

Proposal Section and Page Number	Specify Applicable GSA Area (A, B and/or C)*	PART II: TECHNICAL APPROACH	Total Possible Points	Score	DHH Comments
		Section J: Quality Management (Section 14 of RFP)	125		
J-1	A, B, and C	<p>J.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:</p> <ul style="list-style-type: none"> • Management of high risk pregnancy • Reductions in low birth weight babies • Pediatric Obesity (children under the age of 19) • Reduction of inappropriate utilization of emergent services • EPSDT • Children with special health care needs • Asthma • Diabetes • Cardiovascular diseases • Case management • Reduction in racial and ethnic health care disparities to improve health status • Hospital readmissions and avoidable hospitalizations 	30		
J-28	A, B, and C	<p>J.2 Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.</p>	10		

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J-32	A, B, and C	<p>J.3 Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.</p>	15		
J-37	A, B, and C	<p>J.4 Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.</p>	15		

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J-71	A, B, and C	<p>J.5 Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:</p> <ul style="list-style-type: none"> • The Performance Improvement Projects (PIPs) proposed to be implemented during the term of the contract. • How the proposed PIP s will expand quality improvement services. • How the proposed PIP will improve the health care status of the Louisiana Medicaid population. • Rationale for selecting the particular PIPs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues. • How your will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner. • How the proposed PIPs may include, but is not necessarily, limited to the following: <ul style="list-style-type: none"> ○ New innovative programs and processes. ○ Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics. 	20		
J-84	A, B, and C	<p>J.6 Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.</p>	10		

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J-89	A, B, and C	<p>J.7 Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.</p> <ul style="list-style-type: none"> • If you do not have results for a particular measure or year, provide the results that you do have. • If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line. • If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state). • If you do not have HEDIS results for five states, provide the results that you do have. • In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries. <p>Provide results for the following HEDIS measures:</p> <ul style="list-style-type: none"> • Adults' Access to Preventive/Ambulatory Health Services • Comprehensive Diabetes Care- HgbA1C component 	25		

		<ul style="list-style-type: none">• Chlamydia Screening in Women• Well-Child Visits in the 3,4,5,6 years of life• Adolescent well-Care.• Ambulatory Care - ER utilization• Childhood Immunization status• Breast Cancer Screening• Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)• Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents <p>. Include the Proposer's parent organization, affiliates, and subsidiaries</p>			
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Question J.1

Documentation of Positive Impact on
Healthcare Status of Medicaid and
CHIP Populations

Section J: Quality Management

J.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations.

Louisiana Healthcare Connections (LHC) is a joint venture between Louisiana Partnership for Choice and Access (LPC&A) and Centene Corporation (Centene). LPC&A represents 19 of the 25 Federally Qualified Health Center (FQHC) members of the Louisiana Primary Care Association (LPCA). For more than 28 years, the LPCA has been an integral component of the health delivery system in Louisiana, providing almost 632,000 visits for nearly 203,000 patients in 2010¹. LPC&A members understand the needs and preferences of Louisiana Medicaid recipients and Medicaid providers, and how they differ across the various regions of the state. Centene, a leading multi-line health care organization, has more than 27 years of experience managing the health care needs of Medicaid CHIP, and other low-income populations, which requires a comprehensive understanding of each member's unique physical and behavioral health issues, as well as the social, educational, and economic challenges they face.

Centene currently serves nearly 1.6 million members on a full-risk basis, and operates managed care programs in 11 states: Arizona, Florida, Georgia, Illinois, Indiana, Massachusetts, Mississippi, Ohio, South Carolina, Texas and Wisconsin. Through outreach, education and physician endorsement, Centene's programs are designed to help members navigate the inherently complex health care system, ensuring that they receive appropriate and medically necessary services while managing routine or chronic health problems more effectively.

Centene has particular expertise at delivering health care in states with large rural markets, including its Texas affiliate, which is an Exclusive Provider Organization for CHIP recipients in 170 rural counties across the state. In Mississippi, 79% of the counties in our affiliate's service area are rural; in Georgia, 49% of the counties are rural. Our performance history and reputation are evidenced by the longevity of our contracts in our existing markets. For example, Centene has been providing high quality health care solutions to Wisconsin since 1984, Indiana since 1995, and Texas since 1999. The table below shows the populations served by Centene affiliates in each state, along with the membership.

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

Membership for Centene-affiliate Plans by Population Type – April 2011

Affiliate (those with members)	Population Types	Membership
Arizona	Acute Care - TANF, CHIP, SSI/ABD	17,695
	Long Term Care – SSI/ABD	3,112
Florida	Acute Care – TANF, SSI/ABD	187,000
	Long Term Care – SSI/ABD	1,800
Georgia	TANF, CHIP	303,300
Indiana	TANF, CHIP, Uninsured Adults	209,400
Massachusetts	Uninsured Adults	14,649
	Uninsured Legal Immigrants	19,214
Mississippi	SSI/ABD, Foster Care	33,137
Ohio	TANF, CHIP	141,500
	SSI/ABD	18,900
South Carolina	TANF, CHIP, SSI	84,900
Texas	CHIP, CHIP Perinate (Rural)	71,248
	TANF, CHIP, CHIP Perinate (urban), SSI/ABD	350,854
	Foster Care	31,823
Wisconsin	TANF, CHIP, others	73,986
	SSI/ABD	7,834

Positively Impacting Health Care Status

For the purposes of this draft, we will focus on Centene initiatives since the question is inquiring about other states. However, our owner-partner FQHCs have engaged in a number of initiatives over this same period to improve the quality of care and service delivered to their patients throughout the state of Louisiana. Centene’s mission statement is: “Centene will provide better health outcomes at lower costs.” To carry out this mission, Centene and its health plans have implemented a variety of clinical initiatives designed to positively impact the healthcare status of our members and the communities we serve.

Our affiliate health plans have achieved improvements in outcomes through programs addressing asthma and diabetes management, children with special health care needs, women’s preventive health, depression, well child care, prenatal, postpartum and neonatal care, and coordination of medical and behavioral health care. For example, as a result of targeted programs, our Georgia affiliate, Peach State Health Plan, increased well child visits by 42%, EPSDT by 89%, and Child lead screening by 170%, and reduced asthma related hospital admissions by 21% from 2006 to 2009. Our Texas affiliate, Superior HealthPlan, increased breast cancer screening 24.4% and, through a diabetes initiative, improved nephropathy screening by 45.6% and reduced the proportion of members in poor glycemic control (HbA1c > 9.0) by 28%, all between 2007 and 2009. Our Ohio affiliate, Buckeye Health Plan, developed an innovative collaboration with an FQHC in Akron to provide primary care for members with primary

behavioral health disorders and a carved out behavioral health benefit. The program was named a Pinnacle award-winning best practice by the Ohio Association of Health Plans.

Positively Impacting the Communities We Serve

Service to our communities and positive corporate citizenship creates healthier communities, and Centene's approach to corporate citizenship touches all aspects of our company. For 27 years, we have conducted business in consideration of these core values:

- Community investment
- Philanthropic work
- Staff development
- Corporate governance, transparency and accountability

Centene demonstrates this commitment through two foundations.

The Centene Charitable Foundation. The Centene Charitable Foundation provides charitable support for community initiatives that improve the quality of life and health in communities in which Centene Corporation does business. Sponsorships include, among others, Boys Hope Girls Hope, Asthma and Allergy Foundation, United Way, March of Dimes, St. Louis Crisis Nursery, and Youth in Need.

The Centene Foundation for Quality Healthcare. The Foundation for Quality Healthcare was established to improve the quality, access, effectiveness, and value of healthcare for low-income families and individuals, focused on activities that identify and address core causes of unequal access and treatment in healthcare. Building on our long-standing commitment to deliver healthcare at the local level, the Foundation develops partnerships to implement innovative approaches to promote healthy communities. In 2009, The Foundation funded a \$50,000 grant to LPCA to help support their initiative for member FQHCs to become NCQA recognized as Patient-Centered Medical Homes. This initiative built on the FQHCs' strength as community-oriented providers of comprehensive care to go the next step to achieve and be recognized for fully coordinated, patient-centered care, and accountable for improving the health status of their patient population. Other Foundation grant awardees have included, for example:

- **Fragile Kids Foundation, Inc. (FKF)**, a nonprofit organization based in Atlanta, Georgia to launch the Fragile Kids Partner Program, an effort to better reach underserved, rural Georgia families caring for medically fragile children with a range of diagnoses, including cerebral palsy, spina bifida, muscular dystrophy, mitochondrial disorder and other genetic/trauma disorders. The goal of the program is to provide medical equipment and therapy tools.
- **Madison County Community Health Centers** to support the development and implementation of a School Based Health Clinic in Alexandria, Indiana. The clinic addresses the effects of inaccessible primary healthcare for school aged children. This Clinic specifically focuses on conducting health assessments for all elementary, intermediate, and high school students in the Alexandria, Indiana area.
- **Texas Parent to Parent** to support its Medical Education Program (MEP). The MEP works with pediatric and family practice residents, as well as other medical professionals to widen their perspective of the needs of Texas children with disabilities and chronic illness from hospital and office to the home and community.
- **The Center for Black Women's Wellness, Inc. (CBWW)** to support *Journey to Wellness*, a program designed to address the disparity of mental health among black women in Atlanta, Georgia.

- **Healthy Connections Network** to support additional case management services for individuals in the Access to Care program, the first and only comprehensive collaborative effort in Summit County, Ohio to provide free or low-cost health insurance to the uninsured poor.
- **Arizona Health Care Foundation** to provide scholarships to qualified individuals who currently work in long-term care areas such as skilled nursing facilities and assisted living communities. The scholarship awards provide an opportunity for these individuals to continue formal education in the healthcare fields.

Local Support. All Centene's health plans are actively involved in the communities they serve, sponsoring community health fairs or other events or contributing toward local initiatives. Many health plan staff from executive leadership to MemberConnections™ outreach teams are involved as volunteers in community groups that support the members we serve. Examples of just a few of the organizations we partner with include:

- Kids of Katrina Art Camp - Mississippi
- Mississippi Coalition for Citizen's with Disabilities
- Cleveland Food Bank
- United Cerebral Palsy of Greater Indiana
- Indiana Black Expo
- The Martin Luther King Community Center - Indiana
- Milwaukee Latino Health Coalition - Wisconsin
- Safe Communities Coalition- Wisconsin
- Center for Black Women Wellness - Georgia
- Child Abuse Prevention Coalition - Georgia
- Boys and Girls Club of America – Georgia

Experience Positively Impacting Health Status

The following descriptions are examples of some of Centene's experience with programs and initiatives and our effectiveness in improving member outcomes.

Management of high risk pregnancy

Reductions in Low Birth Weight babies

The Institute of Medicine estimated that the annual societal economic burden associated with preterm birth in the United States was over \$51,000 per preterm infant in 2005.² Poor birth outcomes, including low birth weight, prematurity, and NICU admissions are a significant cost driver for any managed Medicaid population. As a managed health care organization, effectively managing our high-risk populations is an integral component of our mission to provide better health outcomes at lower cost. Early identification and assessment are key to providing the opportunity for successful intervention. The use of administrative claims data is insufficient for timely identification and evaluation for the risk factors faced by pregnant Medicaid and CHIP members. Risk factors such as smoking, alcohol or drug use, and domestic violence are not coded on claims rendering critical information unavailable. Claims lag and late eligibility information make timely identification of these members inconsistent at best.

Start Smart for Your Baby® Following an exhaustive evaluation of this critical issue in 2006, Centene initiated our comprehensive *Start Smart for Your Baby*® Program to improve birth outcomes by focusing on early identification and risk screening, member education, and empowerment. Start Smart is a comprehensive pregnancy and postpartum management program, extending into the child's first year of life, which incorporates the concepts of case management, care coordination, and disease management.

² Preterm Birth: Causes, Consequences, and Prevention, Report Brief July 2006, Institute of Medicine, <http://www.iom.edu/Reports/2006/Preterm-Birth-Causes-Consequences-and-Prevention.aspx> accessed 6/21/2011

Our multi-faceted approach to prenatal and postpartum care is a team effort by our plan staff and our providers, and includes enhanced member outreach, health screenings, wellness materials, intensive case management, and provider incentives. Educational materials reinforcing healthy behaviors and adherence to recommended preventive care include, but are not limited to MP3 players with educational podcasts. Members attending prenatal, postpartum, and well child visits receive incentives.

In 2010, our Start Smart for Your Baby pregnancy and post-partum management program received the inaugural URAC/ Global Knowledge Exchange Network International Health Promotion Award and a Platinum Award for Consumer Empowerment at the URAC Quality Summit. In 2009, Start Smart was named an NCQA Best Practice.

Each of our employees is trained to identify pregnant members during any interaction. For example, Member Services, Concurrent Review, our NurseWise 24/7 nurse advice line, and Disease Management staff all assist the member with completing the Notification of Pregnancy screening form or refer the member to the Start Smart staff whenever they encounter a pregnant member.

Notification of Pregnancy (NOP). The *Notification of Pregnancy* process is a streamlined approach for identifying pregnant members and assessing their risk factors as early in their pregnancy as possible, and engaging them with Start Smart staff. The NOP form captures the member's current contact information, provider information, Estimated Date of Confinement, and medical and obstetric history. Using this information, Centene assigns a proprietary risk score to determine the most appropriate level of intervention. We incent members and providers and their office staff for timely NOP form submission. For example, Centene's health plan in Texas increased NOP submission by 86% over the year following initiation of a gift card incentive for provider office staff. Centene's NOP Process was accepted for a Poster Session at the 2010 Annual Clinical Meeting for the American College of Obstetrics and Gynecology.

17 Alpha-Hydroxyprogesterone Caproate (17P). Among our most effective interventions in managing high risk pregnancy, our *17P Program* identifies women less than 28 weeks gestation who may qualify for weekly injections of 17P. The American College of Obstetrics and Gynecology recommends use of 17P to prevent preterm delivery in women with a previous spontaneous preterm birth. Through our early adoption of this Program, we provided high-risk pregnant members and their providers with ready access to this custom compounded medication and significantly improved health outcomes. Centene's long experience with 17P and its impact on birth outcomes was recently reported in the journal "Managed Care".³ From 2004 to 2009, Centene affiliate plan members receiving 17P had a statistically significant 36.6% lower rate of premature birth (less than 35 weeks gestation) than a control group. The NICU admission rate was 25.2% lower for recipient offspring than controls. Our 17P program has been honored with several awards, including a Pinnacle Award from the Ohio Association of Health Plans, and it was recently named a finalist in the 2010 Case in Point Platinum Awards for innovative case management programs.

Baby Showers. Among the other components of Start Smart, our *Baby Shower Program* is conducted in a class environment and led by a registered nurse and MemberConnections® outreach staff. The classes cover the basics of prenatal, postpartum, and newborn care, including nutrition, smoking cessation, and other healthy behaviors, normal fetal and newborn development, and the importance of receiving recommended preventive care.

Tobacco Cessation. Pregnant members with asthma or COPD who smoke are enrolled in some states in our *Puff-Free Pregnancy Program* and receive educational materials about the risks associated with smoking during pregnancy and strategies for quitting. They also receive telephonic coaching from a certified Tobacco Treatment Specialist. In Louisiana we will fully support DHH's Tobacco Control

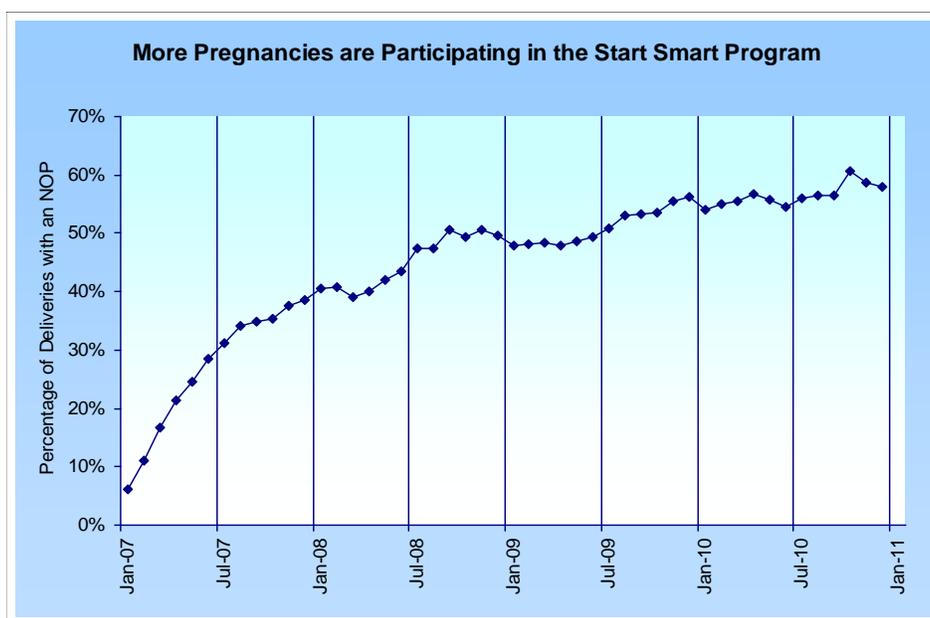
³ Mason MV, Poole-Yeager A et al, *Impact of 17P Usage on NICU Admissions in a Managed Medicaid Population – A Five Year Review*, *Managed Care* 19;2:46-52 Feb 2010

Program and will educate our members about accessing all of the resources available through the program, such as the Louisiana Tobacco Quitline and the Freedom from Smoking Clinics, where our members will be able to receive instructions about topics such as recovery symptoms, weight control, stress management/relaxation techniques and how to calm the urge to smoke, as well as supplementary materials to help them develop a quit plan. Our MemberConnections™ Representatives (MCRs) and Member Service Representatives will receive training on the Program and will provide education to members who express an interest to quit, or who are identified as being smokers during outreach activities or inbound calls to our member call center. Our Case Managers will work with members enrolled in our Case Management Program and/or our Asthma and Chronic Obstructive Pulmonary Disease (COPD) Disease Management Programs who smoke to incorporate an individualized quit plan into their service plan. In addition, we will educate our providers about the Program, the Quitline, how to become a certified Fax to Quit Provider (if they are not already), and resulting access to important tobacco cessation resources for their practice, such as the Certified Health Care Provider Toolkit.

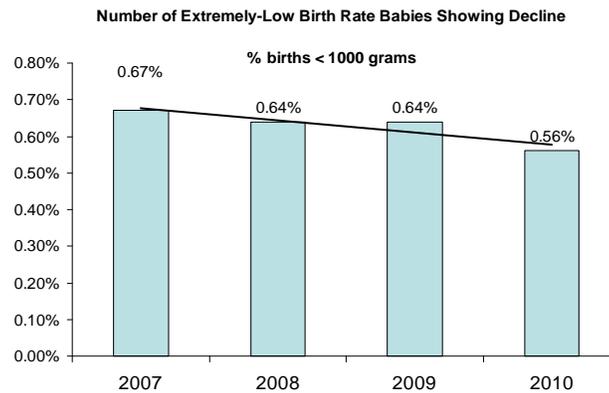
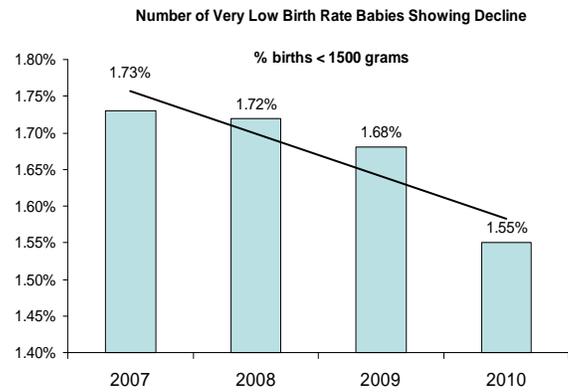
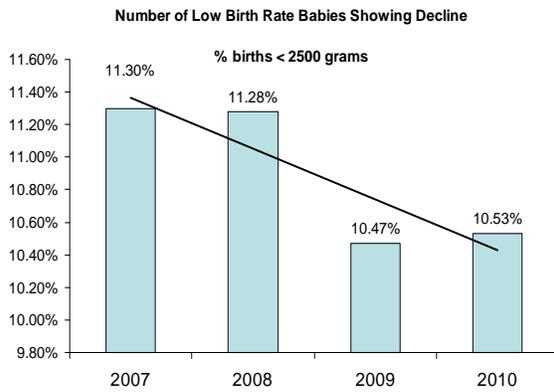
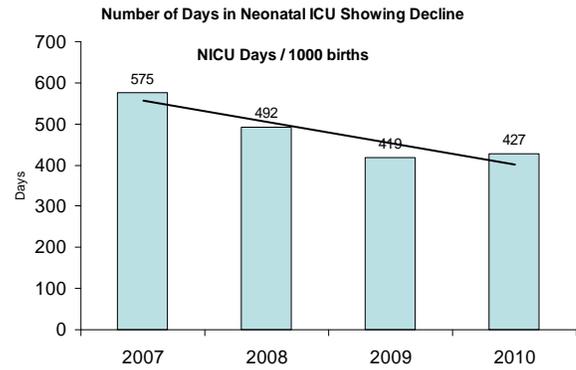
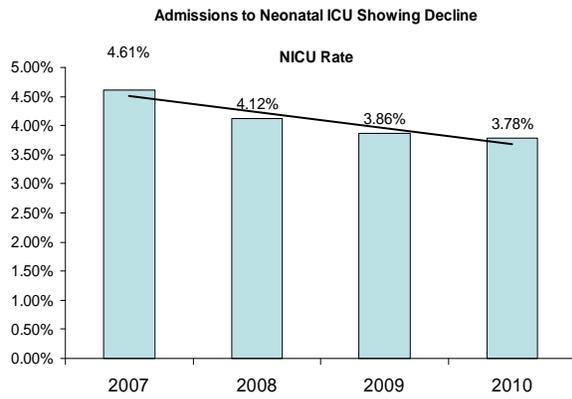
Smart Steps for Your Baby®. This walking program provides a brochure on the benefits of exercise during pregnancy, information about how to set up a safe walking program before and after delivery, a log for tracking steps, and a pedometer.

Start Smart for Your Baby® Program Effectiveness

The Start Smart Program has positively impacted the healthcare of our members nationally. Over the first four years of the program, the proportion of deliveries (over 60,000 each year) for which we had received the critical NOP form increased from negligible to almost 60%.



Key indicators of birth outcomes also improved, including statistically significant decreases in our NICU admission rate and NICU days/1000 births, and decreases in all three measures of low birth weight, all from 2007 to 2010. We obtain birth weight information on over 90 percent of our births each year.



Pediatric Obesity (children under the age of 19)

Approximately 12.5 million or 17 % of U.S. children and adolescents ages 2 to 19 are obese.⁴ Centene has developed comprehensive programs to help our young members learn the value of healthy eating and staying active.

Healthy Lifestyles Program

Our *Healthy Lifestyles Program*, which identifies regional community health education needs in collaboration with community-based organizations, includes childhood obesity related program components. Centene health plans are working to raise awareness with its members and the community concerning the dangers of childhood obesity.

Healthy Schools/Adopt a School Program.

As part of this program, affiliate health plan staff visit local schools to promote our *Kids Club* childhood obesity program, which includes a Thumbs Up Johnnie book about healthy eating, reading from its author, a visit from *Thumbs Up Johnnie* himself, a Girl Scout badge about healthy choices, and other information and outreach geared at reducing childhood obesity. Since 2008, more than



5000 students have participated in the program. The Kids' Club educates child members on a variety of health topics, but focuses heavily on obesity prevention. We use "Thumbs Up Johnnie," a child-friendly, nationally recognized character, to help educate children about fighting obesity. Author Michelle Bain visited students in Gary, Indiana as part of our Indiana affiliate's Adopt a School Program to read, "Super CENTEAM 5, The Adventures of Thumbs Up Johnnie" and "Super Centeam5 Cookbook." Students received autographed copies of the book, character-themed bracelets, and took part in pre/post presentation tests about healthy eating habits. There has been an average 33.6% improvement in correct answers to date. Teachers who turned in their post-presentation tests received a set of Thumbs Up Johnnie books for their classroom and bookmarks for their students, and Centene also donates a set of autographed books to that school's library. Centene also engages children directly through newsletters, contests (such as healthy recipe contests) and other events.

Healthy Choices Brownie Badge. Centene expanded the Kids Club Program with the Healthy Choices Brownie Badge, which is, designed to educate kids on making healthy choices. Centene has already met with the Girl Scouts of America and received their full support to move forward with this initiative. Brownie troops must complete at least 4 of the following health-related components to receive their Thumbs Up Johnnie "Try It" Badge:

- Breakfast - Discuss its importance
- Lunchtime - Discuss and design a healthy lunch
- Fast Food – Learn how to use moderation
- Recipe collection – Write down and exchange 3 healthy snacks
- Water – Learn the need for hydration and measure out 8 glasses of water
- Exercise – Create an exercise routine with a jump rope
- Tell your friends – Design and draw a poster

⁴ NCHS Health E-Stat: *Prevalence of Obesity Among Children and Adolescents: United States, Trends 1963-1965 Through 2007-2008*, CDC, Atlanta
http://www.cdc.gov/nchs/data/hestat/obesity_child_07_08/obesity_child_07_08.htm accessed 6/9/2011

Provider Incentives. In 2010, Centene’s Wisconsin affiliate, Managed Health Services (MHS-WI), offered enhanced reimbursement of \$10.00 to providers who screened for and documented members’ body mass index (BMI), and billed the appropriate supplemental code along with an EPSDT or other office visit code. MHS-WI Provider Relations and Quality Management staff educated providers on this new incentive for screening, resulting in a dramatic increase in the number of children screened for overweight and obesity. In 2010, a total of 6,874 children ages 2-17 were screened compared to 453 in 2009. Approximately 35% of the members screened were overweight or obese. MHS-WI sends a letter to each identified member’s parent or guardian with an “Eat Smart and Be Active” brochure, promoting, for example, eating breakfast as well as 5 servings of fruit and vegetables every day, and an activity and diet log to track exercise and dietary intake.

