Confirms that we have received premium payments from the state for the member for the coverage period corresponding to the claim dates of service.
- Validates that date fields are complete and appropriate, e.g. ensures that start date is not after end date, for example

Step 3: Provider Eligibility and Status. The system checks the submitting provider's eligibility to see members and receive payment from us as well as the provider's network participation status for the dates of service. Edits include:

- Participating or nonparticipating status is verified
- The provider's financial affiliation is determined
- Pend edits will apply if:
  - The provider TIN or NPI is not on file
  - There are multiple affiliations to choose from under one TIN and/or NPI

Note: In the event a pend occurs for either of the above reasons, Centene has an established process to quickly review and resolve those pends. We have specialists that work specific pend types and the pends are routed automatically by our AWD claim workflow system, integrated with AMISYS Advance, to the

appropriate pend specialist queue. See our discussion below on claims workflow management for more information.

Step 4: Prior-authorization. AMISYS Advance is integrated with TruCare, Cenpatico's integrated, member centric health services management platform where primary authorization data is held. AMISYS Advance is configured to determine if an authorization is required for a specific service, then if applicable, verifies the presence of a prior-authorization, and confirms that the dates of service are within authorization date spans, limits etc. Among the prior authorization edits AMISYS Advance applies are:

- Authorization is or is not on file
- Procedure does or does not match authorization
- Service has or has not exceeded the authorized limit

For more detail refer to the responses for 2.g.xxv and 2.g.xxvii

Step 5: Benefits. To define exactly which services are covered and at what levels, the system determines covered services by applying configured eligibility, provider, and benefit management rules, along with tables of valid procedure codes and ranges; diagnosis codes (HCPCS, CPT-IV, ICD-9-CM diagnosis and procedure codes); service type; member gender and age range; provider type; service location; and benefit limitations. This step determines if a member is eligible for the services rendered, if the service date falls within the effective date of the benefit and meets all the criteria established by DHH-OBH for payment.

- Denial edit will apply if:
  - A service is not covered
  - A service has exceeded the benefit limit
- Pend edits will apply if a service has exceeded a benefit amount

Step 6: Pricing. AMISYS Advance prices the claim by applying any member third party liability (TPL) or coordination of benefits (COB) information, copayments or deductible amounts, and provider specific contractual and financial agreements. This step also applies DHH-OBH reimbursement rules such as limiting payment for non contracted in-state and out-of-state providers for emergency services to no more than the DHH-OBH rate. Pricing edits include:

- AMISYS Advance applies appropriate COB And TPL Rules for the specific health plan (e.g. CCN-P), to compute final provider payment.
- If the provider is out of network the appropriate fee schedule is applied.
- When appropriate, pend queues are set up to review claims (by senior claims staff) to determine appropriate pricing, for example:
  - First time claim submission from non-participating providers
  - Claims that exceed high dollar billing thresholds

Clinical Edits

Once claims pass adjudication in AMISYS Advance, they are further analyzed by ClaimsXten® (CXT) to determine clinical appropriateness of claim coding. CXT contains a comprehensive set of rules based on nationally recognized coding guidelines (cited below), which address coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, over-utilization standards, invalid codes, and mutually exclusive procedures. These edits are based on generally accepted principles of coding medical services for reimbursement and are not based on medical necessity, nor are they designed to make reimbursement or payment decisions. Instead, CXT offers a recommendation that is applied to the claim when a provider's coding pattern is unsupported by a coding principle. CXT's flexible configuration tools allow Cenpatico to customize these edits by incorporating Cenpatico provider coding/reimbursement policies and DHH-OBH benefit criteria into the applicability of these edits. For example, the American Medical Association (AMA) recommends therapy codes be limited to only one unit per day. Cenpatico's policy allows providers to bill more than one unit a day for therapy codes based on the amount of time spent

with the member; therefore, this edit is not applicable and would be set to ignore. Standard edits provided by CXT are based on nationally recognized guidelines, including but not limited to:

- American Medical Association (AMA): CXT utilizes the CPT Manuals, CPT Assistant, the AMA website, and other sources
- Centers for Medicare & Medicaid Services' (CMS): In addition to using the AMA's CPT manual, CMS offers a variety of edits including the National Correct Coding Initiative (CCI) for professional and outpatient services
- American Board of Anesthesiology: CXT offers edits based on this and other specialty boards

Below are a few examples of the edits that are performed with ClaimsXten:

- Unbundling: submission of a global CPT/HCPCS code along with other CPT/HCPCS codes that are considered included in the global code billed
- Multiple Surgical Reductions: submission of multiple surgical procedures performed on the same day during the same operative session, which requires price reduction of secondary procedures
- Global Surgical Period: addresses the payment/nonpayment of evaluation and management services billed during the global surgical period of another procedure

Fraud, Waste and Abuse Edits

Centene has entered into a strategic partnership with Verisk's HealthCare Insight (HCI) to further evaluate claims to detect clinical coding errors, inaccuracies, and potential fraudulent behaviors in billing. Through HCI's Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, Cenpatico is able to provide DHH-OBH with proactive fraud, waste and abuse detection/prevention services and an additional screening of clinical billing discrepancies, without disrupting claims turnaround time to any material degree. HCI's clinical edits are based on national coding standards as well as some proprietary rules, and augment and compliment those performed by our Claims Xten software. Once a claim passes through all the edits described above and reaches a status of paid, we provide HCI with a paid claims file along with a historical claims file containing our behavioral health claims. By providing the claim history files, HCI can assess claims based on patterns of claims submissions from a provider such as analyzing medications ordered versus substantiating the need for those medications through supporting medical claim data. HCI then evaluates these files utilizing their proprietary code validation and profiling software. HCI conducts an initial sweep of the paid claims file (typically within two hours) and returns notification of claims failing the edits requiring further review and evaluation by HCI's certified coders and licensed nurses. We are then able to release all claims successfully passing the HCI edits and suspend only those requiring additional review as notified by HCI. Upon completion of their review, typically within 12 hours of the claim failing the edits, HCI makes a pay/deny recommendation to Cenpatico based on a review of the immediate claim and the patient's claim history. Prior to finalizing the claim, our Claims Compliance Team reviews and approves or denies all HCI recommendations.

The types of edits typically encountered within PCI and FFP include national correct coding (NCCI) edits; procedure upcoding; and multiple radiology reductions. We generate a notification of Remittance Advice (RA) for any claim failing edits throughout the various stages of claims adjudication. The RA clearly outlines for the provider the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable. In addition, we furnish copies of claims processing and coding guidelines to providers in writing and through our Provider Portal utilizing the Clear Claim Connection tool designed by McKesson Information Solutions, Inc. The tool "mirrors" how Cenpatico's claims software evaluates medical code combinations during the adjudication of a claim allowing providers access to Cenpatico's claim auditing rules and clinical rationale. The result: cleaner claim submissions, quicker claim turnaround time, and successful encounter processing.

Claims Adjudication Edits. AMISYS Advance handles member enrollment and eligibility, authorization management, benefits management, coordination of benefits, and premium payment processing. After pre-processing, AMISYS Advance executes six adjudication steps for each claim to reach a paid, denied,

or internally pended status, please refer to the response for 2.g.xxv for details. During adjudication, explanation codes (EX codes) will be assigned by service line based on the adjudication outcome. Up to six (6) EX codes can be assigned per service line although rarely are more than two assigned. Cenpatico has developed several hundred EX codes as edits will be created specific to each market or benefit if necessary. The most commonly received edit codes are in the following table. For perspective on the frequency in which certain system edits impact claims, the explanation codes attached to claims processed in a one-week period for Cenpatico were counted and the volume is displayed.

Explanation Code	Explanation Code Description	Count	Type
EX92	PAID ACCORDING TO CONTRACT / PROCESSING GUIDELINES	30,010	Pay
EXVI	GLOBAL FEE PAID	1512	Pay
EXJ0	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER	343	Pay
EXJU	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM	299	Pay
EXMX	PAY: MAXIMUM ALLOWABLE HAS BEEN PAID BY PRIME INS	149	Pay
EXPK	PAY: MULTIPLE REFERRING AFFILIATIONS QUALIFY	106	Pay
EXJW	ADJUSTMENT: ORIGINAL SERVICE PAID INCORRECT AMOUNT	84	Pay
EXJO	ADJUST: NOT A COVERED BENEFIT	44	Pay
EXJA	ADJUSTMENT: PAY ON APPEAL	39	Pay
EXJB	ADJUST: RECEIVED COB PAYMENT	14	Pay
EXJV	ADJUST: OTHER INSURANCE PAID PROVIDER	12	Pay
EXJN	ADJUST: DUPLICATE PAYMENT	8	Pay
EXJT	ADJUST: PROCESSED FOR INCORRECT MEMBER	6	Pay
EXPJ	PAY: REFERRING PROVIDER AFFILIATION NOT FOUND	4	Pay
EX0Z	AURORA PROVIDERS - NO AUTH REQ'D	2	Pay
EXG3	PENDED CLAIM REVIEW COMPLETED	1471	Info
EX0Y	AUTH WAIVED FOR ALL PROF OPT SVCS EXCEPT PSYCH TESTING	42	Info
EX18	DENY: DUPLICATE CLAIM/SERVICE	1149	Deny
EXA1	DENY: AUTHORIZATION NOT ON FILE	1149	Deny
EX29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED	932	Deny
EX35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED	821	Deny
EXL6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.	695	Deny
EX5L	DENY: BENEFIT LIMIT FOR SERVICES WITHOUT AN AUTHORIZATION HAS BEEN MET	581	Deny
EXZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY	570	Deny
EXMA	PROVIDER NPI, TAX ID,AND/OR TAXONOMY NOT ON STATE FILE	553	Deny
EXDZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	468	Deny
EXIM	DENY: RESUBMIT WITH CORRECT MODIFIER	425	Deny
EXNT	DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT	295	Deny
EXMP	DENY: PLEASE RESUBMIT TO THE MEDICAL PLAN FOR CONSIDERATION	240	Deny
EX28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED	233	Deny
EXMQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT	186	Deny
EXP6	SERVICE PAYABLE ONLY ONCE PER DAY	149	Deny
EXZW	AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS	141	Deny

Explanation Code	Explanation Code Description	Count	Type
EXNE	DENY: PLEASE SUBMIT CLAIM TO MANAGED HEALTH SERVICES (MHS)	131	Deny
EXHT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	106	Deny
EX46	DENY: SERVICE NOT COVERED, PROVIDER RESPONSIBILITY, DO NOT BILL MEMBER	94	Deny
EXHP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING	85	Deny
EXLO	DENY: CPT/HCPC/REV CODE & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.	85	Deny
EXXE	REVENUE/PROCEDURE CODE BILLED FOR THE DIAGNOSIS SUBMITTED IS NOT COVERED	80	Deny
EX4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT	74	Deny
EXHF	DENY:PROCEDURE DOES NOT MATCH AUTHORIZATION	74	Deny
EX51	DENY : PLEASE RESUBMIT CLAIM TO THE STATE FOR CONSIDERATION	66	Deny
EXDS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS	66	Deny
EXEB	DENY: DENIED BY MEDICAL SERVICES	55	Deny
EX0H	ADJUSTMENT: PROVIDER BILLED INCORRECTLY & SUBMITTED REIMBURSEMENT	54	Deny
EXZL	DENY:SERVICE IS LIMITED TO ONE PER DAY	52	Deny
EX86	DENY: CODE WAS SUBMITTED WITH AN INVALID MODIFIER OR TOO MANY MODIFIERS	45	Deny
EX0B	ADJUST: CLAIM TO BE RE-PROCESSED/CORRECTED UNDER NEW CLAIM NUMBER	29	Deny
EX6L	EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL	25	Deny
EX0I	ADJUSTMENT: ADJUSTED PER CORRECTED BILLING FROM PROVIDER	21	Deny
EXI1	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT	21	Deny
EXHZ	DENY: LOCATION CODE IS NOT VALID	16	Deny
EXRD	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.	16	Deny
EX17	DENY: REQUESTED INFORMATION WAS NOT PROVIDED	14	Deny
EXDX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.	14	Deny
EXHX	DENY: MUST BE BILLED SAME DAY AS CORRESPONDING CODES	14	Deny
EXK4	DENY: MEMBER IS NOT THE RESPONSIBLITY OF MANAGED HEALTH SERVICE	14	Deny
EXQR	DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT	14	Deny
EXY6	DENY:INSUFFICIENT INFO FOR PROCESSING,RESUBMIT W/PRIME'S ORIGINAL EOB	14	Deny
EXZR	INAPPROPRIATE DIAGNOSIS FOR BEHAVIORAL HEALTH/SUBSTANCE ABUSE SERVICES	13	Deny
EX3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT	12	Deny
EXKZ	DENY: INVALID PLACE OF SERVICE, PLEASE CONSULT THE PROVIDER MANUAL	12	Deny
EX5D	REVENUE CODE CAN ONLY BE BILLED ONCE PER DAY	10	Deny
EXLP	DENY: SERVICE LOCATION NOT APPROPRIATE FOR PROCEDURE	10	Deny
EXLR	DENY:WHEN PRIME INS.RECIEVES INFO-RESUBMIT TO	10	Deny

Explanation Code	Explanation Code Description	Count	Type
	SECONDARY INS.		
EX96	DENY: SERVICE CAN NOT BE COMBINED WITH OTHER SERVICE ON SAME DAY	9	Deny
EXEC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT	8	Deny
EXFP	DENY: CLAIMS DENIED FOR PROVIDER FRAUD.	8	Deny
EXMG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT	8	Deny
EX10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX	7	Deny
EXAQ	DENY:BILLED SERVICE DOES NOT MATCH UNITS/DATES - CORRECT AND RESUBMIT	6	Deny
EX09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE	5	Deny
EXIE	DENY: THIS CPT IS BILLABLE ONCE PER CALENDAR YEAR PER MEMBER W/O AN AUTH	4	Deny
EXIX	DENY: CPT IS BILLABLE ONCE PER 6 ROLLING MONTHS PER MEMBER W/O AN AUTH	4	Deny
EXYU	ADJUST BASED ON APPEAL RECEIVED. UPHELD ORIGINAL DENY DECISION	4	Deny
EXN8	INCORRECT NPI FOR PROVIDER	3	Deny
EXOD	DENY: SERVICES ARE LIMITED TO ONE PER PROVIDER, PER DAY	3	Deny
EXSV	DENY: SERVICE NOT PAYABLE IN THIS LOCATION FOR SPECIALTY	3	Deny
EXHL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH	2	Deny
EXVC	DENY: INAPPROPRIATE MODIFIER FOR PROVIDER SPECIALTY	2	Deny
EX0M	ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM	1	Deny
EX50	DENY:NOT A MCO COVERED BENEFIT	1	Deny
EXND	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE	1	Deny

Cenpatico also has edit descriptions defined for when claims pend. The following table shows the most common pend codes.

