SECTION X – CLAIMS MANAGEMENT

X.1 Describe system capabilities and limitations of all requirements stated in Section 17.8 Encounter Data, and identify areas where change would be necessary based on requirements stated in the Systems Companion Guide. Identity any limitations or disparities to requirements stated in Section 17.2, 17.8, and 17.10.
Describe system capabilities and limitations of all requirements stated in Section 17.10 Pharmacy Claims Processing and the NCPDP Guide located in the Systems Companion Guide.
If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

Experience Processing Louisiana Encounters

Louisiana Healthcare Connections (LHCC) and our parent company Centene Corporation (Centene) have over 30 years of experience receiving, processing, reporting, and securely transmitting membership, provider, encounter, and other reporting data to our state clients and their fiscal intermediaries. We receive and supply encounter data to 18 state Medicaid agency clients on schedules ranging from daily to annually, depending on the specific information and data product required by our state partners. LHCC currently submits almost 700,000 HIPAA compliant encounters each month to DHH for all services including medical, basic behavioral health, dental, vision, pharmacy, and value-added services rendered under our existing DHH contract. For the period July 2013 to June 2014, we maintained an average acceptance rate of over 98%. LHCC and Centene view DHH as a partner in the encounter submission process. We will continue to work collaboratively to resolve any barriers to meet any requirements that enhance and simplify DHH administrative oversight processes.

Louisiana Healthcare Connections averages a first time success rate of over 98% for submitted encounters.

We have reviewed in detail all claims requirements stipulated in Section 17 of the RFP and also requirements indirectly impacting claims processing such as those found in Section 16 (general Information Technology capabilities and security); Section 9.5 (Claims Processing Requirements and encouraging Electronic Data Interchange - EDI); Section 5.11 (Third Party Liability processing); Section 5.12 (Coordination of Benefits); Section 18 (Reporting); and finally the Bayou Health Systems Companion Guide (Encounter Processing). We have also examined the Bayou Health Medicaid Managed Care Organizations System Companion Guide Version 1.0 (MCO Companion Guide), and the LAMMIS Batch Pharmacy Companion Guide (both documents dated February 2015) and we either currently support, or in the case of new requirements contained in the MCO Companion Guide, can and will support, all requirements through configuration of our MIS.

As a Bayou Health incumbent, and through Centene's years of supporting state public sector health care programs, we understand the dynamic nature and evolution of both healthcare and technology. Collaboration, adaptation and change are necessary for continuous process improvement. For this reason, Centene created a centralized Encounter Business Operations Unit (EBO) to define and establish best practices in encounter submission processes. The EBO is an agile organization that is able to learn and share expertise based on the variations in requirements across our affiliate health plan operations and the states they serve. The EBO supports LHCC's encounter submissions to DHH and Centene's Management Information System (MIS) offers DHH best-in-class technology that is configurable to meet the specific needs of LHCC, DHH and DHH's Fiscal Intermediary (FI), and the State's Medicaid Management Information System (MMIS). Today, we deliver the majority of requirements stated in the RFP. For the few new requirements that we do not deliver today, we will be able to configure our systems and processes to accommodate these, and will review our plan with DHH if we are awarded the privilege of continuing to serve the Bayou Health Program.

System Capabilities and Limitations per Section 17.8 Requirements

System capabilities and/or limitations per each requirement in Section 17.8 of the RFP are described below.

17.8. Encounter Data Requirements. *Please also see our response to Section X.2 for a detailed description of our encounter submission process.*

17.8.1. Transmit and Receive Encounter Data. Today, LHCC prepares, and submits data as encounters to DHH's FI on a weekly basis. We use our Encounter Data Manager (EDM), a best-in-class encounter processing application developed specifically for Medicaid managed care and Medicare encounter data. EDM is a workflow enabled encounter reporting system that allows us to extract, prepare, receive, and process errors according to DHH requirements. EDM's integration with our Centelligence™ Enterprise Data Warehouse (EDW) and AMISYS Advance, our claims processing subsystem, allows us to capture all claims for encounter submission for each weekly payment cycle.

EDM has pre-scrub edits which are configured to specific processing rules required by DHH and DHH's FI for encounter submissions. This enables us to submit accurate and complete data, in the requisite format according to the claim type, Provider-to Payer-to-Payer COB 837I (Institutional) and 837P (Professional) transactions, for all claims paid or denied. We utilize EDIFECS software (the same software used by DHH's FI) to test our weekly submission for HIPAA compliance before we submit our files in production. We use our COVIANT Diplomat Transaction Manager (COVIANT) for automated, scheduled file exchanges (transmission and receipt) with DHH's FI, using the secure FTP–SFTP (SSH) data transmission protocol.

We also receive encounter responses from the FI such as the 999 acknowledgement file from the FI, typically the day of, or the day after the file was submitted. We monitor for this acknowledgement to ensure that the encounter submission was retrieved by the FI. Also, typically a few days after the acknowledgement is received, we receive response files from the FI with any records that did not pass the FI encounter edits. These files are loaded into EDM for complete and auditable tracking, resolution, and resubmission to the FI in the next weekly encounter submission.

17.8.2. *Processor Control Number and Bank Identification Number.* We have the capability to create a unique Processor Control Number or group number for Louisiana Medicaid. Today we have a Submitter ID that we use with each of our encounter submissions to the FI. We will clarify with DHH and DHH's FI the exact definition for a Processor Control Number, or group number and the requirements for the Bank Identification Number submission to ensure we provide this information to the FI in accordance with DHH requirements.

17.8.3. *Encounter Submission Timeliness.* LHCC creates and submits encounter files per each *weekly* claims payable run. Our EDM workflow subsystem monitors and tracks all our encounter submission steps, allowing us to submit encounter data no later than the 25th calendar day following the month in which the claim was finalized to a paid or denied status.

Reporting Encounters for Capitated Services. Our processes and integrated MIS currently support the submission of encounter data to DHH and DHH's FI, derived from both inbound Fee for Service (FFS) claims and encounters submitted by providers for capitated services. We support exactly the same level of detail data validation and encounter data submission to DHH for both types of inbound transactions: FFS claims and capitated service encounters.

Completeness. To ensure completeness of encounter data submitted to DHH, on a monthly basis LHCC balances all claims data (paid and adjusted); including claims submitted by non-participating providers and subcontractors, with the corresponding encounter data files submitted each week. We do this by comparing each weekly payment run to the corresponding weekly claim payment and claim count, and to the corresponding encounter submission. Each encounter record is also tracked to ensure that errors or rejections are handled in a timely manner. *LHCC consistently submits encounter data that is 98.6% complete within 90 days, and 99.0% within 180 days, exceeding the DHH requirement of 95%.*

17.8.4. ***Encounter Submissions – Document and Line Level.*** LHCC currently submits inpatient HIPAA 837(I) encounter data at the document or "claim" level and all other encounter data at the line level, per DHH FI requirements. We can adjust this to submit claims at either the claim or the line level according to DHH and DHH FI specifications, and we can be prepared to do this within 60 days after the contract start date, or sooner. Our end-to-end view of encounter data production: from the provider's claim submission on the "front end" of the process to our submission of corresponding encounter record data to DHH, allows us to submit encounter data in alignment with DHH specifications.

LHCC subcontracts pharmacy benefit services to our affiliate company, US Script. Our vendor contracts call for timely, accurate, and complete encounter submissions. US Script is required to comply with the same encounter submission requirements as LHCC. We will submit pharmacy encounters, as we do today, using the NCPDP Batch Pharmacy 1.1 D.0. format, at the line level.

17.8.5. ***EDI Compliance and Authorization Reporting.*** EDM is configured to submit encounter data compliant with DHH FI Systems Companion Guides, including standards for electronic file submission, HIPAA file format (specifically ANSI X12N HIPAA 837 provider-to-payer-to-payer COB transaction format), file size, and submission frequency, as required by DHH and DHH's FI. We are certified with DHH's FI today through EDIFECS and understand that we are responsible for all costs that may be incurred for recertification, if necessary. Beginning August 2014, LHCC began submitting a weekly Prior Authorization and Denial transaction file to DHH. We have adhered to the audit process to submit documentation to DHH including a copy of the written notification and documentation regarding the criteria used to make the authorization denial. Based on the requirement in the RFP and Addendum 8, Q/A # 369 and 370, *we recognize that this is a new requirement*. Because our Centelligence™ EDW allows us to report on all data elements captured in the care of our members, and our ability to submit proprietary file formats to DHHs, we will be able to comply.

17.8.6. ***Complete and Accurate Data for All Levels of Healthcare.*** LHCC currently submits, almost 700,000 HIPAA compliant encounters a month to DHH's FI for all services including medical, basic behavioral health, vision, pharmacy, and value-added services rendered under our existing DHH contracts with a first time success rate of over 98% in Louisiana. We will continue to submit encounters for all levels of service in accordance with DHH requirements.

17.8.7. ***Paper Claims into Electronic Encounters.*** LHCC accepts paper claims from providers and requires all paper submitters to use standard CMS 1500 and UB04 paper formats. LHCC employs our Centene Document Management System (CDMS), an automated content management system centrally integrated with our MIS to convert paper or fax submitted documents into machine readable data. CDMS's integrated architecture incorporates a full featured, secure inbound/outbound fax communications system with enterprise level document scanning, Optical Character Recognition (OCR), indexing, and routing workflow capabilities, to streamline and automate the capture and processing of paper claims and conversion into machine readable data.

Once converted into data, paper claims are processed through the same validation and code set edit checks, as are claims submitted electronically. In addition, our EDM system treats claims data derived from paper claim submissions no different than claims submitted electronically. All encounter records extracted, scrubbed, and prepared are submitted as HIPAA 837 transactions to the FI.

17.8.8. ***Subcontractor Encounters.*** Our encounters include those from our subcontracted vendors for vision, pharmacy, and value-added services rendered under our existing DHH contracts. We submit these encounter files on a weekly basis in the file format as appropriate for the claim type and in accordance with DHH's FI requirements. LHCC's subcontractors do not submit encounter files separately. To maintain and attest to the quality of encounter data produced by our subcontractors, LHCC monitors subcontractor encounter submission quality and metrics, including timely delivery, appropriate coding and data elements, adherence to format set forth by DHH, before passing encounter data through to the FI. If an LHCC subcontractor falls outside our monthly performance guidelines, has any outliers in encounter

volume, and/or any other anomalies in the subcontractor's submission, LHCC will contact the subcontractor as needed for any appropriate action. The subcontractor is subject to a Corrective Action Plan and potentially liquidated damages. In addition, we perform an annual delegation audit related to claims and encounter administration.

17.8.9. ***Capitated Provider Encounters.*** Our processes and integrated MIS currently support the submission of encounter data to the FI derived from both inbound FFS claims and 'encounters' submitted by providers for capitated services. We support exactly the same level of detail data validation and encounter data submission to the FI for both types of inbound transactions: FFS claims and capitated service encounters. EDM is configured to submit encounter data that comply with all DHH data element standards. EDM reports the same line item detail regardless of the claim type, third party liability indicators, or capitation arrangements. Encounter records from EDM include all rendered services, original and adjusted claims, application of retroactive fee or member changes, as appropriate for the claim type, as well as capability to adjudicate a claim with a $0.00 payment and submit that data both as an Explanation of Payment to the provider as well as an encounter to DHH.

17.8.10. ***DHH Billing Manuals and Data Requirements.*** LHCC's Claims Liaisons and Contract Implementation Analysts are experts on DHH's provider billing manuals and work closely with our Provider Relations staff to educate and assist providers in the submission of complete claims with all necessary data elements for encounters submission. These Claims and Encounters specialists also work closely with the EBO. Centene currently supplies encounters data to 18 Medicaid agency clients (as well as CMS for Medicare). Although all State Medicaid contracts differ in business rules and contract requirements, with the support of the EBO, we are able to expertly adjust encounters-driven modifications, as we are aware that any changes made may have indirect impact on other business processes.

The EBO unit will work with teams "up-stream" or with supporting systems to modify business processes or data transactions, when necessary, to ensure all required data elements are collected and retained in claims history for encounter data submission. Since 2011, LHCC and its EBO Specialists have worked closely with DHH, FI, and DHH Auditors to meet, change, or add encounters-specific requirements that may enhance and/or simplify DHH's administrative oversight process.

17.8.11. ***Payment Rules.*** LHCC's Claims Liaisons and Contract Implementation Analysts are experts with DHH's provider billing manuals and work closely with our Provider Relations staff to educate and assist providers in the submission of complete claims data for encounters submission. EDM is configured to be in compliance with all Federal and DHH payment rules. We adhere to NCQA, AMA coding, UB-04 editor, and NCCI standards. Our encounters display the same line item detail as received on the claim, regardless of claim type and disposition (e.g., paid or denied); we include diagnosis, or DRGs as appropriate, and various DHH standards regarding the definition and treatment of certain data elements captured on claims (e.g. counting methods, units, etc.). For example, DHH requires pints of blood as a unit of service in encounter data submission, so LHCC requires this from our providers when this service is rendered. We provide all rendered services, rendering provider's identification numbers and billed amounts.

17.8.12. ***Paid, Denied, Adjusted and Voided Encounters.*** LHCC currently submits as encounters to the FI paid, adjusted, and voided claims. In 2013, we began submitting denied claims (per changes made to the Systems Companion Guide). LHCC and its EBO specialists work closely with DHH, FI, and DHH Auditors to meet, change, or add encounters-specific requirements that may enhance and/or simplify DHH's administrative oversight process.

17.8.13. ***Adjusted Claims and Encounter Submissions.*** If a provider payment error is discovered, LHCC will recoup the payment, adjust in the claim payment in the source system, AMISYS, and resubmit the encounter to the FI as an adjustment. For capitated providers, LHCC adjudicates the claim with $0.00 payment and its corresponding encounter data is submitted to the FI.

17.8.14 ***DHH FI Edits and Encounter Resubmissions.*** Response files received from DHH's Intermediary (FI) are loaded into EDM's Repository (reporting and analysis of encounter edits warnings or rejections). Encounter errors received are parsed out by the EBO team to the appropriate team for root cause analysis and resolution. Change Requests are completed in EDM and/or AMISYS to correct program logic issues. Encounter submission errors for processed claims are corrected, per program guidelines, and, when appropriate (a repairable edit), are resubmitted to the FI in the next payment cycle.