Reduction of inappropriate utilization of emergent services

From 1997 to 2007, US emergency room (ER) per capita use increased 11%. In 2007, there were 117 million ER visits, 8% of which were classified as non urgent.⁵ The estimated cost of each ER visit has been estimated at \$1000. Centene’s approach to reducing inappropriate use of the ER has been comprehensive, encompassing education for all members about when to use the ER, targeted education for members whose ER utilization is outside expected utilization parameters, community outreach, provider education and support, and aligned provider and member incentive programs.

Comprehensive Member Education. Health plan Member Handbooks, Member Newsletters, and Member Portals provide extensive information about the importance of selecting and establishing a relationship with a primary care provider, when members should use the ER or urgent care, and how to contact NurseWise, our 24/7 nurse advice line, for guidance in determining the most appropriate care setting. Our NurseWise and Member Services staff encourage members during New Member Welcome Calls to review these tools. Our Member Call Center lines include on-hold messaging to remind members of the availability of NurseWise to answer any health care questions.

In 2008, Centene’s Indiana affiliate, Managed Health Services (MHS-IN) implemented a targeted outreach program to assist members with scheduling appointments with their primary care provider or other providers and arrange transportation when needed. That first year, their Quality Outreach Team staff made approximately 10,000 outbound calls each month and in 2010, that number increased to 20,000 calls per month, using automated calls in addition to live-person calls to contact members and encourage them to schedule appointments with their medical home. Other Centene plans have used similar approaches to proactively facilitate the PCP/member relationship.

Targeted Outreach to Frequent ER Users. All Centene health plan staff track monthly reports listing members with frequent ER utilization, as well as daily logs from NurseWise, and outreach to those members to educate them and assess barriers to primary care access. For example, in 2009 MHS-IN initiated outreach by MemberConnections staff to members with a recent ER visit who used the ER three or more times in six months. The staff identified 91 members for outreach in the first quarter of the initiative. The results showed that direct contact immediately after an ER visit held promise: the ER visit rate for these members dropped 48 percent (from 2.84 visits/month to 1.47 visits/month). MHS-IN also launched a Televox[®] automated outbound call campaign for this ER diversion program to increase the number of member contacts. Automated calls were successfully completed with 4,449 members in the first three months compared to 1,550 members educated for the entire year of 2009.

Our Georgia affiliate implemented similar targeted outreach initiatives and achieved positive results. From 2009 to 2010, Peach State Health Plan realized a 31% decrease in total ER visits.

⁵ Debra Draper, Director Healthcare Director at the General Accounting Office during testimony to US Senate subcommittee on primary health and aging. May 11, 2011

Member Incentives. Centene plans also provide aligned member incentives for the use of preventive and primary care services. Rewarding members with a credit on a CentAccount™ Mastercard® debit card for targeted healthy behaviors increases the likelihood of continuing these behaviors through positive reinforcement. Eligible members can earn rewards for completing annual preventive health visits, and completing other recommended preventive health and chronic disease care screening, such as appropriate diabetes testing. Members may use their CentAccount card to pay for medical copays or to purchase approved health care goods and services at many familiar retailers, such as Wal-Mart, Walgreens, Target, and CVS/Pharmacy. Rewarding members for healthy behaviors can help reduce urgent or emergent conditions that send members to the ER. Many members take advantage of this incentive. For example, since CentAccount was implemented by MHS-IN close to 2 years ago, 362,914 rewards have been paid to members, amounting to \$5,729,480.

Targeted Community Outreach. During Centene’s 27-year history serving Medicaid members, our affiliate health plans have collaborated with many non-profit community-based organizations across the states we serve to promote the early and frequent use of primary care services, thus reducing the need for inappropriate ER use. Last year, MHS-IN, for example, touched more than 11,000 members and additional non-members statewide during over 65 community-based events in cooperation with local agencies and advocacy groups. MHS MemberConnections™ outreach staff helped organize and staff health promotion and education events, such as wellness clinics and health fairs. In each instance, they reinforced the importance of the medical home and preventive services.

We customize our efforts to meet the needs of each community, but consistently reinforce the importance of early primary care preventive services. For example, some of our affiliate plans that have identified target communities of high member ER utilization reinforced the message about using primary care services with general public communications on billboards and bus signage.

Provider Education and Support. Centene health plans educate providers about their role in reducing unnecessary ER use and support their efforts to educate members about the advantages of having a strong medical home relationship. Plans educate providers and facilities about our emergency service and medical home policies during the contracting process, and then through provider orientations and ongoing trainings, in provider manuals, on Provider Portals, and in quarterly Provider Newsletters. Provider Relations staff meet monthly with high volume PCPs and regularly with new providers to encourage provider availability and access. Affiliate plan staff routinely conduct “secret shopper” after-hours availability audits to ensure all PCPs have the after hours coverage we require of our providers. Our care management staff often help providers with outreach calls and mailings, and reinforce the plan of care with members, providing disease-specific self-management education, and reinforcement related to accessing services appropriately.

Centene’s *Online Care Gap Notification* feature (Care Gaps) further supports the medical home relationship by alerting PCPs about linked members in need of recommended preventive care services. When providers log onto our secure Provider Portals to view their member roster or check eligibility, Care Gaps informs the provider that the member is due or overdue for a check-up, screening, or immunization. Our Centelligence Foresight system generates these alerts by comparing the member’s utilization (through claims) with evidenced-based, guideline recommended services and timelines.

Provider Performance Reporting and Incentives. Centene monitors provider performance on a variety of quality, utilization and member satisfaction indicators, and provides quarterly feedback to providers. The same or similar indicators may be used as the basis for financial and non-financial provider incentives health plans use to promote excellence in care. ER utilization is typically one of the key indicators measured when determining eligibility for both recognition awards and financial incentives. Some plans also provide an incentive for after-hours member access to care in the provider’s office.

Program Effectiveness

Centene’s experience has demonstrated our ability to decrease inappropriate ER use resulting from inadequate care. In addition to the initiatives and resulting positive outcomes presented above under **Targeted Outreach to Frequent ER Users**, our affiliate NurseWise has successfully redirected members to more appropriate care, as shown on the table below. During the 12 months prior to the end of Q3 2010, over 81% of all members whose conditions did not indicate the need for ER care heeded NurseWise advice and sought other care alternatives. Additionally, Centene’s population-based disease management programs successfully improved self-management by members with chronic conditions, thus reducing their ER use. As presented in the table below, members with asthma who participated in our Asthma Management Program had a statistically significant lower rate of asthma-related ER visits than matched controls.

ER Redirection by NurseWise Advice Line Q4 2009 – Q3 2010

<i>Measure</i>	<i>Q4 2009</i>	<i>Q1 2010</i>	<i>Q2 2010</i>	<i>Q3 2010</i>
Total Number of Dispositions	12,614	11,773	11,242	11,159
Patient Original Inclination was to go to ER	4,621	4,731	4,508	4,449
NW RN Advised Other than ER visit	2,891	3,200	3,113	3,113
Patient Followed RN advice	2,346	2,573	2,602	2,478
% Compliant with RN Advice	81 %	80%	84%	80%

Emergency Room Utilization Related to Asthma – All Centene Plans CY2008-CY2010

<i>ER visits per 1,000 members (# participants)¹</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant¹</i>	<i>Participant Difference</i>	<i>p – value</i>
Asthma-Related Children (49,761)	108.7	144.1	-24.6%	0.001
Asthma-related Adults (7,473)	581.4	664.7	-12.5%	0.001

¹Centene generated a comparative control group using propensity scoring that matched each DM participant with a non-participant using a logistic regression model that factored disease, presence of co-morbidities, age and gender. We excluded from the analysis DM participants for whom no match was available.

EPSDT

Centene’s considerable experience with and core focus on managing Medicaid services has taught us the value of the EPSDT program in assuring the availability, accessibility, and timeliness of comprehensive health care resources for child and adolescent Medicaid recipients. Collaboration with our providers has been vital to the success of our EPSDT compliance and has resulted in our comprehensive approach to providing education for and assistance to our providers. Their input has also assisted us in developing a multi-faceted approach to member engagement through outreach and education.

Engaging our Provider Partners

Initial and Ongoing Provider Education. Centene health plans educate providers about EPSDT requirements and support available to providers during face-to-face office visits; online through the information, clinical guidelines, and other tools available on our Provider Portal; and as a part of ongoing provider training sessions. Provider Relations Specialists (PR Specialists) educate all new PCPs regarding the EPSDT program during a comprehensive new provider orientation which occurs before the PCP can see a Centene member. This orientation reviews EPSDT requirements, including, but not limited to the schedule of visits and services, the required components of each EPSDT visit, and all screening, treatment and referral requirements. We also educate providers about EPSDT requirements and provide updates

through the Provider Manual (a comprehensive reference for all network providers); Provider Newsletters including Centene's nationally distributed *Provider Watch* and *Communicator*; webinars hosted by Centene medical staff; and regional seminars hosted by plan Medical Directors. We also review the schedule of required newborn and early infancy visits with OB/GYN providers. PR Specialists acknowledge the efforts of providers demonstrating a high level of EPSDT compliance for their assigned members.

Tools and Resources. Centene facilitates PCPs' efforts to improve EPSDT compliance and other accountability for their assigned members. For example, Medical Directors and QI staff offer consultations about improvement strategies through face-to-face visits or by phone with interested providers. We also provide information about best practices through our Provider Newsletters, Provider Portals, and provider orientation and training. To facilitate EPSDT compliance, we provide access to practical tools and resources such as provider toolkits. For example, in 2010 Provider Relations staff in our Texas affiliate, Superior HealthPlan (Superior), delivered toolkits to PCPs in a lower performing region that contained preventive health tools, such as immunization and EPSDT periodicity schedules and registration materials for the state immunization registry, and clinical guidelines for prevalent conditions. To facilitate accountability, we have supplied PCPs with monthly reports that identify all of their assigned members who are due for an EPSDT visit the following month, as well as members who are past due for services. This report is posted on their Provider Portal and gives providers a valuable tool on which to base their member outreach allowing them to preserve valuable office staff resources. Superior and other Centene plans have included chart stickers and mailing labels along with these monthly reports.

Care Gap Alerts. In addition to the monthly reports, Centene affiliates use Care Gaps to alert providers to a member's potential need for EPSDT and other condition-specific routine testing when checking member eligibility on the Provider Portal. An alert is triggered if we have not received a claim for a required service within the recommended time period specified by the EPSDT periodicity schedule or clinical guidelines.

Provider Performance Reporting and Incentives. Centene helps to facilitate provider performance improvement related to EPSDT compliance by providing them with timely feedback about their performance. Our Provider Overview Report (or scorecard) is a highly effective tool that compares individual provider practices and group practices to normative data, so that providers can improve their practice patterns, processes, and quality of care in alignment with evidence-based clinical practice guidelines and EPSDT and other state goals. Performance reporting increases provider awareness of performance, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of clinical improvement initiatives. Centene also motivates providers with a package of financial and non-financial incentives to recognize and encourage superior quality of care, including EPSDT compliance. Non-financial incentives recognize PCPs who demonstrate exemplary quality of care and clinical excellence in a given year and OB/GYN providers who achieve the highest performance in perinatal care quality measures.

Member Engagement

Member Education. Centene health plans use a defined, multifaceted approach to achieving member engagement, particularly related to their understanding the value of timely preventive services, and compliance with EPSDT requirements. Plans begin EPSDT member education prior to pregnancy, and continue throughout pregnancy and beyond. The Start Smart for Your Baby® Program (see Management of High Risk Pregnancy above) provides health education to all of our pregnant members, including information about, and the importance of, timely EPSDT services for their new babies.

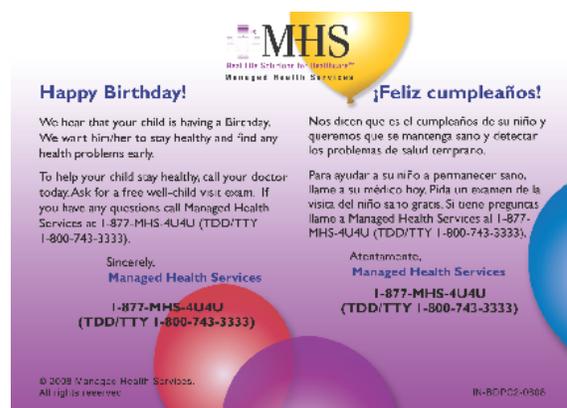
New members receive information about EPSDT services in New Member Welcome Packets and Welcome Calls. Four times each year, Centene affiliates send Member Newsletters to all members that cover a variety of topics, such as available services, seasonal health information, and reminders to receive

appropriate preventive care, including EPSDT services. Recent newsletter articles have included *Take Time for Well Care*, *We've Got You Covered*, *Shots Save Lives*, and *Why Check-Ups?*.

Members calling our toll-free Member Call Center may hear messages promoting preventive services should they be placed briefly on-hold. Member Service Representatives (MSRs) also educate members at appropriate opportunities when speaking with them. For example, through the MemberConnect function of Centene's innovative Member Relationship Management System (MRM), MSRs can see a message on their screen during a member call that alerts them that the member is due or overdue for recommended EPSDT services.

Each Centene affiliate health plan maintains a member website that meets state access and content requirements, and provides a wide variety of information, including the Member Handbook and a Member Quick Reference Guide, both of which include information about EPSDT services. The websites are bilingual in English and Spanish, culturally appropriate and written at the 5th grade reading level. If members visiting the website have a question about EPSDT services, they may use the secure email on the website and receive a response by the end of the next business day. Of course they may also call the toll-free Member Call Center for additional clarification.

Member Outreach. In addition to the member education discussed above, affiliate plans proactively identify members who are due or overdue for EPSDT and other preventive services, using our Centelligence Foresight system, and outreach to them with reminders at different times and different ways. In addition to outbound automated or in-person call campaigns, we send targeted mailings of reminder postcards to non-compliant members and those due for an EPSDT exam during the upcoming month. Reminders explain how to obtain help scheduling appointments and arranging for transportation, and remind members that they are eligible to receive an incentive for timely receipt of these services. Centene also sends birthday cards to members age 1 to 21 years during their birthday month, reminding them of the need to get a check up and offer to help with appointment scheduling.



Our MemberConnections™ community outreach program provides unique, in-person, “boots on the ground” interaction with our members and our communities. MemberConnections Representatives (MCRs) are lay health outreach workers hired from within the communities Centene health plans serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs receive comprehensive training and are an integral part of both our Member Services functions and Integrated Care Management Teams (ICTs). Throughout the year, MCRs participate in local health fairs and other community events, and during these events, MCRs provide basic health education, including the importance and availability of timely preventive care, and encourage members and other attendees to schedule any needed EPSDT services. MCRs also conduct targeted outreach, visiting members in familiar settings such as their homes or provider offices when they are hard to contact or in need of services.

MCRs also assist other plan staff in supporting Health Check Health Days (HCHD). For HCHD, affiliate plans partner with PCP offices to identify members who have missed well child/EPSDT visits or services, such as immunizations and lead screening. Health plan staff contact the identified members to offer them an appointment for the needed service on a certain day set aside by the practice, and to arrange transportation to the appointment with our transportation vendor. MCRs attend the event to assist the provider's office staff with check-in, reinforce the importance of preventive care, and answer questions about the member's health plan benefits.

Centene plans also take our message about the importance of EPSDT services to the community with public service educational campaigns. These campaigns allow us to inform not only our members, but the community at large about the importance of preventive care. We have posted messaging in newspapers, on billboards, bus signs, and bumper stickers distributed at community events.



Member Incentives. Centene’s CentAccount member incentive program offers valued financial incentives to members for healthy behaviors such as receipt of EPSDT services. Information about the incentives available through our CentAccount Program is included in New Member Welcome Packets, the Member Handbook, the Member Quick Reference Guide and on our websites. Please see Reduction of Inappropriate Utilization of Emergent Services above for more details.

Program Effectiveness

Several Centene affiliate plan’s have maintained and/or improved compliance with EPSDT benchmarks. For example, our Indiana Affiliate, MHS-IN, saw an increase of more than 20% in member well visits in the first six months after initiating the CentAccount member incentive program, compared to the same period the previous year. Comparing full year 2009 to 2010, MHS-IN members realized the following improvements.

Improvement in HEDIS Performance MHS-IN CY2009 – CY2010

<i>Measure</i>	<i>% change (CY2009 – CY2010)</i>
Well Child Visits First 15 Months of Life (>=6)	16.3%
Well Child Visits 3 rd , 4 th , 5 th & 6 th Year of Life	12.1%
Adolescent Well Care Visits	23.7%

In addition, our Georgia affiliate realized a 26.5% increase in six or more well child visits in the first 15 months of life and a 33.1% increase in adolescent well visits between 2007 to 2009, as a direct result of targeted health plan activities. Our Texas affiliate achieved a 15.2% increase in childhood immunizations (combination 2) during that same period.

Children with Special Health Care Needs

Centene’s health plans have extensive experience providing services to Children with Special Health Care Needs (CSHCN) with conditions such as autism, bipolar disorder, ADHD, seizure disorder, cerebral palsy, and congenital defects, giving us in-depth understanding of how to effectively meet their multiple complex needs. We have found that improving outcomes requires going beyond managing cases; rather taking a holistic approach that involves the family as a partner in determining how to meet the child’s needs. Our staff use initial and ongoing contact with the family to establish a trusting relationship, so they can thoroughly understand and address factors that affect member condition and care. Developing trust with the member or member’s guardian requires a level of personal attention that many health plans don’t provide. Many members or parents/caregivers will not discuss issues that might affect the member’s condition with people they don’t know well. We also know that establishing trust sometimes requires recruiting assistance from others the member trusts such as a caregiver, pastor or advocate.

Affiliate plans position staff in various parts of any state in which we provide services to enable the in-person contact that is often needed to establish relationships and assess such issues as home environment, family relationships, and unreported conditions and side effects. Plans also empower staff to be creative

and think outside the “covered services box” to meet member needs. For example, meeting a child’s health needs often requires solutions that include the family, such as arranging and finding funding for the family’s travel and hotel if a child member needs a procedure at a facility in another city. Our Texas affiliate had an 11-year-old member with moderate mental retardation, anxiety, and disruptive behavior disorder who was also having issues with wandering. To address this issue once the member was discharged home from an inpatient stay at a psychiatric facility, the staff completed an in-home assessment and authorized an alarm system for all doors and windows, and personal care services to ensure the member was not left alone while the mother worked.

Integrated Model. Our multidisciplinary Integrated Care Team (ICT) case management model maximizes integration of covered and non-covered services by integrating physical and behavioral health Case Managers, support staff and disease management Health Coaches, often in the same office space. Each ICT focuses on a specific population, such as pregnant women and children under one; adult members with severe mental illness; and either adult or child members with special healthcare needs. Different teams for children ensure appropriate focus and expertise since pediatric needs are often different from adult needs. One ICT member acts as the member’s primary point of contact, while the others provide input for their area of expertise, collaborating with the lead Case Manager to ensure all care is integrated. The non-clinical staff takes the lead on social and other needs that affect health and ability to access care. A Complex Care Manager (CCM) may support the ICT to manage care for acute issues that occur, working with the Team to coordinate acute and ongoing care. For those with acute, clinically complex (such as injury or illness) rather than chronic needs, a CCM manages and coordinates care for the acute episode. Our technology solutions support integration by making all information about each member’s needs and services available to all clinical staff interacting with the member. Our ICT model has been recognized as a best practice in serving CHIP CSHCN in managed care⁶.

Identification. We identify possible CSHCN through claims and enrollment file data analysis; New Member Welcome Call screening questions; monthly NurseWise after hours call reports; concurrent review/discharge planning; and referrals from members, families/guardians, schools, providers, and others. In addition, our Centelligence Foresight predictive modeling suite identifies members with high utilization and members with diagnoses or patterns of care that indicate potential CSHCN status. ICT staff use criteria such as the following to confirm CSHCN status:

- Serious illness, complex chronic condition or disability that has lasted/is expected to last 12+ months
- Illness, condition, or disability that results (or without treatment would be expected to result) in limitation of function, activities, or social roles compared to accepted pediatric age-related milestones in physical, cognitive, emotional, and/or social growth, and/or, development
- Need for regular, ongoing therapeutic intervention/evaluation by appropriately trained professional(s)
- Need for health, and/or, health-related services at a level significantly above usual for the child’s age
- Prescriptions for three or more psychotropic medications
- Any referral for Service Coordination, Care Management, Social Services Specialist assistance.

Centene plans use a proprietary screening tool that asks not only about diagnoses and conditions but also family concerns and needs.

Assessment. ICT staff work with the member and guardian (and state case worker for foster child members) to assess functional abilities; physical and behavioral health conditions; social, environmental and cultural issues; medications; and other needs that form the basis of our integrated, holistic service plan. In-home assessments may occur in situations such as follow up to emergent services, when assessment could not be completed prior to care delivery; inability to reach a high risk member/guardian by phone; high utilization; or upon provider or member request. ICT staff share clinical information, care

⁶ *SCHIP Innovations for Children with Special Needs in Managed Care*. Center for Health Care Strategies Resource Paper. Harriette B. Fox, Stephanie J. Limb, and Margaret A. MSCanus. February 2003.

options and reassessments with all applicable providers, and share each provider's input with other treating providers and coordinate ongoing communication. We contract with culturally competent PCPs, board-certified specialists and other providers with CSHCN experience, and arrange care with key providers such as children's hospitals.

Service Plan. A defining feature of our approach is our emphasis on the family as a key player in the child's health and quality of life. Our ICT Case Managers, Social Services Specialists, and MCRs help families address issues, through the service planning process, that interfere with their ability to fully support their child's access to and compliance with needed treatment. Service plans address common needs all children have, such as preventive care (since CSHCN underutilize preventive services like EPSDT due to intense use of specialists and other services) and working with schools on individualized education plans. Because families of CSHCN are often overwhelmed with social and other needs that affect child health and access to care, ICT staff connect families to non-covered services and community resources such as carved out Medicaid services, Individuals with Disabilities Education Act services, WIC, Head Start, school health services, Title V Maternal and Child Health Programs, assistive technology centers, transportation program, food stamps and other programs that serve children with special needs. For example our Mississippi affiliate, Magnolia Health Plan, coordinates services with community organizations such as Delta Community Mental Health Services Crisis Food Pantry, Community Stew Pot, Catholic Charities, NAMI, and Mississippi Coalition for Citizens with Disabilities. Our Program Specialists (social workers) assist CSHCN who may qualify for SSI or SSDI with the application process.

To ensure integration of physical and behavioral health care, we develop coordination protocols with Community Mental Health Centers (CMHCs) through formalized business agreements. These protocols address such areas as Case Manager interaction, and sharing assessment and service information. In some instances, we may also co-locate an RN Case Manager at high-volume CMHCs to enhance coordination of medical and behavioral health care. For example, our Ohio affiliate, Buckeye Community Health Plan, Inc, developed such arrangements with CMHCs for 1500 shared members with severe and persistent mental illness and achieved lower inpatient medical admission and ER visit rates along with a 30 percent increase in PCP visits in the first year.

Continuity of Care and Specialty Care. When CSHCN are receiving specialty care prior to enrollment, plans authorize existing treatment with current providers (including non-network providers) as required by our state contracts or until ICT staff assess the member and develop a new service plan with the PCP, specialists, member and family. For specialty needs that develop after enrollment, authorizations permit a specified number of continuing visits or unlimited access for a specified timeframe, as determined by assessment results, and PCP and specialist input. For members with disabling conditions, chronic illness and other special needs, their family and their providers may request a specialist as PCP at any time. Our Medical Directors review and approve requests after determining that meeting the request is reasonably feasible and the specialist is willing to fulfill the PCP role, including providing EPSDT services.

Program Effectiveness

Our Texas affiliate plan has served as the sole contractor for the STAR Health Program, the Medicaid program for foster children, since 2008. Foster children are special needs children whose care is often fragmented because they are repeatedly relocated and physicians are frequently unaware of a child's existing medication regimen. Data released by the State of Texas demonstrated that children who are in the foster care program were being overprescribed psychotropic medications. Superior HealthPlan (Superior) identified a major barrier to reducing psychotropic polypharmacy for foster children. These children were subject to receiving care from various Providers over a period of time, and caregivers were often not aware of previous prescriptions the child received under other caregivers. Therefore, Providers would often prescribe medication without knowledge of previous prescriptions. In addition to the intensive case management services provided by Superior, they implemented a number of targeted

interventions, including the Health Passport, a patient-centered, internet-based, community health record. This enabled behavioral health providers to get an accurate depiction of the member's psychotropic medication regimen, diagnoses and treating practitioners. In addition, Superior was instrumental in developing a psychotropic medication utilization review (PMUR) process in partnership with health plan medical directors, consulting psychiatrists, the Texas Health and Human Services Commission and other key stakeholders. The PMUR identifies foster care children taking psychotropic medications and monitors the medication regimen against evidence based guidelines.

During the first year of implementation, Superior achieved a **17% reduction** in overall prescribing of psychotropic medications; an almost **50% reduction** in number of children who were prescribed a psychotropic for 60 days or more; and most dramatically, they achieved a **reduction of 70%** in the prescribing of nonstimulant medications and a **75% reduction** in overall polypharmacy.

Asthma/Diabetes/Cardiovascular Diseases

Centene partners with our affiliate, Nurtur Health Inc (Nurtur) to positively impact the lives of our members with chronic conditions, including asthma, diabetes and cardiovascular diseases, with comprehensive disease management programs. Centene affiliate plans or Nurtur currently provide disease management programs for asthma, diabetes, congestive heart failure, coronary artery disease, hypertension, and hyperlipidemia (as well as COPD, chronic kidney disease, back pain, depression, and tobacco dependency) in Texas, Mississippi, Georgia, Florida, South Carolina, Ohio, Indiana, Illinois, Massachusetts, Wisconsin, and Arizona. Programs offered vary by state.

Nurtur has been a leading innovator in disease management since the mid-1990s, offering best-in-class programs for chronic conditions such as asthma, diabetes, and cardiovascular diseases. Since its inception, Nurtur has implemented disease management programs in over 60 markets, both urban and rural. With eleven unique Medicaid/CHIP managed care agreements and over 1,268,000 TANF lives, 139,500 CHIP lives, and 103,000 SSI/ABD lives under contract, Nurtur has significant experience in applying respiratory, diabetes, and cardiovascular disease management principles to improve care and support to Medicaid, CHIP, and other low income populations. All of Nurtur's programs are NCQA and URAC accredited.