Explanation Code	Explanation Code Description	Type
EX64	PEND: ERROR IN ANY FIELD PASSED THRU CODE AUDITING SOFTWARE	PEND
EX66	CODE IS BEING QUESTIONED BY CODE AUDITING SOFTWARE	PEND
EX88	PEND: PENDED FOR CLAIMS TRAINING REVIEW	PEND
EX0K	PEND: ROUTE TO ADJUSTMENT QUEUE	PEND
EX0L	PEND: ROUTE TO A2 COB ADJUSTMENT	PEND
EX0P	PEND: MOR: Member qualifies for ABA Services	PEND
EX0T	PEND: CLAIM SUBMITTED WITH AUTH INDICATED - MANUAL REVIEW REQUIRED	PEND
EX1A	PEND: GROUP,DIVISION,CONTRACT,MEMBER RECORD/SPAN MISSING OR OVERLAPPING	PEND
EX1S	PEND: PROVIDER CONTRACT IS NOT ON FILE.	PEND
EX1U	PEND: DOSE MORE THAN RECOM UNITS PER DOSE REQUIRES CLINICAL REVIEW	PEND
EX5T	PEND: UNITS OF SVC GREATER THAN MAX DAILY UNIT ALLOWED	PEND
EX5X	PEND: INVALID PROC CODE, MODIFIER, AND PLACE OF SVC COMBINATION	PEND
EX5Y	PEND: MODIFIER 1,2,3 OR 4 IS INVALID ACCORDING TO STATE REFERENCE TABLE	PEND

Explanation Code	Explanation Code Description	Type
EX6A	PEND - Partial Approval	PEND
EX6F	PEND: INVALID TOB	PEND
EX6H	PEND: ADMIT TYPE IS BLANK	PEND
EX6I	PEND: DIAG CODE (SVC &/OR CLM) INVALD ACCORDING TO STATE REFERENCE TABLE	PEND
EX6K	PEND: DATA VALIDATION DUP	PEND
EX6P	PEND: FOR REVIEW BY MEMBER SERVICES	PEND
EX7A	PEND - Partial Approval, on Appeal	PEND
EX7P	PEND: FOR REVIEW BY APPEALS COORDINATOR	PEND
EX9A	PEND: AWAITING ADDITIONAL INFORMATION -CLAIM QUESTIONED BY CODEREVIEW	PEND
EX9G	PEND: MRU REVIEWING CLAIM	PEND
EX9W	PEND: ADJUSTED CLAIM WITH PAID SERVICE LINES	PEND
EX9Z	PEND: PROVIDER ON REVIEW FOR NEGATIVE BALANCE RECONCILIATION	PEND
EXA0	PEND - CHECK FOR AUTH WAIVER	PEND
EXA9	PEND: TOTAL NUMBER OF DAYS IS GREATER THAN COVERAGE PERIOD	PEND
EXAP	PEND: PAY SERVICE IF AUTHORIZED. DENY WITH EX=35.	PEND
EXAU	PEND: MULTIPLE AUTHORIZATIONS QUALIFY, PICK CORRECT AUTH.#	PEND
EXAY	PEND: ANESTHESIA SERVICE MUST BE ON THE SAME DATE OF SERVICE TO PAY	PEND
EXB4	PEND: SERVICE DOES NOT MAP TO EXISTING BENEFIT	PEND
EXB5	PEND: COUNTER TABLE IS FULL,COUNTER EXCEEDED OR AMOUNTS INCOMPATIBLE	PEND
EXB9	PEND: MULTIPLE BANK CODES, ROUTE TO BENEFIT CONFIGURATION	PEND
EXBA	PEND: DUPLICATE MEMBER RECORDS, PLEASE CORRECT.	PEND
EXBC	PEND: MEMBER CHANGED BENEFIT PACKAGES DURING HOSPITALIZATION	PEND
EXBL	PEND: SERVICE EXCEEDS THE BENEFIT LIMIT. SPLIT SERVICE AND REPROCESS	PEND
EXC3	PEND: POSSIBLE DUPLICATE SERVICE	PEND
EXC7	PEND: VERIFY ANESTHESIA UNITS ON SWITCH TABLE	PEND
EXcf	PEND: WAITING FOR CONSENT FORM	PEND
EXCP	PEND: MEMBER CHANGED PROGRAMS DURING CLAIM COVERAGE PERIOD	PEND
EXCQ	PEND: SPLIT SERVICES TO CAPTURE CORRECT UNITS BILLED	PEND
EXCR	PEND: PROVIDER NEEDS TO BE CREDENTIALED	PEND
EXCW	PEND:MED&SURG DAYS AUTH'D/LOOK AT AUTH REMARKS FOR DAYS	PEND
EXCZ	PEND: CLAIMS VERIFY CORRECT PROVIDER/AFFILATION WAS PICKED	PEND
EXD5	PEND: MODIFIER SUPER TABLE ENTRY IS MISSING OR INVALID	PEND
EXDA	PEND: FEE NOT FOUND	PEND
EXDF	PEND: MANUAL PRICING REQUIRED	PEND
EXDO	PEND: POSSIBLE DUP SERVICE HITTING AGAINST A PREV DENIED SERVICE	PEND
EXE7	PEND: PLEASE CHECK FOR INPATIENT FACILITY AUTHORIZATION	PEND
EXEP	PEND: VERIFY ELIGIBILITY AND PRICING. PROCESS MANUALLY.	PEND
EXET	PEND: VERIFY ECT TREATMENT BEFORE COVERING ANESTHESIA SERVICES	PEND
EXEZ	ROUTE TO CLAIMS MANAGER	PEND
EXFF	PEND: MULTIPLE COUNT SHOULD ONLY PAY 1 AT FLAT RATE	PEND
EXFR	PEND: MEMBER ON REVIEW - FRAUD INVESTIGATION UNDERWAY	PEND
EXGH	PEND: POSSIBLE MEDICAL / SURGICAL CLAIM	PEND
EXH5	PEND: ENTER CPT/HCPCS INSTEAD OF REV CODE & MANUALLY PRICE	PEND

Explanation Code	Explanation Code Description	Type
EXHB	PEND: CLAIM AND AUTH DATES OF ADMISSION NOT MATCHING	PEND
EXHf	PEND:PROCEDURE DOES NOT MATCH AUTHORIZATION	PEND
EXI8	PROVIDER ON REVIEW FOR INTERNAL AUDIT	PEND
EXIi	PEND: MEMBER ON REVIEW - DUAL INSURANCE ISSUE (MEDICARE-MEDICAID)	PEND
EXIR	PEND: PROV ON REVIEW FOR IRS LEVY, SEND PAYMENTS TO IRS	PEND
EXIS	SYSTEM OR CONFIG PROBLEM, SEND CLAIM TO IS DEPARTMENT.	PEND
EXIT	PEND: PROVIDER UNDER FRAUD INVESTIGATION	PEND
EXKF	PROVIDER ON REVIEW	PEND
EXL3	PEND: MEMBER OTHER COVERAGE INCOMPLETE OR NO RESPONSE	PEND
EXL7	PEND: MAKE SURE MEDICARE ALLOWED/PAID IS ENTERED	PEND
EXL9	PEND: T-19 MEMBER HAS OTHER INSURANCE - NEED TO VERIFY.	PEND
EXLA	PEND:OTHER INSURANCE IS EITHER HMO OR PPO	PEND
EXLD	PEND: PLEASE CHECK FOR PRESENCE OF ECT AUTHORIZATION	PEND
EXLL	PEND: CLAIM IS SET TO PAY OVER AUDIT AMOUNT ($10,000 FOR H, $5000 FOR M)	PEND
EXM4	MULTIPLE EDITS BY CODEREVIEW	PEND
EXM9	SEND TO ENROLLMENT DEPARTMENT	PEND
EXMB	PEND: ELIGIBILITY FOR STATE VERIFICATION	PEND
EXMC	ERROR ON SUPER TABLE FIND FOR MEMBER CARRIER	PEND
EXME	PEND: MEMBER ON REVIEW - ELIGIBILITY UNDER REVIEW	PEND
EXNQ	PROVIDER SET-UP PROBLEM, SEND TO NETWORK QUALITY DEPARTMENT	PEND
EXof	PEND: OFFICE VISIT LIMIT EXCEEDED (1 PER DAY)-PENDING FOR CLAIMS REVIEW	PEND
EXOO	PEND: CHECK PRINCIPAL ICD-9 PROCEDURE CODE IN MASTER AND DETAIL SCREEN	PEND
EXOR	PEND: MAX AMOUNT ALLOWED REACHED, CHECK FOR AUTH - ELSE DENY:AC	PEND
EXPG	PEND: SERVICE PROVIDER AFFILIATION NOT FOUND	PEND
EXpO	PEND: REQUIRES MANUAL PROCESSING FOR POA REQUIREMENTS	PEND
EXRd	PEND:PROV BILLED OVER $1000 IN DAY VERIFY AUTHORIZED AMT	PEND
EXRK	Recovery Claim Investigation	PEND
EXse	PEND: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX	PEND
EXSG	PEND: POSSIBLE SUBROGATION CASE	PEND
EXSP	PEND: REVIEW FOR SPECIAL CONSIDERATION - LOOK FOR AUTH	PEND
EXT8	PEND: SENT FOR COB AUTHORIZATION SET-UP	PEND
EXTP	ROUTE TO TPL DEPARTMENT - OTHER INSURANCE	PEND
EXU2	PEND: UNLISTED PROCEDURE NEED RECORDS TO PROCESS	PEND
EXU7	PEND: PROVIDER ON REVIEW - DUE TO MISSING OR INSUFFICIENT INFORMATION	PEND
EXU9	PEND CLM RESOULTION 10 NO DOLLARS BEING PAID	PEND
EXUJ	PEND: UR REVIEWING DOCUMENTATION	PEND
EXUL	PEND SUM AMTPAY GREATER THAN TOT AMT CHARGE FOR CLAIM	PEND
EXX1	PENDED BY AUDITOR	PEND
EXX3	PEND: SYSTEM DEFAULT ERROR (INQUIRY)	PEND
EXXP	PEND:PENDING STATE MEDICAID ENROLLMENT	PEND
EXXZ	PEND: CONTRACT IS IN INFORMATION SYSTEM DEVELOPMENT	PEND
EXyc	PEND: PENDED PER INTERNAL COMPLIANCE REVIEW	PEND
EXYW	DUPLICATE PROVIDER FOUND WITH SAME NPI AND TIN	PEND

Explanation Code	Explanation Code Description	Type
EXz4	PEND: SYSTEM DEFAULT ERROR FOR CLAIMS SUBSYSTEM	PEND
EXz5	PEND: SYSTEM DEFAULT ERROR FOR PRICING SUBSYSTEM	PEND
EXz6	PEND: SYSTEM DEFAULT ERROR (BENEFIT)	PEND
EXz7	PEND: SYSTEM DEFAULT ERROR (AUTHORIZATION)	PEND
EXz8	PEND: SYSTEM DEFAULT ERROR (MEMBER ELIGIBILITY)	PEND
EXz9	PEND: SYSTEM DEFAULT ERROR (CAPITATION)	PEND

2.g. Technical Requirements
xxxii. Provide the policy and procedure for fraud detection in claims submissions.

Cenpatico will cooperate and assist DHH-OBH and any other State or federal agency in identifying, investigating, sanctioning or prosecuting suspected waste, abuse or fraud (WAF) in the LBHP program. Cenpatico's Waste, Abuse and Fraud (WAF) Plan (*see policies and procedures below*) provides detailed guidance for the prevention, detection and resolution of billing conduct and other activities (related to WAF) that do not conform to federal and State laws and regulations. Our staff, providers, members, and subcontractors play key roles in our WAF Plan, and Centene's Special Investigation Unit (SIU) provides dedicated resources for the investigation and technical support needed to operate an effective WAF Plan. Our Plan incorporates best practices identified by the National Health Care Anti-Fraud Association (NHCAA), of which Centene is a member, and it will be fully compliant with all applicable State and federal laws and regulations, including all relevant DHH-OBH requirements.

WAF Plan Objectives. Cenpatico's WAF Plan objectives are to: 1) prevent waste, abuse and fraud; 2) provide a systematic method for identifying, investigating and taking corrective action against any provider suspected of improperly billing for services; 3) ensure that all Cenpatico providers, subcontractors, officers, directors, managers and employees understand the WAF Plan and their role in the process; 4) ensure confidential reporting of WAF issues and prevent retaliation against providers, members and staff for reporting incidents; and 5) provide a method for reporting investigated cases of WAF to the DHH-OBH.

Program Components - Accountability. All Cenpatico and Centene staff are responsible for carrying out our WAF Plan. Our Cenpatico Director of Compliance (Director) in Louisiana will provide daily oversight and will coordinate WAF efforts with Centene's SIU, which investigates all potential WAF cases with the help of the Cenpatico Director. Our inter-departmental Fraud Control Committee, a subcommittee of our Compliance Committee, will meet on a regular basis to coordinate and oversee WAF activities. Cenpatico's CEO will have overall responsibility and authority for the Program.

Program Components – Prevention. Cenpatico will use the following approaches to prevent potential waste, abuse and fraud:

Employee Training and Expertise. All Cenpatico employees are responsible for reporting potential WAF cases. To support this mandate, we will educate all employees on how to identify and report potential or actual instances of WAF. New staff will be trained within 90 days of employment and all employees will receive annual training thereafter. To stay current with WAF trends and schemes, SIU investigators, analysts and managers attend workshops conducted by the NHCAA that address such topics as: overutilization, long term care fraud, pharmacy fraud, emerging schemes, prosecutorial challenges and medical tourism. The SIU Senior Director is a certified coder and an expert in health care fraud and abuse. Also, several SIU investigators have achieved Certified Professional Coder (CPC) certification.

Provider and Member Education**.** Cenpatico will also educate providers and members about WAF prevention through the Provider Manual and Member Handbook; Provider and Member Newsletters; the Provider web portal; and through provider and member orientations. Our materials provide guidance to members about how to report persons suspected of abusing program benefits, and all training sessions and educational materials encourage members and providers to report suspected WAF cases. Beyond this, since we will be introducing brand new Medicaid coding principles to some providers, our teams will focus on meeting providers where they are and working with them to learn and/or change certain practices. We expect this to be an ongoing activity but will require particular focus during implementation and in year one. These mentoring sessions will also include explanations of how our systems perform data mining and triggering for potential fraud or abuse at a high level to reinforce the systematic approach.

Post Investigation Targeted Provider Education and Prepayment Review. If wasteful provider billing patterns are detected, the SIU will develop an educational letter which outlines the inappropriate billing

trend, and will include appropriate documentation that supports the SIU's position. Our teams will work one-on-one with the provider to determine if additional training is needed or if more stringent steps are required. The SIU may also place providers on prepayment review at the request of DHH-OBH or if audits reveal a pattern of inappropriate billing.