17.8.15 ***DHH FI Edits and Response File.*** EDM's ability to receive and process inbound acceptance reports from DHH's FI system facilitates encounter reconciliation workflows and prioritization of encounter correction activities. Our EBO Business Analysts use EDM's reporting functionality to identify encounter trends (e.g. volumes processed, work in process, encounter record aging, rejects and scrubs by specific "edit" type, etc.) to monitor our acceptance rates with FI and to proactively correct issues. For example, for a "non-repairable" denied encounter like "exact duplicate", LHCC has worked with the FI to identify and supply the encounters duplicating against each other. Once we know which encounters are duplicating against each other, LHCC undergoes an inspection process to decide if one encounter needs to be re-voided or re-keyed, and whether the original encounter is still in the system. For denials that are repairable, we will analyze, correct and resubmit the encounter to the state as described in 17.8.14 above.

17.8.16 ***Repairable Error Corrections.*** Our EDM's table driven configuration function allows us to implement DHH-specific business rules that scrub Encounter Data prior to submission, allowing us to proactively address any identified issues accordingly. LHCC meets and exceed expectations for addressing 90% of reported repairable errors within 30 calendar days and 99% of reported repairable errors within 60 calendar days. We configure conditional process workflows, job queues, and import routines to accept acknowledgments and processing results from the FI, thereby expediting encounter reconciliation and prioritization of encounter correction activities. Similarly, EDM captures and organizes "post submission" rejections (encounter records not accepted by the FI), expediting the identification, prioritization, and resolution of identified issues, as well as resubmission of accurate, complete encounters in timely fashion. This allows our LHCC Claims Liaison and Contract Implementation Specialists and the EBO to rapidly identify the issue, segment follow-up work, and address the issue for subsequent resubmission to FI. This process also ensures that resubmitted encounter data records are accurate, complete, and resent in a timely fashion. LHCC has not been sanctioned with monetary penalties or provided a corrective action plan.

17.8.17 ***Attestation.*** The EBO sends separate attestations to the health plan with every encounter submission, so that LHCC's CEO, or designee, can attest to the truthfulness, accuracy, and completeness of all encounter data submitted to DHH and the FI.

17.8.18 ***Claim Errors, Adjustments and Encounters.*** EDM is configured to DHH encounter specifications. Our EDM pre-submission scrubs ensure that the quality of encounter data is good prior to submission. LHCC does make adjustments to encounter claims if LHCC discovers incorrect encounter data. For example, if a provider was paid incorrectly, LHCC will recoup the payment, adjust the claim accordingly in AMISYS, and re-submit the encounter data to the FI. If DHH or its subcontractors discover errors or a conflict with a previously adjudicated encounter claim, we will resolve as follows. If DHH discovers an encounter defect where a data element is missing or incorrect, we will resolve the encounter within 14 calendar days. From past experience, these defects are easily resolved as the data is usually available in our systems. If DHH modifies the file format, including any additions of data elements to be included, we will implement within 60 calendar days.

Our use of industry–recognized best practices in Change Management, including the Agile Software Development Life Cycle discipline, in conjunction with an array of industry-standard software tools and platforms, such as our ServiceNow integrated Change Management and Configuration Management workflow system, will ensure prompt implementation of any new edits or changes DHH intends to implement regarding encounter data, given the minimum 60 calendar days notification. LHCC does regularly meet with each health plan, our state partners, finance, and claims departments weekly to

proactively address any upcoming changes or process improvement initiatives, leading to a more seamless integration of new features for all parties involved. If any adjustment to encounter claims impacts greater than 100,000 encounter claims, LHCC will obtain prior approval from DHH before submission so the FI can prepare their systems to receive the file.

Limitations & Disparities for all Requirements in Section 17.2, 17.8, 17.10

LHCC has reviewed the requirements and identified limitations and/or disparities in the listed requirements. LHCC and US Script have not identified any significant limitations and disparities to the requirements detailed in Section 17.10.

17.2.2. ***Notifications to Providers for Rejected Claims.*** As mentioned in 17.8.7 above, LHCC accepts paper claims from providers, and requires all paper submitters to use standard CMS 1500 and UB04 paper formats. LHCC employs CDMS, an automated content management system centrally integrated with our MIS to convert paper or fax submitted documents into machine readable data. Once converted into data, paper claims are processed through the same validation and code set edit checks as are claims submitted electronically:

HIPAA EDI Compliance. The EDIFECS XEngine (XEngine) software component of our MIS verifies HIPAA format compliance real-time, validating inbound data against ANSI Accredited Standards Committee (ASC) X12N Companion Guides' rules for syntax and data structure, then triggering notification to trading partners and providers (via ANSI TA1/999 Functional Acknowledgment) accordingly.

Pre-adjudication Edits. Our Service Oriented Architecture middleware maps, translates, and validates claims data against data we have in our MIS prior to adjudication, ensuring the consistent application of common edits, such as member eligibility, provider eligibility, etc. are valid.

Electronic Claim Submissions. When a provider submits a claim electronically, and if a transaction is rejected, our middleware systematically issues an ANSI 277 Unsolicited (277U) notification citing the specific DHH-approved edit(s) responsible. The 277U transaction provides a reference to the original claim as well as all the data mentioned in section 17.2.2.3.

Paper Claim Submissions. When a provider submits a claim on paper, even though we validate the claim data as if it were an electronic submission, we send a rejection letter referencing the original claim back to the submitting provider, explaining the reason for the rejection, (citing the specific edit(s) responsible), providing information as specified in section 17.2.2.3, and the process for resubmission. We will send an accompanying original claim with the rejection letter as specified in section 17.2.2.1.

17.2.5.1 ***Provider Claim Submission Timeliness.*** LHCC adjudicates claims filed within a year of the date of service. Per DHH's updated requirement, upon contract start date, LHCC will adjudicate claims filed within 180 days of the date of service. LHCC will update provider contracts to necessitate timely filing guidelines per 180 days. We will update the Provider Manual with information about the new timely filing rule, and our Provider Relations team will conduct appropriate outreach and re-training to the provider community. Communications may include sending fax blasts, newsletters, bulletins, etc.

17.4.1. ***Remittance Advice.*** LHCC's Remittance Advice currently includes Third Party Liability (TPL) information such as Carrier Name and Policy Number. TPL Mailing Address is currently not on the Remittance Advice, but is accessible through the Provider Portal.

17.4.2. ***Remittance Advice Voids.*** Adjustments do appear on the Remittance Advice. However, voids are currently not included. Per DHH's new requirement, LHCC will work with DHH on including voided claims in the Remittance Advice.

17.8.2. ***Processor Control Number.*** We have the capability to create a unique Processor Control Number or group number for Louisiana Medicaid. Today we have a Submitter ID that we use with each of our

encounter submissions to the FI. We will clarify with DHH and DHH's FI the exact definition for a Processor Control Number, or group number, and the requirements for the Bank Identification Number submission to ensure we provide this information to the FI in accordance with DHH requirements.

System Capabilities & Limitations of all Requirements in Section 17.10

LHCC will continue to contract with US Script for Pharmacy Benefit Manager (PBM) services for Bayou Health members in compliance with all DHH policies and requirements as listed. LHCC has selected US Script as the PBM to administer the Bayou Health plan and pay claims in accordance with Section 17 of the contract. US Script is a wholly owned subsidiary of Centene Corporation and the current PBM responsible for the administration of the prescription drug benefit program for Bayou Health members. US Script has a retail pharmacy network in place with over 66,000 member pharmacies and one mail order facility. As the current pharmacy claims payment administrator, US Script complies with the provisions outlined in Section 17.10.5.2.

17.10. Pharmacy Claims Processing

17.10.1. *System Requirements*

17.10.1.1. US Script provides a proprietary, state-of-the-art claims processing system, developed and managed in-house by US Script IT professionals. LHCC has used US Script's claims platform since we began providing PBM services in 2012. The production adjudication server is a mainframe class Sun Microsystems Sunfire 3800 running 64 bit Solaris. PBM applications are hosted on Oracle 10g Forms and Reports Runtime using a distributed process model. This server supports our Oracle 11g Enterprise database and the US Script proprietary adjudication and eligibility software.

17.10.1.2. PBM claims are processed using the most current HIPAA compliant transaction standard, National Council for Prescription Drug Programs (NCPDP) D.0. All claims submitted electronically are secured through a private network from the pharmacy to the PBM application. A real-time adjudication decision is made; with the response provided immediately back to the pharmacy via the NCPDP formatted response.

17.10.1.3. Because US Script owns their processing software, they can implement benefit design changes quickly and efficiently. When a claim enters the USS adjudication engine, fully automated and configurable edits check member eligibility for benefits, drug coverage benefit limitations, and applies prescriber and prospective/concurrent drug utilization review edits at the point of sale. These edits fall under two basic categories, soft edits and hard stops. Soft edits will trigger a POS message back to the pharmacy and request that they use professional judgment when deciding whether or not to fill the prescription. Hard stops will prevent the claim from adjudicating.

Benefit design edits include, FDA Approved Quantity Maximums, Safety Edits, Additional Quality Limits, Narcotic Edits, Age Limits, Gender Edits, and Step Therapies. Claim Validation Edits include:

- Duplicate prescription
- Refill too soon
- Member eligibility
- Pharmacy provider not eligible to provide service
- Drug-drug interaction
- Duplicate therapies

The claims processing system does more than help ensure clients pay for only those medications they want covered by their plan, it also automates drug utilization review. If the automated review process

detects any potential clinical problems, the pharmacist is notified at the point of sale and provided with the information needed to make a responsible and professional decision to dispense medication.

17.10.1.4. US Script has procedures in place to price drugs and review price changes. US Script utilizes Medi-Span, a third-party pricing source, to obtain current drug prices. Pricing files are received from the vendor *daily*, and uploaded into the PBM system through an automated job. US Script IT reviews the daily pricing upload for completeness. The system utilizes the National Drug Code file and contains information on all products dispensed including information on the prescription and current and historical pharmaceutical pricing information. The system is available to contracted pharmacies 365 days a year, 24 hours a day and *processes over 99% of all claims in less than eight-tenths of a secon*d, after which a message is sent to the pharmacy confirming acceptance or denial of the claim submitted.

Changes in Maximum Allowable Costs (MAC) pricing are compared to historic data for reasonableness, on a weekly basis. The US Script PharmaHealth Analytics team receives a file every Friday from US Script IT, and this is compared to the previous week's file. This variance report shows the dollar and percentage variance between the previous week and current week.

17.10.1.5. US Script follows Centene's Record Management Policy and its associated Records Retention Schedules. Records are *only* retained as long as it is required for the Company's business operations and archival purposes to ensure protection over a member's personal health information. Per DHH guidelines, US Script information enables online retrieval and access to documents and files for six years in live systems for audit and reporting purposes, and ten years in archival systems.

17.10.1.6. Audit history is captured through every step of the claims adjudication and encounter preparation process. If an audit or administrative, civil or criminal investigation, or prosecution is in progress or unresolved, all information related to the event shall be electronically kept until all tasks or proceedings are completed. US Script enables online retrieval and access to documents and files for six years in live systems for audit and reporting purposes, and ten years in archival systems. Upon request, US Script and LHCC will provide 48 hour turnaround or better for request to information less than 6 years old from date of service, and 72 hour turnaround or better for request to information between 6 to 10 years old from date of service.

17.10.1.7. US Script contracts with pharmacies, to require that the NDC, manufacturer number, product number, and package number for the drug dispensed shall be taken directly from the inventory from which the drugs were dispensed. These data are required on all claims for adjudication. Our online system captures the pharmaceutical number, product number and package number taken from the actual package from the pharmaceutical vendor and dispensed to the member. To make sure pharmacies and providers are complying, US Script auditor will perform reviews of aberrant claims for accuracy by contacting the pharmacy to validate actual claims submission. If inaccuracies are confirmed, pharmacies are instructed to reverse and resubmit claims, or claims are processed for recoupment. This process is applied to all channels including retail, mail order, and specialty pharmacies. The Network Oversight Committee reviews summarized audit reports for analysis of errors and corrective actions taken to identify possible quality or safety issues.

17.10.1.8. US Script's claims system will flag all services that have a once in a life-time indicator, as defined by DHH. US Script maintains a permanent history record by service date in active claims history, and we will put in place an edit to identify any provider submitting a subsequent claim for the same member, same service, which will denied.

17.10.2. ***Pharmacy Rebates.*** US Script sends *all* drug encounters, with the exception of inpatient hospital drug encounters as described in the RFP, to DHH. US Script does not filter any encounters based on rebate eligibility unless specifically asked by DHH or the health plan. US Script has experience supporting Federal rebates due to States. A few of US Script's existing contracts explicitly require support for resolving disputes from pharmaceutical manufacturers, though all states where US Script covers some of the Medicaid population implicitly requires this capability.

17.10.3. Pharmacy Encounters Claims Submissions

17.10.3.1. Prior to the Contract start date, US Script will move from bi-weekly to weekly submission based on the new requirements listed regarding encounter data. Centene submits NCPDP compliant encounters in claim-level detail, for submission to DHH's FI in the file format as appropriate for the claim type and in accordance with DHH's FI requirements. The encounter will include all attributes in the format as indicated on the Systems Companion Guide, including the member name, dosage form, strength, package size, and NDC of each covered outpatient drug dispensed for Bayou Health members.

17.10.3.2. The US Script claims system automatically updates with 340B pharmacies daily. Claims for the 340B discount drug program and filled by 340B pharmacies are recognized by the PBM adjudication system and priced appropriately at the point of sale.

17.10.4. Disputed Pharmacy Encounter Submissions

17.10.4.1. Before submission of drug encounters to DHH's FI, US Script has procedures in place to review, calculate, submit, and report on rebates. Designated US Script personnel review and reconcile rebate eligible claims for accuracy prior to submission to DHH. US Script will review all disputed encounters identified by DHH through the drug rebate invoicing process.

17.10.4.2. US Script utilizes an issue tracking system when notified of a dispute to record the actions to resolve the issue. Depending upon the nature of the rebate dispute, US Script staff will reach out to the submitting pharmacy to obtain evidence as to the validity of the prescription. If there are any mistakes along the way, US Script will initiate reversal of the pharmacy claim(s) and resubmission of any corrected information within 60 days. US Script will implement a process to provide a detail explanation report if any disputed encounters cannot be corrected, including all documentation attempts and data elements described in the Systems Companion Guide.