Centene identifies eligible members with chronic conditions by data-mining all available member information, using predictive modeling, and persistently pursuing newly enrolled members for health risk screening to achieve early identification of members with or at risk for chronic conditions or co-morbidities. A key focus for us is to ignite in each member the behavior changes needed to improve health status. Each member participating in the program works with an assigned Health Coach to establish both short and long-term goals that include modifying unhealthy behaviors. Each targeted condition has condition-specific measurable goals that allow us to measure the effectiveness of the program. One or more evidence-based guideline supports each targeted condition.

Health Coaches function as part of our multidisciplinary Integrated Care Teams that use a person-centered approach and frequent, ongoing collaboration to ensure that all of the member's medical, behavioral and social needs are addressed. All identified members receive an introductory mailing of program and condition-specific information, and an Initial Health Assessment. Those at moderate or high risk then receive a comprehensive Baseline Assessment including an assessment of their readiness for increased self-management. Based on this information, Health Coaches stratify members to appropriate levels of intensity of intervention and develop self-management plans with the members. Please see Question E.1 for more details about our disease management programs.

Asthma

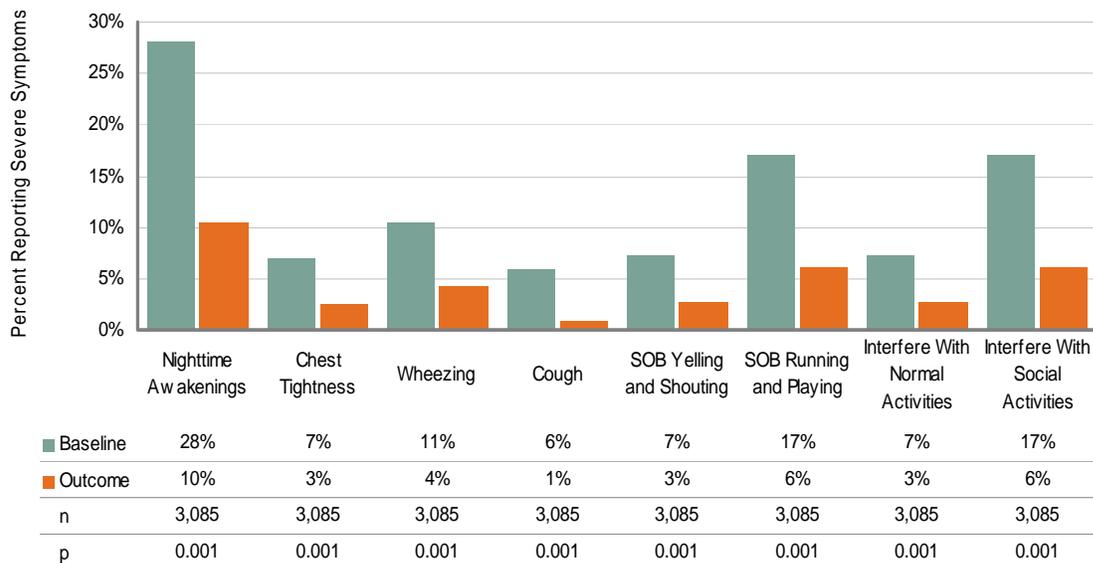
The goals for Centene's Asthma Management Program are:

1. Reduce the need for rescue inhalers

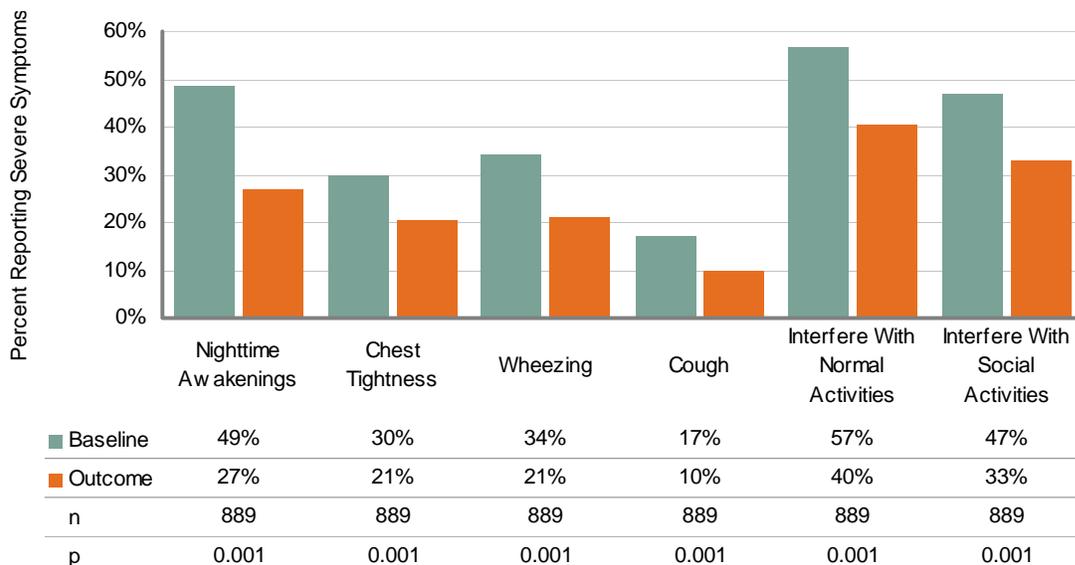
2. Reduce asthma-related emergency room visits and inpatient admissions
3. Increase use of long-term controller medications
4. Achieve improvement in control and understanding of disease
5. Improve quality of life
6. Promote member adherence to treatment guidelines and improve self-management skills to control asthma and optimize quality of life.

Program Effectiveness. In CY2010, child and adult asthma program participants across all Centene plans significantly improved in *all* monitored symptom and functional measures. All improvements were between baseline and most recent reassessment (≥ 90 days post baseline) and were statistically significant ($p < 0.05$). For example, 28% of child program participants at baseline responded that they awakened at nighttime, “more than once a week,” “five or more times per week,” or “one to four nights per week.” At outcome, this value had decreased to 10%.

Child Asthma Symptom and Functional Outcomes – All Centene Plans CY2010



Adult Asthma Symptom and Functional Outcomes – All Centene Plans CY2010



For the period from CY2008 through CY2010 for all Centene plans, our asthma programs significantly improved rates of emergency room use and inpatient admission. In the analysis of these claims-related measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Emergency Room and Inpatient Utilization Related to Asthma – All Centene Plans CY2008-CY2010

<i>Utilization Measures (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Asthma-Related ER Children (49,761)	108.7	144.1	-24.6%	0.001
Asthma-related ER Adults (7,473)	581.4	664.7	-12.5%	0.001
Asthma-Related Admissions Children (49,761)	339.9	390.3	-12.9%	0.001

Diabetes. The goals for Centene’s Diabetes Management Program include:

1. Increase the percentage of members who receive at least one HbA1c, LDL cholesterol, and retinal eye exam to the 75th percentile of the national Medicaid NCQA Quality Compass
2. Promote member adherence to treatment guidelines
3. Improve self- management skills in order to minimize the development and/or progression of diabetic complications and optimize quality of life.

In CY2010 for all Centene plans, our diabetes program significantly improved physiologic outcomes. For example in the diabetes program there was a nine percentage point increase in the number of participants

reporting LDL levels <100 mg/dl, a five percentage point increase in participants with controlled systolic blood pressure (< 130 mm Hg) and an increase in exercise of 150 minutes per week for 57% of members who started outside of the target goal, all between baseline and most recent reassessment.

Diabetes Physiologic Outcomes – All Centene Plans CY2010

<i>Physiologic Measures (# participants)</i>	<i>Baseline</i>	<i>Outcome</i>	<i>Difference</i>	<i>p – value</i>
Diabetes (412) LDL <100mg/DL	59%	68%	9	0.011
Diabetes (889) Systolic BP<130mm Hg	58%	63%	5	0.033

For the period from CY2008 through CY2010 for all Centene plans, our diabetes program significantly improved the rate of inpatient admission. In the analysis of these measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Diabetes Inpatient Utilization - All Centene Plans CY2008 – CY2010

<i>Utilization Measure (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Diabetes-Related Admissions Adults (12,472)	291.7	394.4	-26.0%	0.001

Cardiovascular Diseases. The goals for Centene’s Cardiovascular Disease Management Program include:

1. Congestive heart failure

Promote Member adherence to treatment guidelines and improve self- management skills in order to prevent subsequent cardiac events and optimize quality of life

2. Coronary artery disease

Promote Member adherence to treatment guidelines and improve self -management skills in order to prevent subsequent cardiac events and optimize quality of life.

For the period from CY2008 through CY2010 for all Centene plans, our cardiovascular programs meaningfully impacted the health status of our members, in some cases with statistical significance or near significance. In the analysis of these measures, we assess improvement by generating a comparative control group using propensity scoring that matches each disease management participant with a non-participant using a logistic regression model with disease, presence of co-morbidities, age and gender. We exclude from the analysis program participants for whom no match was available.

Cardiovascular Disease Outcomes – All Centene Plans CY2008 - CY2010

<i>Measures (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Congestive Heart Failure				
Heart Failure-Related Admissions (1,217)	1,102.4	1,343.6	-18.0%	0.211
All Heart-Related Admissions	1,826.1	2,481.5	-26.4%	0.046

<i>Measures (# participants)</i>	<i>Rate per 1,000 Participants</i>	<i>Rate per 1,000 Matched Non Participant</i>	<i>Participant Difference</i>	<i>p – value</i>
Congestive Heart Failure				
Heart Failure-Related Admissions (1,217)	1,102.4	1,343.6	-18.0%	0.211
Influenza Vaccination Rate (1,217)	226.1	185.7	21.8%	0.055
Coronary Artery Disease				
CAD-Related Admissions (1,671)	480.3	549.9	-12.7%	0.002
All-Cause Admissions (1,671)	1,982.3	2,396.2	-17.3%	0.001
Influenza Vaccination Rate (1,671)	206.5	163.5	26.3%	0.001
Lipid Screening (1,671)	3,214.2	2,654.6	21.1%	0.008
ACE/ARB Prescriptions (1,671)	2,747.1	1,689.8	62.6%	0.001
Anti-Lipid Prescriptions (1,671)	1,847.1	1,572.2	17.5%	0.001

Case management

Centene has been providing case management services since 1984 to populations similar to those covered by the CCN-P, including adult and child members with a wide variety of chronic, complex and/or catastrophic conditions and special health care needs. These members include those on SSI; those who are eligible for Medicaid due to age, blindness, or disability; those dually eligible for Medicaid and Medicare; and children in foster care in addition to the TANF population. Centene affiliate plans currently serve approximately 81,500 SSI members. Our affiliates have managed conditions including, but are not limited to high-risk pregnancy, severe and persistent mental illness, diabetes, asthma, congestive heart failure, cancer, transplants, spinal cord injury, para/quadruplegia, amputations, HIV/AIDS, multiple sclerosis, severe trauma with multiple system involvement, traumatic brain injury, autism, bipolar disorder, seizure disorder, cerebral palsy, and co-morbid/co-occurring conditions.

Our Case Management Program includes a systematic approach for early identification of eligible members; needs assessment; development and implementation of an individualized service plan that includes member/family education and actively links the member to providers and support services, including peer supports for members with behavioral health/substance abuse conditions; as well as outcomes monitoring.

Integrated Model. Centene health plans manage and coordinate services and community resources to meet members' complex needs through Centene's nationally recognized⁷ Coordinated Care Model (CCM), which each affiliate health plan adapts to the unique needs of their membership. Through the CCM, the full range of covered, carved out, and non-covered services each member needs is integrated into a seamless, holistic experience of care that improves outcomes and enhances quality of life.

Because multiple co-morbidities often exist in individuals with chronic illness or other special health needs, and the level of support required by these individuals is likely to change over time, our

⁷ SCHIP Innovations for Children with Special Needs in Managed Care. Center for Health Care Strategies Resource Paper. Harriette B. Fox, Stephanie J. Limb, and Margaret A. McManus. February 2003.

multidisciplinary Integrated Care Team combines case and disease management staff and includes Registered Nurse Case Managers, Behavioral Health Case Managers, Program Specialists (Social Workers), disease management Health Coaches, and Program Coordinators. Often co-located, the ICT facilitates regular, in-person communication about the member's care and achieves a level of coordination and integration that voicemails and emails among case managers in different locations cannot. Our experience has shown that locally delivered services achieve the best outcomes, so we hire staff who are from and familiar with the communities they serve, and embed our ICT members in our regional offices as well as in high volume provider offices.

We also recognize the importance of health plan staff being accessible to caregivers and supporting them as key players in ensuring Member well-being. Because active member direction and engagement are key factors in compliance and improved outcomes, plan ICT staff encourage and support member self-determination in the assessment, service plan development, and implementation processes. Service plans address common needs all members have, such as preventive care, since those with special health needs often underutilize preventive services due to intense use of specialty and other services.

Key Technology and Support Programs. Our ICTs are supported by our state-of-the-art Centelligence™ family of integrated decision support and healthcare informatics solutions. Centelligence enhances ICT ability to anticipate, identify, monitor, and address issues and improvement opportunities. For example, staff can use Centelligence™ Foresight, our proprietary predictive modeling and care gap/health risk identification suite, to track conditions; monitor care gaps or health risks; identify Members with comorbid conditions and those at risk of developing chronic conditions; identify those in need of additional services or higher levels of management; and take action. Centelligence is integrated with TruCare, our member-centric health management platform that integrates care/service, disease and utilization management. Our Member Relationship Management (MRM) System supports our member outreach efforts. For example, a Case Manager can use MRM to alert Member Services staff to their need to speak with a member we have been unable to reach by phone, the next time the member calls the Member Call Center.

Centene has experience using innovative programs to support case management activities and increase integration of care and member compliance for individuals with complex and chronic conditions and/or disabilities. In-home telemonitoring services for certain high risk members provide electronically transmitted biometric values, such as a blood glucose level or a diabetic or a blood pressure or weight for a member with congestive heart failure, to monitoring case managers and with alerts to the member, ICT staff, and provider. Through our award-winning ConnectionsPlus® Program, we provide pre-programmed cell phones to high risk members who lack reliable phone access, allowing them to make and receive calls from providers, the ICT, other LHC staff, NurseWise (our 24/7 nurse advice line), and 911. Members are educated to call promptly for advice with any change in health status rather than waiting until the next appointment. The program also provides MP3 players loaded with condition-specific podcasts in Spanish and English. Examples of podcast topics include diabetes, alcohol abuse, chronic kidney failure, COPD, depression, headaches, healthy weight, osteoporosis, hypertension, stress, taking your medicine, smoking cessation, generic drugs, heart attacks and advance directives.

Program Effectiveness

In addition to the positive outcomes resulting from our Case and Disease Management Programs reflected above for our Start Smart, Asthma Management, Diabetes Management, Cardiovascular Disease Management and ER Diversion programs, Centene affiliate plans have improved member health status through other targeted approaches within their case management programs. For example, our Georgia affiliate, Peach State Health Plan, developed a pain medication management initiative within their case management program in response to concerning statewide data on drug overdose deaths in 2008, the frequent involvement of prescription drugs, and a new state requirement for a pharmacy lock-in program.

The initiative identified members who had the highest ER utilization and exhibited poly-facility, poly-provider and poly-pharmacy adverse drug seeking behaviors through monthly monitoring reports. Identified members were restricted to using program-only pharmacies and enrolled into a provider outreach case management program. The program has achieved great success. Only 21.3% of the 4,733 members identified during baseline period as having 10 or more ER visits continued to have high ER utilization following implementation of the initiative. There was a decline in utilization of services related to drug-seeking behaviors and associated negative outcomes that yielded estimated savings of \$2.3 million, comparing expenditures in 2009 to 2010.

In another example, our Texas affiliate implemented an intensive case management program to reduce readmissions for members with severe and persistent mental illness. Recognizing in 2007 that members with schizophrenia accounted for more than 50% of all behavioral health hospital admissions and more than 60% of readmissions, Superior HealthPlan initiated intensive case management to all members with schizophrenia. Following QI methodology, they implemented a number of interventions such as structured telephone contact after hospital discharge including assessing satisfaction with current outpatient providers and compliance with prescribed medications; joint treatment team meetings between physical health and behavioral health case managers; in-home appointments for members unable to secure outpatient follow up care after hospital discharge; and most recently, in 2010, a pilot of intensive outpatient services, including Assertive Community Treatment and Cognitive Adaptive Training, that are beyond the benefits covered by Medicaid. From 2009 to 2010, the 30-day readmission rate decreased from 30.5% to 26.3% for their SSI/ABD population.

In addition, our ConnectionsPlus™ Program has demonstrated a positive impact on the health status of high risk members receiving case management services. Since December 2006, the Program has distributed preprogrammed cell phones to over 3680 members. A 90 day pre- and post-comparison review of data for 347 adults who received phones between April 2007 through March 2010 showed a 27% decrease in inpatient admissions, a 18% decrease in average length of hospital stay, and a 12% decrease in emergency room visits.

For additional details on our Case Management Program, please see our response to question F2.

Reduction in racial and ethnic health care disparities to improve health status

According to the Centers for Disease Control, African-Americans have the poorest health outcomes of any major racial or ethnic group in the United States, with higher adult and infant mortality rates than other groups.⁸ African-Americans have higher death rates from breast and cervical cancer, heart disease, stroke and HIV⁹, and this significant variation in healthcare quality exists even when condition of income, age and severity of condition are comparable.¹⁰ Centene affiliate plans are cognizant of the challenges involved with reducing and addressing these disparities and are committed to being part of the solution, resulting in improved health outcomes for members. Examples of how affiliate health plans have developed tailored programs to reduce ethnic and racial disparities follow.

As our Mississippi affiliate, Magnolia Health Plan, prepared to initiate operations in 2011, we learned that African-Americans were the single largest minority group in Mississippi, comprising 37% of the population (compared to 12% nationally) and almost 60% of the population in the rural Delta region. The African-American infant mortality rate in Mississippi is over twice that of whites and overall life

⁸ National Vital Statistics Report, Center for Disease Control; Hsiang-Ching Kung, Ph.D.; Donna L. Hoyert, Ph.D.; Jiaquan Xu, M.D.; and Sherry L. Murphy, B.S.; Division of Vital Statistics. http://www.cdc.gov/nchs/data/nvsr/nvsr56/nvsr56_10.pdf.

⁹ U.S. Department of Health & Human Services, Office of Minority Health, African American Profile; <http://www.omhrc.gov/templates/browse.aspx?lvl=2&lvlIID=51>

¹⁰ January Angeles and Stephen a. Somers, PhD, From Policy to Action: Addressing Racial and Ethnic Disparities at the Ground-Level, August, 2007, Center for Health Care Strategies, Inc.

expectancy was four years shorter than that of whites. African Americans in Mississippi experience worse health disparities than do those who live elsewhere. In response, Magnolia and Centene executive leadership engaged with leading Mississippi organizations working to reduce health care disparities, including the University of Mississippi Medical Center (UMC). Centene became a participant with UMC and others in the Mississippi Institute for Improvement of Geographic Minority Health and Health Disparities.

Providers may not be fully aware of the extent of racial disparities in the country or the state, and are even less likely to recognize it locally or in their own practice. Even providers who have chosen to work in clinics with large ethnically diverse patient panels may be unaware of the disparities among their own patients, due to the stress and lack of resources in the clinic environment.¹¹ To address this issue, Centene plans require all PCPs, OB/GYNs, and high-volume specialists to complete a provider orientation during which we provide information about cultural competency, including information on the CLAS standards. Although these standards were originally directed at health care organizations, we encourage providers to adopt these standards to make their practices more culturally and linguistically accessible. We also encourage providers to complete the U.S. Department of Health and Human Services' Physician's Practical Guide to Culturally Competent Care, a free, online accredited educational program.¹²

Nationally, African Americans continue to have poorer birth outcomes compared to whites and Hispanics, with the highest rates of infant mortality, low birth weight babies, preterm births, and the second lowest rates of first trimester prenatal care.¹³ Centene's Texas affiliate, Superior HealthPlan, identified that its African American members obtain timely prenatal care at statistically significant lower rates than Hispanics and Whites. In CY2009, only 76.6% of African American members received a prenatal care visit in the first trimester or within 42 days of enrollment compared to 80.7% of whites and 81.9% of Hispanics. Only 52.5% of African American women attended 81% or more of recommended prenatal visits compared to 62.7% of Whites and 58.8% of Hispanics. As a result, Superior is developing a Performance Improvement Project targeting African American women of childbearing age for improvement in prenatal care. Superior will work collaboratively with key African American community stakeholders such as church leaders, service sororities, advocacy groups, or other community-based organizations, such as Zeta Phi Beta Sorority's Stork's Nest program of education and incentives for early prenatal care. Centene's Wisconsin affiliate, Managed Health Services, already participates in the Stork's Nest program.

Centene plans aggressively pursue contracts with minority providers, especially African-American providers, who are more likely to recognize and address disparities and be more familiar with the local culture and idioms. Our experience includes partnering with an 85% minority network in Florida. In addition, one of our core network-building strategies is to contract with the Federally Qualified Health Centers (FQHCs) and Rural Health Clinics, traditional Medicaid providers dedicated to serving populations at-risk for health disparities. Many FQHCs around the country are participating in the Institute for Healthcare Improvement HRSA Health Disparities Collaboratives, working to eliminate disparities and improve the health of their patients. In addition, Magnolia is funding a UMC resident to work at a Mississippi FQHC each year, supplementing the health care workforce and providing added experience working with minority patients.

Our affiliate plans also address health disparities for other groups. For example, our Texas affiliate, Superior HealthPlan, has developed an aggressive community outreach program using Promotora outreach workers hired from the community to educate Mexican-American members and the community

¹¹ Varkey A, et al "Separate and unequal: clinics where minority and nonminority patients receive primary care" Arch Intern Med 2009; 169: 243-250.

¹² cccm.thinkculturalhealth.org accessed 6/12/2011

¹³ The Health Disparities Task Force, 2008 Biennial Report to the Texas Legislature, Austin TX

about their higher risk of diabetes and complications of diabetes¹⁴, the benefits of periodic screening for early diagnosis, and the value of diet and exercise for disease prevention. Our Wisconsin affiliate, Managed Health Services, serves the Hmong people, understands their increased risk of obesity and diabetes¹⁵, their low breast and cervical cancer screening rates¹⁶, and the cultural barriers in place. MHS has addressed this by hiring Hmong employees from the community who understand the culture, teach other employees about it, and facilitate communication with Hmong members. MHS has also developed translated health education materials for Hmong members.

Although Question J.1 requests information from other states, our partner FQHCs have unique experience right here in Louisiana participating in the Louisiana Health Disparities Collaborative (HDC). The HDC took a systematic approach to improving health care quality and reducing disparities for low-income patients with diabetes and cardiovascular disease. Participating FQHCs (and Rural Health Clinics) collaboratively implemented practice-based innovations, measured outcomes, and shared their experiences. Participant clinics showed greater improvements in outcomes than those without HDC support. Please see Question L.4 for more details about the HDC.

Hospital readmissions and avoidable hospitalizations

Centene's general approach to potentially avoidable hospitalizations and readmissions is to identify members at risk for hospitalization and enroll them in case management to ensure the coordination and management necessary to avoid acute episodes and exacerbations. We also analyze plan-wide utilization and quality data to identify areas for further improvement aimed at reducing avoidable ER use and hospitalization.

Identification. Our approach begins with identifying members at risk for hospitalization through review of information received from member contacts as well as ongoing analysis of data. We also work with certain high-volume providers, such as FQHCs, Rural Health Centers, and Community Mental Health Centers (CMHC), to co-locate ICT staff members onsite who can help identify members who may require immediate intervention to avoid ER use or hospitalization. As previously described in this narrative, our health plan staff identify at-risk new members through enrollment file data and our HRS tool that identifies chronic disease or special needs, as well as risk factors such as non-compliance with medications or follow-up care; lack of understanding of the disease process and treatment; or lack of financial or social resources for transportation, nutrition or emotional support. Plans also identify members at risk through ongoing analysis of data such as utilization and claims data reports, and NurseWise after-hour call reports identifying members referred after-hours to the ER or calling with unstable conditions. Centelligence Foresight predictive modeling reports of members at increased risk of future inpatient utilization supplement this information. Our Pharmacy Directors provide drug utilization review reports identifying members with multiple or conflicting drug regimens that could result in hospitalization. Often referrals from providers, families, caregivers, community organizations, and other staff identify at-risk members. Case Managers co-located at high-volume providers facilitate identifying members at risk for hospitalization. Affiliate plans also work closely with high-volume contracted hospitals to arrange daily post-ER visit reports. We consider recent or repetitive ER visits to be a risk factor for inpatient admission or readmission. As described in Reduction of Inappropriate Utilization of Emergent Services above, Centene plans have a comprehensive approach to identifying members with such behavior and intervening, especially improving access to preventive services.

Provider Preventable Conditions (PPCs), including Never Events, can result in avoidable hospital admissions or readmissions. As described in Question J.2, Centene has experience identifying PPCs both inpatient and outpatient, educating providers about them, and taking corrective action to reduce occurrences.

¹⁴ The Office of Minority Health, HHS, www.minorityhealth.hhs.gov

¹⁵ Hmong and Diabetes, <http://www.diabetesyouth.com/hmong.htm>

¹⁶ The Hmong Breast and Cervical Cancer Project, Oregon State University, <http://www.hhs.oregonstate.edu/ph/hmong-breast-and-cervical-cancer-project>

Case/Disease Management. Affiliate plans outreach to members identified at risk for admission and attempt to enroll them in our Case/Disease Management Programs, as applicable, where they can receive support from an ICT. Criteria for these programs include specific diagnoses and risk scores as well as CHCS risk predictive diagnosis dyads.¹⁷ Once enrolled in case management, A Case Manager completes a comprehensive assessment of the member's medical, behavioral health, social and other needs, and works with the member, family or caregiver, and providers to develop a service plan that includes services that address each identified need. Service plans for members with chronic or disabling conditions or special health needs include needed specialty services, home care, equipment, and therapy services to stabilize their condition. All service plans include preventive and primary care services. Service plans also include community resources and non-covered services to address other determinants of health. For example, our ICT seeks a local social service agency to assist a member with unpaid utility bills or identify alternative storage locations for medicines requiring refrigeration.