Program Components –Detection. Cenpatico will detect potential fraud and abuse using the following:

Cenpatico is committed to detecting, preventing and reporting waste, abuse and fraud (WAF) in connection with its claims review and adjudication processes.

As described in the response to 6.j, we will implement a WAF Plan which provides resources for detecting and reviewing suspected WAF cases. The Plan includes tools for detecting suspected WAF, such as billing irregularities, and a dedicated team of local Compliance Auditors as well as resources from these teams through our parent Company, Centene Corporation:

- Special Investigations Unit;
- Compliance Coding Management Department; and
- Internal Audit Department.

We utilize several tools to help detect suspect WAF when applying our claims review and adjudication processes.

1. Prepayment Editing/Claims System Edits.

   Centene's Compliance Coding Management (CCM) Department will use ClaimsXten code editing software to review claims against common coding standards established by the American Medical Association (AMA), the Centers for the Medicare & Medicaid Services (CMS) and medical specialty societies.

   ClaimsXten identifies such potential fraud triggers as unbundling, mutually exclusive codes, procedure frequency-by-day, and age/gender discrepancies. The CCM regularly reviews edit results and will report concerns to Cenpatico and the SIU. In addition, the CCM will provide Cenpatico with reports that assist with educating providers on appropriate coding practices.

2. Claims Payment Audit.

   Centene's Internal Audit Department (Internal Audit) completes periodic, comprehensive audits on statistically valid samples of all processed claims, and validates whether a claim was authorized, entered and processed correctly, paid timely and to the correct provider. They refer any suspicious claims to the SIU for further investigation.

3. Fraud, Waste and Abuse Edits

   Centene has entered into a strategic partnership with Verisk's HealthCare Insight (HCI) to further evaluate claims to detect clinical coding errors, inaccuracies, and potential fraudulent behaviors in billing.

   Through HCI's Physician Claim Insight (PCI) and Fraud Finder Pro (FFP) programs, Cenpatico is able to provide DHH-OBH with proactive fraud, waste and abuse detection/prevention services and an additional screening of clinical billing discrepancies, without disrupting claims turnaround time to any material degree. HCI's clinical edits are based on national coding standards as well as some proprietary rules, and augment and compliment those performed by our Claims Xten software.

   Once a claim passes through all the edits described above and reaches a status of paid, we provide

HCI with a paid claims file along with a historical claims file containing our behavioral health claims. By providing the claim history files, HCI can assess claims based on patterns of claims submissions from a provider such as analyzing medications ordered versus substantiating the need for those medications through supporting medical claim data.

HCI then evaluates these files utilizing their proprietary code validation and profiling software. HCI conducts an initial sweep of the paid claims file (typically within two hours) and returns notification of claims failing the edits requiring further review and evaluation by HCI's certified coders and licensed nurses.

We are then able to release all claims successfully passing the HCI edits and suspend only those requiring additional review as notified by HCI. Upon completion of their review, typically within 12 hours of the claim failing the edits, HCI makes a pay/deny recommendation to Cenpatico based on a review of the immediate claim and the patient's claim history. Prior to finalizing the claim, our Claims Compliance Team reviews and approves or denies all HCI recommendations.

The types of edits typically encountered within PCI and FFP include national correct coding (NCCI) edits; procedure upcoding; and multiple radiology reductions. We generate a notification of Remittance Advice (RA) for any claim failing edits throughout the various stages of claims adjudication.

- The RA clearly outlines for the provider the reason(s) for claim denial, along with instructions for correction and resubmission, if applicable. In addition, we furnish copies of claims processing and coding guidelines to providers in writing and through our Provider Portal utilizing the Clear Claim Connection tool designed by McKesson Information Solutions, Inc.
- The tool "mirrors" how Cenpatico's claims software evaluates medical code combinations during the adjudication of a claim allowing providers access to Cenpatico's claim auditing rules and clinical rationale. Further, we will be working one-on-one with providers to ensure we are assisting them to improve. The result: cleaner claim submissions, quicker claim turnaround time, and successful encounter processing.

Please reference also our response to section 2.g.xxix.

Centene Policies and Procedures for Waste, Fraud and Abuse

SCOPE: Centene's Corporate Special Investigations Unit (SIU)

PURPOSE: To implement a Waste, Abuse and Fraud (WAF) Plan that prevents potential health risks to our members and minimizes exposure to erroneous, wasteful or fraudulent activities.

POLICY:

1) To provide a systematic method to identify, investigate and take corrective action against any provider/member suspected of submitting health care claims that indicate waste, abuse, or fraud has occurred.
2) To report potential overpayments made as a result of WAF issues to the Cenpatico staff and Centene Management.
3) To ensure all health plans, providers, contractors, officers, directors, managers and employees know and understand the WAF process and their role in the process.
4) To provide a method for reporting cases of waste, abuse or fraud, after investigation, to Cenpatico Representatives and/or the state and federal government.
5) To provide a method for prevention of waste, abuse and fraud.

PROCEDURE:

All Centene employees have the responsibility to identify, investigate, and report fraud. The Vice President of Ethics and Compliance has delegated the responsibility to coordinate efforts and assist the health plans and state agencies with any related issues. The VP has employed a Senior Director of Special Investigations to manage the SIU. The SIU will assist the health plans with investigations, conduct systematic testing, review regulatory requirements, track investigations and work with various state agencies/departments as necessary.

All investigations are considered confidential. The SIU will contact employees who have to be involved in the investigation. The plan representative will be aware of all investigations and will receive quarterly summary reports.

SECTION I WAF EDUCATION/TRAINING

For a WAF program to be successful there must be a systematic way to identify and report suspected WAF cases to the SIU. Centene will follow the following steps to educate the health plans and their employees.

WAF training will be presented in conjunction with Centene's yearly ethics and compliance training. The training will be mandatory for all plan officers, directors, managers and employees. Several dates and times will be made available to the employees to ensure all are trained on the WAF process. All employees will be required to sign-in, documenting they received the training. New employees hired after the initial training will receive the training as part of their orientation. The topics to be covered, at a minimum, will be:

1) What is Waste, Abuse and Fraud (WAF)?
2) Why should the plans and employees be concerned?
3) Why should you report suspected WAF?
4) How to report potential WAF issues.
5) What is the purpose of the WAF program?
6) What are the goals of the WAF program?
7) Legislation, both Federal (i.e. False Claims Act) and State.
8) Qui Tam (whistleblower) Provision.
9) Common forms of Waste, Abuse and Fraud (i.e. unbundling, upcoding, misrepresentation).
10) Sources for WAF detection.
11) "Red Flags" for each department for possible WAF.
12) Preventative Measures.
13) Specific examples of potential WAF each department may encounter.

The SIU Management Team will be responsible for reviewing the yearly training and updating as appropriate.

The SIU will update the plan representatives any time a procedure or policy changes within five working days of the change. The plan representative will update all affected areas within fifteen working days.

SECTION II REFERRALS

There are three types of referrals – reactive, proactive and systematic. Reactive is defined as a person or agency, outside of Centene or the associated health plans, who forwards information to the SIU for further review. Proactive is defined as a provider/member who has been identified as an outlier by a Centene or health plan employee. Systematic referrals are obtained with the assistance of software.

> *Hotline Number* - A toll-free hotline number has been established to report potential WAF issues. All suspected WAF issues are sent to the SIU Director to review and assign to an investigator as appropriate. An outside company, Compliance Concepts Inc., will answer the WAF hotline. All calls will be logged and reported to the SIU Director within 24 hours. When a call is received, an attempt to collect the following information will be made:

a. Date of Call.
b. Name, address and telephone number of individual calling (if willing to provide).
c. Relationship to the provider/member to be investigated (i.e. patient, provider associate, provider office staff).
d. Name of provider/member to be investigated.
e. Address and phone number of member/provider to be investigated (if available).
f. If information relates to a provider, identify the type of provider (i.e. physician, hospital, pharmacy, DME supplier).
g. As much detail as possible about the suspected WAF issue.
h. Any evidence or documentation from the individual related to the investigation.

The hotline number is **1-866-685-8664**. All health plans are encouraged to include this number in their provider manuals and member handbooks. The number is available for use by any person, including health plan employees and subcontractors. It is against corporate policy to retaliate against anyone who makes a referral. All callers have the option to remain anonymous.

State Notification – After receiving a request from a state/federal agency, the providers billing history will be reviewed. If any abnormalities are found, the SIU will request permission to proceed with an investigation. Subsequent actions will depend upon the agency's feedback.

Employee Referrals – During the normal course of business, employees will often see or hear unusual information that warrants further review. In addition to the hotline, employees may report the unusual activity several ways:

a. *Completing a WAF referral form.* Employees may fill out a referral form and forward to the Director via fax, e-mail or interoffice mail. Note: The Referral Forms are available on the intranet under the Compliance section.
b. *During monthly/quarterly health plan/SIU committee meetings.* The meetings provide an opportunity for the SIU to update the health plan regarding open investigations. The health plan staff also has an opportunity to talk about unusual trends experienced.
c. *Contacting SIU directly.* At anytime, health plan employees are encouraged to call or e-mail the SIU directly.

Centene employees must report potential billing irregularities to the SIU or their health plan representative within twenty-four (24) hours of identification. If there is doubt as to whether a case should be reported or not, the employee should consult with the SIU team or the health plan representative.

Systematic referrals –

Centene Corporation has several systematic waste/fraud detection audits in place. They help to educate the provider, adhere to state regulations and reduce future potential WAF issues. Below is a brief description of each audit:

1. EDIWatch Intelligent Investigator. Centene's SIU uses software called EDIWatch Intelligent Investigator ©. This application systematically identifies billing irregularities based on hundreds of industry standards. The following is a list of examples that may be identified while reviewing quarterly reports:
    a. Unbundling CPT Codes
    b. Billing E&M services within a global surgery period
    c. Upcoding ambulance/transportation
    d. Providing unapproved procedures at an ambulatory surgery center
    e. Excessive services provided in one day based on CPT time guidelines
    f. Upcoding

g. Excessive utilization

Quarterly, the SIU investigators will review updated reports produced by Intelligent Investigator. They will look for the provider with the most billing irregularities. (*Please note: internal referrals have proven to be much more productive and will take priority over a systematic identification)*

After identifying a provider for review, the SIU Director or their designee will review the investigator's recommendation. After agreeing, a referral will be entered into the database.

2. *Code Editing Software.* Centene health plans currently utilize McKesson LLC.products to review payable status claims. The claims are reviewed against common coding standards established by the American Medical Association (AMA), the Centers for the Medicare & Medicaid Services (CMS) and medical specialty societies. The software edits include but are not limited to:
    a. Unbundling of services
    b. Mutually exclusive services
    c. Maximum frequency per day
    d. Incorrect procedures submitted for the patient's age and/or gender

Centene's Compliance Coding Unit reviews edits/audits and reports any identified WAF issues to the SIU.

3. *Claim Payment Audits.* A comprehensive random audit is completed on two percent of all processed claims. Claims are systematically selected from all claims including adjudicated, rejected/denied and appealed.
4. *Member Audits.* Business Objects member queries will be reviewed to detect any unusual billing patterns. The SIU investigator will review paid claims to validate:
    a. Treatments are not excessive, contraindicated, or duplicative.
    b. The PCP is providing services when appropriate versus another physician.
    c. The patient's ER visits are in conjunction with the diagnosis.

All referrals are logged into a database – Trail Tracker ©, assigned an investigation number and an investigator. It is not expected that all billing irregularities will result in a waste, abuse and/or fraud investigation. The SIU Investigator will be responsible for completing all stages of an investigation according to the timelines defined below.

SECTION III SIU INVESTIGATION PROCESS

After receiving a referral, several stages occur during the investigation process. Each stage has a number of specific activities:

Stage One – Preliminary Investigation

State guidelines should be followed regarding state notification of a preliminary review and timelines. The preliminary investigation phase will be completed within 30 working days..

Initial Investigation Valuation – All referrals are entered into the database but do not always warrant a full investigation. The investigator should first determine if the referral warrants a review for suspicious indicators. A review should *not* be conducted if one or more of the following conditions have been met:

1. The provider has not submitted claims for services performed in the prior nine months.
2. The total billed charges for the prior nine months of service are less than:
    a. Provider - $10,000
    b. Member - $1,500 (including pharmacy)

If the provider/member claim history demonstrates one of the above, the investigator should enter a closure note stating why additional review is not required and request closure. The SIU Director or

their designee will review the closure request and upon agreement, close the case. The provider/member billing history will be reviewed again in six to twelve months. If the review of the history meets the requirements above, the investigator will reopen the case and conduct a full investigation.

Review for Suspicious Indicators

If the case warrants further review after the above validation, the investigator will conduct a review for suspicious indicators.

The investigation will be based on state and federal laws, regulations and the appropriate provider contracts. At a minimum, the preliminary investigation will include:

1. Determination if prior WAF issues have been investigated.
2. When provider education was last conducted (if applicable).
3. Interview appropriate persons regarding the case – i.e. providers, members, health plan employees, family members.
4. Review of internet sources to determine as much information as possible pertaining to the provider.
5. Review of the billing history for suspicious indicators. (Note: A maximum of three years may be reviewed.)
6. Determination of which, if any, state regulations or program guidelines have been violated.

After completion of the above steps, determination of whether suspicious indicators are present should be made. If suspicious indicators do not exist, the investigator will document the conclusion in case notes and request 'file closure'. The request will be reviewed by the SIU Director or their designee and upon agreement, sign the investigation report and close the investigation. An investigation report must be written and approved prior to requesting closure.

Medical Record Determination

If suspicious indicators exist, a determination is made if medical records will be requested. Medical records will not be requested if any of the following criteria exist:

1. The suspicious indicators are strictly coding violations and require no medical review/decision as to whether payment should have been made. Examples include but are not limited to:
    a. Global Pregnancy billed with antepartum and postpartum care.
    b. E&M visits billed within global surgery period
    c. Supplies (gloves, needles) billed in conjunction with an E&M.
    d. Panel codes for labs billed along with individual tests contained in the panel.
2. The Preliminary Error rate is less than or equal to 5%. The preliminary error rate will be calculated by dividing the total amount paid for potentially incorrect procedures by the total amount paid for all procedures performed within the dates of service (DOS) being reviewed.
3. The potential recoupment if *all* instances are determined incorrect after a medical record review is equal to or less than $10,000.

Note: Some state regulations do not allow for medical record determination. A Preliminary Investigation Report will be written if none of the above guidelines apply. (If any of the above guidelines apply, please proceed to Stage 3.) The report will include information such as the initial allegation, a list of suspicious indicators, the approximate error rate and the source used for validation. The report will be reviewed/approved, at a minimum, by Centene's VP of Medical Management, the SIU Director or their designee and presented to the health plan during the health

plan SIU committee meeting. At a minimum, committee health plan SIU meetings are held quarterly. If applicable, the appropriate state agency will be notified. *If required, permission will be obtained prior to requesting records.*

Stage Two – Medical Records Review

During Stage Two, a sample of medical records will be selected, requested from the provider and reviewed. The time allotment is listed under each activity.