17.10.4.3. LHCC will submit a weekly pharmacy encounter claims file and/or response to disputed encounters within the 60 calendar day period.

17.10.5. ***Use of a Pharmacy Benefit Manager.***

17.10.5.1. LHCC uses US Script as its PBM to process prescription claims in accordance with the existing contract under an administrative agreement. US Script receives the vast majority of claims electronically, at the point a member attempts to fill a prescription at the pharmacy. Claims also may be submitted to US Script via Universal Claim Form, which would be entered into the PBM application for adjudication. Paper claims represent less than 1% of all adjudicated claims.

Any new provisions will be addressed by a modification to the current agreement. US Script's Client and Implementation and Benefit Managers review any plan changes, claim rate changes, copay changes, and member address changes for reasonableness. To help ensure that claims are processed as intended by the client's benefit design, US Script personnel perform audits of all new setups and audits a sample changes. Audits include, at a minimum, review of the contract and Benefit Enrollment Form for conformance with copay, formulary, edit and claim rate setups.

17.10.5.2. US Script is a *wholly owned subsidiary* of Centene Corporation, and an affiliate of LHCC. It is not owned wholly or in part by any retail pharmacy provider, chain drug store or pharmaceutical manufacturer.

17.10.5.3. LHCC has an oversight plan in place to monitor US Script's compliance with the contract and all DHH requirements. Centene, LHCC's parent company, performs formal audits of delegated vendors annually. Audits are conducted on samples of claims, stratified into previous quarters. Attributes reviewed include:

- Proof of third party administrator license
- Adjudication of clean claims
- Claim acknowledgement letters

- Adjudication of disputed claims,
- Penalty rates for late claims
- Provide notification of deficient claims
- Disclosure of changes to clean claims
- Reporting
- EDI capabilities
- Claims disaster recovery plans.

The oversight plan, which will be submitted to DHH prior to the contract start date, is continually modified and improved upon each year based on audit result.

If you presently unable to meet a particular requirement contained in Section 17, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

LHCC recognizes that some requirements in Section 17 are new or previously modified from the former 2011 Bayou Health Prepaid contract. *LHCC will implement the following items to ensure we fully meet all requirements.* The items below are not necessarily system limitations, rather they are requirements we have not yet implemented for the Bayou Health program. LHCC and Centene have a collective breadth of experience in delivering claims and encounter processing capabilities customized to the specifications of our State partners. LHCC will work with DHH to meet and implement these requirements prior to contract start date.

17.2.2. Paper Claim Submissions. When a provider submits a claim on paper, even though we validate the claim data as if it were an electronic submission, we send a rejection letter referencing the original claim back to the submitting provider, explaining the reason for the rejection, (citing the specific edit(s) responsible), providing information as specified in section 17.2.2.3, and the process for resubmission. We will send an accompanying original claim with the rejection letter as specified in section 17.2.2.1 as indicated in the RFP, prior to contract date.

17.2.5.1. LHCC adjudicates claims filed within a year of the date of service. Per DHH's updated requirement, upon contract start date, LHCC will adjudicate claims filed within one hundred eighty (180) days of the date of service. LHCC will re-contract providers to necessitate timely filing guidelines per 180 days. We will update the Provider Manual with information about the new timely filing rule, and our Provider Relations team will conduct appropriate outreach and re-training to the provider community (communications may include: sending fax blasts, newsletters, bulletins, etc.).

17.4.2. Adjustments appear on our Remittance Advice. However, today we do not detail voided records. Per DHH's new requirement, LHCC will work with DHH to include details for voided claims in the Remittance Advice. Since Centene and LHCC develop and implement MIS configuration requests on an agile methodology, implementation for the initial phase would take 4 to 6 weeks. LHCC will continue to work with DHH and the provider community to optimize and customize the Remittance Advice beyond the requirements, if necessary. Our goal is to not only meet the requirement but to deliver and meet the needs of our community.

17.8.2. We have the capability to create a unique Processor Control Number or group number for Louisiana Medicaid. Centene has assisted in delivering this requirement to affiliate health plans and their state clients. Today, we have a Submitter ID that we use with each of our encounter submissions to the FI. We will clarify with DHH and DHH's FI the exact definition for a Processor Control Number, or group number and the requirements for the Bank Identification Number submission to ensure we provide this information to the FI in accordance with DHH requirement prior to contract start date.

17.10.4.2. US Script utilizes an issue tracking system when notified of a dispute to record the actions to resolve the issue. Depending upon the nature of the rebate dispute, US Script staff will reach out to the submitting pharmacy to obtain evidence as to the validity of the prescription. If there are any mistakes along the way, US Script will initiate reversal of the pharmacy claim(s) and resubmission of any corrected information within 60 days. US Script will implement a process to provide a detailed explanation if any disputed encounters cannot be corrected, including all documentation attempts and data elements described in the Systems Companion Guide.

X.2 Explain in detail your process for ensuring that all claims (paid, denied, adjustments and voids) are submitted to the Fiscal Intermediary timely and accurately.

Experience in Louisiana

LHCC currently submits to DHH and DHH's Fiscal Intermediary (FI), on average, 700,000 medical, basic behavioral health service, vision, pharmacy and value-added service encounters per month, with an average first time success rate of over 98%, based on DHH FI's Systems Companion Guide requirements and transaction response file data. Our affiliated pharmacy subcontractor, US Script, files NCPDP D.0 compliant encounters through LHCC to DHH, and maintains an overall acceptance rate of 99.6%.

LOUISIANA ENCOUNTERS
700,000 encounters per month
With 98% first time success rate

We have reviewed in detail all claims and encounter requirements stipulated in Section 17 of the RFP and also requirements indirectly impacting claims and encounter processing such as those found in Section 16 (general Information Technology capabilities, security); Section 9.5 (Claims Processing Requirements and encouraging Electronic Data Interchange - EDI); Section 5.11 (Third Party Liability processing); Section 5.12 (Coordination of Benefits); Section 18 (Reporting); and finally the Bayou Health Systems Companion Guide (Encounter Processing). We have also examined the Bayou Health Medicaid Managed Care Organizations System Companion Guide Version 1.0 (MCO Companion Guide), and the LAMMIS Batch Pharmacy Companion Guide (both documents dated February 2015) and we either currently support, or in the case of new requirements contained in the MCO Companion Guide, can and will support, all requirements through straightforward configuration of our MIS.

An End-to-End Approach to Accurate and Timely Encounter Data Reporting

LHCC organizes our people, technology and processes around an end-to-end view of accurate and timely encounter data production – from providers' claim submissions, through claim adjudication and the resulting encounter data submission directly to DHH's FI. We leverage an operational "feedback" mechanism to inform, adjust, and continuously improve each step in the process. The expertise of our team, the configuration of DHH rules in our best-in-class technology, and the process we have in place including training, workflows, and structured collaboration, all help ensure we submit the highest quality encounter data to DHH in order to support rate setting, risk adjustment, quality improvement, and financial reporting. We make certain we submit all claims (paid, denied, adjusted and void) to DHH's FI through a combination of:

- **People** – The LHCC "Encounter Team"
- **Processes and Technology** - Encounter Data Management
- **Encounter Quality and Monitoring Processes** to Ensure Accurate, Complete and Timely Encounter Submissions
- **At the Beginning** - Claims Processing Capabilities and Processes to Facilitate Accurate, Complete and Timely Encounter Reporting

People – The LHCC Encounter Team

Local LHCC Expertise. LHCC has a local team of experienced Claims Liaisons and Contract Implementation Analysts who have in-depth understanding of DHH-specific claims and encounter processing rules. This team provides critical feedback to our claim configuration and encounter reporting processes and staff, allowing us to provide DHH and DHH's FI with accurate and timely encounter submissions. This team also works with our Provider Relations specialists to support provider communication and education, and works directly with our providers, as needed, to resolve issues related provider claim submissions.

Enterprise Support Teams. The LHCC team is supported by our parent company Centene's Encounter Business Operations Unit (EBO), Claims Configuration team, and an enterprise-level MIS and Information Technology team. Within the Claims Configuration and EBO teams, LHCC has *dedicated specialists* who also have expertise in DHH rules for claims and encounter processing. Because the EBO is centralized, we are able to supplement local expertise with the best practices gleaned from our encounter submission processes across all Centene health plan operations. Centene brings over 30 years of experience receiving, processing, reporting, and securely transmitting membership, provider, encounter, and other reporting data to our state clients and their agents, including their Fiscal Intermediaries (FI) and other partners.

We have the experience and capability to meet or exceed DHH standards and expectations in relation to encounter submission requirements, delivering accurate, timely, and complete encounter data.

A Coordinated Team Approach. LHCC coordinates the expertise of the above team through a formalized bi-weekly "Encounter Team" meeting which includes the LHCC Claims Liaisons and Contract Implementation Analysts; our dedicated EBO staff members; and others from various teams related to encounter submissions such as Finance, and Compliance, and representatives from our subcontracted vendors, as appropriate. Agenda items include (1) overall encounter status including pass rates, paid claims to encounters reconciliation, as well as outstanding and upcoming business concerns; (2) any underlying claims issues; and (3) subcontractor encounter reporting status. Typically the Team discusses items related to FI encounter edits, solutions for any rejected encounter records, and strategies to continuously improve the process.

Participating in DHH Contractor Technical Meetings. We view ourselves as partners with DHH and we take a collaborative approach to meeting the State's objectives. LHCC and our EBO participate in weekly DHH Technical Meetings and at least two LHCC representatives participate in those meetings. We do and will continue to work with DHH and DHH's FI when issues are identified, or when we find areas where we might be able to improve operations. For example, together with DHH's FI we were able to determine that modifiers were not being included in the FI's "professional duplicate edit" logic causing appropriate encounters to reject. The edit was eventually turned to "informational," which allowed those encounters to be accepted going forward.

Processes and Technology - Encounter Data Management

We employ a proven system that automates encounter record preparation. LHCC utilizes ***Encounter Data Manager*** (EDM), a HIPAA compliant software application designed specifically for managed care Medicaid encounter processing. EDM gives our team a comprehensive tool to schedule, or manually create, encounter files, run reports, and automatically load encounter response files from DHH's FI.

EDM enables:

- Configuration of DHH-specific business rules to "scrub" data prior to encounter data submission, resulting in more accurate submissions.

- Automation of LHCC-defined correction actions, in concurrence with DHH guidelines, to automatically correct encounter rejections.
- Automated prioritization of encounter correction activities.
- Automated extract and delivery mechanisms to minimize bottlenecks and need for manual intervention.
- Linkages to our claims database through to Centelligence™ (our data warehouse and informatics platform), to outbound encounters, and encounter response reports to facilitate comprehensive encounter reconciliation efforts.
- Extensive operational and executive reporting to identify encounter trends, monitor acceptance rates and proactively correct issues.

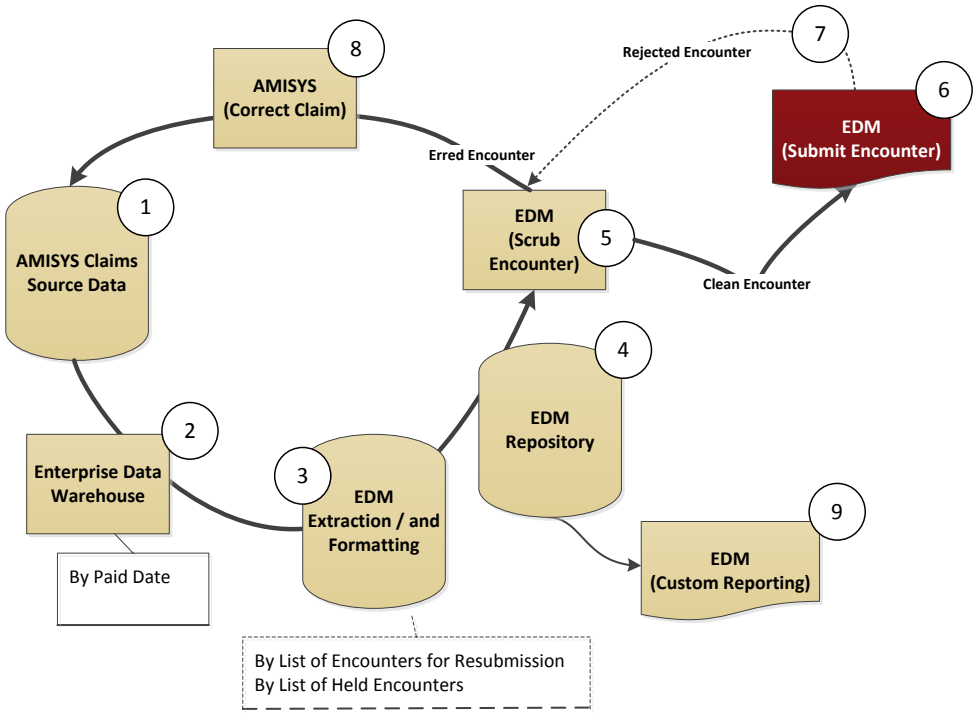
EDM is integrated with Centelligence™, our award-winning family of integrated data warehousing, reporting, decision support and health care informatics solutions. Our Centelligence™ Enterprise Data Warehouse (EDW) is the heart of our integration capabilities, capturing transactions in near real time from our core applications including AMISYS Advance (claims processing system), TruCare (our clinical care and utilization management platform), and our Member Relationship Management (MRM) and Provider Relationship Management (PRM) (master data management for provider and member demographic information, respectively) and populate them into EDW.

EDW houses both paid claims data from AMISYS Advance (AMISYS) and encounter data from EDM (including the most recent encounters processed), providing comprehensive reporting support for encounter reconciliation. In addition to enabling encounter processing functions, Centelligence™ informatics also provides expansive business intelligence support, including flexible desktop reporting and online Key Performance Indicator (KPI) Dashboards with "drill down" capability. Through Centelligence™, each department has access to the same detailed information needed to coordinate our efforts related to quality encounter processing.