These comprehensive service plans help to prevent or reduce exacerbations that may lead to hospitalization. For example, the service plan for a pregnant member with a history of preterm labor may include a 17 Alpha Hydroxyprogesterone (17P) regimen. As noted previously, Centene plans achieved a 36.6% reduction in preterm deliveries (which have a higher risk for NICU admission) through efforts to identify high-risk pregnant members, and include 17P in their service plans. Members with poorly managed serious mental illness are at risk for medical as well as psychiatric hospitalization.^{18 19} For example, the service plan for members in foster care, who are at higher risk than other children for comorbid physical and behavioral health conditions, often includes a referral to, and coordination with, a CMHC to address behavioral health conditions and lower the risk of medical admission or readmission.

For those identified members enrolled in disease management programs, an ICT Health Coach helps members improve their understanding of their condition and how to reduce their need for acute care services. Centene plans fully integrate DM with case management to ensure the entire range of needed care is well-coordinated. ICT staff routinely assess and monitor member compliance with treatment, and address barriers to compliance and self-management. For example, a member may need self-reminders to take medications at directed times, or education about identifying asthma triggers and the use of spacers. Please see Case Management above, and our response to question F2 – Case Management, for more details on Centene's Case Management Program and innovative solutions such as in-home telemonitoring and our ConnectionsPlus cell phone program.

In addition to these measures, the key to avoiding unnecessary readmissions is careful coordination of the discharge transition process when a high-risk member is discharged from inpatient care. Concurrent Review (CR) Nurses review the medical record and begin discharge planning as early as possible during the inpatient stay. CR Nurses are often onsite at the facility, and establish personal contact with the inpatient member and family/caregiver, and hospital discharge planner. The CR Nurse assesses the member's medical and non-medical post-discharge needs and develops a comprehensive transition of service plan to lower the risk of unplanned readmission. The plan facilitates the transfer of clinical information to the member's outpatient provider; addresses barriers to outpatient follow-up care, such as lack of transportation in rural areas or lack of phone access; and arranges solutions such as community transportation and meal services, or enrolling the member in our ConnectionsPlus Program.

Discharge planning includes member education about needed follow-up care and how to contact the ICT for questions or assistance. Any member not currently receiving case management services is assigned a

¹⁷ The Faces of Medicaid III, Refining the Portrait of People with Multiple Chronic Conditions, October 2009, Center for Health Care Strategies

¹⁸ Gilmer TP, Dolder CR, Lacro JP, et al. Adherence to treatment with antipsychotic medication and health care costs among Medicaid beneficiaries with schizophrenia. *Am J Psychiatry*. 2004;161(4):692-699.

¹⁹ Green JH. Frequent rehospitalization and noncompliance with treatment. *Hosp Community Psychiatry*. 1988;39(9):963-966

Case Manager for post-discharge follow-up monitoring, and the development and implementation of an ongoing service plan if needed. For example, a Start Smart for Your Baby Case Manager reviews information about NICU admissions and initiates case management services to continue until the infant is medically stable and the caregiver can demonstrate appropriate caregiving skills. The assigned Case Manager contacts the member within three days of discharge to assess the member's condition and confirm understanding of the service plan, and ensures that prescriptions, medical equipment, follow up appointments, transportation, and other needs have been addressed.

Program Effectiveness

We have provided data above under several categories in this response that show how our programs help our members avoid hospitalizations and prevent readmissions, such as decreases in NICU admissions resulting from our Start Smart pregnancy management program; improved rates of inpatient utilization for adults and children with asthma; and improved rates of inpatient admissions for members with coronary artery disease. In addition to these positive outcomes, Centene affiliate plans have had success in favorably impacting avoidable readmissions through effective discharge and transition of care programs. For example, our Arizona affiliate, Bridgeway Health Systems, developed and has steadily improved an enhanced discharge planning program for the transition from inpatient care to home or other residence for its SSI/ABD population. A coordinated transition is key to avoiding an early inpatient readmission. The program has improved communication between Bridgeway's CR Nurses, hospital staff, and the member's Case Manager. The program has also enhanced and standardized Case Manager calls to members and their caregivers or family within the first 48 hours after discharge. The 30-day readmission rate for this population decreased 40.8% between 2007 and 2010 (from 26.6% to 15.9%).

Timely follow-up after a behavioral health hospitalization reduces the likelihood of readmission. Our Texas affiliate, Superior HealthPlan, has progressively enhanced their follow up process for CHIP members with a series of changes including care management staff coordinating information exchange and appointment scheduling among hospital staff, members, and outpatient providers; reminding members of appointments; helping members address barriers to keeping appointments, such as transportation; and placing post-follow up visit confirmation calls to the outpatient behavioral health providers. The 7-day follow up visit rate improved 79% between 2006 and 2010 (from 22.8% to 40.8%).

Question J.2

Reduction of Infection, Medical
Errors, and Never Events

J.2 Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.

Overview

Healthcare errors impact 1 in every 10 patients around the world.²⁰ Attention to medical errors and adverse events as well as the resultant literature has grown exponentially over the past decade. LHC understands the importance of improving patient safety and will build on the experience of existing Centene health plans that are already monitoring for occurrence of adverse events including hospital acquired infections, medical errors and preventable serious adverse events. Patient safety is one of our top priorities and is a critical component of our Quality Assessment and Performance Improvement (QAPI) Program. We will proactively educate providers, partnering with facility Risk Management staff, and encourage participation in national efforts to reduce hospital acquired conditions and never events. LHC will implement policies and procedures to monitor and track adverse events so that we can take appropriate action to reduce their occurrence. Our policies will address our claims process, reporting, corrective action, and trend analysis as described below. We will work collaboratively with DHH in developing its policy on Provider Preventable Conditions (PPC) and obtaining local provider input.

Experience. Centene affiliate health plans have been monitoring, investigating and taking action on adverse events through their clinical review and quality investigation processes for more than 27 years. Those with Medicare Advantage Special Needs Plans (SNPs) have been administering claims payment rules in accordance with CMS requirements and the Deficit Reduction Act of 2005 since their inception in 2008. As further described below, our Indiana affiliate implemented policies and procedures in October 2009 to ensure nonpayment for certain Hospital Acquired Conditions (HAC) that were not Present on Admission (POA). Centene began implementing Verisk’s HealthCare Insight (HCI) in 2010 to monitor for never events in physician claims including outpatient claims and the professional component of facility claims.

Centene Affiliate Experience with Non-Payment of Never Events

	Facility Never Events	Practitioner Never Events
Medicaid		
Georgia		x
Illinois		x
Florida		x
Indiana	x	
Ohio		x
Medicare		
Arizona	x	x
Texas	x	x
Ohio	x	x
Wisconsin	x	x

Provider Education

LHC’s Provider Contracting, Provider Relations, Claims Research and Analysis, and Quality Management (QM) staff will coordinate internally to develop and conduct provider education on PPCs. Although DHH has not defined its full policy related to the non-payment of PPCs, we will take a proactive approach in educating our provider network about patient safety initiatives and best practice interventions for improvement in order to reduce occurrence of adverse events. Our provider education

²⁰ http://www.who.int/features/factfiles/patient_safety/en/index.html

program will include training for hospital billing staff regarding POA and related coding requirements to facilitate identification of these events. Because Medicare already requires POA indicators on claims, we expect that some Louisiana hospitals are now including these indicators on their claims. Quality QM staff and the Medical Director will use trended data for education in quarterly newsletters for all providers and targeted mailings or training sessions for regional or practice specific education. Our Provider Portal will include links to Continuing Medical Education (CME) and patient safety webinars such as those offered by Partnership for Patients²¹ and the Agency for Healthcare Research and Quality²² (which often include CME credits to providers). LHC will encourage provider participation in national efforts to improve patient safety including the Institute for Healthcare Improvement and the Leapfrog Group for Patient Safety. We will highlight best practice initiatives on our Provider Portal and at least annually in our Provider Newsletter.

LHC will support DHH initiatives to send mass communication to providers (both participating and non-participating) via an LHC Explanation of Payment (EOP) stuffer and online Provider Portal announcements. The list of DHH-defined PPCs will be included in our Provider Manual and on our Provider Portal for easy access.

Monitoring Patient Safety

LHC will identify adverse events and PPCs in several ways including referrals, claims data, member and provider complaints, medical record review, and utilization management activities. All LHC staff (including Medical Management, Member Services, Provider Services, Provider Relations, MemberConnections[®] outreach, and Grievance and Appeal staff), independent, facility and ancillary providers, members, Medical Directors, and the Board of Directors may advise the QM Department of potential PPCs. Staff will be educated on the definitions of and indicators for identifying these types of events and conditions and will be instructed to report any potential concerns to the QM Department within one business day for investigation and follow up.

Claim Review and Analysis. On facility level claims, we will use Present on Admission (POA) indicators and discharge diagnosis codes to identify Hospital Acquired Conditions (HACs). HCI will monitor physician claims for outpatient occurrences of never events and HACs. Additionally, our QM staff will generate a monthly report using CMS-designated ICD-9 diagnosis codes to identify potential PPCs such as foreign body accidentally left during a procedure, blood transfusion reaction, or Emergency Room visit or readmission within 72 hours of discharge.

Grievances and Appeals. Grievance and Appeal Coordinators will monitor member and provider grievances and complaints for indicators of adverse events or PPCs such as a member complaint that a provider had not been available, resulting in admission to the hospital through the Emergency Room, or a member complaint that the physician prescribed the wrong medication.

Medical Record Reviews. QM staff will conduct medical record reviews as part of the Quality QAPI Program, including ambulatory reviews, HEDIS reviews, and as part of focus studies. If at any point during a review a potential PPC is identified in the record, copies of the medical record will be retrieved for further investigation and review with the Medical Director as part of our quality of care and peer review process.

Utilization Management Activities. Prior Authorization and Concurrent Review staff who have direct access to facility and practitioner staff will be trained to identify potential adverse events and PPCs and directly report these to QM staff. Such an event might be a return to surgery during same inpatient admission. Any supporting evidence that can be obtained will also be forwarded to the QM Department for review and inclusion in the investigation file.

²¹ <http://eo2.commpartners.com/users/pfp/>

²² www.webmm.ahrq.gov

Investigation and Corrective Action

Investigation. All potential adverse events and PPCs forwarded to, or identified by, the QM staff will be investigated by a clinical QM Coordinator. The QM Coordinator will conduct a preliminary review of the situation to determine if it warrants further clinical investigation. If the event or PPC occurred in a facility, this review will be performed in collaboration with the facility's own quality review process. The QM Coordinator will confirm that the facility QM staff are aware of the event in question. LHC will cooperate with the facility's quality management procedures. If the situation does not meet the definition of a quality of care event or PPC, for example, an expected clinical event, we will not conduct an investigation. If further investigation is needed, the QM Coordinator will prepare a confidential case file to summarize the investigation for presentation to the Medical Director for review. The investigation may include but will not be limited to review of claims data, utilization management documentation, medical record audits, and consultation with the member, provider, or any other person with knowledge of the event in question. The Medical Director may request a consult from a board certified practitioner with experience in the diagnosis and treatment of cases similar to the case under review. The Medical Director can assign a severity level or refer the case to the Peer Review Committee for review and determination.

The Peer Review Committee is an ad-hoc subcommittee of the Quality Assessment and Performance Improvement Committee comprised of at least three physicians of the same or similar specialty as the provider and/or issue under review. The committee will discuss the case and come to a consensus on recommended final severity level and corrective action. The committee will assign an appropriate action, ranging from no further action required, development of a corrective action plan, to suspension or termination for cause from network participation.

Corrective Action to Reduce Occurrence. The key to reducing adverse events and PPCs is provider and facility education. Following determination of appropriate action, the provider in question will be notified of the recommendations, including corrective actions and timeframe for completion. There are many levels of corrective action. The Medical Director may conduct informal education such as telephonic counseling or send an educational letter to the provider regarding the specific event that occurred. More intensive actions will include formal oral or written counseling, requiring Medical Director review of authorization requests, proctoring by a designated physician, or mandatory skills training. The most intensive actions, for the most serious adverse events and PPCs, will include probation or termination of participation in the provider network. For events and PPCs involving facility staff or functions, the Medical Director will contact the facility risk management department to develop an action plan for the facility-based parties involved in the incident, in addition to the individual network practitioner. The Medical Director will assess any education or other action that has been taken by the facility and determine if the action meets the requirements of the LHC peer review decision.

In the case of suspension or termination, we will follow the Practitioner Disciplinary Action and Reporting Policy including notification to the National Practitioner Data Bank, the Louisiana State Board of Medical Examiners or other appropriate agency, and DHH. We will inform the provider of the LHC Provider Dispute and Appeal Process. All providers identified with quality of care events will be monitored for trend analysis regardless of severity level assigned. Provider-specific outcomes will be forwarded to the Credentialing staff to be included in the provider's credentialing file. The Quality Assessment and Performance Improvement Committee will review aggregated peer review actions quarterly and may also initiate corrective action.

Supporting DHH Policy on Nonpayment

LHC supports DHH's movement toward nonpayment for PPCs and will leverage the experience of our affiliate plans to quickly comply. For our Indiana affiliate, AMISYS Advance, our claims processing system, uses the POA indicators and HAC diagnosis codes to determine whether and how to pay applicable hospital claims. HAC diagnosis codes with POA indicators Y (for yes) or W (for clinically undetermined) are used for AP DRG grouping and payment. (The POA indicator also may be 1, for

exempt diagnoses.) HAC diagnosis codes with POA indicators U (for unknown) or N (for no) are suppressed from processing through the AP DRG grouping (Version 4.0). By doing so, the HAC diagnosis codes are not included when determining the DRG level and payment of these claims. Providers whose claims do not fulfill POA indicator requirements receive an Explanation of Payment (EOP) for the “unclean claim” that specifies the billing error and timelines for claim resubmission. Our affiliate monitors compliance and educates providers on HAC procedures as needed. Most facilities are now complying with HAC related claim submission requirements.

For physician level outpatient and inpatient claims review, Centene’s Special Investigations Unit (SIU) recently entered into a strategic partnership with Verisk’s HealthCare Insight (HCI) to further evaluate claims to detect adverse and sentinel health care events. Claims are monitored for specific modifiers or condition codes that are reported by the provider to identify PPCs, including but not limited to wrong procedure, wrong body part, deep vein thrombosis, and surgical site infection. The POA indicator is used when reviewing physician claims for professional services provided in a facility. When identified, HCI Registered Nurses will request and review medical records for investigation of the event. HCI will make a pay/deny recommendation based on the review. Prior to finalizing the claim, our SIU Claims Compliance Team will review and approve or deny all HCI recommendations. HCI interacts with the SIU on a daily basis to provide continuous oversight of the process.

Question J.3

Identification of Quality Improvement Opportunities

J.3 Describe how you will identify quality improvement opportunities. Describe the process that will be utilized to select a performance improvement project, and the process to be utilized to improve care or services. Include information on how interventions will be evaluated for effectiveness. Identify proposed members of the Quality Assessment Committee.

Louisiana Healthcare Connections (LHC) will undertake quality improvement projects, also referred to as performance improvement projects (PIPs), as required in Section 14.3.8 as an integral part of our Quality Assessment and Performance Improvement (QAPI) Program. Our first PIP, as required in Appendix DD, Section 1 is Ambulatory Care –ED Visit Category. We will evaluate the number of Emergency Department (ED) visits per 1000 member months with a goal to reach the 2011 Medicaid NCQA Quality Compass 50th percentile or less. We will follow the processes described below to then select subsequent PIP topics. At a minimum, one additional PIP will, as required in RFP Section 14.3.8, be selected from Section 2 of Appendix DD. LHC may implement additional PIPs as indicated based on quality improvement needs. Using ongoing measurements and interventions, LHC will confirm project effectiveness in improving health outcomes and member satisfaction. Each PIP will include:

- Measuring the performance using objective quality indicators
- Implementation of interventions to improve quality
- Objective measurement of intervention effectiveness
- Planning activities to sustain or increase improvement
- Submission as required in Section 14.3.8.4 for approval by DHH within three months of contract execution

LHC will identify opportunities and select improvement projects specific to the **needs of our members**. LHCs Quality Management (QM) staff will collect and facilitate analysis of data to identify potential areas where improvements in clinical and non-clinical outcomes or service delivery are necessary or desired. Such data may include, but not be limited to:

- Demographic information relevant to health risks
- External data related to conditions or risks for similar populations
- Utilization and condition prevalence trends
- Claims payment statistics
- Access and availability studies
- Performance on standardized clinical measures such as HEDIS
- Member and provider satisfaction survey results and other feedback
- Member and provider grievance or complaint trends
- Quality of care complaint data

QM Staff review qualitative and quantitative data using a variety of QI tools to identify the most prevalent issues and those impacting multiple departments.

Centene Corporation, our parent company, supports our QAPI Program by providing sophisticated data management capabilities for data collection, indicator measurement, analysis, and improvement activities. Information Technology and Quality Improvement staff, as well as other needed corporate and health plan resources provide standard and ad hoc reporting and analysis support to QM staff. LHC captures data from internal, subcontractor (vision, behavioral health, pharmacy, dental, and clinical laboratory) and external sources for administration, management, and other reporting requirements. Qualified health professionals, including the Medical Director (a physician) and departmental Directors from Quality and Utilization Management (a registered nurse) along with others analyze the data and reports produced. Our systems submit and receive data as well as interface with other systems. Centene uses a Teradata-powered Enterprise Data Warehouse (EDW) as the central hub for service information that allows collection, integration, and reporting of clinical claim/encounter data (medical, behavioral health, laboratory, pharmacy, dental, and vision; individual and organizational providers); financial information; medical

management information (referrals, authorizations, disease management); member information (current and historical eligibility and eligibility group, demographics, member outreach); and provider information (participation status, specialty, demographics) as required by the QAPI Program. Housing all information in the EDW allows staff to generate standard and ad hoc reports from a single data repository, using our Centelligence Insight[®] suite of reporting applications to build and tabulate HEDIS and other key performance measures, and provide drill-down into metric compliance. Our Centelligence Foresight[®] suite of analytic and reporting applications supports our health stratification and risk identification activities. Starting with TruCare[®], our integrated, member centric health services management platform, all medical and behavioral health data are integrated within the same systems facilitating effective integration of quality management as well as case and care management activities.

Process Utilized to Select a Performance Improvement Project

Select Project and Obtain Quality Assessment/Performance Improvement Committee (QAPIC)

Approval. LHC's Performance Improvement Team (PIT), supported by QM staff, selects projects they believe address priority issues and present them, with supporting data, for approval by the QAPIC and ultimately by DHH. The PIT is a cross-functional, **multi-departmental** team that facilitates the ongoing integration of quality improvement throughout the organization. PIT members include the Medical Director, and representatives from each involved functional area who conduct or directly supervise the day-to-day activities of their department, including QM, Case Management (including behavioral health), Medical Management, and other departments when appropriate, such as Member and Provider Services, Finance or Compliance. The PIT considers the prevalence of a condition among, or the need for a specific service by LHC members; the identified member demographic characteristics and health risks of the population; the interests of members, providers, DHH and CMS in the aspect of care or services to be addressed; LHC priorities as expressed in our Annual QAPI Work Plan; and **member input**, whenever possible, in the selection of topics for a PIP and formulation of project goals. The PIT then identifies those specific conditions or specific health service delivery issues for focused system-wide and individual practitioner monitoring and evaluation. Topics may be clinical (preventive or therapeutic, acute or chronic conditions, coordination of care) or non-clinical (network adequacy or accessibility, cultural competency, plan administrative services), and address a spectrum of member needs and services.

The QAPIC includes representatives from the provider community to ensure that local feedback is obtained and resulting recommendations are population or network specific. For example, after our Arizona affiliate, Bridgeway's QAPIC reviewed their Advanced Directives PIP and the role of cultural beliefs about illness and death as a barrier to care, they implemented a training program for their Case Managers about Mexican-American beliefs and a Spanish language video for members to address their concerns. At times we select and test innovative strategies through PIPs. If we achieve significant improvement, the strategy may be established as a best practice and shared with all Centene affiliate health plans.

Select the Target Population. LHC determines the target populations through careful analysis of utilization, enrollment, claims, encounter, pharmacy, complaint, and satisfaction data, or information acquired through case management assessment or care coordination efforts. QM staff also obtain input from LHC's quality committees, including but not limited to:

- Provider Advisory Committee
- Member Advisory Council
- Community Advisory Committee
- CLAS Task Force
- Utilization Management Committee

This comprehensive process ensures that the population studied reflects the population served in terms of age groups, disease categories and special risk status. The specific health service delivery issue or

specific conditions targeted in each PIP are clearly defined and the methodology indicates if the entire population or a representative sample will be used.

Establish Performance Measures and Goals. The QAPIC evaluates and approves objective, clearly defined, and **measurable** indicators for each project that we derive from clinical practice guidelines or nationally developed clinical or service indicators. We use HEDIS measures, CHIPRA measures as well as Medicare and Agency for Healthcare Research and Quality indicators to measure PIP effectiveness. Non-clinical service indicators may include, for example, access and availability studies, claims adjudication and payment statistics, authorization turn-around times, customer service and call center response times, and credentialing statistics. We determine a baseline and establish goals for each indicator that reflect the desired level of performance. Goals may be established as “perfection,” an industry benchmark, or a projected percentage change from baseline measurement reflective of a demonstrable improvement.

Process Utilized to Improve Care or Services

Develop and Implement Interventions. The PIT solicits input from experts in the field of study, health plan subject matter experts, staff with strong knowledge of statistical analysis, external community resources, and our member, provider and community advisory groups as appropriate. Root causes are postulated, barriers to performance are identified, and interventions are developed that **specifically address** the identified causes and barriers and are likely to achieve improvement in quality. Causes and barriers that cross various functional areas of the organization are addressed via multi-departmental interventions, which are coordinated among the relevant departments by QM staff, monitored for effectiveness, and reported accordingly. In Centene’s experience, nearly all interventions have been cross-departmental. Case Management, Medical Management, Member Services, Provider Services, and Maternal and Child Health are, for example, all frequently involved in multi-departmental interventions. Clinical interventions may be coordinated by the Case or Utilization Management Departments. The implementation plan includes clearly defining specific tasks to be accomplished by specific departments, identifying persons responsible for the tasks, establishing **timelines** for intervention and determining how and when the effectiveness of the intervention will be measured. The PIT actively tracks all interventions and reports to the QAPIC. The Compliance Department ensures that approval of interventions is obtained from, and periodic reports delivered to DHH no less than annually and as outlined in the Quality Companion Guide.

Enhance Interventions. Periodic re-measurement and assessment of success are basic components of LHC’s improvement model. We do both interim checks and assessments following full measurement periods. In either case, LHC employs **rapid cycle** PDSA methodology to test changes or additions to the intervention if there is no evidence of improvement. With that methodology we:

- **Plan** the change, the needed data and the goal
- **Do** a trial of the changed intervention, documenting any barriers
- **Study** the results, comparing them to the goal
- **Act** to further refine the intervention based on the results, and
- Repeat the cycle with incremental changes to the interventions until improvement is achieved and sustained.

For example, Bridgeway, our Arizona affiliate plan planned a project to improve post-hospital discharge follow-up with a call to the member from case management by determining that the baseline 30-day readmission rate was 26.6% for CYE 2007, and that inconsistent follow-up by case management was an underlying factor. The primary goals were to achieve consistent telephonic follow-up by Case Managers and a reduction in the readmission rate. They did a trial with improved notification from concurrent review staff, a standardized tool to structure the follow-up call, and introduced a process for QM staff to monitor the proportion of discharged members receiving calls. After four months, they identified

documentation as a barrier to monitoring the calls and added an electronic assessment form in their medical management system. They studied the results after six months which indicated an improved readmission rate of 20.3%. They acted by further refining the intervention by adding a Discharge Transition Tool that their Concurrent Review Nurses give to hospital staff that included contact information for the member's assigned Case Manager. Reassessment for CYE 2009 indicated sustained improvement and for CYE 2010 demonstrated further improvement in the 30-day readmission rate to 15.9%.

How Interventions are Evaluated for Effectiveness

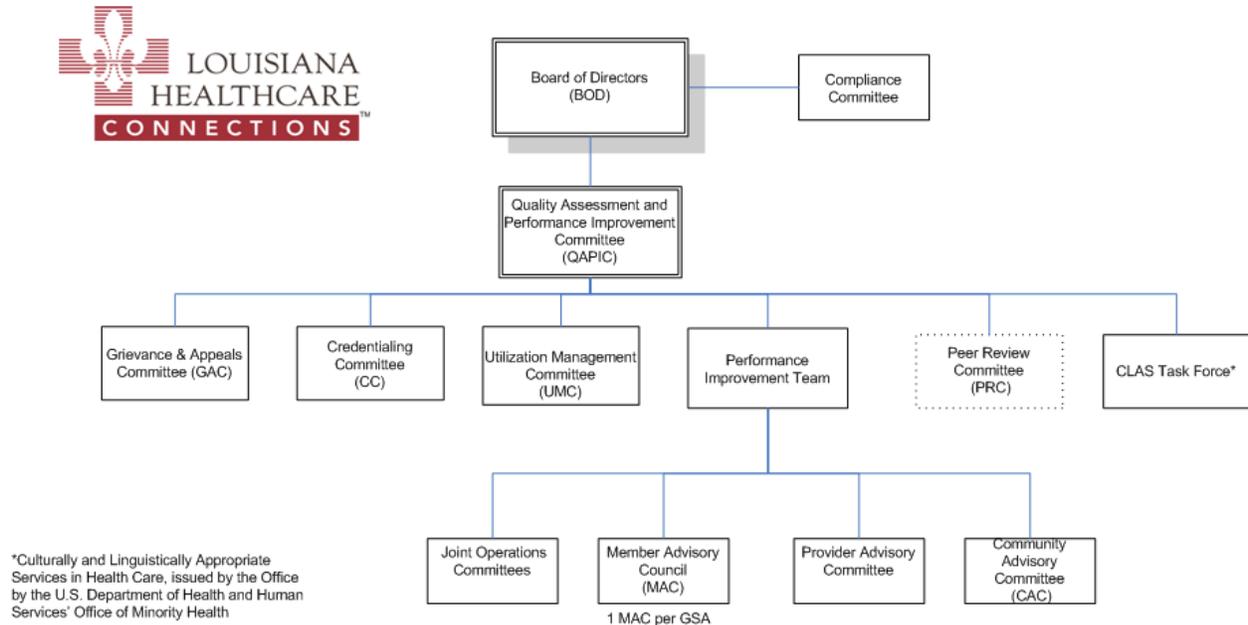
Measure and Evaluate Improvements. LHC achieves real, sustained improvements in care and service through a continuous cycle of measuring and analyzing performance, and by developing and implementing system-wide improvements. As previously described in *How Quality Improvement Opportunities are Identified* above, LHC has an innovative and robust capability for accessing and reporting performance measures. We use clinical care standards and/or practice guidelines to objectively evaluate the care LHC delivers or fails to deliver for targeted clinical conditions. We re-measure each project's established performance measures, compare them to the established benchmarks and goals at the intervals determined at the beginning of the project, and test the comparisons for statistical significance. Intervals are based on the timeframe in which an anticipated improvement in performance is expected to occur. The re-measurement methodology is the same as that used for baseline measurement, to ensure comparability. We may also track additional measures related to the project, such as intermediate process indicators or member or provider satisfaction including monitoring the quality and appropriateness of care delivered to members with special healthcare needs. The PIT evaluates and reports the outcomes of each project to the QAPIC.