Sample Selection

Once it is determined medical records are required, a random sample will be selected for review. The sample will be randomly selected using RAT-STATs (provided by the Department of Health and Human Services) or Texas State Auditor Office Tool Box.

The sample will be based on the number of claims or number of patients. The sample should present a 95% confidence interval. If the sample is based on members a minimum of 30 records will be requested. TX requires 50 records for all cases when based on patients. If the sample is based on claims a minimum of 30 claims will be requested. TX requires 15% if the sample is based on the number of claims.

The SIU staff has 15 working days from completion of the Preliminary Investigation Report to select a sample. Once a sample is selected, the medical records request will be prepared.

Medical Records Request

The SIU will prepare and mail the medical request letter. The letter will be printed on Centene letterhead (unless requested by the health plan to use their letter head), request return of the records within 14 days and contain an 'Attachment A' which lists the record requirements. The letter will be sent certified mail.

If the records are not received within 30 days, the health plan will contact the provider and make arrangements to obtain the records if necessary. The health plans should make a reasonable attempt to obtain copies of the records within 30 calendar days. The exception is Texas, SIU will send a second request for records prior to notifying the Health Plan.

Medical Records Review

Upon return of the medical records, the investigator will prepare a review spreadsheet for the clinical nurses scrubbing any identified duplicate services. The spreadsheet will contain a list of all the CPT Codes to be reviewed (by patient and date of service). The investigator will review the medical records and flag any abnormalities that should be brought to the nurses' attention.

The nurses will compare the claim history (CPT codes billed) to the medical records for medical necessity, appropriateness and completeness. If applicable, CPT codes incorrectly billed will be flagged and marked with the appropriate code. All codes flagged as incorrect must indicate why they are inappropriate. The nurses will review with the VP of Medical Affairs all clinical findings. The nurses will prepare a summary of the clinical findings for sign-off and approval by, at a minimum, the VP of Medical Management.

Stage Three – Final Report Preparation

After receiving the signed clinical findings summary, the investigator will begin writing the investigation report. The investigation report will include a recoupment figure, a savings figure, the investigation steps, the findings and the recommended next steps.

Recoupment figure- Unless otherwise stated in the investigation report, the recoupment figure will represent the extrapolated overpayment made during the prior eighteen months. The figure will be based on the dollar value error rate identified during the clinical review, extrapolated over the above time frame.

The final report will be completed within 15 working days after the clinical review is completed. The report will be reviewed and signed by the SIU Investigator and the SIU Director or their designee. The report will be emailed to Cenpatico and discussed at the next SIU/Cenpatico committee meeting. *Note: If the next meeting is more than 4 weeks away an ad hoc meeting will be scheduled if needed.*

Stage Four – Cenpatico Action

After presenting the report to the Cenpatico SIU committee, final actions will be determined. If the Cenpatico has no further questions, one of the following actions will be taken:

i. *Provider/Member education*. Cenpatico will be responsible for scheduling the meeting and sending someone to talk to the provider. If requested, the SIU will assist in preparing educational materials. The education should be summarized in a memo format and when possible the provider should be asked to sign the letter to acknowledge receipt of education. If no signature will be obtained, the letter should be sent via certified mail and the receipt verification added to the case file.

ii. *State/Federal Referral.* Based on state/federal regulations and/or the seriousness of the violation, the case may be referred to state or federal agencies. The SIU will complete any necessary forms and prepare the documents for presentation to the agency. Cenpatico will submit the form(s) or the SIU will submit them upon request.

iii. *Provider Placed on Review.* Cenpatico will be required to fill out a PACT form, placing the provider on review. The provider will be informed that any claims submitted without attached medical records will be denied for medical records. Once the medical records are received, the clinical nurses will review the record and approve/deny payment.

iv. *No Additional Actions.* Following the clinical review, if no additional actions are required, the case will be closed.

Stage Five – Recoupment and/or Education

Cenpatico will accept responsibility to collect the overpayment in accordance with the Corporate Policy CC.Comp.20, Health Plan Recoupment Policy. The SIU will be responsible for providing any information requested by Cenpatico to assist with this process.

Stage Six – State or Federal Information Request

Typically, after making referrals to state or federal agencies, additional information is requested. The SIU will respond to their requests within 24 hours unless otherwise requested by the agency. The same 24 hours will apply if information is requested pertaining to a provider/member that was not referred.

SECTION IV REPORTING TO THE STATE

The SIU will complete all state required monthly, quarterly and annual reports. Once completed, the reports will be forwarded to the Cenpatico Representative for filing or SIU will file if requested by Cenpatico. DHH will establish the required intervals for filing on behalf of LBHP.

REFERENCES:
ATTACHMENTS:
DEFINITIONS: ***Billing Error*:** The incorrect submission of services due to factors such as uneducated office staff, coding illiteracy, staff turnover or keying errors. Billing errors are resolved after the provider and office staff are educated on proper billing and claim submission. ***Abuse:*** Those practices that, although not considered fraudulent acts, may directly cause financial loss to the health plan. Abuse does not involve a willful intent to deceive. Abusive billing practices are a result of what a provider or provider office staff member feels the provider was entitled to receive.

Fraud: The intentional deception or misrepresentation an individual or entity makes knowing that that the misrepresentation could result in some unauthorized benefit to the individual, or the entity or to some other party. This includes "reckless disregard" of the facts with the intent to receive an unauthorized payment. This party may also conceal facts to receive reimbursement for which they are not entitled.

Inquiries: For the purpose of this policy and procedure, inquiries are the review of a providers/members billing pattern in which no referral has been made or suspicious indicators have been found. If suspicious indicators are found during the review, it becomes an investigation.

Investigation: For the purposes of this policy and procedure, an investigation consists of any referrals sent to the SIU and any inquiries in which suspicious indicators are found.

Provider: Any individual or entity furnishing medical, mental health, dental, pharmacy or other health care services.

CPT-4*:* Current Procedural Terminology. Written and published by the American Medical Association (AMA) for reporting office visits, diagnostic and surgical procedures.

ICD-9-CM**:** International Classification of Diseases, Clinical Modification. Developed by the World Health Organization, National Center for Health Statistics, American Hospital Association, Health Care Financing Association and American Health Information Management Association for reporting diagnoses. Used originally as a tool for tracking morbidity and mortality statistics worldwide.

Unbundling: Breaking a procedure or group of procedures into components and billing separately for each component-even though the procedure or group of procedures is already included in a single, more comprehensive code.

Upcoding**:** Provider bills (codes) a service that was performed as a more complex or time-consuming procedure than was actually performed.

False Claims Act (31 U.S.C. § 3729-3733): This act creates civil liability for any person who "knowingly presents or causes to be presented, to an officer or employee of the United States Government a false or fraudulent claim for payment or approval". In section 3729 (a) (1) it states that anyone submitting such a claim generally is liable to the United States for a civil penalty of between $5,000 and $10,000 plus three times the amount of damages which the government sustains from the false claim.

Qui Tam Provision (31 U.S.C. § 3730): Part of the above mentioned False Claim Act. Authorizes certain private parties ("whistleblowers" or "private attorney generals") to bring lawsuits on behalf of the government. The private party receives a portion of the recovery.

REVISION LOG:

REVISION:	**DATE:**
1.Medical Records Request – SIU will no longer send a second request for medical records to providers. Cenpatico will be responsible to obtain them if not received after 30 days.	3/19/2010
2. Recoupment Figure – The extrapolated recoupment for all Health Plans is for 18 months versus 3 years for all plans.	3/19/2010

Added SECTION IV REPORTING TO THE STATE	3/11

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

SIU Director: Approval on file

V.P. Ethics & Compliance: Approval on file

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxxiii. Describe the Proposer's coordination of benefits (COB) experience for determining payment. **Suggested number of pages: 5**

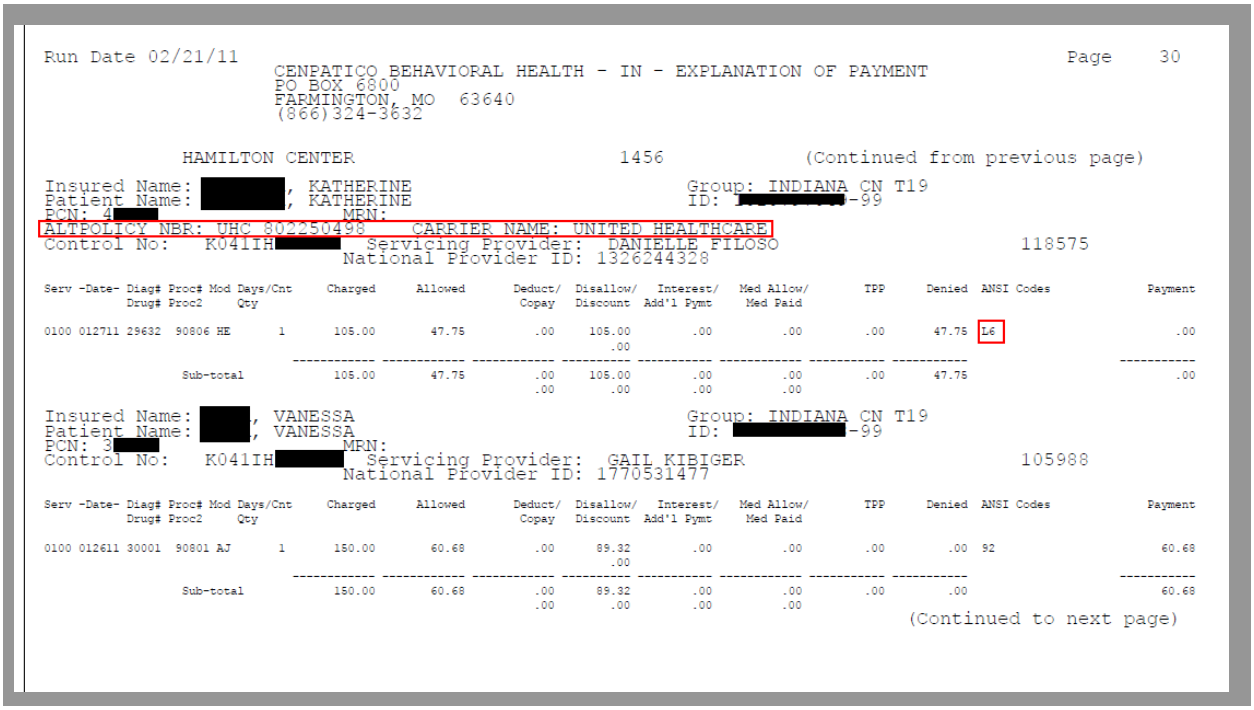
Cenpatico has over seven years of experience coordinating benefits to ensure claims are paid accurately and in compliance with state and federal rules. We process claims involving coordination of benefits (COBs) in eleven states. We ensure all services reimbursable under Medicaid are appropriately billed to Medicaid. We configure our claims payment system (AMISYS Advance) to comply with federal rules and ensure Medicaid is the payor of last resort. We deny a claim when another funding stream/payor is available and the provider has not submitted an Explanation of Benefit (EOB) with the claim identifying payments already received from the primary payor. We configure our Behavioral Health (BH) coordination of benefits payment rules to match the payor rules set by the primary insurance carrier and other funding sources available to pay the claim.

COBs Related to Dual Eligibility (Medicare and Medicaid eligible)

We are very familiar with the specific nuances that apply to dual-eligibility, Medicare, and Medicaid eligibility. For example, Social Workers are the only master's-level clinicians eligible for Medicare reimbursement; however, masters-level Counselors and Marriage and Family Therapists are recognized by and utilized extensively to provide Medicaid services. Similarly, Medicare does not cover all BH or substance use disorder (SUD) services that are eligible for payment under either Medicaid or state-only funds. We configure our claims payment system to take into account these nuances related to Medicare payment rules. Since Medicare no longer provides EOB denials to Medicare ineligible providers or for Medicare ineligible services, we do not require a Medicare EOB for providers or services not approved by Medicare. However, when a Medicare approved service is performed by a provider who is both Medicare and Medicaid eligible, the system is configured to look first for the submission of the Medicare EOB before paying the claim. Services that are a covered Medicaid benefit but not a covered Medicare benefit are configured to identify Medicaid as the primary payor. We configure the same functionality with state-only or grant funding. We have established EOB claims payment rules for State Grand Funds (SGF), Substance Abuse Prevention, and Treatment grants (SAPT), Center for Mental Health Services grants (CMHC), and Mental Health grants. In addition, we will establish COB payment rules for services specific to this contract that fall under the Department of Children and Family Services (DCFS) and the Office of Juvenile Justice (OJJ).

COBs Related to Private Commercial Insurance

We base COB determinations related to private insurance payors based on the benefit package of the member's private insurance carrier. For detailed description of how Cenpatico obtains and uses this information, please see the response to 2.g.xxxiv. Our claims payment system places a flag on the member's file indicating that Third Party Liability (TPL) is available. If the private insurance carrier's EOB is not attached to the claim for a member with this TPL flag, our claims payment system automatically denies the claim and requests a copy of the primary insurer's EOB. To assist providers, Cenpatico places TPL information on the Explanation of Payment (EOP) when a claim has been denied for this reason. Providers are also able to obtain a member's TPL information via our Provider Web Portal. The image below is an example of an Explanation of Payment highlighting the members TPL information for the provider.



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CENPATICO BEHAVIORAL HEALTH - IN - EXPLANATION OF PAYMENT
PO BOX 6800
FARMINGTON, MO 63640
(866)324-3632

HAMILTON CENTER 1456 (Continued from previous page)

Insured Name: [redacted], KATHERINE
Patient Name: [redacted], KATHERINE
PCN: 4[redacted] MRN:
Group: INDIANA CN T19
ID: [redacted]-99
ALTPOLICY NBR: UHC 802250498 CARRIER NAME: UNITED HEALTHCARE
Control No: K041IH[redacted] Servicing Provider: DANIELLE FILOSO 118575
National Provider ID: 1326244328

Serv -Date-	Diag# Drug#	Proc# Proc2	Mod	Days/Cnt Qty	Charged	Allowed	Deduct/ Copay	Disallow/ Discount	Interest/ Add'l Pymt	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment
0100 012711	29632	90806	HE	1	105.00	47.75	.00	105.00 .00	.00	.00	.00	47.75	L6	.00
	Sub-total				105.00	47.75	.00 .00	105.00 .00	.00 .00	.00 .00	.00	47.75		.00

Insured Name: [redacted], VANESSA
Patient Name: [redacted], VANESSA
PCN: 3[redacted] MRN:
Group: INDIANA CN T19
ID: [redacted]-99
Control No: K041IH[redacted] Servicing Provider: GAIL KIBIGER 105988
National Provider ID: 1770531477

Serv -Date-	Diag# Drug#	Proc# Proc2	Mod	Days/Cnt Qty	Charged	Allowed	Deduct/ Copay	Disallow/ Discount	Interest/ Add'l Pymt	Med Allow/ Med Paid	TPP	Denied	ANSI Codes	Payment
0100 012611	30001	90801	AJ	1	150.00	60.68	.00	89.32 .00	.00	.00	.00	.00	92	60.68
	Sub-total				150.00	60.68	.00 .00	89.32 .00	.00 .00	.00 .00	.00	.00		60.68

(Continued to next page)

COBs Related to Services Covered by Non-Title XIX Funds

We configure our claims payment system to manage all COB requirement associated with Non-Title XIX funding (grant and state-only funding). Based on our experience in Arizona and other markets, we are prepared to configure our claims payment system to facilitate the COB related to Louisiana's non-Title XIX funding. Our process includes the following processes.