In ***Figure X2-A. System Integration for Accurate and Timely Encounters Processing*** below, we summarize the system integration flow from claims processing to encounter submission via the numbered steps in the Figure.

1. *From Claim to Encounter.* Encounter data originates from AMISYS as a claim adjudicated to a finalized status (paid, denied, adjusted, etc). Front-end processes help to ensure complete, timely and accurate claim submission from our providers to LHCC. These are described in detail in the section below titled "At the Beginning - Claims Processing Capabilities and Processes to Facilitate Accurate, Complete and Timely Encounter Reporting."
2. *Encounter Data Extraction.* EDM is configured to systematically extract claim data from our Centelligence™ EDW into the EDM repository based on the paid date of the claim.
3. *Encounter Formatting.* Weekly encounter data is combined with corrected, repairable encounters that need to be resubmitted to DHH.
4. EDM produces Professional and Institutional Encounter files for DHH in HIPAA compliant 837P (Professional) and 837I (Institutional) and Provider-to-Payer-to-Payer Coordination of Benefits (COB) format. EDM reports the same line item detail from the original claim, regardless of the claim type. Third Party Liability (TPL) is indicated in the encounter as it was billed by the provider – either line level or claim level. We also report all encounters where we have capitated arrangements with our providers. These encounters are submitted with a $0.00 pay, and include the same level of detail submitted for all encounters.

Figure X2-A. System Integration for Accurate and Timely Encounters Processing



1. *Encounter Scrub for Accuracy*. EDM's table driven configuration function allows us to implement DHH-specific business rules to "scrub" encounter data prior to submission to the FI, making sure the data is accurate and compliant with DHH Quality Guidelines and Systems Companion Guide (including HIPAA compliance, data completion and accuracy, national industry standards and code sets, NPI, zip-code requirements, etc.). These scrubs are continuously monitored to identify process improvement opportunities, as described below. EDM allows encounter staff to "drill down" to the detail claim service line level to rapidly examine and act on any encounter related issues, as appropriate. EDM also allows our EBO and LHCC Claims Liaison and Contract Implementation Analyst to track and monitor the status of encounters at any level (batch, claim, or detailed service line) at any stage in the submission process.
2. *Encounter File Creation*. Encounter files are created via a scheduled or manual request. Scheduled file creation follows the weekly claims payable cycle. Manual (ad hoc) requests are used for file creation outside of the normal scheduled processes. For example, if an encounter failed an initial scrub edit, but the correction did not require an adjustment, we would fix the issue then run a manual request for the encounter to be regenerated and included in the weekly submission.
   Vendor encounter files are created by the contracted vendor and are provided to the EBO for submission to DHH's FI. Our pharmacy benefit manager, US Script, submits NCPDP Batch Pharmacy 1.1 D.0 encounters data to the EBO.

   The EBO runs 837 files through the FI's EDI Ramp Manager to validate HIPAA compliance. All files are then submitted to the FI. File submissions are monitored to ensure the FI's receipt through electronic functional acknowledgements: via EDI standard TA1, 999 and Pre-processor level acknowledgements.

3. *Encounter Error Processing*. EDM's ability to receive and process encounter response file reports from DHH's FI system facilitates encounter reconciliation workflows and prioritization of encounter correction activities. Our EDM system allows us to identify an encounter issue from the batch level down to the individual service line detail level, as well as the processing history of an encounter record and corresponding claim record. This allows our EBO to rapidly identify the issue from two perspectives, segment follow-up work, and address the issue for subsequent resubmission to FI within or before the required timeframe of 2 weeks.
4. *Correction and Resubmission.* Encounter errors received in the response file as well as those encounters that failed scrub edits are parsed out by the EBO team to the appropriate team for root cause analysis and resolution. When needed, we submit a configuration change request for AMISYS and/or EDM to correct program logic issues. Encounter submission errors processed by our subcontracted vendors are corrected by the vendor in collaboration with LHCC. Once corrected, those encounters are batched in a list and are resubmitted to DHH's FI in the next encounter cycle, following the steps above.
5. *Encounter Reporting.* Our EBO uses EDM's reporting functionality to identify encounter trends (e.g. volumes processed, work in process, encounter record aging, rejects and scrubs by specific "edit" type, etc.) to monitor our acceptance rates with the FI and to proactively correct issues. We also use EDM's automated encounter data extract and transmission features to minimize bottlenecks and need for manual intervention. Integrated with our Centelligence™ suite of reporting tools, the EBO can view the encounter process at the aggregate level, trended over time to spot performance anomalies for operational improvement.

Quality and Monitoring Processes to Ensure Accurate, Complete and Timely Encounter Submissions

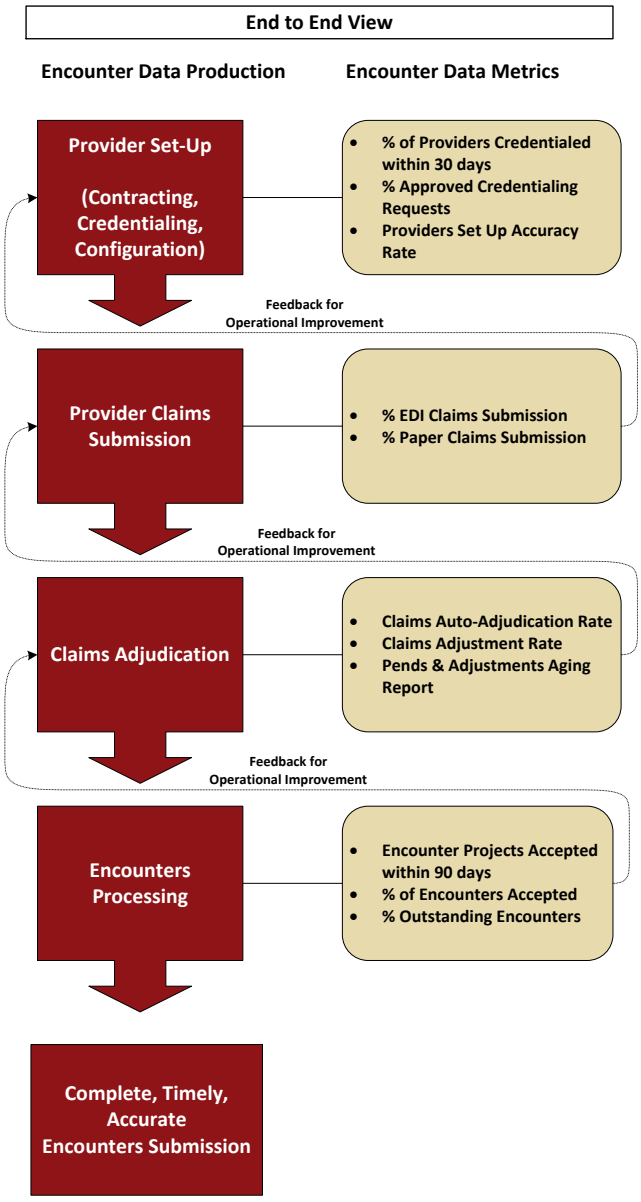
Accuracy. The EBO ensures encounter accuracy by regularly validating a random sample of encounter records against the source data in AMISYS. We perform this audit, at minimum, whenever we modify or change our software configuration, or whenever we discover that an incorrect encounter record was submitted, and that the error cannot be corrected by our usual correction processes.

Completeness. To ensure completeness of encounter data submitted to DHH, on a monthly basis LHCC balances all claims data (paid, and adjusted) including claims submitted by non-participating providers and subcontractors, with the corresponding encounter data files submitted each week. We do this by comparing each weekly payment run to the corresponding weekly claim payment and count, and encounter submission. Each encounter record is also tracked to ensure that errors or rejections are handled in a timely manner. LHCC consistently submits encounter data that is 98.6% complete within 90 days, and 99.0% within 180 days, *exceeding the DHH requirement of 95%.*

Timeliness. LHCC and the EBO create encounters for each claims payable run, and we submit those encounters to the state weekly. This ensures delivery of all encounters no later than the 25th day of the month following the month in which the claim was finalized to a paid or denied status. We currently exceed the timeliness standards established by DHH to submit encounters. An important aspect of timeliness is having an appropriate mechanism for ensuring delivery and receipt of encounter submissions. As mentioned above, we validate that encounter submission files are successfully accepted into the FI's system by monitoring the EDI acknowledgements issued by the FI.

Continuous Quality Improvement. By continually monitoring our end-to-end claim submission and encounter data production process for any recurring issues, we are able to identify and resolve the underlying causes of any systemic encounter submission errors. While encounter data corrections require short-term resolution, LHCC concurrently works to resolve root causes and mitigate long-term encounter data submission issues through continuous monitoring and quality improvement. For example:

- When we identify a provider claim issue that impacts encounter submissions, our Encounter Team develops the appropriate corrective actions necessary to resolve the issue. This may include "feeding back" that information to our Provider Relations staff during our bi-weekly Encounters Team meetings to resolve provider-driven changes.
- When we identify a DHH edit that is causing encounter submission issues, we will move those edits to the "front end" of our claim processing system (claim data submission and validation). This allows us to reject or deny inaccurate claims submissions as early as possible in the process so that we can send notification to the provider (via the ANSI 999 Functional Acknowledgement, ANSI 277 Unsolicited notification, or letter in the case of paper claims). We inform the submitting provider of the specific edit that caused the rejection, whether an X12 EDI edit or a claims processing business rule along with the reason for the rejection/denial. The provider can then correct the claim and resubmit it to us accurately, and we can submit an accurate, timely, and complete encounter to DHH.



Tracking, Trending and Reporting to Drive Continual Improvement. LHCC's Claims Liaison and Contract Implementation Analyst and the EBO use encounter processing operational reports from Centelligence™ to continually look for process improvement opportunities. As mentioned above, our integrated EDW holds both paid claims data and encounter data from EDM (with the most recent encounters processed). This greatly accommodates flexible reporting support for encounter reconciliation, including our paid claim to encounter balancing process mentioned above.

Each month, our EBO uses Centelligence™ to produce and present to LHCC Management a summary report of encounter processing performance. This report includes a snapshot of submitted encounters,

including accepted encounters, encounters pending response (from DHH), and rejected encounters. It also summarizes, on a trending basis, claims we have received that are not yet processed as encounters, and claims we have received that have been "scrubbed" prior to DHH submission. Our EBO summarizes any particular issues across these reporting categories and, if necessary, recommends actions to address identified issues.

Continuous Oversight of Encounter Submissions. Under the oversight of the LHCC's Vice President (VP), Compliance, LHCC staff and our EBO ensure all standards are met as defined in the DHH Medicaid Companion Guides, including submission of all corrected encounters within 14 days of receiving notice of rejection. The VP, Compliance ensures that we track all encounter submissions to DHH in our Compliance 360 system. Compliance 360 is recognized internationally as the leading Governance, Risk Management and Compliance software system across all industry segments (including healthcare). Compliance 360 allows LHCC and Centene to effectively administer and monitor our contractual and regulatory oversight responsibilities (including our encounter data reporting obligations). The application facilitates systematic workflows that track compliance activities, such as encounter data submissions (also with auditable records of management approval and cited contract and regulatory mandates), and ongoing, proactive assessment of any compliance risks.

Ensuring Timely, Accurate, and Complete Encounter Submissions from Subcontractors. In addition to encounter data produced from medical and basic behavioral health claims that we adjudicate, LHCC also monitors and provides encounters to DHH from our affiliated subcontractors, OptiCare Managed Vision and US Script, for vision and pharmacy encounters respectively. Our subcontractors submit their processed claims data to LHCC as encounters in DHH compliant encounter data format, via a Secure FTP (SFTP) connection. All of LHCC's subcontractors who receive claims and encounter submissions from providers on behalf of our DHH programs are contractually obligated to submit this encounter data to LHCC, with financial sanctions applicable if documented service level agreements related to encounter submissions to LHCC are not met. Where appropriate, we also monitor the encounters from our subcontractors to ensure our members are being served appropriately by our subcontractors.

Monitoring Subcontractors. Our LHCC Health and Centene Quality Improvement (QI) departments monitor subcontractor performance (including encounter submissions) formally via quarterly Joint Operating Committee (JOC) operational reviews with each subcontractor. Subcontractor JOCs include executive and operational staff from LHCC, Centene (as appropriate), and the subcontractor. The purpose of the JOC is to monitor all functions delegated to the subcontractor and to help facilitate meaningful health plan/subcontractor operational efficiencies and support for the subcontractor. In addition, we perform an annual delegation audit related to claims and encounter administration.

Centene's Clinical QI department assists with monitoring the encounter submissions from each subcontractor monthly, and identifies any outliers in encounter volume and/or any other anomalies in the subcontractor's submission, contacting the subcontractor as needed for any appropriate action. LHCC monitors subcontractor encounter submission metrics such as timely delivery of encounter files; appropriate coding and data elements; adherence to format set forth by DHH and the LHCC; and an encounter acceptance rate to LHCC of 98%. If a LHCC subcontractor falls outside our monthly performance guidelines, the subcontractor is subject to a Corrective Action Plan and potentially liquidated damages.

At the Beginning - Claims Processing Capabilities and Processes to Facilitate Accurate, Complete and Timely Encounter Reporting

LHCC views claims processing not only as compliance with payment rules, but as a critical opportunity to offer superior service to our providers (ensuring a sound provider network) and members (affording them peace of mind in the financial aspects of their health care). We also view the claims process as arguably the single most important data gathering aspect of our operation, since it supports our quality

and utilization monitoring efforts; provider education and outreach initiatives; and supplies DHH with accurate, complete, and timely encounter information.

LHCC and Centene have processed claims for members and families in the Bayou Health program since 2012, and today we process an average of 137,000 claims per month on behalf of our members. Centene has over 30 years' of experience in claims operations and systems and today serves over 3.1 million Americans in publicly-funded managed care plans across 20 states. Centene processed over 45 million encounter data records across all affiliate health plans in 2013, and maintained a scalable MIS to facilitate an overall 22.9% increase in claim volume (2012 to 2013). We have the tools, people and processes in place to receive and process claims data from our Bayou Health providers on behalf of our members, in compliance with Federal and DHH guidelines, and submit that data as encounters to DHH.

The most critical components of the provider claim submission process are provider training and administrative aids, the accurate configuration and automated checks for compliance of front end systems and edits to receive and process claims data, and claims processing expertise.