Post-Evaluation Activities. LHC's QAPI includes an ongoing mechanism for re-measuring effectiveness and tracking issues over time to ensure that our actions for improvement are effective. If re-measurement does not demonstrate significant improvement and performance is not exceeding established goals, the quality improvement cycle begins again as described above. In such cases, the PIT, in conjunction with the QAPIC, carefully evaluates each intervention implemented, identifies any additional barriers that may be interfering with the achievement of performance goals, and develops actions to revise the intervention, or replace or supplement it with new interventions also related to identified causes or barriers. We conduct additional re-measurement at periodic intervals, consistent with the rapid cycle application of Plan-Do-Study-Act improvement methodology, to test the changed or new interventions quickly and further redesign them as appropriate. LHC considers improvement to be **sustained** if the level of performance is maintained or further improved occurs one year after significant improvement has been achieved, and if the improvement likely was a result of the project interventions. We maintain successful interventions, report them to DHH as possible best practices for other contractors, and communicate them as best practices to other Centene plans. Centene also convenes small workgroups with its top performing affiliate and at least two lower performing affiliates around specific quality metrics. They discuss best practices and develop work plans for the lower performing plans over the course of three months, and these work plans are shared with all Centene plans.

Quality Committee Organizational Structure

Quality is integrated throughout LHC operations, demonstrating LHC's strong commitment to the quality of care and services for members. To this end, LHC has established various committees, subcommittees and ad-hoc committees to monitor and support its QAPI Program. Ultimate authority is held by the Board of Directors (BoD). The QAPIC is the senior management lead committee reporting to the BoD. The QAPIC is supported by the Credentialing, Peer Review, Performance Improvement Team, Joint Operations Committees, CLAS Task Force (cultural competency), Member Advisory Council, Provider

Advisory Committee and the Community Advisory Committee. Ad-hoc committees may include regional level committees for Member Advisory and/or Community Advisory based on distribution of membership.



Quality Assessment/Performance Improvement Committee

The QAPIC is LHC’s senior level committee accountable directly to the BoD. The purpose of the QAPIC is to provide oversight and direction in assessing the appropriateness of care and service delivered and to continuously enhance and improve the quality of care and services provided to members. This is accomplished through a comprehensive, plan-wide system of ongoing, objective, and systematic monitoring; the identification, evaluation, and resolution of process problems, the identification of opportunities to improve member outcomes, and the education of members, providers and staff regarding the QI, UM, and Credentialing programs. Co-chaired by the Chief Medical Officer and the Chief Medical Director, our QAPIC includes:

- At least three (3) network physicians representing the range of practitioners within the network and across the regions in which it operates (i.e. Family Practice, Internal Medicine, OB/GYN, Pediatrics, and other high-volume specialists as appropriate)
- Representation from LHC senior management staff shall include respective
 - Vice President, Medical Management
 - Senior Director, Contracting & Network Development
 - Director Member and Provider Services
 - Vice President, Compliance
- Director of Quality Management
- A member advocate representative
- Delegated entity representatives may also attend the QAPIC as appropriate.

Question J.4

Outcomes of Focus Studies and Quality Improvement Projects

J.4 Provide a description of focus studies performed, quality improvement projects, and any improvements you have implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 2001 and how issues and root causes were identified, and what was changed.

Centene Corporation (Centene), Louisiana Healthcare Connections' (LHC) parent company, has more than 27 years of experience managing the healthcare needs of Medicaid and CHIP populations. We have had a continuing focus on improving outcomes for our members since beginning operations for our first state contract. Our approach is evidence-based and uses well-recognized quality improvement methodology. What follows are descriptions of a sampling of projects and studies that have been performed since 2001 by Centene or our affiliate health plans. They range from studies of pilot initiatives, such as home telemonitoring for high acuity members with multiple co-morbidities, to initiatives to improve member or provider satisfaction, to collaborative studies, such as evaluating a state Medicaid agency's claims-based predictive risk report jointly with the agency, to evaluating and publicly reporting outcomes from clinical programs. The first two project descriptions below are abstracted from papers published in the medical literature in which we have shared our experience nationally.

We have organized the following 33 project descriptions into these categories:

- Pregnancy and Birth Outcomes
- Children's Health
- Women's Health: Cancer Screening
- Diabetes
- Tobacco Cessation
- Behavioral Health
- Pharmacy
- Care management
- Satisfaction
- Access

PREGNANCY AND BIRTH OUTCOMES

Project 1: An intervention to improve birth outcomes through early identification of high-risk mothers

Description

Start Smart for Your Baby[®] is Centene's comprehensive pregnancy and postpartum management program that integrates case management, care coordination, and disease management in an effort to achieve healthier babies for our pregnant and soon-to-be-pregnant mothers. The program promotes education and communication among pregnant members, their Case Managers, and physicians through enhanced member outreach and incentives, wellness materials, intensive case management and provider incentives. Start Smart consists of several components that improve prenatal care, reduce the rate of prematurity, shorten neonatal hospital stays, increase birth weights, and lessen the chance of repeat premature deliveries. Encompassing pre-pregnancy through the first year of life of the baby, the Start Smart program is viewed as a continuum of care. An essential component of Start Smart is the Notification of Pregnancy (NOP) that promotes early and timely identification of high-risk pregnancies, without which the remainder of the program can have little impact. Interaction with pregnant members facilitates access to prenatal medical care, education on the woman's healthcare needs, assistance with social needs and concerns, and coordination of referrals to appropriate specialists and the OB Case Management program as needed.

For the purposes of this study, we analyzed qualitative data collected at the point of care management by case managers who managed the care of individual mothers. The data were collected during the interventions using a standard protocol automated by our clinical management software. This analysis of

the difference in birth outcomes between those for which the plan received an NOP and those without used data for 76,735 babies weighing between 500 and 6000g, delivered from January 1, 2008, through August 31, 2009.

Issue identification. The frequency of adverse birth outcomes, such as low birth weight and preterm birth, continues to rise nationally and statewide. Poor birth outcomes and associated admissions to the NICU (neonatal intensive care unit) are significant cost drivers for any managed Medicaid organization covering the TANF population. It is estimated that that in 2008 the annual societal economic burden associated with preterm birth in the United States was more than \$64,000 per infant (March of Dimes 2008).

Lack of access to prenatal care has been identified as the major impediment to improving pregnancy outcomes. As early as 1985, the Institute of Medicine (IOM 1985, IOM 1988) identified the most important barrier to prenatal care access as financial (amongst other like systems, organizational, and cultural) (Handler 2008). As a result, Congress expanded access to prenatal care through state Medicaid programs. By 2003, more than 40% of births in the United States were to mothers who received their prenatal care benefits under Medicaid (Kaiser Family Foundation 2011) and currently over 70% of Medicaid beneficiaries are enrolled in managed care programs that frequently offer prenatal case management as a benefit (March of Dimes 2011).

Root causes. Effective management of high-risk pregnancies requires timely identification of those at risk. However, identification of these members is often limited due to the absence of sufficient information. Claims data are often utilized to fill this information gap; however, not only is there a lag in claims processing, but many health behaviors associated with high risk pregnancies and adverse birth outcomes, such as smoking, are not captured in medical claims. In addition, given the unique benefit structure of Medicaid for pregnant women, many of our members become eligible only once they become pregnant; they all lose eligibility 6-8 weeks post delivery. This significantly shortens the window of time available to complete interventions that will improve pregnancy outcomes. A lack of understanding by providers of the value of notification of the member's health plan also is a barrier.

What changed. Centene's pregnancy management activities have evolved from a decentralized effort in which individual plans used a mixture of assessment tools, case management plan formats, schedules for follow-up, and documentation formats, into a streamlined and consistent process with tools that are used by the case management teams across all Centene health plans. The process and tools specify the actions of all parties, support data collection, and facilitate the measurement and tracking of outcomes. One of the essential components of the program is the NOP process, that aims to identify and engage pregnant members as early in their pregnancy as possible in order to establish a relationship between the member and health plan staff. The NOP form, widely distributed to providers and members, provides information to the health plan on the member's current contact information, provider information, Estimated Date of Confinement (EDC), and medical history as pertaining to pregnancy. Based on this information, a proprietary risk score is assigned which determines the course of action taken in regard to the member's pregnancy. Centene's NOP Process was accepted for presentation, and was well received, at the Poster Session at the 2010 Annual Clinic Meeting for the American College of Obstetrics and Gynecology.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this study. Based on the decrease in the rate of low birth weight babies from baseline, there has been an estimated \$10 million to \$14 million savings per year for the Start Smart Program overall.

Process efficiencies. Prior to program implementation, Centene plans used different methods and tools for managing their pregnant population. These variations created inefficiencies for Centene as a whole. This program has one set of tools that are used by case management teams across all Centene plans. The processes and tools specify the actions of all parties, support data collection, and facilitate the measurement and tracking of outcomes.

Improvement to member health status. Mothers in the NOP intervention group, compared to mothers in the non-intervention group, were statistically significantly less likely to deliver a low birth weight baby, demonstrating the protective effect of the NOP program. Mothers receiving the NOP intervention were 7.9% less likely to deliver a baby weighing less than 2500 grams, 20% less likely to deliver a baby weighing less than 1500 grams and 31.2% less likely to deliver a baby weighing less than 1000 grams. These results take into account and are independent of other effects, such as region, age and race.

Project 2: An assessment of the effectiveness of using 17 alpha-hydroprogesterone caproate (17P) in eligible but late identified pregnant members to reduce the frequency of preterm delivery and NICU admissions

Description

In this project, 17P was offered as a benefit to pregnant women who had a history of preterm delivery and who were deemed to be appropriate candidates for this treatment by their physician. The project assessed the comparative effect of 17P on reducing the rate of neonatal intensive care unit (NICU) admissions and premature births among 104 pregnant women during 2004-2007 with a confirmed history of preterm delivery with 17P administered either between 16–21 weeks gestation or after 21 weeks gestation..

Issue identification. Preterm delivery, defined as a delivery before 37 weeks gestation, and the resulting large NICU claims, constitute a large portion of a managed Medicaid company's expenses. The National Center for Health Statistics' final birth data for 2005 showed that the percentage of preterm births was continuing to rise, with more than 525,000 babies, or 12.7 %, born prematurely. That is a yearly increase of 12.5 % from 2004. The 2006 preliminary report indicated that the preterm birth rate would continue its upward trend and reach 12.8 %, about 543,000 babies (Martin 2005).

The pathophysiological events that trigger preterm labor are for the most part unknown, however a history of prior spontaneous preterm delivery is one of the strongest risk factors for preterm birth in a subsequent pregnancy (Mercer 1999). A multicenter randomized controlled trial by the National Institute of Child Health and Human Development, published in the *New England Journal of Medicine* (Meis, 2003) showed that treatment with 17P administered at 16-21 weeks gestation led to a statistically significant reduction in preterm labor and delivery for high-risk women with a history of spontaneous preterm delivery.

Since large percentages of high-risk Medicaid pregnant women delay prenatal care, it was important to determine whether or not the use of 17P later than the time period recommended by previous studies (16–21 weeks gestation), would benefit these high risk cases. If it could be demonstrated that 17P injections after 21 weeks gestation would have the same beneficial effects as revealed in other studies, better health outcomes could be provided to plan members, and plan care costs could be reduced.

Root causes. Effective management of high-risk pregnancies requires timely identification of those at risk. A large percentages of high risk Medicaid pregnant women delay prenatal care, reducing the possibility of receiving 17P during the currently recommended period (16–21 weeks gestation).

What changed. From 2004 to 2007, Centene plans were able, through their state contracts, to provide 17P as a benefit for the managed Medicaid population, even though 17P was not offered as a covered benefit in fee-for-service Medicaid in any of their states. Hence, 17P was offered as a benefit to pregnant members who had a history of preterm delivery and who were deemed to be appropriate candidates for this treatment by their physician, including to otherwise eligible members identified for care after 21 weeks gestation.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this study. Centene has realized an estimated cost savings of \$3 million to \$5 million per year related to the use of 17P overall.

Process efficiencies. Potentially relaxing the treatment period requirement will make it easier to manage the program and include more members.

Improvement to member health status. The study found evidence that high-risk mothers who begin prenatal care late would benefit from 17P treatment, provided at least 5 doses of the drug were administered. No statistically significant differences in the percent of NICU admissions and preterm births were found between members who received the intervention at the recommended time frame of 16–21 weeks versus those whose treatment began after 21 weeks gestation. However, at risk mothers receiving at least 5 doses of 17P had fewer NICU admits ($p=0.029$), fewer preterm births less than 37 weeks gestation ($p=0.021$) and fewer preterm births less than 32 weeks gestation ($p<0.0001$) than mothers injected with 17P fewer than five times.

Based on the outcomes of this study and a follow-up 2008 study, Centene continued to offer 17P as a benefit to pregnant women who had a history of spontaneous preterm delivery and who were deemed to be appropriate candidates by their doctor. A 2010 longitudinal review of birth outcomes for members receiving 17P from 2004-2009 continued to show a positive effect on reducing the rate of recurrent preterm delivery and rate of NICU admissions.

Project 3: An intervention to improve the continuity of medical care for newborns by increasing the percentage of newborns who had a PCP follow-up visit within 45 days of birth.

Description

Centene's Ohio affiliate, Buckeye Community Health Plan (Buckeye), undertook a quality improvement project to increase the percentage of newborns having a PCP follow-up visit within 45 days of birth. A series of interventions targeted at mothers were undertaken to address specific barriers identified by staff. Baseline assessment was July 2005 thru June 2006, with remeasurements in June 2007 and June 2008. The interventions consisted of member targeted mailings, telephone calls and incentives.

Issue identification. Numerous studies have demonstrated an absence of continuity, communication and coordination in the medical care system. This disconnect increases the potential for error, a patient safety concern, and subsequent costs. Continuity of care for the newborn child is a concern for Medicaid enrollees who sometimes fail to establish relationships with a primary care practitioner for their newborn, resulting in delays in care at critical periods of child development. A timely first visit to the outpatient primary care practitioner is important as newborns transition from care delivered by the obstetrician while in utero to postnatal care for the infant.

A review of claims data in 2005 by Buckeye staff found that that only 38% of newborn members had a PCP follow-up appointment within 45 days of birth. Buckeye established a goal of 50%, identified barriers to achieving that goal and then created interventions to achieve that goal.

Root causes. Analysis indicated that barriers to attaining the 50% goal were 1) mothers did not understand the importance of the first newborn visit to the primary care physician; 2) Buckeye's current incentive only focused on receipt of timely post-partum care for the mother, and did not reward mothers who made sure their newborn receives the first primary care visit within 30 to 45 days of discharge; 3) the health plan did not communicate the importance of the initial newborn visit early enough in the mother's pregnancy in a timely and consistent manner; and 4) Case Managers did not send Congratulations Cards to mothers following delivery in a timely manner. This card included instructions for initial primary care visit within 30 days of discharge for the newborn.

What Changed. Interventions included:

- *Mailings to Members:* timely postpartum Congratulations Cards; inclusion in Start Smart packet mailed to all mothers of comprehensive list of all well child visits, including newborn visit, the *Help Me Grow Health & Wellness Guide* and the Healthcheck flier that describes services rendered and how to access services
- *Phone Calls to Members:* postpartum follow-up calls to randomly selected mothers to communicate the importance of the first newborn visit; Post partum phone calls extended to all postpartum mothers in the East Central Region

- *Member Incentives:* Included a digital thermometer in the Start Smart packet; created a new incentive of \$25 gift card for newborn first visit in addition to \$25 gift card for postpartum visit.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The process of mailing Congratulations Cards to new moms was changed resulting in improved timeliness.

Improvement to member health status. The first year of the intervention, July 2006 thru June 2007, saw a statistically significant 16% percentage point increase in the proportion of newborns with an outpatient PCP appointment within 45 days of discharge ($p < 0.0001$) over baseline. The second year, July 2007 thru June 2008, saw a statistically significant 18% percentage point increase over baseline (July 2005 thru June 2006) ($p < 0.0001$).

Project 4: An intervention to increase prenatal care

Centene's South Carolina affiliate, Absolute Total Care (ATC), undertook an intervention in 2009 to increase the frequency and timing of early prenatal visits. The first evaluation of the effectiveness of the program covered the twelve month period from January 2009 through December 2009. The second evaluation covered the period from January 2010 through December 2010.

Issue identification. Early, effective prenatal care is essential to identify mothers at risk for adverse birth outcomes and to provide medical and educational interventions. Poor pregnancy outcomes can be costly, though many are preventable with early intervention. The magnitude of this problem is significant. The cost of preterm births in 2005 was more than \$26 billion. According to NCQA, infant mortality is five times higher among infants whose mothers received no prenatal care (www.ncqa.org). Infants born to mothers receiving no prenatal care are three times more likely to be low birth weight and many times more likely to be preterm. Women who receive no prenatal care are also at risk. The rate of deaths related to complications from pregnancy is three to four times higher among women who received no prenatal care compared to women who received prenatal care. The effect of no prenatal care is also evidenced later in life. Preterm infants are at increased risk for a number of health problems, including neuro-developmental handicaps, congenital anomalies and respiratory illness. Baseline ATC data for CY2008 indicate that approximately 20% of pregnant mothers had not received prenatal care within the first 42 days or first trimester, as measured by HEDIS specifications.

Root causes. Analysis indicated that barriers to increasing the number of mothers meeting the HEDIS criteria were 1) members were unaware of the need to see a physician early in pregnancy; 2) members were unmotivated to see a physician early in pregnancy; 3) Physicians were unaware of the need to notify ATC of pregnancy.

What changed. The following interventions were undertaken to achieve the project goal:

- *Member Education:* Newsletter articles referring to seeing physician early for prenatal care and significant incentives for the Start Smart program
- *Member Outreach:* Community Outreach Coordinators educated members on OB benefits and incentives while at community events and health fairs. Concerns were brought back to plan for follow up and member education if necessary
- *Member Incentives:* CentAccount™ rewards for early and timely continuing visits to physicians. Maximum incentive for attending all standard office visits during pregnancy
- *Provider Education:* Provider Relations presented at all onsite meetings with participating provider office staff on the use of Notification of Pregnancy forms
- *Process Enhancements:* Allowed the OB prior authorization form to be used as notification of pregnancy for non participating providers. This allowed quicker registration into Start Smart and CentAccount Programs
- *Community Outreach:* Start Smart program billboards.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Educating providers on the use of the Notification of Pregnancy forms and increasing the use of such forms increased ATC's efficiency in identifying and contacting pregnant women early in pregnancy. Early identification of high risk pregnant women also improved case management outreach efforts.

Improvement to member health status. Compared to baseline (CY2008), analysis of data for CY 2009 indicated there was a statistically significant 5.8 percentage point increase in the proportion of mothers seeking prenatal care in the first trimester or within 42 days of enrollment ($p=0.0391$), from 76.47% to 82.35%. A second assessment covering CY 2010, showed a statistically significant increase of 8.8% percentage points over baseline ($p=0.0005$) to 85.21%.

Project 5: An intervention to increase the frequency of timely maternal post-partum follow-up care

Description

Buckeye undertook a project to increase the percentage of mothers who have a postpartum visit within 21 to 56 days of discharge. Potential barriers to a postpartum visit were identified and interventions were designed to address those barriers. These interventions consisted of mailings, telephone calls and incentives. The baseline period was July through December 2008; remeasurement was in June 2009.

Issue identification. *Postpartum Maternal Health Care in the United States: A Critical Review* (Journal of Perinatal Education) emphasized the importance of postpartum care to the new mother's health. However, unlike the tracking of prenatal visits, there are few national statistics on postpartum health care utilization or postpartum health problems, and Healthy People 2010 addressed only postpartum depression. Most programs focus primarily on pregnant women and children while postpartum maternal care is not emphasized. However, the importance of the postpartum follow up visit should not be underestimated for it is the time when the OB/GYN assesses the health status of the member and when family planning options, including spacing of children, are discussed and decided upon.

A claims analysis of Buckeye members (July through December 2008) recently discharged following delivery found that only 48.9% of mothers were in compliance with postpartum follow-up care. This was low compared to the HEDIS Medicaid 75th percentile measure for 2008 (60.48%). As a result, the Buckeye Quality Improvement Committee determined that an improvement project was needed to improve this outcome.

Root causes. Barriers to achieving the goal were identified as follows: 1) members did not know or understand about the Start Smart program; 2) a common attitude of members was "what's in it for me" to get a postpartum follow up visit; 3) members failed to recognize the importance of timely follow-up after a delivery; 4) providers billed a combined delivery/ postpartum code; and 5) members thought having their stitches removed 10-14 days post delivery constituted the follow-up visit.

What changed. Interventions included:

- **Mailings to Members:** Congratulations and postpartum reminder postcards were sent following delivery; Start Smart reminder article appeared in member newsletter; a contest card and reminder to get the postpartum follow up visit was inserted into the Buckeye newborn Start Smart packets. A state approved quarterly drawing was held for a gift basket "Just for Mom"
- **Phone Calls to Members:** Post partum follow-up calls made by Care Managers to randomly selected mothers to educate them on the importance of the postpartum visit; postpartum phone calls extended to include all postpartum mothers in the East Central Region; Care Managers and MemberConnections outreach representatives followed up with mothers after delivery to remind the new mother of the importance to follow-up with their OB/GYN following a delivery; Televox phone calls made to new moms who delivered during the preceding 30 days, based on real time reports run on the 15th of the month

- *Member Incentives:* Start Smart incentives increased by separating out \$25 gift cards for both a postpartum visit and newborn visit
- *Process Enhancements:* Real-time reports ran on the 15th of each month to identify moms who delivered a baby during the preceding 30 days.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Monthly real-time reports of moms who delivered a baby in the prior 30 days improved the timely reminder to moms for educating on the importance of a postpartum visit.

Improvement to member health status. There was a statistically significant 6 percentage point increase, to 54.9%, in the proportion of mothers who had a postpartum visit within 56 days of discharge ($p < 0.0001$) comparing January through June 2009 to the previous six months. Buckeye remained below the national Medicaid NCQA 75th percentile.

CHILDREN'S HEALTH

Project 6: An intervention to increase the rate of blood lead screening in 2 year olds

Description

Centene's Wisconsin affiliate, Managed Health Services (MHS-WI), undertook a project to address the alarming realities of blood lead poisoning among the population of young child members. Specific interventions were identified to increase blood level screening rates for two year old members, thereby helping to improve the overall health and well being of these young members. Baseline assessment was in CY2008. Re-assessment was done for CY2009 and CY2010.

Issue identification. Lead poisoning is one of the most common and preventable childhood environmental health problems in the United States. More than 40,000 children under the age of six have been identified with lead poisoning in Wisconsin since 1996. There were more than 1,500 Wisconsin children poisoned in 2009 alone. Children from lower income families are at much greater risk for lead poisoning, as they are more likely to reside in older homes with lead paint. In 2006, 86% of the children found to be lead poisoned in Wisconsin were either enrolled in Medicaid or receiving WIC (Women Infants and Children) services. Blood lead levels of children age 12 to 36 months are the highest, due primarily to frequent hand to mouth behavior and increased mobility. Wisconsin confirmed lead poisoning is highest at age two.

Root cause. Analysis indicated that barriers to lead screening rates were 1) members' transient lifestyle making it difficult to reach members; 2) short-lived enrollment within the health plan; 3) physician oversight/missed opportunity; 4) changes in PCP without communication to the plan; and 5) other life barriers such as transportation.

What changed. Interventions included:

- *Phone calls to Members:* Televox[®] reminder phone calls made three times per year related to blood lead screenings
- *Mailings to Members:* reminder letters sent to members identified as having an elevated lead level via the monthly state Care Analysis Project report and those referred via the internal potential preventive health event process
- *Mailings to Physicians:* Lead toolkit mailed to 15 practitioners every month to assist with reaching out to patients regarding blood lead screenings
- *Process Enhancements:* MHS-WI provided two Lead Care II analyzers to Rock County WIC to be utilized at their locations to provide onsite lead screenings
- *Community Outreach:* Coordinated and participated in a lead screening day with a high volume day care center and City of Milwaukee Health Department to provide lead screenings

for children 3 years of age and younger at the center; maintained partnerships with public health departments and WIC agencies encouraging the use of lead analyzers for lead testing; conducted physician and community visits to determine opportunities to collaborate and partner in health fairs and community events where lead screening can be offered and conducted.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The process of screening young children was improved by providing two Lead Care II analyzers to Rock County WIC to be utilized at their location to provide onsite lead screenings. This reduced the number of steps required to obtaining a lead screening test and allowed access to immediate results while the member was still in the office. Immediate education and interventions would occur if a child is found to have an elevated blood lead level.

Of the 72 General Practice, Family Practice and Pediatric practitioners who were targeted and received a lead toolkit in the first year, all had either increased or stable blood lead screening rates. Consequently, the goal was to increase the number of physicians targeted on a monthly basis.