Identification of members and/or eligibility for the non-Title XIX funding

We work directly with provider agencies to establish a reporting mechanism to collect key eligibility information for non-title XIX funding, since eligibility for Non-title XIX funding does not originate in state eligibility files. In Arizona, we have developed an electronic eligibility and demographic submission process to collect the information on a timely and accurate basis. Members who are not already part of the Medicaid program are enrolled based upon their funding eligibility in Cenpatico' s system. This allows us to track, report, and manage the delivery of these services to ensure services are being provided appropriately, persons are able to access the services within guidelines, and the funding is available throughout the contract year. Based on our experience with non-Title XIX members in Arizona, we have identified that it is very beneficial to send non-Title XIX member information to the state. This allows us to validate member eligibility for non-title XIX services as well as assists us with encounter file submission and data reporting. Sharing enrollment and demographic information helps us ensure Medicaid reimbursable services are being charged to Medicaid, Medicaid is the payor of last resort, and non-Medicaid services are being charged to the appropriate funding source. Based on our experience, coordination with the State to develop classification codes will enable both DHH-OBH and Cenpatico to be able to identify the appropriate funding stream and benefits for the member and will allow us to use multiple funding sources to meet member needs..

Coordination of Benefits between Title XIX, Title XXI, and non-Title XIX Services

We determine the appropriate funding source for each member and service based on the member's eligibility and benefit. We link specific benefits to unique financial accounts. Each benefit is tied to a

specific service or group of services. Claims for members with a classification that identifies them as eligible for a particular grant or state-only funding (such as OJJ), are processed against benefits designed specifically for their member classification. Services that are eligible for payment under more than one funding source are programmed in a hierarchical manner that processes those claims against the specifically designed benefit for that funding source. Encounters/claims not eligible for payment through the primary funding source are processed against the secondary or tertiary funding source based upon eligibility. We also establish payment limits when funding sources set particular limits per member. When the funding limit has been reached for the primary payor, the encounter/claim is processed against the secondary or tertiary pay source as appropriate.

Authorized Services

We enter authorizations in our claims payment system for all Non-Title XIX services that need to be prior authorized. We establish procedure codes in collaboration with the state as needed to track the delivery of non-title XIX services.

2. The Proposer should articulate an understanding of, and ability to effectively implement services as outlined within Section II of the RFP. The Proposer should address the following areas consistent with the RFP requirements:
2.g. Technical Requirements
xxxiv. Describe the Proposer's third party liability and COB process for identifying other health insurance. Include the capture and storing of other health insurance information. Include any system edits invoked during claims processing. Suggested number of pages: 3

Experience With Medicaid TPL Processing

As a trusted administrator of public sector programs since 1984, Centene has designed Third Party Liability (TPL) claims processes and data interfaces around the requirement that Medicaid programs are the "payer of last resort." In addition to managing the Management Information System (MIS) for Cenpatico, Centene has a successful history of managing cost avoidance for our managed Medicaid health plans, as well as recovering payments made for our members who were subsequently found to have Other Insurance (OI) with TPL. Our experience with cost avoidance and TPL processing continues to improve as we introduce increasing levels of automation with our providers, in our internal systems, and with our OI and TPL partners. For example, across all of our operations in 11 states, from 2009 to 2010, our cost avoidance figures rose 17% and our TPL recoveries increased 19%, with both figures adjusted for increase in membership.

Taking the Pre-Emptive Approach

Our experience has shown that the best approach to cost avoidance is to *minimize the need to recover costs in the first place* and we employ several methods to support our "pre-emptive" strategy. These methods use the eligibility subsystem in our Member Relationship Management (MRM) System. MRM is our enterprise based, master data management application for member data, containing our master member indices and "all things member related," including history. MRM is tightly integrated with our AMISYS Advance claims processing system to support the collection and maintenance of OI information at the "member level." Once in AMISYS Advance, we use OI information to automatically recognize and prompt the suspension of claims that may be submitted without required Explanation of Benefits (EOBs) or payment information from a primary payer. In cases where we discover the existence of OI with TPL through any of the efforts below, we will update DHH-OBH/BHSF within 5 days using the TPL Notification form. Our pre-emptive strategy includes the following processes:

- ***Reconciling the HIPAA 834 Eligibility File.*** Upon receipt of the 834 eligibility file, coordination of benefits (COB) data will be automatically loaded to MRM. MRM houses current and historical member information and maintains our master member index to assure member data integrity. MRM systematically promulgates updated eligibility data, including COB data obtained from the 834, to our other applications requiring that data, including the eligibility subsystem of AMISYS Advance. This is the first step in our approach to ensure the eligibility subsystem contains current information necessary to identify members who might have OI. If at any time, the OI data we receive from DHH-OBH differs from the information we have received from any other source, we will ensure that DHH-OBH/BHSF receives that updated information to synchronize data between Cenpatico and DHH-OBH/BHSF. We will work with DHH-OBH/BHSF to determine the best way in which to support sending OI data updates to DHH-OBH/BHSF, for example, via the HIPAA 834 transaction.
- ***Diagnosis and Trauma Edits.*** Consistent with our affiliate health plans, we will load accident related ICD-9 diagnosis code edits into our AMISYS Advance claims adjudication system, creating another way Cenpatico will intercept claims that may be the liability of a third party. If a claim is received without documentation to support the liability or non-liability of a third party, and the claim contains an accident- or injury-related diagnosis code and/or trauma indicator of "Y," we will pay the claim and request that the provider submit accident-related documentation or payment information from the

third party. We will then send this information to Health Management Systems, Inc. (HMS), our partner for post-payment recovery services, for further investigation. Please see below for more information on HMS. The flexible nature of our claims configuration rules tables allows claims with services related to prenatal or preventive pediatric care, including EPSDT services, to bypass the "trauma" edits, and continue processing to ensure compliance with DHH-OBH/BHSF and federal requirements. If after processing, Cenpatico discovers a third party is liable for those services, we will bill the third party within 60 days and offset the original claims payment by the amount received from that third party.

- ***Educating Providers.*** Through our regular provider orientations, ongoing training meetings, and our online Provider Manual, we will inform and educate providers about the importance of submitting denial notices from third parties, accident details, and medical records corroborating no other liable parties, or EOB or payment information from a third party where member liability exists. We are also introducing a new capability on our secure Provider Portals, allowing our network providers to submit to us requisite TPL documentation by uploading images, PDFs, Microsoft Word documents, or other digitally formatted TPL related documents electronically. This functionality will be available to Cenpatico Louisiana. This information will be accessible by our claims processors to expedite finalizing claims with TPL. In all circumstances, Cenpatico will review submitted documentation, validate the initial findings, and expedite the processing of the claim.

  We will educate our providers about the importance of identifying OI information at the time the member receives service. We will also provide them with any additional instruction needed related to including OI payer and payment information in the COB and other payer segments of their HIPAA 837 EDI claim submissions, or their paper claim submissions. In addition, a provider may enter a claim directly via our HIPAA compliant Direct Data Entry (DDE) online claim entry facility available through our secure Provider Portal. Our online claim entry application has logical field checks so that, for example, if a provider indicates that the member has other insurance, but no entry is made concerning third party payments, our claim entry application will alert the provider about this missing information at the time the provider is entering the claim. We are also introducing our EDIFECS Ramp Manager to providers, allowing EDI claim submitters to test the sending of COB and other payer information to us via the HIPAA 837 transaction, with instant and detailed test results immediately sent back to the provider. Once testing is successfully completed, providers will be authorized to send this data *directly* to us through our Provider Portal. We will make this functionality available to Cenpatico network providers who submit over 1,000 claims per month, electronically.
- ***Identify and Address Billing Errors***. Centene's Claims Department continuously examines claims submissions for patterns of billing errors from providers, including those related to TPL, through the use of decision support tools within our Centelligence™ Insight reporting system. Please see Section 2.g.xii for more information on Centelligence™. When we identify providers having problems related to billing primary payers, our Provider Relations staff will outreach to the provider to offer targeted provider education.
- ***Our Provider Portal*** will allow authorized provider users to see any current TPL information we have collected for a member. TPL checking by the provider thus becomes a routine part of the member eligibility verification process before the claim is created and submitted.
- ***OI Information on Claims Received.*** Claims may contain OI noted on the claim form itself as information populated in the appropriate boxes on the CMS 1500 or CMS 1450 claim forms, or on an attachment to the claim, such as an EOB from another carrier, or in the COB and other payer segments of the HIPAA 837 EDI claim submission. In this case, our Automated Work Distribution (AWD) claims workflow system, integrated with AMISYS Advance, will electronically route the claim to our COB/TPL Analyst to investigate and validate the existence of OI. Upon confirmation of

OI, the COB/TPL Analyst will update the member's OI information in MRM, which will then electronically update AMISYS Advance for future claims payment determination and allow our claims processor to coordinate benefits for the pended claim and finish adjudication.

- ***Notification from Cenpatico Staff.*** Cenpatico staff may become aware of OI during member and provider interactions, chart reviews, etc. When Cenpatico staff learn about OI that is not already included in the member's eligibility record, they will submit a notification via MRM to the COB/TPL Analyst, requesting that the member record in MRM be updated. When the COB/TPL Analyst updates the MRM master member record, AMISYS Advance will update automatically with the OI information to ensure accurate handling of future claim submissions. Additional coverage information also may be discovered through the authorization, concurrent review, or case management processes. In these situations, the local Case Manager or Referral Specialist creates a claims note in TruCare, our case management and clinical documentation system. The claims note indicates the name of the insurer, the policy and group number, the name of the member, and the effective date. This information is then transferred to the COB/TPL Analyst for updating in MRM, and subsequently AMISYS Advance and our other applications.

Coordination of Benefits (COB)

Cenpatico will capture all results of COB/TPL investigations at the member level within the member's eligibility record in MRM which electronically feeds to AMISYS Advance. During the claims adjudication process, AMISYS Advance checks for OI and will pend or deny the claim based on the information contained within the record. A dedicated team of resources within our claims operations team, who have extensive knowledge and expertise in COB and TPL administration, will process COB. When we become aware of other coverage, we will use AMISYS Advance's table driven parameters to configure the system to coordinate benefits in accordance with DHH-OBH requirements. We understand that DHH-OBH is secondary to all other third party coverage with the exception of the funding we receive via Special Health Services, Vocational Rehabilitation, Indian Health Services, Crime Victim's Compensation Funds and the SAPT Block Grant. We will configure in AMISYS Advance to price claims according to the specific covered service to pay according to these rules. See the response to 2.g.xxxiii for more information on programming this hierarchy.

Pay and Chase, and Subrogation

Cenpatico will augment our prepayment COB processes with the post payment recovery services of HMS for recoupment when OI is not known at the time we pay the claim, and for subrogation to parties with TPL. On a weekly basis, we will provide HMS with a claims detail report of claims processed the previous week. If HMS determines that a claim is related to OI or subrogation, they will initiate steps to recover the overpaid TPL dollars. HMS will bill the primary insurer on behalf of Cenpatico after TPL information is confirmed and seek to obtain payment within 120 days. When HMS confirms that a member's claim has TPL and we have paid the claim as primary, they will submit a claim to the primary insurer and request reimbursement to Cenpatico for their amount of payment. Our recovery efforts are transparent to the provider, easing the provider's administrative and financial burden, as there is no need for Cenpatico to recoup previous claim payments or request the provider attempt to obtain payment from the primary carrier. Centene's Director of Operations Support will provide oversight of HMS and monitor adherence to these requirements. In addition, we will provide DHH-OBH/BHSF with our established procedures for COB and subrogation processes during readiness review. As we do with all of our Medicaid based programs, Cenpatico will comply with DHH-OBH/BHSF and federal requirements for the distribution of TPL recoveries and we will report to DHH-OBH/BHSF any recoveries collected and accounted for payments made on behalf of non-risk services as offsets to medical expenses.

Systems/Processes for Testing, Updating and Validating Enrollment in OI and TPL Data

Centene uses automated processes to support efficient and accurate cost avoidance by systematically identifying members with OI and other third parties responsible for payment. Centene's Claims Department regularly identifies COB and TPL cases by data mining through our Centelligence™ informatics platform and using diagnosis and trauma edits, in addition to member outreach, to confirm the presence of OI based on these edits. We augment our OI identification processes with established national recovery vendors through our partnership with HMS. Each month, we securely send member demographic data to HMS. By matching this data to HMS' database of national insurance eligibility information, HMS can identify other available coverage. HMS verifies coverage directly with the carrier through a combination of online tools and telephone contact, and sends the resulting data back to Centene. We then load this "member level" OI information into MRM and from there the data automatically, and electronically, feeds AMISYS Advance. We validate OI and TPL data we receive from HMS by systematically matching member identifiers in the OI and TPL files we receive from HMS with the corresponding identifiers we have on members in MRM. MRM is our system of record for "all things member" and houses our master member index, linking all records related to the member across the member's historical relationship to our health plan. DHH's use of HMS' services means that Cenpatico and DHH-OBH will literally be working "off the same data," which will ensure communications and reporting clarity between Cenpatico, DHH, and DHH's FI, as well as less opportunity for labor intensive reconciliations in OI, COB, and TPL information.

We also validate TPL whenever we receive a first time claim with an EOB attached, or an adjustment request from the provider. Both of these situations are detected systematically through Centelligence™ Insight. A claims analyst regularly reviews standard Insight claims operations reports focused on first time claims with EOB attachments and claim adjustments. The claims analyst routes this information (member contact information, plus other insurance from EOB or adjustment request) to our Claims Department Phone Call Team (Phone Call Team) to verify enrollment with either the third party and/or the member to ensure we are coordinating benefits appropriately. The Phone Call Team is dedicated to making calls to insurance companies and updating the member's record in MRM with accurate OI and TPL information.

Support for Audits. Centene and Cenpatico will cooperate with DHH-OBH and DHH's vendor regarding cost recovery. We will support any periodic, annual or more frequent, TPL audits of Cenpatico and Centene's operations conducted by DHH-OBH or its authorized agent, and we will make available specific data as requested by DHH-OBH or its agent as required.