Claim and Encounter Processor Expertise and Provider Training. ***Claims and Encounter Processor Expertise.*** As mentioned above, LHCC has locally based staff who provide expertise in DHH processing rules, and who stay abreast of claims and encounter processing issues/concerns and changes. LHCC works closely with our dedicated resources in our centralized claims processing and encounter operations, provided by Centene. Centene also offers a complete suite of training (both onsite and via "e-learning") targeted at all aspects of the claims and encounter preparation process; for both LHCC and Centene staff. Over 40 "courses" are available covering topics from front-end claims processing through claims processing (coordination of benefits, specialty claims, etc.), claims pricing, and all aspects of encounter production. We promote and encourage our Encounter Team members to have an "end to end" process perspective to further ensure efficient and accurate encounter data administration. In addition, detailed "hands-on" training is provided within the Team, critical for understanding the nuances of state level encounter submission requirements.

Provider Training and Administrative Aids. LHCC uses a coordinated mix of training and support strategies to help ensure that our providers file timely, complete, and accurate claim and encounter submissions.

Claim Filing Assists. Providers can access detailed billing instructions, including claims submission time frame requirements, claim dispute information, via a searchable PDF of our Provider Manual on the LHCC Website. In addition, our secure Provider Portal provides:

- Access to Clear Claim Connection, which allows providers to easily check LHCC's adjudication logic prior to claims submission.
- Ability to submit prior authorization requests and view the status of such requests via the Provider Portal, phone, or fax. The authorization is systematically fed into TruCare, our collaborative clinical case management and utilization management platform, which is integrated with AMISYS Advance – enhancing our auto-adjudication claims processing rate.
- EDIFECS Ramp Manager EDI onboarding system – which allows interested providers to "on board" through interactive file testing and certification for production of EDI submissions directly to LHCC.
- Ability to submit claim adjustments by pulling up a previously submitted claim and using that data as the basis of a new (or re-billed) claim;
- Ability to check member eligibility; view Third Party Liability information for a member;
- Ability to inquire and view claims status and payment information and send inquiries to our Provider Services Department via secure messaging, among other capabilities.
- Instructions for enrolling in our free electronic payment (EFT) service through the PaySpan Corporation.

- InterQual Smart Sheets, which offers providers a short but thorough evidence-based online smart checklist of patient conditions that indicate the need for services such as surgical operations, biopsies, imaging, etc.; all at a specific procedure code level.

Webinars. Our Provider Relations team provides a monthly webinar for new providers and a quarterly health plan webinar for all providers covering a variety of issues, including announcements and new features on our portals, new rules regarding claim submissions, etc. These are very well attended and received by our provider community.

Interactive Voice Response (IVR). Our IVR allows both self-service options and live person assistance for multiple administrative services. For example, when providers call our main toll-free number, they have the option to select 'check eligibility', 'medical management' or 'claims.' Under the claims option, they can make further selections such as 'claims status;' under the medical management option, they can make further selections such as 'authorizations,' or 'case management.'

Face-to-face training from our Provider Relations Team. As we do today, we will provide face-to-face training for providers, delivered as both Regional Training sessions (and tailored to specific regions), and one-on-one training at a particular provider site. We offer the latter for all new PCPs in our network, and "on request" from all providers.

Practice Improvement Resource Center. In 2015, we are expanding our online support for Providers through our Practice Improvement Resource Center: a well organized, searchable compendium of best practice and vetted documentation, communication channels (secure messaging, forums, etc.), multi-media content, and interactive tools to help Providers across Clinical, Operational, and Technology aspects of their practices; including additional assists for quality claim submissions.

EDI Help Desk. Available via phone to all submitters, the EDI Help Desk is available to assist providers in on-boarding to use EDI via our portal, or through a clearinghouse, as well as to address any issues EDI claim submitters might have, and/or answer any questions about electronic submissions.

Configuration of our Systems. LHCC's public sector focused HIPAA and DHH compliant claims adjudication process and system is integrated end-to-end: from provider claim submission to provider payment and encounter submission to DHH. Please see ***Figure X2-B LHCC End-to-End Claim to Encounter Workflow***.

Using the table driven and parameter based set/up utilities in our MIS, we configure our systems for the specific rules of DHH, and CMS. LHCC's goal is to ensure that on a monthly basis, at least 85% of all claims received process without manual intervention, or "auto-adjudicate," based on the accuracy of system configuration and claims submission quality. Since January 2013, regardless of provider claim submission method, (paper vs EDI), we have consistently exceeded that goal; the current average is 90% (based on the most current weekly Claims Scorecard).

Centene employs rigorous change processes, controls and tools to ensure the successful delivery of required system configuration and change. These will be applied by LHCC and Centene for contract implementation and on a continuous basis, as DHH and Federal requirements change over time. If DHH presents a recommendation to us that is consistent with industry norms, we will modify our system appropriately to comply, within 90 days from notification by DHH. *For more information on our change management processes, please see our response to Question W.4.*

Accommodating Claim Submissions. We accept both paper and electronically submitted claims from our providers. We offer several electronic submission capabilities to our providers, free-of-charge, through our Provider Portal. We do not derive financial gain when our providers choose to submit claims electronically. We try to encourage our providers to use electronic claims submission methods as we consistently see that electronic claims are filed at least 50% closer to the date of service than paper claims and with significantly fewer submission errors. The prompt submission of claims data allows us to use

that information in our Case Management activities, to identify care opportunities and health care risk. Because of this and other advantages realized from electronic submissions (***timeliness, accuracy, and completeness***) we promote, educate, and support electronic submissions from all providers (medical, network/out-of-network, Fee-for-Service (FFS), or subcapitated).

- ***We currently have an electronic claim submission rate over 95%.*** A key factor in this "front end" is our support for electronic claims submissions. Our EDI interfaces are CAQH/CORE III certified. Today, our providers have several options through which to submit claims:
- Submission of HIPAA 837 EDI claims via EDI interfaces with over 84 clearinghouses nationwide;
- Direct submission of HIPAA 837 Institutional or Professional EDI claims to LHCC through our secure, Provider Portal;
- Online entry of claims directly through the HIPAA Compliant Direct Data Entry (DDE) feature (available on our secure Provider Portal). Our DDE feature provides interactive assists to walk the submitting provider through the claim submission process, with look up and validation assists for codes (e.g. CPT, ICD-9); cross-field logical checks (e.g. if one form field is populated, the system checks that other related and dependent fields are populated); validation of member and provider data; and online help. This results in instant feedback to the provider on any submission issues to maximize clean claim data entry.
- We also accept paper claims from providers and require all paper submitters to use standard CMS 1500 and UB04 paper formats. We use our Centene Document Management System (CDMS) component of our MIS, to convert paper claim submissions into machine readable data. Once converted into data, paper claims are processed through the same data validation routines and edits as electronically submitted claims.

HIPAA Data Validations Systematically Applied. We apply HIPAA compliance checks and validate the submitter, member, and provider information on the inbound claim to ensure data are in compliance with HIPAA Companion Guides (conforming to DHH Companion Guides), and that inbound claim transactions are compliant with Federal mandates and DHH rules.

Rejected Claims. If a claim does not pass initial edits, we will reject and void the claim before it can be loaded into our claims processing system. We send to the provider or the submitter a notification citing the specific DHH approved reason for the claim reject and void. For claims submitted electronically, we send an ANSI standard 277 Unsolicited (277U) response notification; for providers who submit a paper claim, we send a letter explaining the reason for the rejection, as well as all the information stated in section 17.2.2.3. In either case, the notification is sent immediately for electronic claims and for paper claims, well within five days of the receipt of the claim.

Claims Processing Functionality and System Edits - Streamlined Claim Adjudication: A Crucial Step to Quality Encounter Data. Once our MIS checks submitted claims for HIPAA compliance, claim form completion, and valid member and provider information, those claims are then electronically loaded into the AMISYS Advance claims processing component of our MIS for adjudication.

LOUISIANA Claims Processing
We process and pay, or deny as appropriate:
96.8% Claims settled within 15 Days and
99.8% Claims within 30 Days

Edits include but are not limited to: the application of health plan rules (covered services); verification of Member eligibility for the dates of service on the claim; matching of claim to service authorizations if needed; checks on the provider, including eligibility to render the service specified on the claim, that the provider is not excluded from providing Medicaid services, and application of appropriate fee schedule based on the provider information on the claim; edit checks for Third Party Liability (TPL), checks for

duplicate claims, and several other automated clinical and fraud, waste and abuse (FWA) edits and processes, until the claim is finalized to a paid or denied status.

- We require all our providers to submit to LHCC claims for services rendered to our members. We provide training and resources to our providers regarding claims submissions. Please see the section below titled Provider Training and Administrative Aids. When we have capitated arrangements with our providers, we require those providers to submit encounters to us, and we price them at $0.00 and we submit those to DHH's FI as encounters.
- Timely Filing Edits – We edit claims data for the timely filing rules currently required by DHH and we will implement the new DHH requirement of 180 days from date of service for Medicaid only claims. We will not deny provider claims based on this rule when the provider was seeking payment from a third party. When TPL payment is indicated we will use the date of payment/denial from the third party to determine timeliness. We also understand that providers may file claims directly inaccurately (to another MCO or to DHH's FI directly, for example). If the provider can show documentation that the original claim was filed incorrectly to the wrong party, but was done so in a timely manner (within the 180 day timeframe), we will process the claim.
- We ask providers to include all data elements needed to accurately submit encounters to DHH, including DHH standards regarding the definition and treatment of certain data elements e.g. counting methods, units, etc; identification of rendered services, and the billing and rendering provider's identification numbers, and billed amounts. Where possible we implement system controls so that requisite data is required, including conditional logic.
- We adhere to NCQA, AMA coding, UB-04 editor, NCCI standards. We update our reference tables as needed to support the use of CPT/HCPCS. We require the use of CPT/HCPCS on claims submissions. We require providers to file Category II CPT when applicable – such as for claims with:
  - Clinical components, such as those typically included in evaluation, management, or other clinical services;
  - Results from clinical laboratory or radiology tests and other procedures;
  - Identified processes intended to address patient safety practices; or
  - Services reflecting compliance with state or federal law.
- We continue to work towards ICD-10 implementation and we will implement ICD-10 at CMS and DHH's direction and in accordance with the US Department of Health and Human Services (HHS) Final Rule, published on August 4th, 2014, stipulating the ICD-10 compliance date to be October 1st, 2015. Please see Section W.7 for more information on ICD-10 and our readiness to move to this new standard.
- 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. We capture the resulting status of each claim at each step in the process, paid, denied, pended, adjusted, voided, appealed, and claims in the dispute process.

Medical Appropriateness. Through electronic integration with Healthcare Insight (HCI, a unit of Verisk Analytics, Inc.), LHCC proactively and systematically identifies potential fraud, waste and abuse (FWA) in claims data. HCI also provides us with an additional level of screening for clinical billing discrepancies. HCI's FWA and clinical edits are based on national coding standards as well as proprietary

rules informed by HCI's nationwide billing patterns database, and augment and complement those edits performed by our ClaimsXten software.

Pended Claims - Ensuring Expert Encounter Processing Skills. Today we maintain an overall average of 87% automatic adjudication rate for claims submitted. Generally, our Claims Processors examine less than 13% of submitted claims ("pended claims").

We increase claim processing efficiencies and accuracy through the specialization of our Claims Processors, who are experts in specific pend reason types (e.g. prior authorization missing). Our workflow management system routes pended claims in real time to the assigned claims processors. Once a Claim Processor addresses a particular pend edit on a claim, AMISYS Advance immediately continues to process and finalize that claim. Workflow management systems and specialized Claims Processors minimize the amount of time a claim is sitting in pended status, thereby ensuring timely payment to providers and timely encounter submissions to DHH. We will process all pended claims within 60 days of claim receipt.

Payment to Providers and Remittance Advice – Determines Encounter Filing with DHH. Once claims successfully pass through all claim edits, AMISYS Advance processes all claims with a status of paid or denied on the next claims payable cycle. LHCC currently processes claims payment and remittance advice weekly, with subsequent weekly encounter processing. AMISYS Advance captures the date of payment and the check or transaction number with the claim. The payable cycle determines claims timeliness penalties (if applicable) and applies interest payments in accordance with DHH rules and Louisiana Statute (if applicable).