Improvement to member health status. Based on HEDIS criteria for calculating the rate of two year old blood lead screenings for the MHS-WI population, a slight increase in screenings (<1%) occurred from CY 2008 to CY2009 but a larger, almost 5 percentage point increase was observed between CY2009 and CY2010 when the rate increased from 79.5% to 84.1%. These results surpassed the internal goal of 80.96 and exceeded the 2010 national Medicaid NCQA 75th percentile of 80.79%.

Project 7: A pilot program to ensure appropriate care of asthmatics ages 2-13 years.

Description

In 2003, MHS-WI implemented a Pediatric Asthma Care Management Program. This was a pilot study designed to identify opportunities and develop mechanisms for improving the quality of health among Medicaid/BadgerCare members with asthma. Baseline data was from July 2002 through June 2003, and remeasurement was July 2003 through June 2004.

The initial goals of the program were to: 1) identify pediatric members with asthma who were at high risk for complications and for high resource utilization; 2) assure that members had access to appropriate care for the evaluation, treatment, and monitoring of their asthma; 3) assure that these members were receiving appropriate medications and used these medications in the appropriate manner as prescribed by their physicians; 4) assure that these members had a written home action plan and knew how to manage their asthma as soon as they recognize the onset of symptoms; 5) improve the long-term prognosis of these members and reduce the short-term complications rates; and 6) assure the appropriate use of resources in the evaluation and treatment of their asthma.

Issue identification. According to John Meurer, MD, MBA, FAM Allies Coalition Director and Associate Professor of Pediatrics, Center for the Advancement of Urban Children, Medical College of Wisconsin-Milwaukee, asthma is the most common chronic childhood disease in the United States. Wisconsin had the unfortunate distinction of having two large metropolitan areas - Madison and Milwaukee-Waukesha – ranked in the top 20 worst US cities to live in for people with asthma. Between 1990 and 2002, Wisconsin children 0 to 4 years of age had the highest rate of hospital admissions for asthma at 36.1 admissions per 10,000 with rates decreasing with increasing age. Two-thirds of all pediatric inpatient admissions for asthma in Milwaukee were for children under the age of 5.

Children between the ages of two and thirteen constituted approximately 41% of all MHS Medicaid/BadgerCare members. In 2003, asthma was consistently one of the top five admitting diagnoses in their pediatric Medicaid population. In 2002, 5.6% of members between the ages of 0 – 20 carried a primary diagnosis of asthma; 24.8% of these members had at least one emergency department visit and 3.2% had at least one inpatient admission during that year. The magnitude of this problem within the

MHS Medicaid/BadgerCare population required educational and care management interventions for the proper treatment of this asthmatic population

Root causes. Avoiding triggers, daily use of controller medications, and frequent monitoring with the use of a peak flow meter are the best ways to control persistent asthma. However, many parents/guardians lacked the education to support appropriate asthma treatment.

What changed. Interventions included:

- **Initial Assessment:** an RN case manager called the identified member to obtain an Asthma Assessment to verify the severity of the asthma
- **Member Education:** a welcome letter was sent to the member with educational handouts in English and Spanish. The handouts included information about asthma symptoms, asthma medicines, asthma triggers, using a peak flow meter, peak flow tracking sheet, using an asthma inhaler, and using an asthma action plan, and a sample asthma action plan; member newsletter articles on asthma were published
- **Home Visits to Member:** Upon notification by the Director of Member Services, a MemberConnections representative visited the member's home and delivered an asthma kit. The asthma kit included: NurseWise magnet with 24/7 nurse advice line number, *Asthma: Taking Control for a Healthier Life* booklet either in English or Spanish, fanny pack, peak flow meter, daily record sheet for monitoring peak flow measurements, spacer for inhaler, personal health journal, pillow cover, asthma alert bracelet, emergency ID card, asthma coloring book, crayons, pencil, MHS HealthCheck pamphlet, and MHS emergency room pamphlet.
- **Mailings to Physicians:** Letters were sent to the member's primary care provider a) identifying members in the MHS Asthma Care Management Program and including National Asthma Education and Prevention Program guidelines, and b) identifying members with pharmacy profiles that included three or more β -agonist rescue medication prescriptions filled without any controller medication within a six-month period and also including NAEPP guidelines; provider newsletter articles on asthma were published.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. By 2004 the pilot program had successfully contacted 86% of the 29 remaining identified eligible members with inappropriate β -agonist use with at least one asthma intervention, exceeding by 6% the goal to reach 80%. In addition 32% of the asthma program members who remained eligible received a home visit and an asthma kit.

Improvement to member health status. All contacted members were receiving appropriate treatment with controller medications at the end of the project in 2004. A retrospective examination of emergency room visits for the targeted population from the period of 7/1/03- 6/30/04 compared to the period 7/1/02- 6/30/03 found no change in the rate of emergency room use. A comparison of hospital admissions from the period 7/1/03 through 6/30/04 with the period 7/1/02 through 6/30/03 found that inpatient admissions decreased by 25% for this small group of enrollees. One asthma program member had multiple inpatient admissions but no other members of the asthma program had an inpatient admission after asthma interventions.

Project 8: An intervention to improve continuity of follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medications by increasing the proportion of follow-up visits.

Description

Buckeye instituted a program to educate practitioners on ADHD and to promote follow-up care among members who receive ADHD medications in September 2007. Baseline assessment was in 2007 and remeasurement was in 2008. Buckeye and their behavioral health affiliate, Cenpatico Behavioral Health,

had adopted the American Academy of Child and Adolescent Psychiatry (AACAP) Practice Parameters for ADHD.

Issue identification. The American Academy of Pediatrics states that ADHD is generally over-diagnosed and under-treated by practitioners. Treatment generally includes both follow up visits to the physician and adequate dosing of medication once the diagnosis has been made. Buckeye's 2007 baseline rate for the HEDIS ADHD follow up measure for the Initiation Phase was 32.6%, 8 percentage points lower than NCQA's 75th percentile.

Root causes. Two barriers to the continuity of care for the ADHD population were identified: 1) the lack of sufficient tools to assist practitioners in the treatment of ADHD; and 2) members' noncompliance with medications usage.

What changed. Interventions included:

- **Provider Outreach:** The AACAP website location for the ADHD clinical guideline was made available and an ADHD Power Point presentation was sent to network practitioners.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Process efficiency was not a focus of this project.

Improvement to member health status. Increased rates of more than 10 percentage points in the HEDIS ADHD follow-up measures were observed in both the Initiation Phase and the Maintenance Phase in 2008 compared to 2007. The rate of ADHD follow-up in the Initiation Phase in 2007 was 32.6%, 8 percentage points lower than NCQA's 75th percentile. In 2008, the rate of follow-up increased to 44.8%. A more dramatic increase in rates was observed between 2007 and 2008 in the ADHD follow-up in the Maintenance Phase. The rate increased by 15 percentage points, from 38.9% in 2007 to 53.8% in 2008, well above NCQA's 75th percentile for this metric (47.9%).

Project 9: An intervention to increase the rate of childhood immunizations

Description

Centene's Georgia affiliate, Peach State Health Plan (PSHP), undertook a project to do a baseline assessment of childhood immunizations with HEDIS methodology for CY2008 for children 0 thru 2 years of age and to undertake interventions to educate and promote vaccination among practitioners and plan members. Remeasurement was in CY2009 and CY2010.

Issue identification. Studies have shown that for every dollar spent, a routine childhood vaccination program saves more than five dollars in direct health care costs and approximately eleven dollars in additional costs to the nation's health care system. The 2006 National Immunization Survey data released by the Centers for Disease Control and Prevention, ranked Georgia as fourth in the nation for childhood immunization coverage, and among the nation's top five states for immunizing children against vaccine preventable diseases. Despite the national focus and established guidelines, approximately 10% of Georgia's children did not receive their recommended immunizations. PSHP's baseline immunization rate for CY2008, based on HEDIS Hybrid data methodology, was 62.77%, indicating that slightly more than one third of children in the plan were not properly immunized at that time.

Root causes. Analysis determined that barriers to immunization were 1) lack of awareness of well child/EPSDT/Health Check requirements and benefits; 2) members not understanding concept of Medical Home for services; 3) members' lack of knowledge; 4) provider lack of awareness regarding updates with the Health Check Program; 5) provider lack of knowledge regarding revisions in the preventive health schedule for well services; and 6) provider lack of understanding regarding HEDIS measure requirements.

What changed: Interventions included:

- **Phone Calls to Members:** The MemberConnections outreach team completed approximately 60 Welcome Calls per day to members within the first 60 days of eligibility to provide information about

the Health Check Program highlighting the importance of well child visits; Health Check Coordinators completed approximately 50 member telephone calls per day to remind and encourage noncompliant members to schedule a well check visit appointment; Enhanced health plan EPSDT telephone messages to include Health Check screenings and immunizations

- *Mailings to Members:* Distributed welcome packets to new members including a Member Handbook and educational brochures advising of the importance of well child visits and Health Check screenings; Health Plan member newsletter article *EPSDT Health Checks*; Annual mailing of member materials including the Member Handbook, Provider Directory, and HEDIS information notice
- *Home Visits to Members:* The MemberConnections Team visited approximately 85 homes each month to provide Health Check educational information and encourage well child visits to hard-to-reach and non-compliant members
- *Mailings to Providers:* Health Plan Provider Newsletter articles on a) Health Check requirements/standards including resource tools for BMI, lead screening, and TB risk assessment, Vaccines for Children, and periodicity schedule, b) Preventive Health Guidelines including periodicity schedule for well child visits, and c) HEDIS Review Time; Distribution of Provider Manual to all network practitioners; Distribution of *HEDIS Measurement Criteria* magnet; Distribution of *HEDIS Tip Sheets* that provided physicians with HEDIS preventive measure specifications and applicable billing codes
- *Visits to Provider Offices:* Provider Relations Department initiated EPSDT focused outreach. Medical record reminder stickers that contained the immunizations required prior to second birthday distributed during the provider office meetings
- *Provider Incentives:* Established Provider Incentive Program based on HEDIS metrics
- *Community Outreach:* Member Services and MemberConnections teams participated in annual and regularly scheduled health fairs, back-to-school activities, and community events to provide awareness of and access to health care services. PSHP members were notified and invited to these events to receive free screenings, such as hearing, vision, and dental; in some cases, immunization screenings were provided. Hosted Health Check Days in pediatric offices and high volume PCP offices to promote healthy living activities.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The Provider Incentive Program improved data capture efficiency and completeness since the incentives were based on administrative data and providers must bill appropriately to receive their incentives.

Improvement to member health status. Between CY2008 (baseline) and CY2009, child immunizations increased from 62.77% to 67.64%. This represents an increase of 4.87 percentage points but was not statistically significant ($p = 0.1430$). The percentage of children immunized in CY2010 was 78.19%, 10.55 percentage points greater than in CY2009 and 15.42 percentage points greater than baseline. These differences were statistically significant ($p < 0.0001$ and $p = 0.0058$, respectively).

Project 10: An intervention to increase the rate of adolescent preventive care/ well check visits

Description

Centene's former New Jersey affiliate, University Health Plan (UHP), undertook a project in 2006 to increase well care visits in their adolescent population. UHP developed several outreach interventions involving members, providers, and plan staff. Remeasurement was in 2007.

Issue identification. The Major focus of the EPSDT program is the scheduled, comprehensive well child visit that includes a history and a physical examination, screening for abnormal conditions (including dental, vision, and lead screening), anticipatory guidance, immunizations and treatment for any conditions that are diagnosed. Historically, children 12-21 have had the lowest rate of EPSDT services. As of

December 31, 2007, UHP had a total population of 57,264 active members. Of this membership, 20.93% or 11,987 members were 12-21 years of age. Given the large number of members that belong to this adolescent age group, it is important to promote preventive care to maintain a healthy population. The UHP HEDIS Hybrid Rate for adolescent well care visits in CY2006 was 41.4%, approximately 1 percentage point below NCQA'S Medicaid HEDIS 50th Percentile (42.1%).

Root cause. Several member, physician and plan barriers to adolescent well care compliance were identified. The member barriers were 1) lack of knowledge regarding the importance of obtaining preventive care services; 2) non-compliance with scheduling well care visits; 3) need for reminders; 4) access and availability; and 5) inadequate transportation. The physician barriers were 1) PCPs' lack of knowledge regarding the importance of EPSDT services; 2) lack of knowledge regarding panel members in need of EPSDT services; and 3) lack of knowledge regarding access and availability standards. The plan barrier was the lack of complete and accurate data due to provider submission and/or claims lag.

What changed. Interventions included:

- **Member Outreach:** Continue outreach and education to all EPSDT eligible adolescents, which include mailing of letters and materials to educate members on the importance of preventive services, Birthday Notification Reminder postcards, and telephonic outreach; Annual member letter that provides information on such topics as office access and availability standards and how to contact UHP Member Services or NurseWise helpline for information and assistance, including transportation; Outreach to all members in Essex, Hudson and Middlesex counties who did not receive an EPSDT well care exam and offer an incentive for compliance with this preventive service. In order to appeal to a larger number of members, UHP offered a \$10 gift certificate to Wal-Mart instead of movie theater tickets
- **Provider Outreach:** Provider outreach to ensure awareness of panel members who lack needed services, including providing information on a fax back form; Annual provider letter that provides information on such topics as office access and availability standards and how to contact UHP Member Services or NurseWise helpline for information and assistance, including transportation; Expansion of UHP's quarterly "secret shopper" survey calls to eighty participating providers to assess provider's access and availability; Provider Relations Representatives will be responsible for confirming provider demographic information upon every face-to-face contact with provider's office.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. UHP was able to improve provider efficiencies by mailing a list of members on their panel who were non-compliant with needed screenings.

Improvement to member health status. The CY 2007 HEDIS (hybrid methodology) for adolescent well care visits was 50.6%, representing a nine percentage point increase in compliance compared to the CY2006 baseline of 41.4%. UHP also exceeded the national Medicaid NCQA 50th percentile.

Project 11: An intervention to increase the rate of Health Check screening rates among members 0-20 years old.

Description

MHS-WI developed an integrated education and outreach program in 2002 to increase member and physician compliance with the HC periodicity schedule. The target population consisted of members age 20 or below. In addition to educational efforts HMOs typically use, MHS-WI implemented several innovative strategies targeting members not in compliance with the Wisconsin periodicity schedule.

Issue identification. The rate of Health Check screening at baseline in 2002 was only 38.7%.

Root causes. Documentation of analysis is no longer available.

What changed. Interventions included:

- *Home Visits to Members:* conducted in-home visits to parents/guardians of members overdue for Health Check screenings and assisted them with scheduling appointments and arranging transportation; Reimbursed nurse practitioners for performing in-home Health Check screening exams
- *Community Outreach:* MemberConnections outreach staff partnered with the Milwaukee Public School system to offer Health Check screenings at school-based clinics; collaborated with the Milwaukee Health Department to conduct Health Check events across the community; worked with community agencies to schedule Health Check screening days at centralized locations
- *Process Enhancements:* MemberConnections staff coordinated Health Check Days at high-volume FQHCs and PCP offices; Medical Management staff developed and distributed a Physician Preventive Care Services Reminder Sheet for member charts and provided monthly reports to PCPs identifying members due for a Health Check screening exam.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Centralized Health Check events in schools, provider offices and in the community improved efficiencies of delivering the exams and was convenient for members

Improvement to member health status. The largest change in compliance rates was found in teenagers, where performance improved from 38.7% at baseline in 2002 to 59% in 2004. An increase of 12 percentage points over the two-year period was observed in the under 1 year old age cohort where the rate went from 78.2% to 90.7%. Compliance rates in the other age groups increased by approximately 7 percentage points each: rates for those between 1 and 5 years old went from 58.7% in 2002 to 65.8% in 2004 and for those age 6-14 went from 65.0% to 71.1%. The increase in Health Check exams from 2003 through 2004 was statistically significant in all age cohorts.

Project 12: An intervention to increase the rate of yearly dental visits among members aged 2-21

Description

Buckeye undertook a project in 2006 to improve the percentage of members aged 2-21 years who were enrolled with Buckeye for at least 11 out of the 12 months during the year who had at least one visit with a dentist. The study focused on implementation of a dental care education initiative for patients and/or caregivers. Remeasurement was in 2007 and 2008.

Issue identification. Dental caries is the most common chronic childhood disease (for children under age of 6). It is five times more prevalent than asthma. Regular visits to the dentist provide access to early diagnosis and treatment as well as education to children about the importance of oral health. According to the American Academy of Family Physicians, children's teeth should be examined for defects and cavities at every well child visit. Any child with significant risk factors for caries should be referred to a dentist by 12 months of age. Beginning at the 15th month well child visit, dental care messages should become consistent. Oral hygiene and dietary advice should be the focus of the message to patients and/or their caregivers. Buckeye's rate of yearly dental visits for this population, at baseline in 2007, was approximately 42%.

Root causes. A number of barriers to appropriate dental care in this population were identified. These were 1) access to dental services for Medicaid consumers is more restricted than found for commercial consumers; 2) parents may not take their children to the dentist if they are not having any apparent problems; 3) members have a perceived lack of incentive for receiving service, or failure to recognize the risk of not receiving the services; 3) members frequently do not show for routine scheduled appointments (cultural barrier to accessing care); 4) physicians often don't feel the reimbursement for performing services is high enough to devote staff to patient outreach; 5) members' fear of dental care and of provider (dentists).

What changed. Interventions included:

- *Mailings to members: The Emergency Room and Your Dental Care* educational brochure was included in new member packets and distributed to members after ED visits for dental care; Targeted reminder postcards sent to children aged 2 – 21 who had not yet received an annual dental visit; Member newsletter articles regarding dental issues including pregnancy; HealthChek reminder (including dental check) was included in the Member Handbook
- *Phone Calls to members:* Televox automated reminder calls to all noncompliant members to obtain an annual dental visit with the option to get assistance with scheduling the visit if needed
- *Mailings to providers:* provider newsletter articles regarding: children’s teeth should be examined at every well child visit; Any infant with significant risk factors for caries should be referred to a dentist by 12 months of age; dental care during and after pregnancy; the importance of monitoring dental health side effects from prescribed medications
- *Process enhancements:* New contract with a pediatric dental practice, Small Smiles, in Lucas County to do screenings, interventions, and treatment of children. This new provider was included in provider directories and promoted by MemberConnections Representatives; New contract with a mobile dental provider who took dental services into communities where there was limited access, thereby improving member opportunity to receive dental care.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The use of Televox to conduct reminder calls to all non-compliant members to obtain an annual dental visit with the option to get assistance with scheduling the visit if needed. This improved members’ ability to contact a dental provider in their area who can provide services.

Improvement to member health status. There was a 5 percentage point increase in the dental care rate from baseline to 2007 (47.74%) and an additional 2.7 percentage point increase between 2007 and 2008 (50.45%). These differences were not statistically different and did not reach the stated goal of 60%. However it was evidence of sustained improvement in the number of members accessing dental care with an increase of 7.79 percentage points from baseline to 2008 in the face of their 54% growth in membership from 2006 to 2008. Despite this substantial increase, there was sustained improvement over comparable time periods.

WOMEN’S HEALTH: CANCER SCREENINGS

Project 13: An intervention to increase the rate of mammography screening among in the NHP-SSI Medicaid study population aged 40 and over.

Description

This project was developed in 2006 by Centene’s Wisconsin affiliate, Network Health Plan of Wisconsin (NHP). It included the establishment of a Preventive Health Task Force which developed outreach interventions to improve mammography screening rates for female SSI Medicaid members 40 years of age and older. Remeasurement was in 2007.

Issue identification. Breast cancer is the most common cancer in women and is the second-leading cause of cancer death among all women. According to the National Women’s Health Resource Center, Inc. (NWHRC), there were an estimated 178,480 new cases of breast cancer with an expected mortality of 40,460 in 2007. While the age adjusted incidence and mortality rates of female breast cancer in Wisconsin in 2007 were among the lowest rates of all the 50 states, these rates vary geographically. Within the State of Wisconsin, NHP-SSI served eight of the top ten counties with the highest concentration of known breast cancer; Milwaukee, Waukesha, Brown, Outagamie, Winnebago, Rock, Kenosha and Marathon counties.

Mammography screening can detect breast cancer at earlier stages, thus improving the prognosis for woman diagnosed with breast cancer. Less than 20% of women in the NHP-SSI Medicaid population had

a mammogram between January 1, 2006 and December 31, 2006. Approximately 19% of those age 40-49 and 16% of those age 50-59 did so during this time period.

Root causes. The six major barriers to obtaining a mammography were identified and remain challenges: 1) inadequate age-appropriate member knowledge; 2) members' transient lifestyle resulting in difficulty reaching members for outreach and education; 3) short-lived enrollment time within the Health Plan; 4) physician oversight may be less than optimal; 5) physician notification of changes to their physical office location without informing the plan of an address change, and thus prevent receipt of important health care reminders and/or preventive health guidelines; and 5) life barriers such as transportation, access to child care.

What changed. Interventions included:

- *Mailings to members:* Articles in member newsletters with recommendations for mammography screening; Reminder cards to women identified as not having a mammogram in the past 12 months; Including Preventive Health guidelines on the plan website and in the member handbook
- *Phone calls to members:* Outreach phone calls to members in need of a mammogram
- *Mailings to Providers:* Articles in provider newsletters with recommendations for mammography screening; Targeted provider mailings eliciting PCP's assistance in reminding non-compliant members to obtain a mammogram
- *Process enhancements:* NHP-WI developed an internal Preventive Health Task Force that was the guiding team for implementing education and outreach campaigns.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Process efficiencies were not a focus of this project.

Improvement to member health status. Twenty four percent of women age 40-49 years of age in the NHP-SSI Medicaid study population between January 1, 2007 and December 31, 2007 had a mammogram while only 19.1% of women did so the previous year. This was not statistically significant ($p=0.48$) but does represent an increase of close to 5 percentage point in mammogram screening rates. Similarly, 22% of women age 50-59 years of age in the NHP-SSI Medicaid study population between January 1, 2007 and December 31, 2007 had a mammogram compared to 15.5% in the previous year. This too was not statistically significant ($p=0.4800$) but also represents an increase of close to 5 percentage points in mammogram screening rates.

Project 14: An intervention to increase the rate of Cervical Cancer Screening among women age 18 and older

Description

This project undertaken by MHS-WI was designed to increase the percentage of female members 18 years of age and older who receive a Pap smear for cervical cancer screening. The project was part of a five-year effort, and included numerous interventions targeted at both health care providers and plan members. Baseline was 2005, with remeasurement in 2006.

Issue identification. During the past four decades, incidence and mortality of cervical cancer have declined significantly, primarily due to the widespread use of the Pap smear to detect cervical abnormalities. However, cervical cancer remains a problem. It is estimated that more than \$2 billion per year is spent in the United States on the treatment of this preventable disease.

In 2004, 88% of Wisconsin women aged 18 and over had a pap smear within the previous three years. However, according to Wisconsin's Comprehensive Cancer Control Program, approximately 235 women are diagnosed with cervical cancer each year in Wisconsin. And, although cervical cancer mortality rates decreased 42% in Wisconsin between 1990 and 2003, women are still dying from this disease - an average of 57 women each year from 1999 to 2003.

Approximately 49% of all MHS-WI members are women 18 years of age and older. Thus, a large number of members could reduce their risk of cervical cancer by completing a Pap test. However, the MHS-WI Pap smear completion rate declined between 2003 and 2005, from 38.1% to 36.7%.

Root causes. Numerous barriers to cervical cancer screening have been identified nationally. These include 1) the absence of a physician recommendation; 2) women not knowing it was needed; 3) women never thought about it; 4) fear; 5) pain; and 6) embarrassment. The plan identified additional barriers. These are 1) lack of member knowledge regarding the importance of cervical cancer screening and the guidelines associated with the screening; 2) frequent change of address for members so members do not receive the reminder mailings related to Pap smear testing and cervical cancer; 3) members utilizing multiple providers vs. one primary care provider; 4) missed opportunities by physicians - PCPs may not review the Pap smear status and history during a sick/follow-up visit; 5) frequently missed or cancelled appointments; and 6) transportation issues with getting to appointments.

What changed. Interventions tailored to these barriers were:

- **Member Outreach and Education:** Reminder postcards mailed to all eligible females aged 18 years and older on a quarterly basis; Reminder letters and Televox automated reminder outreach calls to targeted specific members 18 years and older who had not received a pap smear based on a listing generated monthly; Articles related to Pap smears and cervical cancer published in member newsletters on a regular basis
- **Community Outreach:** Collaborated with MHS-WI MemberConnections outreach staff to disseminate the Women's Health Brochure with information regarding Pap smears to age appropriate members during Health Fairs
- **Provider Outreach:** Articles related to Pap smears and cervical cancer published in provider newsletters on a regular basis; Developed and mailed physician-specific reports to all primary care physicians identifying their assigned members in need of a Pap smear; Distributed Quality Improvement Committee approved Preventive Health Guidelines to providers via Provider Manual and Provider Website
- **Process Enhancements:** Developed a monthly report indicating those female members 18 years and older who have not received a pap smear; Collaborated with Member Services Department to ensure all members are assigned to an appropriate PCP; collaborated with Maternal Infant Department to work with Case Managers who may be able to distribute preventive health educational materials and educate members regarding Pap smears during home visits.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. MHS-WI was able to improve provider efficiencies by mailing them a list of members on their panel who were non-compliant with cervical cancer screenings. This assisted the providers in identifying who was in need of services. MHS also improved their targeted distribution of educational materials through the Maternal Infant department Case Manager home visits.

Improvement to member health status. The MHS-WI Pap smear completion rate in 2005 (baseline) was 36.7%. This increased by approximately 5 percentage points to 42.1% in 2006. This rate was marginally below the 2008 goal rate of 43%.

DIABETES

Project 15: An intervention to increase the rate of HbA1C and LDL-C screening among diabetic members

Description

MHS-WI started the MHS Diabetic Reminder Program in 2007 to insure that members with diabetes have routine monitoring of HbA1c and LDL levels in order to delay the onset of adverse complications. The program used evidence-based guidelines including the American Diabetic Association's 2009 Clinical Practice Recommendations and the Wisconsin Department of Health and Human Services 2008 Wisconsin Diabetes Mellitus Essential Care Guidelines. Baseline was CY2007. Remeasurement was in CY2008, CY2009, and CY2010.