COB/TPL Reporting. Cenpatico will report all OI information to DHH-OBH in the format and medium prescribed by DHH-OBH, for all members, within five business days of discovery. Additionally, we will submit, via our encounter data submissions, post payment TPL recoveries we make to DHH-OBH. We currently submit TPL information and adjustments for retrospective findings in our encounter submissions to most of our state partners and will also do so for DHH-OBH as required. We will make available any supporting documentation not submitted on the encounter within 30 days of any request made by DHH-OBH.

2.g. Technical Requirements
xxxv. Describe the Proposer's hardware and platform on which the software runs. Describe the environment in which the processor is or will be located. Suggested number of pages: 3

Technology Infrastructure

All of the functions and supporting information technology (IT) infrastructure that we describe in this section is in place *today* (unless otherwise noted) and are ready for deployment in service of Cenpatico and the Louisiana Behavioral Health Partnership (LBHP).

A Hardware Architecture Engineered for Dependability and Growth

The core Information Technology services provided to Cenpatico are housed in St. Louis, MO and are managed by our parent company, Centene Corporation (Centene). We maintain and continually enhance our MIS related capabilities through the meticulous design and technology refresh we incorporate in all the hardware, software, and networking components of our IT architecture.

Our MIS architecture is based on these principal design points:

- ***Reliability*** – for sustained availability through redundancy in our entire computing infrastructure
- ***Scalability*** – to expand the capacity of our operations without affecting current business operations
- ***Data Integration*** – allows us to use common data across processes to power our unified care model
- ***Flexibility*** – to maintain agility in our MIS, allowing for quick changes based on business imperatives

Our Server Architecture - Delivering the Right Processing Power. We use proven, industry standard hardware components for our core processing applications to deliver the necessary computing power to our local plans. These are realized in each layer of our architecture: *Database Layer, Business System Layer, Presentation Layer, Network Layer and Telecommunications Layer*.

Database Layer. All core Cenpatico data (claims, member, provider, etc.) will be stored on our fully redundant Storage Area Network (SAN), which supports access to 2 highly available NetApp SAN Storage Arrays configured with over 200 TBs of shared storage. Our Centelligence™ family of reporting and decision support applications is powered by our Teradata® Extreme Data Appliance. Please see our response to section 2.g.xiv for more information on how we protect DHH-OBH data and section 2.g.xii for more information on our Teradata reporting capability.

Business System Layer - Engineering Performance and Availability in Servers and Storage. Five HP 9000 servers running HP/UX Unix power AMISYS Advance, our core eligibility and claims processing system. Three *application* servers operate as a cluster using Veritas technology and are configured to provide a scalable, redundant computing array for our claims platform. Three *database* servers use Oracle 10g Real Application Clustering (RAC) for high availability and are configured to provide a fully redundant, scalable architecture for our claims data. Two batch servers, capable of backing each other up, are configured to run all claims management jobs. Each of these clustered solutions are designed to grow in capacity either vertically (adding more CPU's and Memory) or horizontally (adding additional nodes) to meet our processing needs. For our Clinical Applications (such as our TruCare clinical system), we use rack mounted Windows/Intel ("WinTel") blade servers operating in a virtual environment, using EMC's VMware VSphere virtualization software technology.

Our multi-tiered hardware platform delivers highly available application services using Clustering, Server Virtualization, and Blade Servers. Clustering technologies, including Oracle RAC, VMware, Windows Server 2008r2, and Citrix, allow us to deliver presentation, application, database, and networking services across a group of server nodes configured so that any one of the nodes can provide appropriate end-user access. *In the event that one of the nodes is lost, the surviving nodes pick up the workload, usually averting an outage*. With the use of VMware's Server Virtualization Infrastructure and High Availability Services, we deliver a fully redundant server farm capable of running a number of different application

services. Virtualization reduces our power consumption and air conditioning needs, and optimizes the amount of CPU performance and data storage that we can house in our building space. Virtualization also provides high availability for our applications, and streamlines application deployment and migrations. The servers are automatically load balanced to provide the best performance. If one of the physical nodes were to fail, be taken out of service for maintenance, or experience higher than expected utilization, the application service automatically moves to another node in the server farm without any interruption to the application service (i.e. no impact to the user). Because our MIS is architected for horizontal and vertical growth, we do not anticipate any changes in our current infrastructure footprint or design. Through our existing vendor relationships, we will easily be able to grow horizontally adding the necessary servers into vacant positions within our existing environment and vertically upgrading the Central Processing Unit to service DHH-OBH and our LBHP member population. Reference ***Figure 2.g.xxxv-A: Windows Server Architecture Reinforces Availability***.

Presentation Layer (User Desktop). We deploy virtual desktop and remote application support using Citrix XenDesktop, XenServer, and XenApp products. Essentially, a virtual desktop separates the workstation computer hardware from the operating system and client applications that are utilized by the end-user. Our corporate datacenter in St. Louis, Missouri, will centrally run and maintain All Cenpatico programs, applications, processes, and data. Our high-speed network, described in section 2.g.xxxvi, will connect Cenpatico virtual desktops to our centralized IT resources. We configure, provision, and use a standardized desktop environment for all Centene and health plan staff with operating systems that include Desktop Windows Server 2003, SP2 with Citrix XenApp 4.5 for thin clients, and Windows XP, SP3 for desktops and laptops. We use IBM WebSphere technology web and portal platforms operating on Red Hat Enterprise Linux. WebSphere Portal Server (WPS) is used to integrate our electronic business applications across multiple computing platforms, using Java-based Web technologies. Centene was selected as a finalist in the 2010 Citrix Innovation Award for our rapid deployment of virtual desktops.
Network Layer. Cenpatico Louisiana staff will connect to core applications via Centene's Wide Area Network (WAN). Please reference our response to section 2.g.xxxvi for information on our network infrastructure.

Telecommunications Layer. We use the Avaya IP Telephony platform with Dual S8730 Media Servers in our datacenter; capable of failing over to a redundant pair of Avaya S8730 Enterprise Survivable Servers (ESS) for back up and disaster recovery. For more information on our Telecommunications capability, please see our response to section 2.g.i.

Datacenter Facilities - Designed for Dependable, Reliable Operations

Cenpatico's Datacenter is managed by our parent company Centene in St. Louis, Missouri and is home to all of the core application services that are furnished to Cenpatico. Our Datacenter is equipped with two diverse power feeds into the facility with redundant Uninterruptible Power Supplies (UPS) providing battery back-up power to all IT equipment. There are two separate power systems in the facility which provide redundant power to each rack of equipment on the Datacenter Floor. This capability allows for equipment within the electrical plant to be taken offline and maintained without power interruption to the computing equipment and provides continuous power in the event of the loss of power to either power feed entering the facility. In addition, the facility is also equipped with a diesel generator capable of supporting all IT services in the event of a loss of both power feeds entering the facility or a prolonged power outage. We execute a full load test quarterly, switching all power loads to the generator, to validate the generator's effectiveness. Less than 15 seconds is required to automatically switch to backup generator power. Battery backup systems provide power during the transition to generator power resulting in zero downtime for the IT infrastructure.

Environmental Safeguards. Temperature and humidity levels in the datacenter are controlled with a redundant chiller plant. The chiller plant utilizes a highly efficient water cooled system and is backed up

by an air-cooled system to provide cooling in the event of loss of water to the facility. It is an N+1 design ensuring that the loss of any one unit does not affect our ability to maintain safe temperatures. All environmental systems are tied into Centene's security system and send an audible remote alarm when temperature or humidity falls outside of predefined ranges or water is detected. Environmental monitoring sensors are located within the server racks and wireless temperature sensors placed throughout our Datacenter that send out automated alerts when temperatures and/or humidity levels exceed defined thresholds. These alerts are sent to Centene's Network Operations Center and key IT technical and management staff enabling rapid response.

Fire Protection. Centene Datacenter facilities are protected by an advanced fire suppression system, which includes a VESDA (Very Early Smoke Detection Alarm) system. This system takes air samples throughout the Datacenter sensing particulates that are present in the air prior to actual combustion. The alarm system is integrated with the building alarm system which is connected to the local fire authorities. The fire suppression system is a Ecaro-25 Clean Agent Fire Suppression System. A pre-action water sprinkler system provides a second level of protection. Safeguards are in place to minimize the risk of accidental discharge of both the clean-agent and sprinkler suppression systems.

Centene's New Datacenter

In the 4th Quarter of 2011, Centene will complete construction of our new, fully-functional, Tier 3 (concurrently maintainable equipment), 19,000 square foot datacenter, with capacity for over 167 IT racks; 6,000 square feet of datacenter floor; and fully redundant environmental, power, and network connectivity systems. It was designed to be fully HIPAA compliant and provides state of the art security measures. In the 1st Quarter of 2012, we will operate our two fully-redundant enterprise datacenters as mutual "*hot site*" backups. Each datacenter will have the capacity to assume operation of all **business critical** production systems if the other datacenter is rendered inoperable.

Scalability and Growth. Our new datacenter was designed for a 20 year growth plan. All systems to support Centene operations today (datacenter floor, electrical, mechanical, fire systems) consume only 1/3 of the planned capacity for the facility. The datacenter floor was designed by creating 'Compute Pods'. Each pod is designed with 2 rows of 8 racks designed to be a self contained, mini datacenters on their own. We have the ability to outfit 4 full pods and 2 half pods at full capacity. Because each pod is designed to be fully autonomous, we can choose to take full advantage of new technologies as we deploy and outfit future pods. We currently have 1 of our 4 full pods outfitted and in use. Additional features include:

- 76 racks currently installed, with the ability to grow to 167 racks at maximum capacity.
- Two (2) additional water cooled chillers and one (1) additional air cooled chiller.
- Generator plant has been designed to grow by two (2) additional 1500kw generators
- Electrical system designed to grow to a full capacity of 6 UPS modules

Datacenter Hardening. The entire facility was designed to withstand penetration due to natural or other security threats.

- Designed for a 1.5 Seismic Importance Factor based on the IBC (International Building Code) Section 1604.5 standards. This design classification indicates a fully functional facility following an earthquake.
- Designed to withstand 165 MPH (F3 tornado) conditions
- Surrounded by an 8 foot security fence with security monitoring at the single entrance
- Equipped with security cameras which are broadcasted back to our Corporate security system

Fire Protection System. The facility has advanced fire detection and alert systems including:

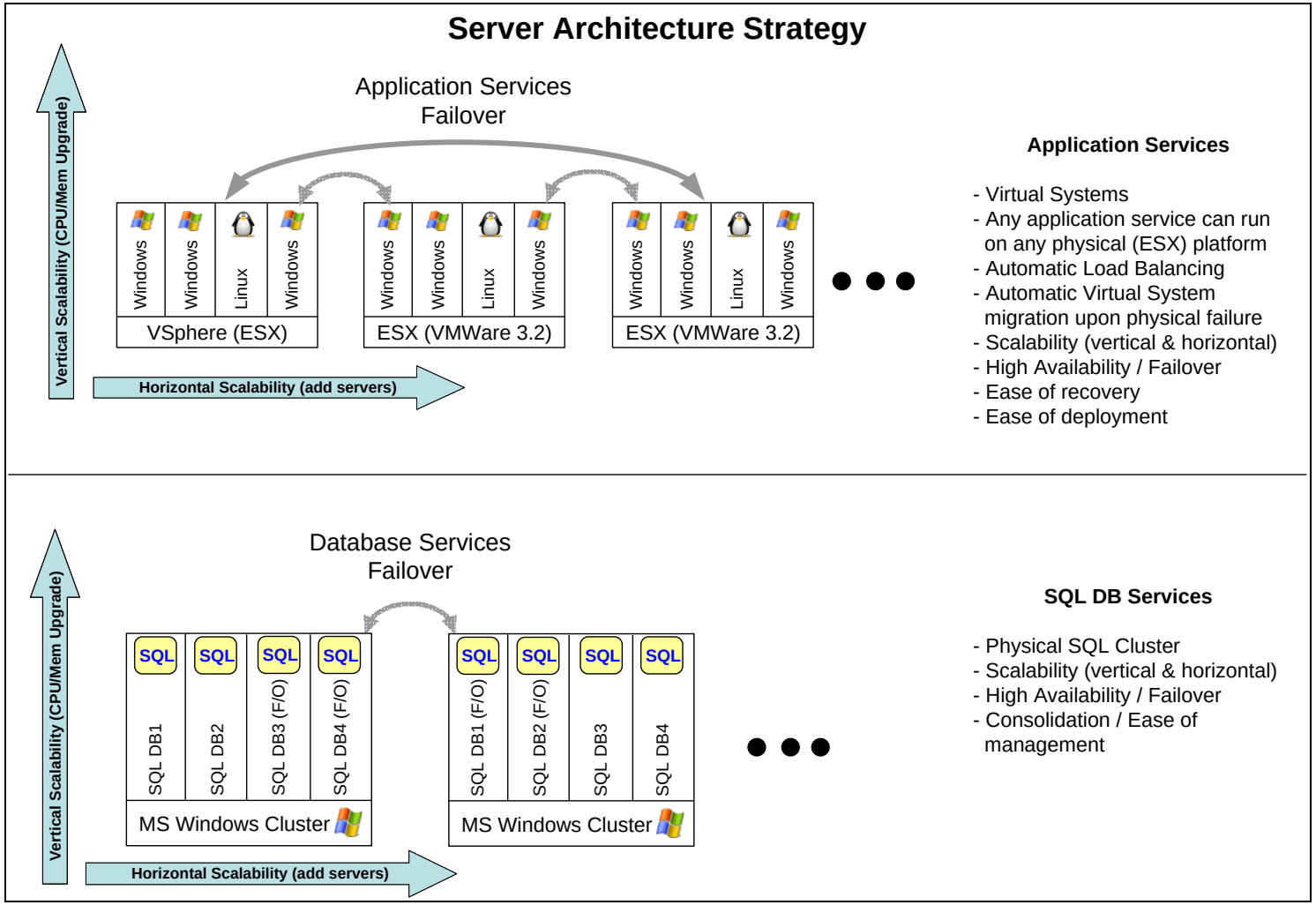
- The Data Center, MDF, Lab, UPS rooms, and Demarc rooms are protected by a VESDA (very early smoke detection apparatus). This system has the ability to detect a very small amount of smoke and will send alert notification before a large fire event develops
- The Data Center, MDF, Lab, UPS rooms, and Demarc rooms are protected by an ECARO-25 Clean agent system. The Clean Agent system is designed to dump in the event of fire detection. This removes the necessary oxygen from the affected area in order to extinguish a fire. There is a total of 368 lbs of clean agent on site
- In the event the Clean Agent system is unsuccessful at extinguishing the fire we have a Fire Protection sprinkler system consisting of two (2) Pre-action systems and one (1) wet system that will deliver water to the fire automatically

Network Access. *The facility was designed with fully redundant networking infrastructure and network circuits* between our two datacenter facilities to ensure that an outage by one of our telecommunications providers (AT&T & Qwest communications) will not result in our systems being rendered unavailable. Each network circuit reaches the facility from distinct path and terminates in a private network DMARC area. Each of the vendors are only allowed in their DMARC to provide full separation and security

Electrical Plant. The power infrastructure of Centene's datacenter was engineered and constructed to provide the highest levels of reliability, performance, and fault tolerance. It is monitored both on-site and at our corporate network operations center to ensure optimal performance is maintained. Redundant utility power feeds, UPS battery backup systems, and power feeds to the individual equipment racks, together with a diesel generator sized to handle the full power load of the datacenter and automated systems to manage the transfer of load between power systems, ensure that power events that would normally be disruptive, ranging in severity from a minor short in a power cord to a major extended outage of regional utility power, will be transparent to our systems, our users, and the members and providers that we serve.