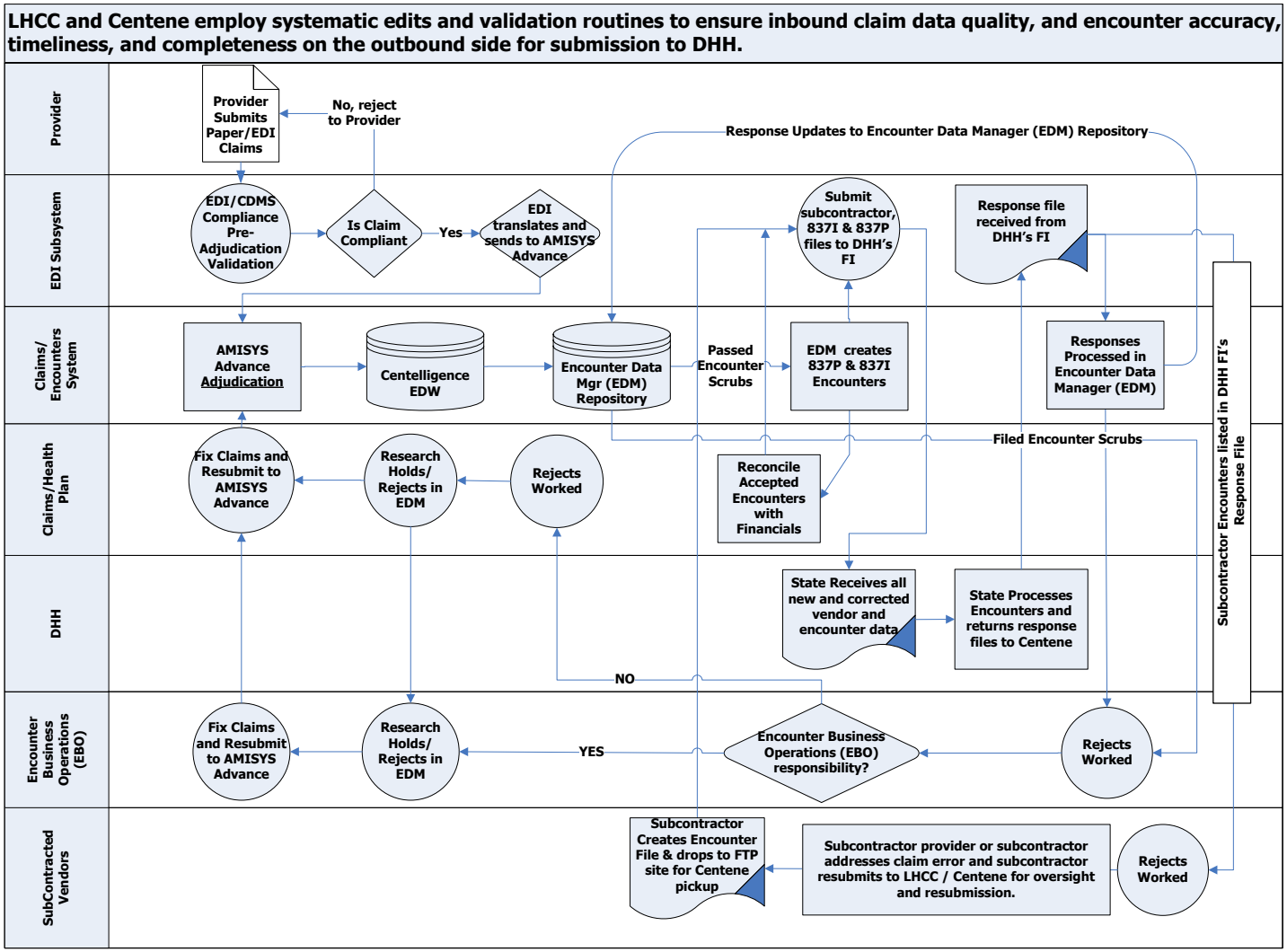
At the provider's option, we will mail a check along with an Explanation of Payment (EOP), or the provider can elect to receive an Electronic Funds Transfer (EFT) into the provider's designated bank along with a HIPAA 835 Electronic Remittance Advice (ERA) in lieu of paper EOPs. EOPs are also available online via our secure Provider Portal. Our ERAs/EOPs provide an itemized accounting of the individual claims included in the payment including, but not limited to, the member's name, date of service, procedure code, service units, and the amount of reimbursement.

Finally, we also offer providers a payment option through our free PaySpan service. PaySpan offers our providers a comprehensive payment management solution which is "payer agnostic" (open to all health plan payers, adding to provider convenience). PaySpan supports online EFT enrollment and activation, including bank depository accounts and remittance preferences, enables providers to view detailed remittance information online.

Providers can also download HIPAA 835 electronic remittance files directly to the provider's practice management system and/or financial system. Our remittance advice includes Third Party Liability (TPL) information per minimum HIPAA codeset requirements. Additional TPL information specified in section 17.4 is available through our Provider Portal. We will be able to modify our remittance advice to include all TPL information as specified in section 17.4 requirements prior to contract start date.

Provider Claim Disputes. We will submit our claims dispute process to DHH for approval within 30 days after contract finalization. LHCC processes, tracks, and attempts to resolve, provider claim issues directly with the provider, as quickly as possible, and within DHH approved requirements and timeframes for claim adjustments. If the provider is not satisfied with the findings, we advise the provider that they may appeal the decision. LHCC notifies providers of our delivery/mailing address for the receipt of claims disputes and/or appeals through the provider contract, during our provider orientation, on the Provider Portal, in the Provider Manual (available on our Provider Portal as well as the provider section of our public website), and on remittance advices (EOPs). Claim disputes from non-contracted providers are handled in the same manner as those from contracted providers. All documentation received during the claims dispute resolution process is date stamped upon receipt, scanned and routed for resolution to the appropriate claims staff. We capture all decisions around disputes, as well as related documentation, within our MIS.

Figure X2-B: End to End Claim to Encounter Workflow below provides a flowchart that summarily illustrates the entire process.



X.3 Describe your ability to provide and store encounter data in accordance with the requirements of the RFP and the Louisiana Medicaid specific requirements described in the Systems Companion Guide.

LHCC in conjunction with Centene currently provides encounter data to DHH and DHH's Fiscal Intermediary (FI), and we submit almost 700,000 encounters a month with an average acceptance rate of over 98%. Since 2011, LHCC has and will continue to leverage our experience, expert staff, best-of-breed technology, and the processes they support to ensure the integrity, validity, and completeness of all data we provide to DHH.

Ready to Continue Service for Bayou Health. Our ability to provide and store encounter data in accordance with RFP and DHH requirements stems from:

- An organization experienced in working with DHH and the FI, and with nationwide expertise in Medicaid encounter data processing.
- An enterprise, modular MIS, providing end-to-end support for efficient, accurate, timely and complete encounter data submissions.
- Systematic and configured adherence to DHH's Companion Guides.
- A scalable, high performance Enterprise Data Warehouse to store claims and processed encounter data.

We have reviewed in detail all claims requirements stipulated in Section 17 of the RFP and also requirements indirectly impacting claims processing such as those found in Section 16 (general Information Technology capabilities, security and encouraging Electronic Data Interchange - EDI); Section 9.5 (Claims Processing Requirements); Section 5.11 (Third Party Liability processing); Section 5.12 (Coordination of Benefits); Section 18 (Reporting); and finally the Bayou Health Systems Companion Guide (Encounter Processing). We have also examined the Bayou Health Medicaid Managed Care Organizations System Companion Guide Version 1.0 (MCO Systems Companion Guide), and the LAMMIS Batch Pharmacy Companion Guide (both documents dated February 2015) and we either currently support, or in the case of new requirements contained in the MCO Systems Companion Guide, *can and will* support, all requirements through configuration of our MIS.

Organizational Staffing and Workflow

LHCC and Centene view DHH, and DHH's FI, as partners in our encounter reporting process. We recognize that encounter data collection is vital to DHH administration, including areas such as contract requirement compliance, rate setting, and quality management and improvement. Our ability to provide and store encounter data in accordance with DHH's requirements is built upon our dedicated Encounters Business Operations (EBO) unit, Centene's dedicated team that serves LHCC and DHH as the centralized resource for encounter submissions. The EBO works closely with key functional areas (e.g., Finance, Claims, and applicable Information Technology (IT) Departments), to ensure a successful

LHCC in action…

A recent example of our close working relationship with DHH and the FI involves seemingly "duplicate" encounters. Working together, we determined that, in excluding modifier codes from certain of its encounter edits, DHH' FI's system was inadvertently flagging legitimate encounters as duplicates. For example, if a member had a procedure done on their left and right arms on the same day, FI's system – by excluding the left/right arm modifiers from consideration – would fail one encounter as a duplicate of the other. The FI was able to "turn off" the edit in question, resulting in increased encounter completeness and acceptance rates across all Bayou Health health plans.

encounter submission process. The EBO works closely with LHCC's local Claims Liaisons and Contract Implementation Analysts, specialists in DHH-specific requirements, to organize and coordinate services, communication, issue resolution, and encounter data preparation to meet DHH's needs in accordance with the requirements of the RFP and the Systems Companion Guide. We participate in regular weekly meetings with DHH, DHH's FI, and current Bayou Health Managed Care Organizations (MCOs). Standing agenda items include, but are not limited to, encounter operations and ICD-10 implementation.

In addition to our weekly meetings with DHH and DHH's FI, LHCC meets with DHH and DHH's auditor on an ad hoc basis to assist with questions, provide information, and discuss potential system enhancements that will allow DHH to capture additional information in encounters. For each encounter submission, LHCC's CEO, or designee submits an attestation confirming the truthfulness, accuracy, and completeness of all encounter data submitted to DHH and the FI.

An Integrated System Supporting Encounter Processes

From provider claim submission to LHCC, to our submission of the corresponding encounter record data to DHH's FI, our systems are designed to be effectively modular. We have the ability to enhance specific components for ongoing quality improvements, while enabling cohesive end-to-end integration for storage and provision of timely, accurate, and complete encounter data. Our MIS is compliant with Federal guidelines and ***we configure our MIS to support specific DHH processing rules for encounter submissions,*** utilizing DHH Systems Companion Guide and Billing Manual. Specifically, to provide timely, accurate and complete encounter data to DHH and DHH's FI, we rely on:

- **Data and file communications** protocols, controls and supporting systems to allow us to send and receive formatted data (including HIPAA and HL7 transactions, and state proprietary formats) both from DHH and/or DHH's FI, as well as our providers and subcontractors
- **Centene Document Management System (CDMS),** allowing us to receive paper claim submissions, scan and digitize them into compliant HIPAA 837 claim transactions for systematic edits, claims processing and ultimately for submission as an encounter data to DHH's FI
- **Provider Portal**, offering to providers multiple administrative and clinical functions, including the ability to submit claims through online direct data entry or batch EDI submissions
- **AMISYS Advance**, one of the health care industry's premier health plan claims processing systems, along with integrated, ancillary systems that efficiently support accurate claim adjudication
- **Encounter Data Manager (EDM)** encounter tracking, history and resubmission functionality, based on years of Centene and LHCC's experience processing Medicaid and DHH encounters
- Finally, it is our award winning **Centelligence™ integration and informatics** platform, which we describe in more detail below, that provides our storage and reporting capabilities.

Automating the Encounter Submission Process. After claims pass all EDI and pre-adjudication edits for HIPAA compliance, they are loaded into AMISYS Advance for claims processing. When AMISYS Advance adjudicates claims to a finalized status, our EDM workflow system extracts, prepares, and submits the data as encounters to DHH's FI. We configure EDM to submit encounter data that complies with all DHH standards for electronic file submission, standard HIPAA file format, file size, submission frequency, and submission method as required by DHH and DHH's FI. Our encounters capture the same line item detail regardless of the claim type, disposition (e.g., paid or denied), third party liability indicators, or capitation arrangements. We include all rendered services, original and adjusted claims, application of retroactive fee or member changes, etc. We adhere to NCQA, AMA coding, UB-04 editor, NCCI, and DHH standards regarding the definition and treatment of certain data elements captured on

claims, use of standard codes (including CPT Category I and II, HCPCS Level II and ICD-9-CM), counting methods, units, etc. We will conform to all current and future standard code sets in compliance with federal guidelines. We retain all data elements in our claims history necessary for creating encounters in compliance with DHH and DHH's FI requirements.

Specific functionality provided by EDM includes, among other capabilities:

- Support of DHH-specific business rules to "scrub" data prior to submission
- Automation of LHCC defined actions, in conformance with DHH guidelines, to correct repairable encounters
- Linkage to our base claim database, outbound encounters, and inbound acceptance reports to facilitate comprehensive encounter reconciliation efforts
- Automated prioritization of encounter correction activities
- Extensive operational and executive reporting to identify encounter trends, monitor acceptance rates, and proactively correct issues
- Automated extract and delivery mechanisms to minimize bottlenecks and the need for manual intervention.

EDM includes a module that provides a 'pre-submission scrub' mechanism to customize and apply edits to encounters, prior to submission to DHH's FI, as a final check for encounter accuracy. Once prepared, the encounter data is submitted in accordance with DHH timeliness requirements. Encounter response files are processed by EDM, updating the encounter history and identifying encounters that must be reprocessed. EDM provides an online management tool and extended reporting for encounter submission and response analysis. For example, as errors are reported in the FI's response file, EDM provides a platform by which each error can be researched by our EBO and LHCC staff. Once the solution is determined, the claim will be reprocessed and the encounter is then resubmitted using the EDM application.

Adherence to HIPAA Transmission Standard. LHCC will continue to submit encounter data in the standard HIPAA 5010 electronic transaction formats (specifically ANSI X12N 837 provider-to-payer-to-payer COB transaction formats (including 837P-Professional, 837I-Institutional, and NCPDP Pharmacy formats)), file size, submission frequency, and submission method (Secure FTP) required by DHH. As an incumbent Bayou Health health plan, LHCC currently holds the requisite EDIFECS and FI certifications (we provide DHH a copy of our EDI Certification Form annually) attesting to our demonstrated, proven EDI capability, mitigating risks traditionally associated with new health plan implementations.

We use the Electronic Data Interchange (EDI) validation services provided by DHH's FI to validate our encounter files before submission for ANSI X12 formats using EDIFECS Ramp Manager, a tool we also use for on-boarding and testing 837 claim transactions from our providers. The ability to test before sending each weekly claim submission allows us to make sure that our final encounter data files are 100% HIPAA compliant to the FI before we formally submit. LHCC successfully receives, processes, acknowledges, updates, and transmits formatted data to and from our integrated MIS from a wide variety of Trading Partners (state agencies, fiscal intermediaries, enrollment brokers, claims clearinghouses, medical test labs, providers, etc.) through all industry standard methods (VPN, Secure FTP, https, etc.).

Data Management of File and Encounter Submissions. Once encounters are ready for transmission, our Coviant Diplomat Transaction Manager (Coviant) handles our automated, scheduled file exchanges (transmission and receipt) with DHH and/or the FI, Enrollment Broker or other authorized Trading Partners. Coviant protects our file exchanges with access control, authentication, and secure configuration features for total data integrity and encryption protection during transmission.

From an internal data networking perspective, our network backbone is highly redundant through a mesh design that provides multiple paths to and from each point, allowing maximum network *availability* to DHH, enabling us to meet DHH transmission schedules. In addition, our EDIFECS and TIBCO software suite, in conjunction with Coviant, supports a wide range of *file transmission acknowledgement* protocols, including proprietary formats as well as ANSI standard 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 *that the sender was* as well.

Encounter Data Submission – DHH System Companion Guide

Our EBO team closely partners with DHH, DHH's FI, and is available to DHH auditors to provide information and support encounter data submissions and requirements. As mentioned above, we configure our EDM for the specific processing rules of DHH and the FI. The following are several examples where LHCC has adhered to DHH System Companion Guide rules and where we have configured our system to implement new requirements for encounters reporting based on DHH, DHH's FI, and auditor recommendations.

Encounters and Claims. Today, we send both Fee-for-Service claims and encounters with $0.00 for capitated providers as required by DHH's FI in separate files.