Issue identification. According to 2007 prevalence estimates released by the Centers for Disease Control and Prevention, diabetes has affected nearly 24 million people in the United States. Diabetes is the major cause of heart disease and stroke and is the seventh leading cause of death in this country. Diabetes can also lead to other complications such as kidney failure, eye disease, nerve disease and amputations. Through aggressive screening, early detection and treatment, many of the complications of diabetes can be slowed or delayed.

In 2007, MHS-WI established a Preventive Health Task Force to develop interventions in an attempt to improve the HbA1c and LDL screening rates for BadgerCare Plus members with diabetes. More than 25% of diabetics were not screened for HbA1C or LDL during calendar year 2007. The HbA1C screening rate was 71.3% and the LDL screening rate was 58.3%.

Root causes. Barriers to increasing the rate of HbA1C and LDL-C screening among diabetic members were: 1) inadequate age-appropriate member knowledge; 2) members' transient lifestyle; 3) variations in length of enrollment; 4) physician oversight may be less than optimal; 5) physician notification- change in physician location without notifying the plan; and 6) other life barriers, such as lack of transportation.

What changed. Interventions included:

- **Member Outreach and Education:** Quarterly postcard reminders and bi-annual Televox calls reminding members with diabetes that were noncompliant with obtaining their HbA1c, LDL, or retinal eye exam within the previous twelve months; Letter from the Chief Medical Officer to all members identified as having a claim for diabetes related lab tests suggesting that they follow up with their PCP; Educational material mailings to those members identified with diabetes complications from potential preventive health events; Member newsletter article stating recommendations for HbA1c & LDL screening
- **Provider Outreach:** Newsletter articles bringing attention to diabetic care guidelines for obtaining an HbA1c, LDL, and dilated retinal eye exam, current screening results and on resources available for provider-patient education/discussion; Posted annual Preventive Health and Clinical Practice Guidelines on the MHS-WI website
- **Process enhancements:** development of an internal MHS Preventive Health Task Force; Medical Case Managers began to collect HbA1c and LDL levels while reviewing a hospitalized plan member's chart for incorporation into the administrative claims data as supplemental data; Provided pocket record cards and diabetic education packets to the MemberConnections and Case Management for distribution to members with diabetes as needed; Initiation of the Diabetes Home Test Kit Pilot Project for those members with diabetes identified as being non-compliant in obtaining their HbA1c or LDL; StartSmart for Your Health program for Diabetes included a letter, magnet and journey book informing members of needed routine screenings, documenting blood sugar and BP results and incentives for members who completed all recommended diabetic screening tests; initiated a website Provider Care Gap Alert project that will bring attention to the

provider when checking eligibility of a member, informing them of a potential gap in care due to insufficient claims data for HbA1c or LDL screening within the previous twelve months.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. MHS was able to improve provider efficiencies by mailing to them a list of members on their panel who were noncompliant with needed screenings. Providers were also able to get this information as they check eligibility online.

Improvement to member health status. The HbA1c compliance rate for CY2008 was 67.1%, a not statistically significant drop from the baseline rate of 71.3% for CY2007 ($p=0.952$). The compliance rate for CY2009 increased to 76.8% and the rate for CY2010 was even greater at 84.3%. The compliance rates for CY2009 and CY2010 were statistically significantly higher than baseline ($p=0.009$ and $p<0.0001$, respectively).

The LDL compliance rates evidenced a similar pattern. The rate for CY2008 was 49.5%, a not statistically significant drop from the baseline rate of 58.3% in CY2007 ($p=0.999$). The compliance rate for CY2009 increased to 63.9% and the rate for CY2010 was even greater at 69.6%. The compliance rates for CY2009 and CY2010 were statistically significantly higher than baseline ($p=0.015$ and $p<0.0001$, respectively).

TOBACCO CESSATION

Project 16: An intervention to increase the rate of smoking cessation within the SSI population

Description

MHS-WI undertook a project in 2007 to increase smoking cessation rates by implementing numerous outreach efforts to its BadgerCare Plus Medicaid members. Remeasurement was in CY2008 and CY2009.

Issue identification. According to the American Lung Association, every year in the U.S. over 392,000 people die from tobacco-related disease, making it the leading cause of preventable death; an additional 50,000 people die from exposure to secondhand smoke. Each day approximately 1,100 kids become regular, daily smokers and one third to one half will eventually die as a result of their addiction.

Furthermore, in states with successful tobacco prevention and control programs, each dollar invested saves more than \$3.60 in tobacco-caused healthcare costs. Wisconsin is the 19th highest state in the nation with the greatest population of adult smokers with a smoking rate 1.5% greater than the national average. The smoking cessation rate for the MHS-WI Family BadgerCare Plus population in CY2007 was 35%.

Root causes. Six major barriers to smoking cessation were identified. These were 1) inadequate age-appropriate member knowledge; 2) members' transient lifestyle; 3) short-lived enrollment in the health plan; 3) physician oversight may be not be optimal; 4) physician notification of change of address without informing the plan; and 5) other life barriers such lack of adequate transportation.

What changed. Interventions included:

- **Member Outreach:** Mailings of education and resource materials, and Televox calls about the benefits available within their plan and state, and encouragement to make a quit attempt to members identified as smokers from the Health Risk Member Assessment Reports received from the State, claims, smokers that utilized their smoking cessation pharmaceutical benefit from Script Solution Reports, smokers with asthma or COPD identified by the disease management program; Development of educational materials for Case Managers to distribute to members who smoke; Member newsletter articles addressing smoking and encouraging members to make a quit attempt
- **Provider Outreach:** Provider newsletter articles on smoking cessation treatment, smoking cessation benefits available and the proper billing codes to use when submitting claims, plan's program to assist pregnant patients with a quit attempt, and current performance results; Mailing

on proper coding of tobacco cessation interventions and encouraging assistance in addressing the need to quit for their patients; pocket sized plastic laminated card with billing codes also provided; Second Hand Smoke Fact Sheet distributed by Provider Relations to pediatricians to have available to parents that smoke; Easy reference guide for Provider Relations to present to providers/clinics of smoking cessation materials available for use at their clinics

- *Process enhancements:* Initiated a Smoking Cessation Registry; quarterly Smoking Cessation Registry survey mailing developed and implemented which also asks if the member would like to be referred to the Wisconsin Tobacco Quit Line for counseling; Initiated the Wisconsin Tobacco Quit Line's Fax To Quit program in collaboration with the Center for Tobacco Research and Intervention (CTRI); collaboratively worked with behavioral health subcontractor to add proper billing codes for smoking cessation intervention to their Website; Added reimbursable codes 99406 and 99407 to the MHS-WI claims system.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project. In states with successful tobacco prevention and control programs, each dollar invested saves more than \$3.60 in tobacco-caused healthcare costs.

Process efficiencies. Added codes 99406 and 99407 to our claims system as being reimbursable improved the efficiency of measuring the outcomes and for office staff who are submitting claims for services provided. Working collaboratively with the CTRI and initiation of the Wisconsin Tobacco Quit Line's "Fax To Quit" program gave members another simple avenue for information and assistance.

Improvement to member health status. The smoking cessation rates for MHS Family BadgerCare Plus increased significantly. For CY2008, the rate was 40%, a statistically significant 5 percentage point increase from baseline CY2007 ($p < 0.0001$). The smoking cessation rate for CY2009 was approximately 47%, a statistically significant 7 percentage point increase compared to CY2008 ($p < 0.0001$), and approaching the current goal of 50%.

BEHAVIORAL HEALTH

Project 17: An intervention to improve psychotropic polypharmacy by reducing the rate of psychotropic drug prescribing among foster care children

Description

Centene's Texas affiliate, Superior HealthPlan, undertook provider-targeted interventions in 2007 to improve provider compliance with guidelines for psychotropic pharmacy use among children in foster care. This initiative was co-led by the Texas Department of Family and Protective Services Medical Director and Superior's Vice President of Medical Affairs. The guidelines were developed by a consensus panel of mental health and pharmacy consultants.

Issue identification. Data released by the State of Texas demonstrated that children in the foster care program were being overprescribed psychotropic medications. In 2005 the Texas Department of Health Services released a practice parameter regarding psychotropic medication use in foster care.

Root causes. Superior identified two major barriers to provider compliance with the parameters for psychotropic pharmacy use. Children enrolled in the foster care program had unstable living arrangements and were likely to receive care from various providers over time who were often not aware of previous prescriptions the child received from other providers. Secondly, these children have a high prevalence of severe behavioral health conditions requiring complex medication regimens.

What changed: Interventions included:

- *Process Enhancements:* Implementing the Health Passport, a patient-centered, internet-based, electronic health record system, including diagnoses, current medications, and visit data, accessible to multiple providers treating a member; Implementing the Psychotropic Medication

Utilization Review (PMUR) Program to review pharmacy data and providing consultation to behavioral or physical health prescribers for complex medication management for behavioral health conditions

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The Health Passport improved the ability of providers (and guardians and state case workers) to access complete, coordinated health records.

Improvement to member health status. This project significantly impacted psychotropic drug usage in the foster care population. Since implementing the PMUR process in Texas we have seen dramatic decreases in polypharmacy due to physician awareness of and improved compliance with quality and clinical practice guidelines. There was a 28.98% decrease in class polypharmacy and a 36.01% decrease in overall polypharmacy (5 or more psychotropic medications) for foster children between FY2007 and FY2010.

Project 18: An intervention - Caring Voices Phones- to increase the coordination of medical and behavioral healthcare and thereby reduce utilization of services for members with no telephone

Description

Buckeye instituted the Caring Voices Program in 2009 to provide members without reliable access to a telephone a means to contact their primary care practitioner, behavioral health practitioner, care manager and community support system. The Caring Voices cell phones were preprogrammed with the telephone numbers of the providers mentioned above. The cell phones can make unlimited outbound calls to the preprogrammed numbers and receive unlimited inbound calls. When the member no longer needs the Caring Voices Program, the member's care manager will arrange to collect the Caring Voices phone.

Issue identification. Continuity and coordination of care between medical and behavioral health is an important aspect of care requiring focused and proactive assessment. A patient with a medical or surgical condition may have a behavioral health complication or co-morbidity. Likewise, a patient with a behavioral health disorder may have a medical co-morbidity with medical implications. The delivery system may not have within its structure a mechanism to ensure the seamless transfer of information between medical and behavioral care. This lack of structure is commonly found in the industry today; members can experience lack of continuity in behavioral and medical care provided.

Root causes. Some Medicaid members have unreliable access to telephones that makes it very difficult for providers, Case Managers, and Social Workers to ensure that appropriate care is coordinated, provided and received.

What changed.

- **Process Enhancements:** During the first half of 2009, Cenpatico identified and provided 269 Caring Voices cell phones to Buckeye behavioral health dual diagnosis members who had a history of forgetting appointments or who were noncompliant and just do not show up for appointments.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project. The cost savings of this program were realized from both the decline in admissions and the decrease in the average length of stay for members who were admitted.

Process efficiencies. By providing high-risk members a cell phone with unlimited access to plan staff and their providers, the program increased the efficiency of plan staff and providers who were attempting to contact the member to ensure appropriate follow up appointments are kept and that members were educated on the importance of medication adherence. It also improved the ability and timeliness of member calls for information or advice.

Improvement to member health status. Utilization analysis of the 269 members in the Caring Voices program for the period from January 1, 2009 until September 9, 2009 showed a dramatic decline in utilization of services after receiving the Caring Voices phone. Comparing the inpatient utilization for the 180 days before and after receiving a cell phone, the number of inpatient psychiatric admissions decreased from 118 to 15, and the number of inpatient medical admissions decreased from 195 to 86. The average length of stay (LOS) for an inpatient medical admission decreased from 4.57 days to 3.74 days. There were insufficient LOS data to evaluate the difference in average LOS in inpatient psychiatric facilities.

Project 19: An intervention to increase the rates of anti-depressant medication management among members 18 years and older diagnosed with a new episode of major depression.

Description

Buckeye undertook several provider and member targeted interventions in 2007 to improve anti-depressant medication management among members 18 years of age and older who were diagnosed with a new episode of major depression, treated with antidepressant medication, and who remained on an antidepressant medication treatment. Remeasurement was in 2008.

Issue identification. Among Buckeye's TANF and ABD population, the baseline rate in CY2007 for the antidepressant medication Effective Acute Phase Treatment was 42.5%, below the national Medicaid NCQA 50th percentile of 44.7%. The baseline rate among the same population in the same time period for Effective Continuation Phase Treatment was 23.19%, also below the national Medicaid NCQA 50th percentile of 28.5%.

Root causes. The barriers that Buckeye members with mental health diagnoses have in obtaining care were 1) members with a dual diagnosis not adherent with their psychiatric medications, and therefore unable to manage other co-morbidities; 2) some members were homeless and focused more on the whereabouts of their next meal or next lodging place; 3) members forgot to take maintenance medications and or to get refills; 4) members used the emergency room and urgent care since they did not have an established PCP; 5) members resisted disease management outreach; 6) members feared the side effects of the medications; 7) members may have had a language or cultural barrier; and 8) member demographic information may have been incorrect on the state file. Provider barriers were 1) practitioners may not have been familiar with Cenpatico's Depression Practice Guidelines; and 2) physicians may not have referred the member to the appropriate specialist to manage depression.

What changed. Interventions included:

- **Member Outreach:** Pharmacy began providing to QI a weekly listing of members who receive a new prescription for an anti-depressant medication. This listing of members is sent to Televox who made phone calls to members to remind them of the need to return to the prescribing physician for follow up; Member newsletter article presented a Living Well topic, *Get Help for Depression*; created an informative on hold message for the Member Services call center
- **Provider Outreach:** Provider newsletter articles on the capabilities of Buckeye's Integrated Case Management Team, perinatal depression and the Start Smart Program screening tool, recognizing and treating depression is critical to addressing other chronic illnesses, discussing medical treatments with a severely mentally ill patient, approved Clinical Practice Guidelines, and Buckeye's HEDIS performance including Antidepressant Medication Management..
- **Process enhancements:** the QI committee approved the Guidelines for the Treatment of Depression; Cenpatico Behavioral Healthcare completed medical record abstracting for members treated for depression and letters were sent to behavioral health providers with feedback by the Medical Director for Cenpatico; Developed new Preferred Drug List including more anti-depressant medication options and quality edits to promote the appropriate use of medications based on age and gender; addition of a mail order pharmacy option for maintenance medications

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project. An estimated 16% of the costs of anti-depressant treatment were found to be associated with patients who were never adequately treated.

Process efficiencies. The weekly pharmacy lists of members who were newly identified as filling anti-depressant medication improved the efficiency and timeliness of member identification for outreach calls. Waiting for claims submission from the diagnosing provider caused delays in outreach to educating the member on appropriate follow-up care and medication management.

Improvement to member health status. Among the TANF and ABD populations, the rate for the Effective Acute Phase Treatment increased by approximately 8 percentage points from 42.50% in CY2007 to 50.26% in CY2008. The new rate was above the national Medicaid NCQA 50th percentile of 44.7% but below the 70% goal.

Among the same population, the rate for Effective Continuation Phase Treatment increased by approximately 9 percentage points, from 23.19.50% in CY 2007 to 32.86 % in CY2008. The new rate was above the national Medicaid NCQA 50th percentile of 28.5% but below the 60% goal.

While Buckeye was not able to reach the goal for both measures in the initial year of the program, there was noticeable improvement in the rates of each measure. For the effective acute phase there was an 18.4% increase in the rate and for effective continuation phase there was a 41.8% increase from 2007 to 2008.

Project 20: An intervention to increase the rate of outpatient follow-up after hospitalization for mental illness

Description. Centene's Texas affiliate, Superior HealthPlan, undertook a project to increase the rate of 7-day follow-up after hospitalization for mental illness utilizing several specific interventions.

Issue identification. The Plan considered this HEDIS measure to be a key quality indicator. The risk of readmission is increased when there is not timely outpatient follow-up following hospital discharge for a mental illness. The baseline rate (CY2006) of follow-up after hospitalization for mental illness (7 day) was 28.32%, below the national Medicaid NCQA 50th percentile.

Root causes. Root cause analysis found that barriers to follow-up were: 1) some inpatient facilities may not be routinely setting up outpatient follow-up visits for within 7 days of member's imminent discharge; 2) some members may not remember to keep the appointment, or didn't understand discharge instructions to make the appointment; 3) some practitioners may not be familiar with the measure and goal.

What changed. Interventions included:

- Discharge assessments by behavioral health Care Managers for inpatient facilities, and documentation if timely follow-up appointments are being made for the member. Continue to instruct appropriate inpatient facility personnel on the standard.
- Initiation of calls by behavioral health Care Managers 1 to 2 days post discharge from an inpatient facility. The call a) asks if the member has an appointment with a mental health practitioner within 7 days of his or her discharge, and b) assists with appointment and/or transportation arrangements. The Care Manager will call after the scheduled appointment to assure that the appointment was kept.
- Share HEDIS scores with providers in the Provider Newsletter
- Meet with Corporate QI and behavioral health to explore other root causes and interventions.

Outcomes

Cost savings realized. Superior's cost savings was estimated to have been \$104,972, based on 30 avoided admissions.

Process efficiencies. None noted

Improvement to member health status. The 7-day follow up rate increased from 28.32% at baseline (CY2006) to 40.56% in CY 2007. This increase was statistically significant (p=0.0012) and exceeds the goal of 35.83%.

Project 21: An intervention to increase compliance with antidepressant medication management

Description

Centene's Indiana affiliate, MHS-IN, undertook a project in 2007 to increase compliance with antidepressant medication management, targeted at both the provider and member. Remeasurement was in 2008.

Root causes. Barriers to compliance were: 1) lack of member and provider knowledge; 2) inadequate member transportation to follow-up appointments; and 3) member lack of understanding regarding the importance of follow up appointments while taking medication for the treatment of depression.

What changed. Interventions included:

- **Provider Education:** MHS-IN initiated a new depression management education program that incorporated targeted outreach to the top 40 prescribers of antidepressant medication, including personal calls to the top 20 prescribers and presentations to local FQHCs and CMHCs by the MHS-IN Medical Director and Cenpatico Vice Presidents Medical Affairs.
- **Phone Calls to Members:** Reminder calls to members with new prescriptions for antidepressants

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies None noted.

Improvement to member health status. Compliance with antidepressant medication management increased from 43.5% in CY2007 to 47.7% in CY2008, surpassing the national Medicaid NCQA 50th percentile.

Project 22: An intervention to increase the length of time members with schizophrenia remain in the community

Description

Superior HealthPlan sought to improve the length of time enrollees with schizophrenia remain in the community.

Issue identification. Members with schizophrenia have a high rate of readmissions, medication compliance issues, and lack of trusting relationships with providers, requiring additional support systems to ensure they are receiving the appropriate care and services.

In 2007, Superior found that readmissions for schizophrenia accounted for more than 50% of all SSI/ABD behavioral health admissions and readmissions. This high rate for readmissions negatively impacts the member's ability to maintain community integration and further contributes to their dependence on higher levels of care for support.

Root causes. By the nature of their disease state, members with schizophrenia have a difficult time establishing trusting relationships and complying with recommended treatment.

What changed. Interventions included:

- **Member intervention:** Superior automatically enrolled these members into their Intensive behavioral health Case Management Program which includes regular follow-up by a licensed clinical social worker, as well as prompt post discharge assessments of medication compliance and satisfaction with outpatient Providers. The behavioral health Case Managers were able to proactively address any issues identified during their contact with the member.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. None noted.

Improvement to member health status. Community tenure (Proportion of days of enrollment not spent in a facility) increased by 1% from the end of 2008 through the first six months of 2009.

Project 23. An intervention to increase adherence to long-term medication, decrease emergency department utilization and increase self-reported improvements in quality of life among persons with serious and persistent mental illness who were prescribed psychotropic medications.

Description

Nurse Response™, a subsidiary of NurseWise® and Centene™, provides quality telehealth services to Centene plans as well as other plans, provider groups, and employers. Nurse Response developed a pilot outbound call program that targeted persons with serious and persistent mental illness (SPMI) who were prescribed psychotropic medications. This program was designed to assist participants in self-managing their acute and chronic symptoms in an effort to increase adherence to their medications.

Issue identification. Members on anti-psychotic medications are at high risk for medication non-adherence.

Root causes. Barriers to medication adherence among the SPMI population were identified as: 1) member lack of knowledge of the benefit of the medication; 2) member doesn't want to take the medication because of the stigma; 3) member doesn't like the side effects of the medication; 4) member lack of support system for diagnosis and need for treatment; and 5) provider lack of knowledge of members' non-adherence.

What changed. The six month pilot program incorporated case management, disease management and motivation enhancement principles. Several techniques were used to modify behavior, including motivational interviewing, assertiveness training, cognitive restructuring, self-monitoring, problem solving, and other behavioral interventions. Interventions included:

- A welcome/screening call and multiple subsequent follow-up calls from a nurse over a six-month period.
- Follow-up mailings were made to emphasize themes of the calls.
- Educational materials consisted of coaching leaflets on communicating with physicians, stress management and drug-specific materials.
- Written communication to the attending physician and case manager about the nature of each call, adherence status, techniques used and materials sent.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. None noted.

Improvement to member health status. The medication adherence rate for program participants was more consistent, ranging from 55% to approximately 50%. This contrasts favorably with the non-participant pharmacy rate which began at almost 70% in month one and decreased to almost 30% by month six. In addition, participating members averaged 1.1 visits to the emergency department, compared to 5.03 visits for those not enrolled in the program. The self-report quality of life score improved from initial intervention to conclusion.

Project 24: Improving Follow-Up after Behavioral Health Hospitalization (CHIP)

Description

In 2009, Superior instituted enhanced care coordination and discharge planning to improve follow up for CHIP members after mental health hospitalization. Baseline assessment was in 2008. Remeasurement was in 2010.

Issue Identification. Timely follow-up after a behavioral health hospitalization reduces the likelihood of readmission. In CY 2008 (baseline), the 7-day follow-up rate for Superior CHIP members was only 22.8%.

Root causes. Root cause analysis indicated that both members and providers lacked complete understanding of the importance of timely follow up, and that poor communication at hospital discharge contributed to lack of follow up.

What changed. Interventions included:

- Calls reminding members of appointments and helping members to address barriers to keeping appointments, such as transportation
- Faxing the discharge summary to the PCP and behavioral health provider;
- Post-visit confirmation calls to follow-up with behavioral health Providers
- Adjustments to the times of our post-discharge and post-visit calls to facilitate timely follow-up care
- Behavioral health case management staff assisted hospital discharge planners and members with scheduling follow-up visits, and linking members to their previous outpatient behavioral health providers.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Behavioral health case management staff assistance for hospital staff improved the efficiency and reliability of visit scheduling.

Improvement to member health status. The 7-day follow-up rate after behavioral health discharge increased 78.9% from CY2008 to CY2010.

PHARMACY

Project 25: An intervention to increase the rate of generic drug fills.

Description

Centene health plans either offer a drug benefit or cooperate with state pharmacy benefit contractors. In either case, the objective is to provide appropriate and high-quality drug therapy to members, which also promotes adherence and improved medication outcomes while achieving lowest net drug costs. The goal of this particular project was to improve generic fill rates.

Issue identification. In 2006, Centene identified a need to improve the generic fill rate of 72.3% to help decrease the rising cost of pharmacy utilization.

Root causes. The barriers to generic drug fills were 1) the Preferred Drug List (PDL) benefit was not maximizing market place generic drug offerings; and 2) providers were not aware of less costly but equally effective PDL therapeutic alternatives.

What changed. Interventions included:

- Mandatory generic benefit set-up at the Pharmacy Benefit Manager
- Step Therapy and Prior Authorization Edits requiring trial and failure of a generic therapeutic equivalent PDL product prior to use of a brand-name product
- Point of Sale Messaging that advised the pharmacist of generic therapeutic equivalent PDL products
- PDL Quick Reference Guides were posted on plan websites and distributed to provider offices
- Brand/generic overrides required submission of an FDA MedWatch adverse reaction reporting form
- Selective use of co-pays when allowed by State contracts
- Over-the-counter medication benefits

- Timely communication of PDL changes to providers and members
- Web posting of PDL.

Outcomes

Cost savings realized. Three Centene plans experienced a negative year over year trend line for the average cost per prescription during Q1 2010.

Process efficiencies. Distribution of a PDL Quick Reference Guide made it easier for providers to obtain information on available generic alternatives.

Improvement to member health status. Generic Fill Rates have steadily increased from 72.3% in 2006 to 84.2% in 2010, resulting in better adherence to medications as well as lower costs.

Project 26: An intervention to decrease the inappropriate use of antibiotics among children and pregnant women (TANF and CHIP)

Description

This was an education program by Superior targeted at providers with high prescribing rates of antibiotics. It was designed to increase provider knowledge of antibiotics and alternatives and thus decrease the inappropriate use of antibiotics.

Issue Identification. In 2007, Superior analyzed utilization data from November 2006 through April 2007 that indicated antibiotics were prescribed for 31% of typically viral respiratory infection episodes. Reflecting the Centers for Disease Control and Prevention campaign against overuse of antibiotics, they developed an initiative to reduce inappropriate use of antibiotics, with the measurable goal of reducing antibiotic use for these conditions to 25%.

Root causes. The primary barrier to decreasing inappropriate antibiotic use was the lack of sufficient information for the provider.

What changed. Interventions included:

- **Provider Support:** The plan identified providers with high prescribing rates and distributed Cold Kits that contained bilingual patient educational materials and samples of non-prescription medication they could give to their patients; and bilingual CDC brochures, posters and prescription pads recommending non-prescription treatments.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The Cold Kits enabled providers to more efficiently educate members on the appropriate use of antibiotics.

Improvement to member health status. The rate of antibiotic use for presumed viral respiratory infections for Superior members improved to 19% for November 2007 through April 2008 from the baseline 31% for November 2006 through April 2007.

CARE MANAGEMENT

Project 27: An intervention to increase the percentage of SSI/ABD members completing advanced directives.

Description

Centene's Arizona affiliate, Bridgeway Health Solutions (Bridgeway), undertook a project to increase the percentage of SSI/ABD members who have any form of advance directives documented in one or more medical records maintained by network providers. Baseline assessment was in 2007. Remeasurement was in 2009.