Mechanical Plant. Datacenters generate a great deal of heat. As a result, the systems used to cool a datacenter are every bit as critical to operations as are the power systems. With that in mind, the Centene datacenter incorporates a high performing and highly efficient cooling system built to support our exacting standards for both reliability and fault tolerance. The redundancy that we have engineered and built into each component including chillers, pumps, condensers, air handlers, and reserve water tanks, together with our use of both water cooled and air cooled technologies, ensures that our systems will remain at optimal operating temperatures even if components of the cooling system fail or need to be taken off-line for service. What's more, Centene's use of "green technologies", such as a plate/frame heat exchanger and cooling tower system, enable us to use the ambient temperature of the outside air to cool the datacenter when the weather allows. Centene's environmentally conscious and well reasoned approach to datacenter cooling systems is one of the many factors that have contributed to our datacenter achieving the third-party Leadership in Energy & Environmental Design (LEED) certification.

Figure 2.g.xxxv-A: Windows Server Architecture Reinforces Availability.



2.g. Technical Requirements
xxxvi. Describe the Proposer's operating system/network infrastructure on which the software runs. Describe the programming language utilized and the software used to develop it. Describe how the source code can be purchased and if the Proposer can customize the software. Describe the Proposer's policy and procedure on software upgrades. Suggested number of pages: 5

Centene Corporation (Centene) will provide local and enterprise level Management Information System (MIS) hardware, software, and communications networking systems for Cenpatico Louisiana operations. Throughout Centene's 27 years of supporting Medicaid, CHIP, and other state funded managed health programs, we have *carefully* but *continuously enhanced* the individual components and integration of our software architecture, building on our core system foundation, including our claims processing system, AMISYS Advance, which we have operated and upgraded over the past 15 years, and our Centelligence™ Enterprise Data Warehouse (EDW) which forms the heart of our data integration and informatics strategy.

Engineering Performance Through Operating & Sub-system Software and Hardware

Centene utilizes industry standard operating systems, sub-system, application software and hardware including:

- Windows, Linux, and HP-UX operating systems.
- SQL standard relational database management systems from Microsoft, Oracle, and Teradata.
- Virtualization platforms (e.g. VMWare VSphere, Citrix XenServer and XenApp).
- AMISYS Advance claims processing; Microsoft Dynamics Customer Relationship Management (CRM); TruCare care, case and utilization management; and more.
- Hardware components from hardware leaders, such as Cisco, Hewlett-Packard, NetApp, EMC, Wyse, and Avaya.

Our use of *Blade Servers*, *Virtualization*, *Clustering*, *Storage Area Network*, and *hardware redundancy* affords us the availability, performance, and scalability to power the three broad service tiers of our systems architecture: presentation, application, and data storage.

Hewlett-Packard's ServiceGuard® Server Clustering software allows us to deliver application services across a group of server nodes configured so that any one of the nodes can provide appropriate end-user access. In the event that one of the nodes is lost, the surviving nodes pick up the work load, averting a prolonged outage.

With the use of VMware's Server Virtualization Infrastructure and High Availability Services, we deliver a fully redundant server farm capable of running a number of different application services. Virtualization provides high availability for our applications, and streamlines application deployment and migrations. The servers are automatically load balanced to provide the best performance. If one of the physical nodes were to fail, be taken out of service for maintenance, or experience higher than expected utilization, the application service automatically moves to another node in the server farm without any interruption to the application service with no impact to the user. Virtualization reduces our power and air conditioning needs, and optimizes the amount of CPU power and data storage that we house in our building space.

Cenpatico data will be stored on an HP XP24000 SAN-attached Storage Array, with multiple paths to RAID 5 storage devices facilitating high performance, scalable and fault tolerant data access. For more information on storage hardware, please see our response to question 2.g.xxxvi.

An Open Standards, Secure and Highly Available Network Infrastructure

Please see Figure 2.g.xxxvi-A Centene Wide Area Network (WAN) for a graphical overview of our enterprise network. Today, our local plan offices connect to our core applications via Centene's WAN: a secure, high-performance, fault-tolerant network architecture designed for stability, interoperability and

growth through a *mesh design* that provides multiple paths to and from each point. If one path is disabled, or not performing optimally, the request is rerouted through an alternative branch.

Centene's network provides a secure access medium for mission-critical applications including voice, video, and time-sensitive data. Our data and voice services are provided through a Dedicated OC-12 (622Mbps) SONET Ring Service (DSRS). The OC-12 provides a resilient ring topology that connects Centene headquarters with geographically diverse Local Exchange Carrier (LEC) Central Offices. All Centene Corporate data circuits use this Dedicated SONET Ring Service. Carrier diversity is established by using dual SONET ring service from two independent, inter-exchange carriers. Each SONET connection consists of a resilient ring topology that connects the corporate office to the service provider's telecommunications infrastructure. Additional physical link protection is provided by establishing geographic diversity through physical separation of fiber routes.

Our primary network infrastructure consists of a high-speed, virtual full-mesh, Private IP Multiprotocol Label Switching (MPLS) network. Centene's corporate campus is linked to this MPLS infrastructure via an OC-3 (155Mbps) circuit transported within the OC-12 DSRS. Field offices are connected to the MPLS infrastructure using aggregated T1s bonded via Multilink PPP (MLPPP). Remote office connections range in bandwidth from 3 Mbps for smaller offices to 12Mbps for large regional offices such as will be the case with Cenpatico's office.

Our local field offices have a Centene standard Local Area Network (LAN) configuration using 100 Mbps T100 or 1GB Network Interface Cards (we will install 1GB NIC's for the Cenpatico offices) and Category 5 (Cat5) dual port wiring to each work area. The LANs are connected to our WAN using Cisco 2600/3600 switches which allow for extensive expansion and fast data transfer. Redundant WAN connectivity is established through a secondary Service Provider to enable *carrier-diversity*. This redundant network consists of multiple point-to-point T3 (45Mbps) and T1 (1.5Mbps) leased lines. Cenpatico's office will be connected to this backup network through direct circuits to Centene headquarters. Multiple T3s enter our Centene headquarters location, with two of these T3s delivering remote T1 circuits to/from the LEC. A 45Mbps connection is provided for our dedicated business-continuity and disaster recovery site.

All Centene field locations are independent so that high-utilization in one location will not impact system performance in another. In the event an office loses its direct connection with Centene corporate headquarters, alternate route paths are available for redirecting traffic through backup connections on the secondary network. In addition, all network equipment used for primary and secondary service delivery is designed for high-availability using redundant component configurations.

In the event of complete system failure or environmental catastrophe, our Business Continuity Plan (BCP) provides direction for sustaining operations during any site disabling event. Network performance is monitored 24/7 from our Network Operations Center (NOC). Using Citrix and Avaya Voice-Over IP (VOIP) Phone Systems, our staff can access all of Centene's systems remotely to address issues. Staff can resolve issues any time, any place, and from any Centene-registered IP node to fully support the delivery of services.

Presentation Layer (User Desktop & Web Portal). We deploy virtual desktop and remote application support using Citrix XenDesktop, XenServer, and XenApp products. A virtual desktop separates the workstation computer hardware from the operating system and client applications that are utilized by the end-user. Centene was selected as a finalist in the 2010 Citrix Innovation Award for our rapid deployment of virtual desktops. Our corporate datacenter in St. Louis, Missouri, will centrally run and maintain all Cenpatico programs, applications, processes, and data. Our high-speed WAN will connect Cenpatico virtual desktops to our centralized IT resources. We configure, provision, and use a standardized desktop environment for all Centene and health plan staff with operating systems that include Desktop Windows Server 2003, SP2 with Citrix XenApp 4.5 for thin clients, and Windows XP, SP3 for desktops and

laptops. We use IBM WebSphere technology web and portal platforms operating on Red Hat Enterprise Linux. WebSphere Portal Server (WPS) is used to integrate our electronic business applications across multiple computing platforms, using Java-based Web technologies.

Our virtual desktop approach (VDI), also known as a "thin client," allows our standardized PCs to present an engaging, intuitive, and responsive interface to the user, while the enterprise servers house our high transaction, critical business applications and data in a safe and reliable computing environment, which is the kind of large scale, environmentally secure infrastructure that only an enterprise scale installation can deliver. We have moved to the "thin client" based on experience learned from setting up field offices across affiliate plans in 11 states, and this thin client approach has several pertinent benefits for LBHP:

- Data Integrity. Because Protected Health Information (PHI) and Cenpatico's core applications and operational data will be housed in our central datacenter, Cenpatico will benefit from all the infrastructure support of our corporate datacenter including our data integrity controls, back-up capabilities, audit trails, help desk support.
- Business Continuity. With centralized data, our local plan's information is safe in the event of any local site disabling events, and further, operations can continue from any other location throughout our enterprise.
- Confidentiality. VDI and thin client hardware support more secure operations. The theft risk of the thin client, virtual workstations is reduced because they do not have any operating hardware or system software stored locally on the machine. Further, PHI is better protected because it is not stored on the virtual desktop; it is only accessed through the virtual desktop. Our encrypted laptop drives also contribute to data confidentiality and secure operations.
- Centralized application control. Changes to our core business applications can be developed and systematically deployed by our MIS staff across our network from a central location, which allows for quick, secure, and non-risky business and technical changes and upgrades, including specific changes for a particular health plan. We are also able to more efficiently deliver rapid upgrades and patches because these are done centrally in our data center with no need to "push" software to end-user equipment - enabling a less error prone, labor intensive upgrade process. The bottom line: we can respond more quickly and in an operationally non-disruptive manner to business requirements from DHH-OBH or Cenpatico.
- Protection from viruses**.** Although we have enterprise wide anti-virus software for our PC based applications (predominantly Microsoft Office applications) by having our core transactional data and applications centrally housed, we eliminate the exposure to any Windows virus or malware impacting operational data.
- Efficient workstations. Employees are able to access their virtual desktop on any capable device, such as a traditional personal computer, or thin client hardware, which will be the case for Cenpatico office workstations. Thin client hardware far exceeds traditional workstation computers typically using 1/10th the power of traditional workstation computers. The process for logging into a virtual desktop system is the same familiar process as logging into a local workstation. Once authenticated to the VDI, Cenpatico staff will be presented a full Windows desktop that appears to operate as a local workstation. Our high-speed WAN ensures optimal application performance to our staff.
- Superior User Experience. Users of our thin client systems enjoy a performance advantage that is a key benefit to the thin client architecture. Thin clients, with the virtualized desktops and applications that they present, process applications requests utilizing the CPU, memory, I/O, and disk resources of the enterprise class server machines that host the virtualization software. The performance capabilities of this server class hardware are significantly greater than the commodity hardware that is used to build traditional desktop and laptop machines.

Secure, High Capacity Internet Connectivity. Today, Centene provides field offices with Internet access through Centene's OC-3 circuit. The 155Mbps Internet service is transported and terminated on a Cisco access router. The access router is connected to redundant corporate firewalls (Cisco 6500s with Firewall Switch Modules). The Cisco 6500 Internet Access switches are connected to the internal network using Gigabit Ethernet over fiber. Centene's Internet infrastructure defines trusted and untrusted segments. Intrusion Detection Systems (IDS) are located in strategic locations within the trusted and untrusted segments to assist in the detection and prevention of security violation attempts, including unauthorized access attempts, denial-of-service attacks, or other malicious attempts to disrupt normal business activities. In addition to the trusted and untrusted zones, we have established De-militarized Zones (DMZs) to provide semi-trusted segments for Web Servers, Domain Name System (DNS) Servers, and Secure Access Gateways. We provide remote access to Centene Corporation's network through encrypted web access sessions using Citrix Secure Gateways. Please see our response to question 2.g.xvi for more information. In June 2011, we are further hardening our network perimeter security with the deployment of Intrusion Prevention Security (IPS) technology from Sourcefire, Inc. Our Sourcefire Next-Generation IPS integrates real-time contextual awareness into the IPS' inspection. This IPS gathers information about our network and host configurations, applications and operating systems, user identity, and network behavior and traffic baselines. The utmost visibility of what is running on our network allows our Sourcefire system to offer event impact assessment, automated IPS tuning, and user identification. The emphasis is on shifting from intrusion detection, to *intrusion prevention*.

Using Industry Standard Desktop Operating Systems. For all of our staff at Centene and our field offices, we configure, provision, maintain and use a standardized desktop environment, and each desktop is maintained in compliance with our software upgrade policies.

An Integrated Software Infrastructure

While our hardware, systems software, data and voice architecture will supply the requisite computing platform for Cenpatico operations, it is through our *integrated business applications* that Centene delivers the functionality in service of our health plans, including Cenpatico, and our State clients. Our software applications integrate tightly via underlying standards based transactions, file interfaces, and a data storage array that retains pertinent information such as Member, Provider, encounter, and clinical case management activity. Our front-end clinical case management system (TruCare), claims processing system (AMISYS Advance), our Member and Provider Relationship Management (MRM/PRM), our secure Provider, State Agency, and Member Portals, and our Centelligence™ reporting, business intelligence and decision support applications, access data from this array to provide our staff, state clients, providers, and members with comprehensive information to effectively manage the member's and provider's needs. Please also see our response to question 2.g.iv for more information on our integrated system software.

Our Service Oriented Architecture (SOA) approach to software deployment uses industry standard, message-oriented interfaces, such as Java Messaging Services (JMS), Open Database Connect (ODBC), Service Oriented Access Protocol (SOAP) web services and other open interoperability tools, and affords us maximum flexibility in incorporating best of breed solutions quickly and responsibly into our overall MIS in strategic timeframes yet with limited project risk. Centene's SOA based on TIBCO and Informatica products, fully integrates all systems in a secure environment, from internal systems, including our MRM and PRM member and provider data systems, our AMISYS Advance claims processing, our TruCare clinical care management system; to our front-end components such as our web portals and secure EDI gateways. TIBCO and Informatica are industry leading middleware software vendor and an early adopter of the Service Oriented Architecture (SOA) paradigm.