Coordination of Benefits (COB) and Third Party Liability (TPL) Indicators. We send TPL in the COB set of segments within the 837 file, in either service line level or claim document level. For inpatient records, the TPL is given at claim document level (in Loop 2320 per the Systems Companion Guide). For non-inpatient records where there is a service line level TPL data, the service line specific TPL is submitted, as it is reported by the provider, (in Loop 2430 per the Systems Companion Guide).

Batch Limitations. LHCC will only send batch encounters up to 99 files per day, not exceeding 20,000 encounters per file. If any adjustment to encounter claims impacts greater than one hundred thousand (100,000) encounter claims, LHCC will obtain prior approval from DHH before submission so the FI can prepare their systems to receive the file.

Provider Identifiers and Atypical Providers. We submit provider NPI, Taxonomy Codes and nine digit zip codes on our claim and encounter submissions. For submissions from atypical providers who do not have an NPI, we validate and provide on the encounter the LA Medicaid (Legacy) Provider ID with the state provider file before encounter submission.

File Naming Conventions. Encounter files are submitted to the FI in the requisite format and file type (and file extension) according to the claim type. This includes Transportation, DME, and Home Health services.

Internal Control Number Formats. We modified our Internal Control Number (ICN) for the submission method in which the claim was received (paper (P), electronic (E), and web (w)) and we provide that number to DHH's FI.

Encounters for Claims with Multiple Lines. For a claim level encounter submission (i.e. inpatient claims), we submit the same Internal Control Number (ICN) for all service lines. For a service level encounter submission (i.e. non-inpatient claims), we submit unique but sequential ICN per line level submitted. When an encounter adjustment is submitted, it is assigned a new ICN and the original ICN is voided out. The ICN is prefixed with a 4 digit prefix for claim submission media (paper, electronic, web), claim status (paid, denied), and subcontractor information (referenced in LHCC's Data Dictionary to DHH) that is captured in our EDM application.

Encounter Financial Fields. We provide all the financial fields required by DHH's FI including the submitted amount, paid amount, adjustments and any interest paid. For non-inpatient claims when interest was paid to a provider, we break this down on the encounter at the service line level, in accordance with DHH's FI instructions.

COB Paid date, Received and Paid Date. For all submitted encounters, the COB Paid date, and claim received and paid date are submitted in the 837 P and 837I at the claim and line level.

Transformed Medicaid Statistical Information System (T-MSIS). LHCC is currently working with DHH to implement the T-MSIS changes required by Centers for Medicare & Medicaid Services (CMS). Our Centelligence™ EDW will enable us to fully comply with these changes and to add those data elements to the 837 transactions, in accordance with DHH and Federal requirements.

Timely, Complete and Accurate. ***Timeliness.*** LHCC and the EBO create encounters for each claims payable run, and we submit those encounters to the state weekly. This assures delivery of all encounters no later than the 25th day of the month following the month in which the claim was finalized to a paid or denied status. We currently exceed the timeliness standards established by DHH to submit encounters. An important aspect of timeliness is having an appropriate mechanism for ensuring delivery and receipt of encounter submissions. As mentioned above, we validate that encounter submission files were successfully accepted into the FI's system by monitoring the EDI acknowledgements issued by the FI.

Accuracy. The EBO ensures encounter accuracy by regularly validating a random sample of encounter records against the source data in AMISYS Advance. We perform this audit, at minimum, whenever we modify or change our software configuration, or whenever we discover that an incorrect encounter record was submitted, and that the error cannot be corrected by our usual correction processes. Each month we balance and reconcile paid claims with processed encounters. We do so by comparing the medical expense dollar figure we send to DHH in monthly financial reports with the total dollar amounts in all the encounter record submissions we send in a given month. This process accounts for every dollar and assures that all inbound and finalized claims have been processed as outbound encounters to DHH.

Completeness. LHCC encounter submissions include *all* claims and encounters adjudicated for our members, including those submitted by out-of-network providers and our subcontractors.

To ensure completeness of encounter data submitted to DHH, on a monthly basis LHCC balances all claims data (paid, and adjusted) with the corresponding encounter data files submitted each week. We do this by comparing each *weekly* payment run to the corresponding *weekly* claim payment and count, and encounter submission. Each encounter record is also tracked to ensure that errors or rejections are handled in a timely manner. LHCC consistently submits encounter data that is 98.6% complete within 90 days, and 99.0% within 180 days, exceeding the DHH requirement of 95%.

Change Management. LHCC recognizes that requirements for encounter submissions change from time to time. We use industry–recognized best practices in Change Management, including the Agile Software Development Life Cycle (SDLC) discipline, in conjunction with our systematic Capacity Monitoring, Planning, and Annual Systems Refresh Program, to provide rapid, iterative deployment of system enhancements or changes. We will comply with future federal and/or DHH specific standards for encounter data exchange within the requisite 90 calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH. Our change management processes provide that we notify our subcontractors of such changes upon notice from DHH. See Section W.4 for more detail on our Change Management methodology.

Encounter Data Storage

Our Centelligence™ Enterprise Data Warehouse (EDW) is at the heart of our integration and reporting capabilities. EDW houses both paid claims data from AMISYS and encounter data from EDM (including the most recent encounters processed), providing comprehensive reporting support for encounter reconciliation. EDW is a centralized, relational database repository that supports our MIS with data integration, dictionary, and normalization capabilities. Informatica Power Exchange and Change Data Capture extract transactions in near real time from our core applications including AMISYS Advance and populate them into EDW. EDW is essentially the high performance data "junction" in our MIS - the system where operational data is integrated and consolidated - and available for a variety of informatics and reporting applications, such as EDM. All of the interfaces in and out of EDW have audit trails to assure data integrity and process transparency, but, in addition, we assure continuous data quality in EDW itself through a number of ongoing controls. EDW systematically performs quality checks to ensure both content quality and to prevent data duplication, and data over- or under-representation.

LHCC and our MIS fully support DHH's requirements for document retention. Any and all records, whether originated as electronic data (e.g. EDI or data entry) or paper and subsequently scanned to image, are kept online for six years in accordance to DHH's specific retention schedule. All of our production applications are capable of housing data for six years or beyond this timeframe - including AMISYS Advance, our TruCare health services management system, our MRM and PRM system (member and provider data management, respectively), and the EDW.

Existing Storage Capacity to Accommodate Near and Long-Term Growth. Centene's MIS strategy follows a simple operating tenet: MIS capacity will never limit our ability to grow in any of the public sector health care markets we strive to serve. From 2008 through 2013, Centene has experienced an average annual growth rate of 19% in membership, and an increase of 25% average annual growth in membership over the past 2.5 years (2012 through mid 2014), with *no negative impact* on claims processing performance. Centene submitted over 45 million encounter data records across LHCC and all our affiliate health plans in the previous year, and maintained a scalable Management Information System (MIS) (used by LHCC) to facilitate an overall 22.9% increase in claims volume (2012 to 2013). Our ongoing capability and capacity assessment process, in conjunction with the scalability inherent in our MIS, allowed us to accommodate the growth with no negative impact on associated service levels. Centene owns two enterprise datacenters that support all of LHCC's core applications. Both facilities employ redundant environmental, power, and networking systems, and "hotsite" backup capability. If a site disabling event occurs at either facility, the alternate data center can instantly assume critical data and voice network operations, and resume essential business systems within 48 hours. For more information on our data storage technology, resiliency and capacity, please see our responses to Section W.3 System Availability and Section W.1 Implementation and System Capacity respectively.

X.4 Describe your methodology for ensuring that claims payment accuracy standards will be achieved. At a minimum address the following in your response:
• The process for auditing a sample of claims as described in Section 17.5 Sampling of Paid Claims;
• Documentation of the results of these audits; and
• The processes for implementing any necessary corrective actions resulting from the audit.

Audit Methodologies from Multiple Vantage Points

LHCC and Centene employ a number of complementary audit methodologies throughout the organization ***(Please reference Figure X.4A Audit Teams***). This approach helps to ensure that *end-to-end,* Louisiana and Federal Medicaid and CHIP matching funds are appropriately and accurately applied toward the healthcare of our members. We recognize claim audit activities as an *opportunity* to identify system, staff,

provider, or systemic process improvements, in addition to compliance and monitoring. LHCC and Centene will use the information collected from our auditing process to enhance payment accuracy and ensure all funds are targeted for appropriate member care.

We have reviewed the RFP, its Appendices and Addenda, including Sections 16 and 17 (and in particular to this response, Section 17.5, 17.9, 17.10 and 17.11). We can and will meet all requirements. We currently meet similar requirements in our existing Bayou Health contract, and we can smoothly accommodate the incremental requirements called for in this RFP.

Ensuring Claim Payment Integrity. We achieve high standards of payment accuracy through our:

- Complementary teams for comprehensive, efficient audits
- Thorough audit documentation
- Our organizationally independent Claims Audit Division
- Our team of Quality Review Analysts, for close monitoring and ongoing training of our claims processor workforce
- External audits, including those for Sarbanes-Oxley (SOX) and the SSAE-16 SOC Type II reviews.
- Regular, structured scrutiny of our subcontractors
- Continuous quality driven correction methods
- Complementary battery of other audits and continuous oversight activities.

Audit Documentation

Audit reviews and any identified issues are documented in our Governance, Risk Management, and Compliance (GRC) system, Compliance 360. Recognized internationally as the leading GRC software system across all industry segments (including healthcare), Compliance 360 allows LHCC to systematically track compliance activities (with auditable records of management approval), and effectively administer and monitor our internal governance, as well as our contractual and regulatory oversight responsibilities.

Compliance 360 also enables workflow routing per policy and procedure formulation (with history of documentation and sign offs), and allows ongoing, proactive assessment of compliance risk. Within Compliance 360 we are able to route issues or action items to the appropriate internal departments and subcontractors for follow up. We also track and monitor the status of corrective actions, following issues through to resolution. We communicate audit activities and results to management and executive management staff through regular status updates. Monthly audit dashboard reports are available through our Intranet. In partnership, across the organization, regular quality meetings and communication accompany the GRC process to remediate issues and identify root causes for upstream resolution.

Complementary Teams for Comprehensive, Efficient Audits.

Our claim related audits are conducted by the following teams:

Table X.4A: Audit Teams

Internal Audit (Claims Audit Division) ***specifically targets financial and administrative claims processing and payment accuracy***	
Audit	**Sampling Methodology**
Financial Accuracy Audit	Weekly randomized sampling of adjudicated claims. Random sample is stratified into financial quartiles.
Payment Accuracy Audit	
High Dollar Audits	All claims that meet threshold of $100,000.

Centene Claims Department - Quality Review Analysts ***focused on continuous improvements in claim processor staff performance***	
Audit	**Sampling Methodology**
Claims Staff Audits	Frequency and sample size varies based upon claim staff experience level and recent quality performance, with no less than 10 claims audited per processor per month.
Claims Processor Accuracy	Frequency and sample size varies based upon claim staff's experience level and recent quality performance, with no less than 10 claims audited per processor per month.
Targeted Audits	Frequency and sample size varies based upon remediation efforts and/or process improvement efforts.

LHCC – Claims Analyst and Contract Implementation Analyst ***focused on continuous improvements in claim processor staff performance***	
Audit	**Sampling Methodology**
Claims Payment	*All* claims payment on weekly check runs.

External Auditors ***ensure claim processing and payment controls are appropriate***
SOX Management Report on Internal Controls over Financial Reporting
SSAE-16 SOC Type II over Claims Processing

Claims Audit Division (CAD)

For year to date 2014, LHCC has achieved:
99.7% Financial Accuracy
98.0% Payment Accuracy
Both above industry norms.

Through Centene, LHCC has an established, independent Internal Audit Department, with the Chief Audit Executive reporting to Centene's Chairman, President and Chief Executive Officer (CEO); and administratively and functionally to the Chairman of the Audit Committee. The Internal Audit Department includes an Internal Audit – Claims Division (CAD) that is responsible for providing an ***independent and objective evaluation of claims payment accuracy.*** Regularly, the Chief Audit Executive meets with the CEO and the Management Oversight Committee, which is comprised of Centene senior leadership, including LHCC leadership, to review claim audit results. CAD audits encompass claim entry, adjudication processes, as well as whether determinations on enrollment, benefit, and payment, for example, are accurate. All attributes mentioned in section 17.7.2 of the Request for Proposal are included in the audit process.

CAD staff perform statistically valid audits based on a random sample of processed claims, to assess claims for processing, payment and financial accuracy, as well as compliance with contract obligations. As mentioned, CAD is independent from LHCC and the claims department, enabling unbiased, objective evaluation of our operational processes. CAD employs an auditing methodology derived from state statutes, the Centers for Medicare & Medicaid Services (CMS), and Health and Human Services (HHS) guidelines and program requirements. CAD continuously reviews and improves its auditing methodology with feedback from internal operations and external stakeholders.

Sampling of Paid Claims. LHCC and Centene engage members to help identify cases where billed services may not have been performed, or may have been improperly billed. Monthly, we will use our Centelligence™ informatics platform to select a sample size no less than 2% of claims processed per month, of claims paid in the previous 45 day period. These audits may have various objectives dependent upon MCO and DHH concerns. The sampling of claims may be a targeted selection based on unusual patterns of care (e.g. rare, high-cost services or neighbors receiving the same service on the same day), a random selection of claims from high-abuse categories (e.g. DME, radiology), and a broad random sample across all claims for statistical sampling. All claim types are proportionally represented in the sample pool, from the entire range of covered benefit services. The Customer Service Department sends out individual explanation of benefits (EOB) notices to the sample of members. The EOB requests that the member validate the listed service by calling the LHCC Member Call Center. LHCC tracks responses from members and resolves any issues through member education, provider education, or referral to our Special Investigations Unit (discussed below). We enhance our sampling methodology based on lessons learned from each sampling cycle.

Financial and Payment Accuracy Audit. Our CAD performs a monthly audit of 250 claims, exceeding DHH requirements in Section 17.7. On a weekly basis, CAD audits a sample extract of finalized claims processed from initial claim submissions. Claims are stratified into dollar quartiles; this stratification allows us to help isolate different systemic factors that are characteristic of the dollar value, helping us identify patterns and issues in claims processing. To illustrate: any issues with a claim in a higher quartile range are generally different from those in lower quartiles. For example, higher dollar claims are processed by more experienced staff, and are generally more complex in terms of coding and general claim type. We also focus audits on high dollar quartiles, giving these claims more rigorous and intensive audit attention. For instance, we select all claims paid greater than $100,000 and randomly select remaining claims from the remaining quartiles. The resulting data is imported into Compliance 360, our governance system for audit workflow, documentation, and history. Claim dollars in the audit sample will be traced to the *specific* underlying provider contract or fee schedule using our claims processing data warehouse.

When an error is found, we document the specific error reason and if applicable, dollar amount incorrectly processed. These errors will be communicated back to the responsible department (i.e. Claims, Health Plan or Configuration teams) and within our Compliance 360 governance system. CAD will track the error through final resolution, documenting the reason for the error and the solution that was implemented to correct the error. For 2013 and year-to-date 2014, financial accuracy was 98.9% and 99.7%, respectively, and payment accuracy was 97.5% and 98.0%, respectively. The CAD audit will include all the attributes listed below. When reviewing the claims sample, CAD staff will review, at a minimum, the following (as CAD does for LHCC today):

- Was the claim entered correctly?
- Was the claim associated with the correct provider?
- Was proper authorization obtained for the service, if required?
- Was member eligibility correctly applied?
- Did the allowed payment agree with the contracted rate?
- Were non-contracted providers paid in accordance with Medicaid rates and DHH requirements (in accordance with RFP Section 9.3 Reimbursement to Out-of-Network Providers)?
- Were identified duplicate claim submissions denied?
- Were claims processed in accordance with utilization review/case management decisions made about those services and if the reason for payment was applied appropriately (denial reason applied appropriately)?
- Were non-covered services appropriately identified and denied, and the reason for non-payment applied appropriately?
- Was other insurance investigated for coordination of benefits, and when appropriate, was liability reduced?
- Was the processed claim supported by adequate documentation?
- Were the appropriate modifier codes correctly applied?
- Was proper coding consistent with provider credentials?

Quality Review Analysts

In addition to the monthly Financial and Payment Accuracy Audit conducted by CAD, the Claims Department Quality Review Analysts (QRA) conduct Staff Audits to evaluate the performance of all staff involved in claims processing *before and after* claims are paid, and staff adherence to job specific guidelines. As a best practice, LHCC ‘s local Claims Specialist, and our dedicated LHCC Claims Analyst, support the CAD and QRA staff audits to make certain the auditing staff is aware of DHH requirements and concerns. The combined team of the QRA, the CAD staff and the LHCC Claims Analyst conduct ***Targeted Audits*** to evaluate specific areas, including claims paid with high financial impacts, high rates of denials for individual Claim Processors, and key provider claims review. All audit teams use supporting information from AMISYS Advance, our claims processing system and related, integrated systems to evaluate claims processes and produce audit reports. Our management team uses these reports to *monitor* and, in conjunction with QRAs and CAD, take appropriate corrective *action*, if needed.

Claims Staff Audits. Although frequency, function, and methods of individual staff audits differ along each step in the claims life cycle, our approach to staff audits focus on determining if staff have successfully completed applicable training; know the performance benchmarks for their position and the role audit plays in performance achievements; understand their job function; and know how their job as a claims processor impacts the entire claim life cycle. QRAs are Claims Subject Matter Experts with

extensive claims administration experience. Many have held operational positions in the functional areas they now audit.

The QRA staff audit each processor with a frequency and sample size appropriate to that processor's experience level and recent quality performance, with no less than 10 claims audited per processor per month. QRAs randomly select claims for audit using AMISYS Advance, configured with processor specific thresholds. QRAs review all processor adjudication actions to confirm whether they adhere to LHCC and Centene policies and procedures, and whether the processor is correctly using and maximizing the use of workflow tools. When the QRA completes the 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 QRA or supervisor may implement a follow up, targeted audit to confirm whether the processor has a clear understanding of the proper handling of the erred claim situation.

Claim Processor Accuracy. QRAs regularly review all Mail Production Specialists tasks to confirm the accuracy of the claim form sort and preparation for scanning into our Centene Document Management System (CDMS). This includes: *Scanning* – to confirm the accuracy of the image capture and reimaging procedures, if applicable; and *Claim Data Capture* – to confirm the accuracy of optical character recognition (OCR) technology, interpretation and entry ("vertexing"), or data entry for Key From Paper, paper claims (for claims that cannot be processed by OCR).

Targeted Audits. QRAs conduct *targeted audits* to monitor a claim processor's accuracy, efficiency, and any systematic errors that could call for corrective action. If any gap or discrepancy is identified, we conduct a focused analysis to identify the root cause and resolve the concern. If the claims team detects a claim error, the claim will be pended and the correct outcome noted and communicated to the claims department, who manually reprocesses these flagged claims. This may include the following.

- ***Claim Processor Production***. 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.
- ***High Threshold Audits of Professional Claims.*** 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.
- ***High Frequency Paid and Denied Claims***. The Claims Team uses pricing and benefit audit tools to review paid and denied claims for accuracy.
- ***Encounter Data to Financial Lag Comparison.*** To compare encounter data to our financial lag, we utilize monthly lag data and compare "adjudicated claim to claim encounter data" and "dollar-to-dollar" with those claims maintained in our Encounter Data Manager (EDM) system. EDM is our integrated encounter data workflow system for processing and reporting encounter data to DHH's Fiscal Intermediary (FI).

Claims Liaisons and Claims Implementation Analysts

Efficient but Thorough LHCC Audits on Every Claims Payment Cycle. In addition to our sample-based internal audits that continually monitor the integrity of claims payments and Claims Processor staff performance, LHCC also monitors every weekly claims payment cycle. Each week, prior to issuing checks and electronic payments, LHCC's Claims Team (comprised of Claims Analysts and Contract Implementation Analysts) monitors payments about to be released. The Team examines all claims payments for accuracy, and focuses in particular on recent DHH directives, complex, multi-service claims and high dollar claim payments. If errors are detected during this check run review, this information is given to the assigned members of the Claims Team, with correct processing instructions, to ensure

optimal claims payment accuracy for our providers. Our multi-level audit review practice ensures that we are continuously monitoring for any potential need for configuration changes or staff training opportunities.

External Audits

In addition to our internal audit functions, Centene undergoes regular external audits annually, including the following:

SOX Management Report on Internal Controls over Financial Reporting. Centene's management is responsible for establishing and maintaining adequate internal controls over financial reporting and supporting MIS controls, including those related to security. 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 annually tests the design and operating effectiveness of Centene's internal controls over financial reporting. Centene's assessment of the effectiveness of internal controls is also audited by Centene's external auditor. Our external auditor expressed an unqualified opinion on the effectiveness of internal controls over financial reporting for the period ending December 31, 2013. *No significant deficiencies or material weaknesses were identified.*

SSAE 16 SOC 1 Type II. Centene's external auditors perform this annual audit for Centene to test the design of controls over Claims Processing and Data Center Operations and the operating effectiveness of such controls. In its most recent SOC 1 Type II report (2013), *Centene received an unqualified opinion from our external auditors.*

Subcontractor Audits

Our LHCC and Centene Quality Improvement (QI) departments monitor subcontractor performance (including encounter submissions) formally via quarterly Joint Operating Committee (JOC) operational reviews with each subcontractor. Subcontractor JOCs include executive and operational staff from LHCC, Centene (as appropriate), and the subcontractor. The purpose of the JOC is to monitor all functions delegated to the subcontractor. The JOC also helps facilitate meaningful health plan - subcontractor partnerships, encouraging operational efficiencies and delivering support to our subcontractors. In addition, we perform an annual delegation audit related to claims and encounter administration. Audits are conducted using predetermined audit tools that incorporate contractual, NCQA, CMS, and DHH requirements. The auditing process reviews the following:

- Proof of Third Party Administrator (TPA) License
- Timely adjudication of all provider clean claims
- Accuracy of adjudication
- Timeliness of adjudication.

Centene assists our QI Departments with monitoring the encounter submissions from each subcontractor, monthly, and identifies any outliers in encounter volume and/or any other anomalies in the subcontractor's submission, contacting the subcontractor as needed for any appropriate action. If an LHCC subcontractor falls outside our monthly performance guidelines, the subcontractor is subject to a Corrective Action Plan and potentially liquidated damages. Please see Section F.5 for more information on how we monitor our subcontractors.

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 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 LHCC's Provider Services Department where outreach and education can be arranged and conducted by their Provider Relations Specialist.

Change Request (CR). If an audit finds that the error is due to configuration, our LHCC 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, and User Acceptance Testing, and are then promoted to production when these steps are completed. Please see Section W.4 for more information on our systems change management process.

Process Modification. Upon identification of any potential systemic process deficiency**,** our QRA or CAD staff notifies Centene's Process Quality Department, which employs 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.

Addressing Provider Non Compliance. Our routine audit activities allow for the early identification of possible billing or coding issues. When issues are identified, LHCC 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 LHCC'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 LHCC Claims Team, our EDI specialists or other relevant department to conduct retraining in person if necessary. The LHCC 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 LHCC staff member suspect a provider of potentially fraudulent billing, they will immediately engage Centene's Fraud, Waste, Abuse (FWA) and Special Investigations Unit (SIU) departments, which provides oversight and guidance for the prevention, detection, and resolution of billing misconduct including inappropriate billing and coding.

Other Audits and Continuous Oversight Activities

Outlined below are several additional audits and continuous oversight activities LHCC conducts, or conducts in conjunction with the LHCC Claims Team. These are examples of best practices gleaned from our experience with our affiliate Medicaid and CHIP managed health plans:

Monitoring Claims Processing Closely Ensures Consistent Service. Our Louisiana Claims Team in Baton Rouge holds a daily LHCC Claims Operational Status Meeting (Claims Status Meeting), where we identify, track, manage, document and close any issues or emerging requirements with our supporting claims management team at Centene, maintaining the closest possible working relationship and assuring smooth and consistent operations. The regular and frequent round-up of performance status that the Claims Status Meeting provides informs our day-to- day and strategic approach to claims service.

Claims Xten® Reviews. We review the results of the Claims Xten® edits to determine if a provider is consistently billing with unbundled, incidental or retired codes. If identified, LHCC's Provider Relations, and claims specialists will outreach to, and educate the provider's office.

Clinical Appropriateness. Through Centene and their strategic partnership with Verisk's HealthCare Insight (HCI) subsidiary, LHCC incorporates an additional level of flexibility to claims processing to further detect clinical coding errors, inaccuracies, and potentially fraudulent billing practices without disrupting claims turnaround time to a material degree. HCI conducts pre-payment review on claims for appropriate coding based on the patient's claim history and diagnosis.

If any claim is determined to require additional clinical review, a clinician will review and recommend payment accordingly. If the claim is denied, the provider does have the right to appeal the decision and can submit medical records to support their claims. If the medical records do not provide support of clinical appropriateness, the claim will remain denied. HCI also conducts pre-payment reviews on provider billing patterns compared to his/her peers. Providers under review will receive an EOP requesting medical records for the accompanying claim. Centene's Special Investigation Unit (SIU) has a staff of certified coders and nurses who will review the medical records for inappropriate billing patterns. If they happen to identify a reoccurring pattern or concerns involved with clinical appropriateness, SIU will refer the claim to the medical director, who will work with the provider to resolve the issue.

Quarterly Key Provider Claim Reviews. The local LHCC Claims Specialist will review the top twenty claim submitting providers or *key provider group* claims quarterly and provide scoreboard results to LHCC's Contracting and Network staff. LHCC's Provider Relations staff will also evaluate top denials and intervene with providers if billing patterns reveal potential errors.

Provider Specific Monitoring and Audits. LHCC and Centene are committed to supporting providers with tools and systems to help 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. Outreach may be conducted in person, via email or telephonically. Our LHCC claims liaisons 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.

EDI Claims Submission Analysis. Centene's Electronic Data Interchange (EDI) Help Desk and the local LHCC claims team identify and educate providers who submit paper claims through our Provider Claims Scorecard. The EDI Help Desk works with providers to encourage electronic submissions via our Provider Portal or EDI clearinghouses. The EDI Help Desk also communicates directly with providers or clearinghouses that may experience issues or have questions about electronic submissions. EDI Help Desk technicians *reach out* and work directly with providers who currently submit a high volume of paper claims, or have high rejection rates, and help resolve any issues that cause claim rejections. The EDI Help Desk also offers *training or technical expertise* to encourage EDI submissions from those providers not yet submitting claims electronically. Our EDI help desk is accessible from the LHCC provider services options on our Interactive Voice Response system. EDI Help Desk staff respond to all voice messages and emails within 24 hours, and they are available to participate in *conference calls* with providers, software vendors and clearinghouses as needed.

Program Modification Audits. With the introduction of any program changes, such as a change in state reimbursement rates, our LHCC claims team reviews claim outcomes to ensure complete compliance with federal and DHH compliance requirements. Even before those changes are put into effect, LHCC Finance Team uses Centelligence™ 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.

Reporting Fraud, Waste, and Abuse

LHCC, through our Program Integrity Officer, has an affirmative duty to report all activities on a quarterly basis to DHH. Reports include the number of complaints of fraud, abuse, waste, neglect and overpayments made by LHCC that warrant preliminary investigation, and the number of complaints reported to the Program Integrity Officer. Reports also will include the total number of survey notices sent out to members, those completed, validated, and resolved from the Sampling of Paid Claims audit. For each complaint that warrants further investigation, LHCC will provide the name and ID number, source of complaint, type of provider, nature of complaint, approximate dollars involved if applicable, the disposition of the case and any other information requested by DHH. Immediately upon confirmation of suspected fraud and abuse, Centene's Special Investigation Unit will e-mail an investigation report to LHCC. LHCC will review and forward the information to the Program Integrity Section and the State's Attorney General Medicaid Fraud Control Unit within three business days. The referral will, at a minimum, contain:

- The fraud referral form;
- An investigative report including the allegation, statutes/regulations violated or considered, and the results of the investigation;
- Copies of program rules and regulations violated for the time period in question;
- The estimated overpayment identified;
- Summary of interviews conducted;
- The encounter data submitted by the provider for the time period in question; and
- All supporting documentation obtained as the result of the investigation.