Programming Languages and Development Software

Centene's relational database design provides the flexibility and extensibility needed to quickly develop new methods for collecting data to continually meet DHH-OBH's requirements. For example, AMISYS Advance, while having its own "built in" capabilities, is built with open application programming interfaces (API's) that allow our skilled MIS Application Developers to customize AMISYS Advance to meet the contractual requirements of DHH-OBH. Please see Table 2.g.xxxvi-B for Cenpatico's integrated enterprise software portfolio, including programming languages for each of our applications, that we propose to employ for the Louisiana Behavioral Health Partnership. Please also see our response to section 2.g.ii and 2.g.iii which describe our IT organization and the training that we provide for our IT staff enabling them to configure and develop, where necessary, solutions to specifically meet the needs of DHH-OBH and the Louisiana Behavioral Health Partnership program.

Source Code

Our application architecture uses best in class purchased software for specific functions (e.g. claims adjudication, predictive modeling, clinical criteria), with a custom integration layer that allows us to adapt, configure, customize, and innovate as necessary to adapt to the needs of LBHP. For areas that have the deepest functional complexity, Centene either owns and manages the source code (e.g. data warehouse, enrollment), or has rights to modify the source code with the support of the vendor (e.g. DST Health Solutions, the vendor which owns AMISYS Advance). The remainder of our purchased systems, while not making true source code available to customers (e.g. Oracle PeopleSoft), have an extensive configuration layer fully accessible to and managed by Cenpatico and Centene staff. Finally, in the rare case that configuration cannot accomplish a required capability, Centene can adapt the custom integration layer to accomplish any necessary capability. We continue to execute a rigorous application governance structure that enforces standard processes and technologies whenever possible, but we can and have adapted our application architecture to meet the needs of our State clients.

Upgrading Software Through Change Management Discipline

We balance the demand for software reliability, data integrity and availability with the need to *carefully* infuse relevant new software versions and innovations. We implement changes and deploy new and updated software through well-documented Software Development Life Cycle (SDLC) and MIS operation techniques, and in partnership with our clients, providers, and users. Our use of the Agile method for SDLC, allows us to formulate, develop, test, and introduce new software versions quickly, yet within the confines of auditable change management, allowing for total project risk mitigation. Our clients, partners, and users are able to see and experience new functionality *incrementally* so that processes can be enhanced smoothly and documented with clearly identifiable revisions, and training courses can be updated with new functionality "curricula," incorporated seamlessly and naturally.

In addition, every year we review and compare all hardware and software components in our integrated MIS portfolio with the latest product versions from our vendors and overlay the projected needs of our business for the following year. The output of this effort is our Strategic Technology Refresh Plan (Systems Refresh Plan), which serves as our annual roadmap for planned introduction of new software versions for both Centene proprietary and vendor supported software components. Perhaps the most critical component of our approach to significant software updates and new software integration is our *regular communication with our state partners, which will include DHH-OBH,* about any material updates related to our MIS operations.

Agile Software Development Life Cycle. Centene and Cenpatico use an Agile Software Development Life Cycle (SDLC) process to deliver higher quality software upgrades faster, while maintaining effective business controls. Agile is an industry best practice development discipline that has a collaborative and evolutionary approach with consistent outcomes in both quality and customer satisfaction. We implement MIS changes as part of an integrated release management process. Each Centene application team (e.g. claims, reporting, case management) works with their Cenpatico business partners to capture

requirements and define priorities, and then establishes and publishes a release calendar with controlled releases typically every two to four weeks. This frequency mitigates operational risk by reducing emergency changes. Our SDLC includes the following stages facilitated by our IT Service Management Team and the Change Review Board (CRB):

1. **Requirements -** Our IT Development Team facilitates several design sessions between IT and business stakeholders to ensure understanding of all business requirements. Our business analysts then document the results of these meetings and develop specific design documents (e.g. configurations for the business rules, specific edit settings, benefit plan configurations, and file and data formats for inbound and outbound file exchanges). These are reviewed and signed off by all key business stakeholders.
2. **Input on Release:** During this phase, our Development Team creates technical specifications from requirements and testing scenarios. We hold daily meetings to check progress, ensure understanding of requirements, and identify barriers for management.
3. **Development and Unit Testing -** During unit testing, our Development Team works closely with business sponsors to keep the project on track, and our engineers perform Peer Review to ensure the new software code (code) meets Centene standards.
4. **Review of Release/Change and Deployment to Test -** The Release Team reviews the code to make sure it is ready to move to the test environment. The Release Team uses a checklist to ensure all requirements are taken into consideration before the code is released to integration testing.
5. **Integration Testing/User Acceptance Testing -** After numerous iterations in our Agile IT processes, we perform integration testing that includes our business stakeholders to ensure appropriate outcomes for business areas related to member, provider, authorization, claims and reporting (our Centelligence™ Enterprise Data Warehouse (EDW) and Centelligence™ Insight reporting system). During this phase, we complete regression testing to prevent unintended impact on current functionality. We use IBM Rational automated testing tools to assist in this process.
6. **Management Validation -** The Development Team Leads review each Agile user story or use case and approve or deny the change.
7. **Change Review -** The Change Review Board (consisting of project managers and architects from key areas) performs final release review, including risk and impact of the release. All relevant parties must agree on a release date.
8. **Move to Production -** Once the release has all been approved by all parties, the Release Team moves the release into the production environment. We use Subversion and Serena ChangeMan for our Unix and Windows environment library and software versioning control processes as software configurations move from unit test to production.
9. **Validation of Production -** Here the Development Team reviews the release to validate that enhancements function as planned. Should issues be discovered, they implement the backout plan for this change. Otherwise, the release is closed.

Figure 2.g. xxxv-A: Centene Wide Area Network.

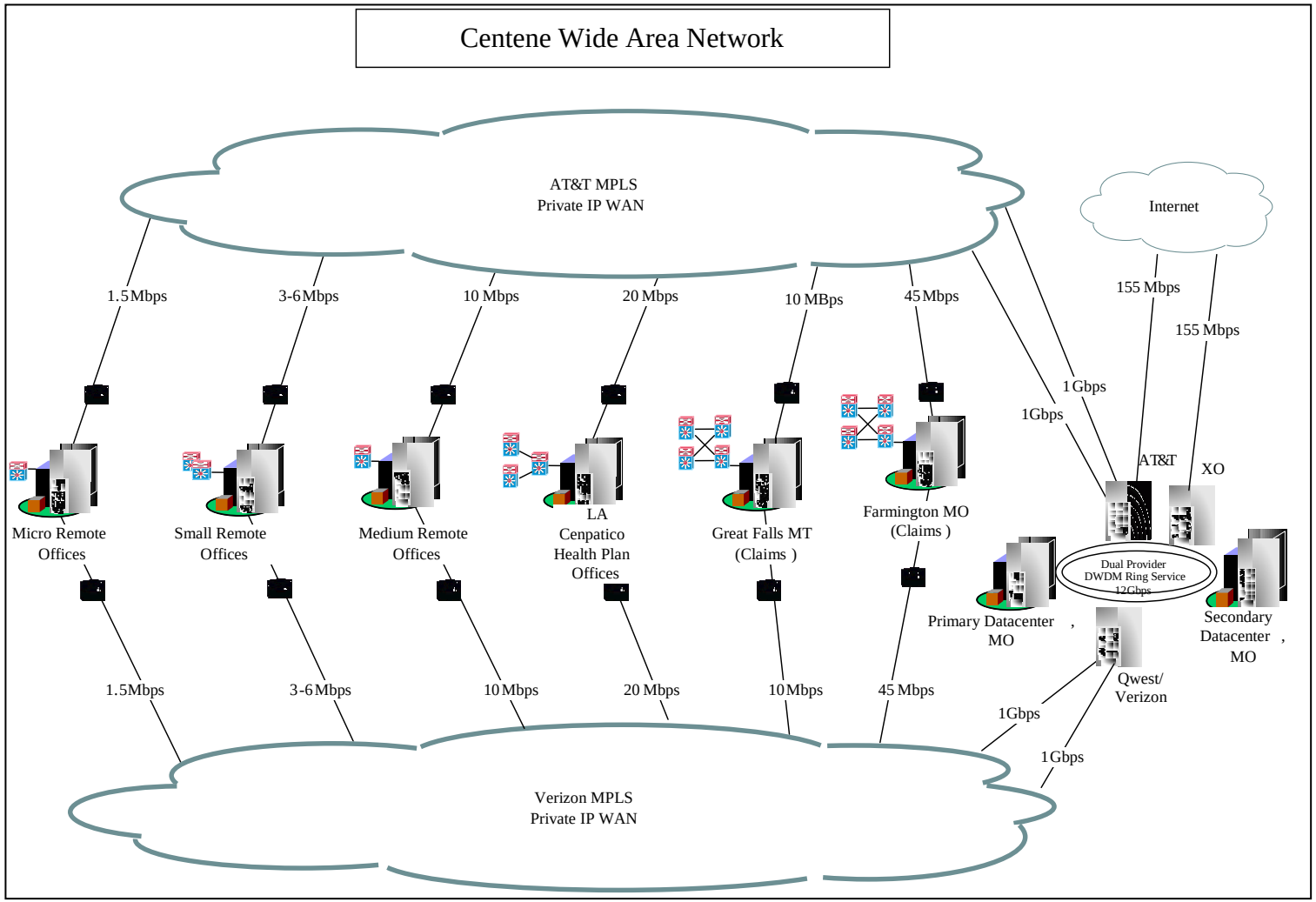


Table 2.g.xxxvi-B:

Application	Vendor	Application Description	Current Version	Database structure	Programming Language
Medical Management					
TruCare	CaseNet	Clinical Case Management	4.3	MS SQL	Java, FLEX
InterQual	McKesson Health Solutions	Medical Necessity Criteria software	4.4	MS SQL	Powerbuilder
Centelligence™ Platform					
Enterprise Data Warehouse (EDW)	Teradata	DBMS Platform for the Enterprise Data Warehouse	13.00.00.22	Teradata	ANSI-SQL
Executive Dashboard	Custom	Reporting dashboard	5.15.0	Oracle	Flash, Business Objects Reports
XCelsius Enterprise	SAP	Dashboard and Visualizations	2008 SP1	Oracle	Java, Flash
Business Objects Crystal Enterprise XI	SAP	Compliance reporting and Business Intelligence tools	XI 3.1	Oracle	C/C++, Java, .NET, XML, HTML
Impact Intelligence	Ingenix	Utilization, patient outcomes analytics software	1.3	Oracle	.NET, Java
Impact Pro	Ingenix	Predictive modeling and care management analytics software	5	Oracle	.NET, Java
Quality Spectrum Insight (QSI)	Med Assurant, Inc./	Performance measurement and Quality Improvement (QI) reporting - HEDIS	13	MS SQL	.NET
Negotiator	Custom	Contract modeling software to aid in analysis of new or modified provider contract	1	Teradata	SharePoint
Power Center	Informatica	Extract, Transform and Load Automation Tools	8.6.0	Oracle	C/C++, Java, XML
Power Exchange	Informatica	Updates EDW in near real time with changes from core applications	8.6.1	Oracle, SQL	C/C++
Web Services					
Provider/Member Portal	Custom	Secure web based portals for secure transactions with members and providers	7	Oracle	Java, C/C++
Clear Claim Connection	McKesson Health Solutions	Allows providers to access claim auditing rules for cleaner claim submissions	5.5	NA	Service from Application Service Provider (ASP)
Claims Processing					
AMISYS Advance	DST Health Solutions	Eligibility, enrollment, claims processing, COB	4	Oracle	COBOL, Java, JCL, Perl, HTML
AWD	DST Health Solutions	Document and workflow management	10	Oracle	Java
ClaimsXten	McKesson Health Solutions	Medical review and code auditing	CXT.2.0	SQL	TCL

Application	Vendor	Application Description	Current Version	Database structure	Programming Language
MACESS.exp (Includes IMAX and Storage)	SunGard Workflow Solutions	Document imaging, OCR, and document management	IMAX - 4.4	N/A Proprietary	C++, Visual Basic & Proprietary language
EXP Form Works/RRI	SunGard Workflow Solutions	Image Storage	Form Works 4.0	Pervasive SQL / Btrieve	C++, Visual Basic, Proprietary Language
Encounters					
Xpress Encounter pro	Medical Data Express	Encounters Processing	3.1	MS-SQL	.NET, SQL
Member and Provider Relationship Management					
Customer Relationship Management (CRM)	Microsoft Corporation	Integrated member/provider inquiry, tracking, management	2011	SQL Server	.NET, SQL, XML
Portico	Portico Systems	Provider credentialing, demographics, financial information	6.1	Oracle	Java
Emptoris	Emptoris Inc.	Contract management and reporting	7.5.9.1	Oracle	Java
Enterprise Content Management (ECM)	N/A	Next generation paper & fax document scanning, indexing, storage and management.	2011	N/A	N/A
After Hours NurseWise Support					
N-Centaurus Telehealth Triage	LVM	Nurse triage and call center workflow for NurseWise	2010	MS SQL	Java, .Net
Financial Applications					
PeopleSoft Financials	Oracle Corporation	G/L, A/R, A/P,	9	SQL	C++
Hyperion Planning & Reporting	Oracle Corporation	Financial Planning & Reporting	9.3.1	SQL	C++
Payment Reconciliation	Centene	Eligibility and remittance reconciliation	1	Teradata	ETL, SQL, Business Objects
Telecom Services					
Avaya Communication Manager (CM)	Avaya Inc.	World class call routing and applications; call centers managed through automatic call distribution (ACD) and advanced vectoring	5.2.1	NA	C/C++
Avaya Call Management System (CMS) Supervisor	Avaya Inc.	Tracks and reports information processed through the ACD	14	NA	C/C++
Avaya Modular Messaging	Avaya Inc.	Multimedia messaging platform - users to respond to messages via voice, fax, text, and file attachments.	5	NA	C/C++
Avaya Voice Portal	Avaya Inc.	Speech-Enabled self-service IVR	5.1	Oracle	Java, VXML
Middleware Services					

Application	Vendor	Application Description	Current Version	Database structure	Programming Language
Business Connect	TIBCO Software	Data translation software; supports HIPAA, other ANSI, proprietary formats	3.6.0	Oracle	Java
iProcess Suite	TIBCO Software	Rules Engine	4.1.1	Oracle	Java, C/C++
EDIFECS X-Engine	EDIFECS	HIPAA compliance checking: translator/ validator component of EDIFECS	6.2.1	NA	XML and JavaScripts
EDIFECS Ramp Manager	EDIFECS	Automate EDI trading partner administration	6.4	NA	NA
Diplomat Transaction Manager	Coviant Software	Enterprise file transfer; supports FTP, SFTP, or local network delivery	3.5.3	XML	Coviant scripting language (using Java Runtime Environment)
Change Management					
Service-Now	Service-Now	Enterprise service desk software: incident, problem, change management	Fall 2010	Proprietary	Java, Java Script,
Compliance					
Compliance 360	Compliance 360, Inc.	Enterprise governance, risk management, compliance and audit management solution	2011.1.3.21	NA	NA