Issue identification. Mandated by the state Medicaid agency in 2007, this study's baseline data indicated that only 50.6% of Bridgeway SSI/ABD members had any documented advanced directive. However, all of the nursing facility residents in the sample had completed advanced directives.

Root causes. Key barriers to the use of advanced directives were 1) incomplete knowledge about advanced directives by Case Managers; 2) lack of member knowledge; 3) cultural beliefs about illness and death; and 4) difficult-to-understand advanced directive forms.

What changed. Interventions included:

- **Member Education:** Case Managers educated each new member about advanced directives during the initial assessment and reviewed them at every subsequent reassessment. The Case Manager requested copies of completed advance directives, which when received were scanned into Bridgeway's clinical management system.
- **Process enhancements:** the method used by the Case Managers to document their activity was changed to facilitate data collection. In January 2009, after an interim evaluation of the initiative, Bridgeway initiated training with the Case Management staff by an attorney from an outside agency. The easier-to-understand Five Wishes® advanced directives form was adopted and Case Managers provided copies to members and encouraged its use. QM staff began reporting the study measure quarterly, and Case Management Supervisors began reviewing member files for documentation and copies of advanced directives in order to provide more timely feedback to staff.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The adoption of the easier-to-understand Five Wishes® advanced directives form simplified the process of member education and member compliance.

Improvement to member health status. The proportion of members with completed advance directives increased 32% (16 percentage points) from the 2007 baseline of 50.6% to 66.7% in 2009, a statistically significant improvement ($p = 0.02$).

Project 28: An intervention to reduce the rate of hospital readmissions through the development of a discharge transition tool

Description

This 2008 project by Bridgeway developed protocols aimed at reducing the 30-day medical inpatient readmission rate.

Issue identification. Readmissions are costly, potentially harmful, and often preventable. Experts estimate that as many as 20% of hospitalizations are readmissions within 30 days of discharge. According to data from the Agency for Healthcare Research and Quality's (AHRQ) Healthcare Cost and Utilization Project (HCUP), in 2006 nearly 4.4 million hospital admissions, costing nearly \$30.8 billion, could have been potentially preventable with timely and effective ambulatory care or adequate patient self-management of the condition. Bridgeway's 30-day readmission rate at baseline (CY 2007) for SSI/ABD members was 26.6%.

Root causes. Barriers to reducing hospital readmissions were 1) many members were not following up with their primary physicians following discharge; 2) discharge medications, durable medical equipment, medical supplies, and appropriate levels of home or community-based critical services were not consistently being ordered, obtained and utilized; 3) members' assigned Case Managers were not being notified of pending discharges and therefore were not able to initiate proper follow-up; and 4) lack of transportation or caregiver accompaniment for clinical follow-up appointments.

What changed. Interventions included:

- Concurrent review nurses (CRNs) began notifying the Case Manager of the discharge date via their medical management system to assist Case Managers in identifying members for post-discharge calls
- A discharge transition tool was implemented to structure communication between CRNs and hospital discharge/social work staff regarding discharge education for members, including providing members with Case Manager contact information so they know how to quickly access assistance post-discharge.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. Improved communications between CRNs and Case Managers facilitated Case Managers' follow up calls. The discharge transition tool improved the transmittal of key contact information to members.

Improvement to member health status. This coordinated initiative reduced their 30-day readmission rate by 8 percentage points, from 26.6% in CY 2007 to 18% in CY 2009.

Project 29: An intervention to reduce inpatient readmissions through implementation of a telemonitoring program among members with diabetes, hypertension, heart failure and COPD

Description

Bridgeway implemented a pilot telemonitoring program in 2009 in an attempt to reduce inpatient admissions and readmissions in SSI/ABD members with diabetes, hypertension, heart failure, and COPD who were high risk due to multiple comorbidities and complex treatment plans and who had frequent ED and inpatient admissions and readmissions.

Issue identification. High-risk patients with frequent ED visits and multiple inpatient admissions and readmissions for the same chronic condition have a disproportionate financial impact on a health care system. In May 2009, a review of a series of inpatient admission, readmission and ED utilization reports identified a subset of SSI/ABD members who had frequent ED visits and multiple inpatient admissions and readmissions for the same chronic condition. Case Managers had identified many of these members individually in the past and provided assistance, which was frequently focused on home-based services. These high-risk members often had multiple comorbidities and a complex treatment plan. Follow-up indicated that many of them continued their high utilization of acute care services and were often moved from their natural setting to assisted living or skilled nursing facilities to attempt more consistent monitoring of their chronic conditions.

Root causes. Analysis indicated that root causes for eligible members' risk for readmission were 1) limited member mobility; 2) transportation barriers; 3) an insufficient natural support system; and 4) limited health literacy.

What changed. The pilot program included:

- In-home telemonitoring devices such as glucometers, pulse oximetry, blood pressure monitors, and weight scales
- Biometric values were transmitted electronically to Bridgeway's monitoring office and evaluated against patient-specific or national guidelines and analyzed for favorable or unfavorable trends. If the value was outside physician-defined parameters, the monitoring nurse immediately informed the member or caregiver, physician and Case Manager as appropriate.
- Nurse Case Managers and the monitoring nurses held bi-weekly case conferences to discuss any member-specific issues, as well as updates on each member's compliance with transmissions and the results. The Nurse Case Manager updated the member's Social Work Case Managers and assisted with any recommendations.

- The monitoring nurse sent a report to the primary physician at least monthly, or more often if requested, with a summary of the member's data.
- The Bridgeway Case Manager and monitoring nurse coordinated any interventions or change in monitoring as prescribed by the physician, including assistance with scheduling appointments and arranging transportation, if necessary.

Outcomes

Cost savings realized. For the 25 members enrolled in the program as of February 1, 2011, with an average participation period of 10.4 months, the cost savings from avoided readmissions was estimated at \$839,000 (66 stays were only Medicaid and 15 were both Medicaid and Medicare),

Process efficiencies. The telemonitoring program provided real-time biometric information, bypassing the mobility, transportation and other barriers to office or laboratory visits. It also permitted immediate intervention for unsafe test results.

Improvement to member health status. Since 2009 these 25 members had a total of 98 inpatient admissions during the 12-month period prior to participation (3.92 admissions per member) and only 17 inpatient admissions while enrolled (0.68 admissions per member), yielding an annualized 80.1% reduction in inpatient admissions per year for participating members. The average rate of compliance with recommended self-monitoring (blood sugar, blood pressure, weight, blood oxygen saturation) increased from 27% to 63%.

Project 30: A comparative assessment of two Case Management Decision Support Tools- Predictive Risk Report and Health Risk Assessment - to ascertain their respective contribution to case management support for Medicaid adults with disabilities.

Description

This was a study led by MHS-WI to assess the comparative value of the Health Risk Assessment (HRA) and claims-based Predictive Risk Report (PRR) in improving outcomes for Medicaid adults with Disabilities. It was done in collaboration with the Wisconsin Department of Health and Family Services (DHFS) and APS Healthcare (the DHFS enrollment broker), and supported through a grant received from the Center for Health Care Strategies as part of their 17-month Medicaid Value Program: Health Supports for Consumers with Chronic Conditions.

Issue Identification. Critical to the success of MHS's SSI Program is its care delivery model, which ensures that enrollees are screened as expeditiously as possible upon enrollment and then triaged to the appropriate level of intervention. This screening is accomplished through completion of the HRA. The HRA is an assessment completed upon enrollment through an interview of the new member by MHS staff that consists of a functional review, service review, and dependency review of the enrollee's health status. Completion of a HRA is attempted on all newly enrolled MHS SSI enrollees and is currently mandated by the Medicaid managed care waiver to be conducted by a qualified professional in compliance with 42 CFR Sec. 438.208 (c). The PRR was a one-page Medicaid claim history report generated by DHFS for each new enrollee. This report highlights the consumer's health condition relative to other Wisconsin Medicaid adults with disability, and features predictive modeling for future health-care resource consumption.

The amount of intervention required by a particular enrollee is influenced by the type(s) of conditions the enrollee has (physical, chronic medical, and/or mental illness/behavioral conditions) and the types of needs the enrollee has (functional, service, and/or dependency). The objective of the study was to determine if a high risk score on the PRR or the HRA was an indicator of the need for integrated case management interventions and to determine if case management interventions improved outcomes for Medicaid adults with disabilities.

Root causes. Root cause analysis was not part of this study.

What changed. In April 2005, DHFS began enrolling SSI recipients in Milwaukee County in participating health plans. To ease the transition for both consumers and providers, the Medicaid Program shared the PRR with insurers to assist in prompt completion of assessment interviews for new enrollees. For the study, standardized regression equations were used to construct path analysis diagrams for the effects of risk scores on case management and outcomes. Factor analysis and correlation were used to examine the relationships between individual items on the risk measurement instruments that comprise the over-all risk scores.

Outcomes

The results showed that the PRR was a reliable source of information about a new enrollee's health status and need for medical care. The predictive modeling information did increase the likelihood of case management placement, over and above the influence of a HRA. This suggested that in the absence of HRA information CM placement decisions could be made just as well based on PRR information alone. The use of the PRR to make rapid case management decisions would overcome several barriers of the HRA: more people had a PRR (89%), which was readily available at the time of enrollment at no cost, whereas the HRA was expensive and was not available until the enrollee could be contacted and the HRA completed.

Although correlations indicated strong overlap between the PRR and HRA instruments in a number of important areas, there were some items on the HRA that had no corresponding counterpart on the PRR. Most notable in this regard were the questions about social supports and living situation. It is possible to elicit in an interview more personal information that is not available in a claim history such as the PRR. Therefore, it would be wise to maintain the health interview function, but to do so efficiently, without dwelling on information that is readily available from claim history. Thus, the best use of the PRR may not be as a replacement of the HRA, but as a pre-screening tool. PRR data can be used to very quickly determine which new enrollees require intensive medical care and which do not. After making that initial sort, personal health interviews could be conducted, either as a case-management intake interview for the high-risk cases or as a face-to-face/telephonic administered HRA for individuals with a lower risk profile on their PRR (and individuals without a PRR).

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. As a result of this study, MHS revised the HRA questionnaire by eliminating almost half of the items on it, while retaining core items that addressed each of the ten major issues represented by the original items. Guided by the analysis, MHS was able to eliminate redundant items without sacrificing the key information that feeds into our enrollees' health status scores. The HRA process efficiency was increased by decreasing the number of questions required to answer on each member assessment, as well as using the PRR scores to sort members into high and low risk pools and assign the appropriate level staff member to conduct the initial HRA.

Improvement to member health status. More timely assessments by Case Managers can lead to more timely referrals to needed services that can improve the members' health status. The study indicated that the PRR predictive modeling information reduced the risk of negative healthcare outcomes, indirectly through incorporation by case management, and case management reduced negative outcomes regardless of initial differences in risk.

SATISFACTION

Project 31: An intervention to increase the rate of member satisfaction

Description

Peach State developing interventions in 2009 to increase the satisfaction of its members based on Consumer Assessment of HealthCare Providers and Systems (CAHPS) 4.0H Medicaid Adult and Child Member Surveys. Remeasurement was in 2010.

Issue identification. In order to formulate effective action plans and improve performance, based on the results received from the CAHPS, plans need to understand the problems their members report and determine how these problems relate to processes the health plan can affect. Improving Member Satisfaction addresses a broad spectrum of care and services.

Member satisfaction, as measured by responses to CAHPS Question 32 – *Getting information/help from customer service* – was 68.5% in the 2009 Survey. Member satisfaction, as measured by responses to Question 33 - *Treated with courtesy and respect by customer service* – was 86.4% in 2009.

Root causes. Based on an analysis of survey results, Peach State focused on the following barriers member satisfaction: 1) the need to further improve members’ ability to get needed care; 2) the need to further enhance the assistance members receive from Member Service Representatives (MSR’s); 3) the need to revise monitoring of MSRs to ensure members are treated with courtesy and respect; and 4) the need to receive feedback from members in order to respond to discrepancies in a timely manner.

What changed. Interventions included:

- **Member Feedback:** Establish a telephonic satisfaction survey where callers are directed to an internal Customer Care call queue to complete a survey; Develop rewards program to recognize staff for encouraging members to complete the survey (the MSR with the most referrals win a prize); Enhance process to track all incoming member concerns. Utilize Appeals & Grievance database to capture all member grievances; Develop process to follow up with members with complaints relative to ease of getting needed care;
- **Member Call Center:** Redesign call center call flows to promote use of IVR and web; Incorporate changes into call flows to direct callers to the appropriate source for ‘once and done’ assistance (member service representative trained to answer all questions; transfers not needed)
- **MSR Training and Performance:** Align staff to call queues to accommodate new structure for calls (English vs Spanish) and removal of specialization; Create new slogan with emphasis on quality: “Minor details make the ‘Difference’ ”; Conduct quarterly customer service refresher training for 100% of MSRs to improve and enhance services to our members; Update goals for staff to measure performance monthly; Make modifications to the MSR Quality Monitoring Form; metrics to be aligned to global standards for achieving extraordinary service; Increase quality performance standard from 95% to 97% for MSRs; Team Leads to complete biweekly side by side reviews with MSR staff with written feedback given within 24 hours of review; To partner with Contracting to bring more providers into the network, new provider updates and recruiting strategies will be requested and shared with the department
- **Employee Recognition:** Implement monthly incentive program for employees who provide Quality results i.e. “Caught in the Act” conducted monthly; “I See You” announced quarterly; “Spot Light Award” announced quarterly
- **Mailings to Members:** Provide supplemental directory to members each quarter
- **Member Education:** Reinforce member education on resources found on the Peach State web site via call scripts. Educate members on web quick reference guide features to quickly access information about prior authorization requirements for specialty services and specialty care.
- **Provider Outreach:** Implement process to outreach to providers to ensure availability prior to providing listing to members; Enhance questions for outreach calls to providers to inquire about wait times during visits, and share information with members in quarterly newsletter, web and/or on hold messages.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process Efficiencies. Member call center enhancements improved efficiency for members seeking advice. **MMMImprovement to member health status.** Member satisfaction, as measured by responses to Question 32 – *Getting information/help from customer service* – increased approximately 12 percentage

points, from 68.5% in the 2009 Survey to 80.8% in the 2010 survey. This improvement was statistically significant (p=0.0388). 2010 survey results fell approximately 8 percentage points below the industry benchmark of 88.3%. Member satisfaction, as measured by responses to Question 33 - *Treated with courtesy and respect by customer service* – increased 16 percentage points, from 86.4% in the 2009 Survey to 90.4% in the 2010 survey. This difference was not statistically significant (p=0.3600). 2010 survey results fell approximately 6 percentage points below the industry benchmark of 96.3%.

Project 32: An intervention to increase the rate of provider satisfaction

Description

Peach State developed interventions to increase the level of provider satisfaction after assessing provider satisfaction in 2007 and then reassessing in 2008 and 2009.

Issue identification. Managed Care organizations conduct Physician Satisfaction Surveys to assess satisfaction with claims processes, utilization management programs, quality management programs and general satisfaction with the health plan. Studies indicate that greater physician satisfaction is associated with more appropriate prescribing practices and patient adherence, fewer outpatient procedures and referrals, and improved quality of care. Physician satisfaction also results in lower turnover, which contributes to members' continuity of care, member satisfaction and retention and lower administrative costs of recruiting and replacing physicians. In 2007, a Provider Satisfaction survey was fielded to all PCP's by The Meyers Group (TMG).

Provider satisfaction summary scores at baseline (2007) were 15.8% with respect to *Timeliness to answer questions and/or resolve problems*, 14.2% with respect to *Quality of provider orientation process*, 10.7% with respect to *Health Plan taking physician input and recommendations seriously*, and 12.1% with respect to *Accuracy of Claims Processing*.

Root causes. The barriers identified to increasing provider satisfaction were 1) the need to build collaborative relationships and further enhance communication between PSHP and provider groups; 2) the need for improved reporting analysis and follow through of service metrics; and 3) the need for updating provider orientation materials periodically.

What changed. Interventions included:

- **Provider Communication:** The key provider groups (500+ members) were identified across all regions and invited to attend regular Practice Manager Advisory Group meetings to share information and identify plan opportunities for improvement. To date, nine meetings were held across the state in 2008 and three in 2009; Updated the Provider Manual periodically with changes in processes, policies & procedures, and new state contract requirements; Implemented the new Provider Portal with enhanced capabilities: member rosters online, auth requests, claim processing and claim adjustment features, provider communication capabilities, a self-directed registration process and enhanced layout (new look and feel). Enhancement to the *Contact Us* section of the provider secure web site to allow for feedback from providers and to let them know that the plan is "listening to them." Include articles in the provider report detailing provider input that is being implemented at the plan.
- **Process Enhancements:** Joint Operating Committees (with large contracted entities) were developed for all hospital systems, IPA's, PHO's and key direct contacts covering about 80% of the network - a direct opportunity to address key provider issues and develop collaborative action items; Developed and implemented a process for a New Issues Grid. The Grid provides tracking of issues through an internal workflow and utilizes an interdisciplinary mgmt team in Peach State to resolve; continue new issues grids updates and review monthly in regional Joint Operations Meetings; All H denials and therapy A1 denials (related to authorizations) are reviewed prior to check run to ensure processing accuracy.
- **Provider Support:** Distributed newly developed Provider Tool Kit across the network. Initially created in hardcopy form, and then electronic version of toolkit to enhance capabilities and ease

access to forms and requirements including key contacts, pharmacy processes, case management, claims, member information, NPI requirements and Quality goals. Ongoing distribution of the Tool Kit continues through monthly new provider orientations. Distributed to PCP's and to all newly contracted specialties; Provider Orientation presentations to be more regionally focused. To be implemented Q3 2010 with the new Regional Service Model

- *Provider Call Center*: Update provider call center policies, procedures and workflows to implement a turn-around-time metric of two business days for responses on all provider inquiries; Establish timeframes to respond to all providers inquires. Set expectations for responses during the call – response no later than 2 business days. Create internal and external customer service representative queues to route questions; Create call back Customer Service Forms (CSFs) in Macess Reporting software; Adjustment to call center script to improve satisfaction allows immediate response from caller on how satisfied they are with the service received real time; Complete Customer Service Staff – Service Training quarterly; Complete scorecard to identify provider billing errors; weekly discussion and intervention in order to decrease number of weekly errors; Top 10 claims denials posted to the web each quarter.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process Efficiencies: Distributing an electronic version of the Provider Toolkit improves provider office staff efficiency and satisfaction by providing electronic versions of forms that provider offices use frequently. Deployment of the web portal also improves office staff efficiency by providing needed data and resources on the web at all times. These two tools also free up PSHP Provider Relations staff to do more intense provider outreach and education. Creating scorecards weekly to identify provider billing errors allows provider offices to improve their billing processes to receive accurate reimbursement on the first claim submission. Educating providers on the top ten claims denials each quarter allows them to improve their processes to decrease the amount of denials they receive.

Improvement. Four attributes were evaluated in 2007, 2008 and 2009. All evidenced an increase in provider satisfaction over the three year period, from baseline in 2007 through 2009.

1. *Timeliness to answer questions and / or resolve problems (Q5):* The rate scores in 2007, 2008 and 2009 were 15.8%, 28.0% and 32.3%, respectively. The percentage change in rates between 2007 and 2009 was 104.4% and was statistically significant ($p < 0.0001$). The percentage change in rates between the 2008 and 2009 was 15.3% and was not statistically significant ($p = 0.2016$)
2. *Quality of provider orientation process (Q6):* The rate scores in 2007, 2008 and 2009 were 14.2%, 24.1% and 31.0%, respectively. The percentage changed in rates from 2007 to 2009 was 118.3% and was statistically significant ($p < 0.0001$). The percentage change between the 2008 and 2009 was 28.6% and was statistically significant ($p = 0.0453$)
3. *Health Plan takes physician input and recommendations seriously. (Q18):* The rate scores in 2007, 2008 and 2009 were 10.7%, 15.2% and 24.5%, respectively. The percentage changed in rates from 2007 to 2009 was 129.0% and was statistically significant ($p < 0.0001$). The percentage change between the 2008 and 2009 was 61.2% and was also statistically significant ($p = 0.0027$)
4. *Accuracy of Claims Processing (Q34):* The rate scores in 2007, 2008 and 2009 were 12.1%, 16.0% and 29.8%, respectively. The percentage changed in rates from 2007 to 2009 was 138.0% and was statistically significant ($p < 0.0001$). The percentage change between the 2008 and 2009 was 80.0% and was also statistically significant ($p < 0.0001$)

ACCESS

Project 33: An intervention to increase access to preventive/ambulatory health services among adult members

Description

Centene's Georgia affiliate, Peach State Health Plan, developed interventions to improve their members' access to preventive/ ambulatory health care and services. These interventions were targeted at providers and members age 20 through 44.

Issue identification. Access to health care services is the cornerstone of maintaining health, and the prevention, detection and treatment of illness and disease. As such, efforts to improve access to health care services are mandated by the states and the federal government. Peach State's performance on the HEDIS Adults' Access to Preventive /Ambulatory Health Services measure was 78.8% in CY2008, below the NCQA national benchmark goal of 87.8 % and the State goal of 88.9%.

Root causes. Analysis indicated that barriers to access were: 1) member lack of knowledge about Health Check Program and services; 2) provider lack of knowledge regarding revisions in the recommended preventive health schedule for services; 3) provider lack of understanding regarding HEDIS measure requirements; and 4) need for increased Plan/provider focus on HEDIS measures.

What changed. The following interventions were implemented between January 2007 and January 2010.

- **Member Education:** Distributed welcome packets to new members including a Member Handbook and educational brochures advising of the importance of preventive health care; a member newsletter article, *Peach State's Goals To Keep You Healthy*, encouraged preventive health screenings for adults; another member newsletter article, *Your Care At The Click Of the Mouse*, discussed preventive information members may review on the plan's website; annual mailing to current members of member materials such as the Member Handbook, Provider Directory and HEDIS information notice
- **Community Outreach:** Member Services/MemberConnections outreach teams participated in annual and regularly scheduled health fairs, back-to-school activities, and community events to provide awareness of and access to health care services. Peach State members were notified and invited to these events to receive free hearing, vision, and dental screening, and in some cases, immunization screenings.
- **Provider Education:** a provider newsletter article about the preventive health guidelines. These include the periodicity schedule for well child visits; Provider newsletter article, *It's Healthcare Effectiveness Data and Information Set (HEDIS) Review Time*; distribution of Provider Manual to all network practitioners.
- **Process enhancements:** Distributed medical record reminder stickers that contained key adult screenings, such as blood pressure checks, cholesterol, mammography
- **Provide Incentives:** Establish Provider Incentive Program based on HEDIS metrics. First groups to start program began on 1/1/2010.

Outcomes

Cost savings realized. Assessment of cost savings was not a focus of this project.

Process efficiencies. The Provider Incentive Program will improve data capture efficiency since the incentives are based on administrative data and providers must bill appropriately to receive their incentives.

Improvements to member health status. The HEDIS Adult Access to Preventive /Ambulatory Health Services rate increased by approximately 6 percentage points from CY2008 to 84.26% in CY2009. This was slightly below the revised state goal of 84.8 percent (FY 2010) and the NCQA Quality Compass 90th percentile rate of 88.27%. The improvement in rates was statistically significant (p=0.0001).

Question J.5
Performance Improvement Projects

J.5 Describe your proposed Quality Assessment and Performance Improvement (QAPI). Such description should address:

LHC's Quality Assessment and Performance Improvement (QAPI) Program will define and facilitate improvement in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management, achieving the highest level of success. LHC will use an integrated, data- and outcome-driven performance monitoring and improvement model to ensure effective, efficient delivery of quality care and service. We will develop our program in compliance with the current NCQA Standards and Guidelines for the Accreditation of Managed Care Organizations and use the QAPI Program as our guide to drive improvement in daily health plan operations. Our model will incorporate improvement strategies that include performance improvement projects (PIPs) as required by Section 14.3.8, and we will establish and implement ongoing PIPs that focus on clinical and non-clinical performance measures as specified in 42 CFR 438.240. We will use the Plan-Do-Study-Act model for improvement. For each PIP, we will:

- Develop one or more quantitative quality measures with specific goals.
 - Implement system interventions based on root cause analysis.
 - Measure and evaluate the effectiveness of the interventions.
 - Develop additional interventions to improve, sustain improvement, or further improve performance.
- The Performance Improvement Projects (PIPs) proposed to be implemented during the term of the contract.
 - How the proposed PIPs will expand quality improvement services.
 - How the proposed PIPs will improve the health care status of the Louisiana Medicaid population.
 - Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.

LHC will implement two PIPs during the first contract year:

- Ambulatory Care Measure/Emergency Department (ED) Visit category - The number of ED visits per 1000 member months
- Well Child Visits in the First 15 Months of Life – The percentage of children in the denominator that received at least 6 well child visits in the first 15 months of life

In successive years, LHC will implement two additional PIPs:

- Breast Cancer Screening – The percentage of women 40-69 years old that received a breast cancer screening
- Cervical Cancer Screening - The percentage of women 24-64 years old in the denominator that received a cervical cancer screening

PIP #1: Ambulatory Care Measure/ED Visit category - The number of ED visits per 1000 member months.

Measurable Goals

Decrease the number of ED visits per 1,000 member months to the 2011 national Medicaid NCQA Quality Compass 25th percentile or below.

System Interventions

Targeted Member Interventions. LHC Utilization Management staff will use monthly reports from our innovative Centelligence™ health informatics and reporting platform to identify members who have accessed the ED three or more times in the previous three months and refer them to an Integrated Care Team (ICT; see Section F2 for details about ICT staffing and processes) for an assessment and possible enrollment into our Case/Disease Management Programs. Since interventions are more effective when applied near real time, we will also request daily lists of members receiving ED services from network high-volume facilities. Centelligence Foresight, our integrated suite of predictive modeling applications, will generate monthly ED Potential Misuse Reports using medical and pharmacy (as available) claims data to identify additional members, based on age and disease condition, that are likely to misuse the ED or are exhibiting drug-seeking behavior. Our multidisciplinary ICT staff will prioritize outreach to members under age 13, those who have been identified as having a higher risk of ED use (such as those with asthma, sickle cell, and heart failure), and those accessing a second ED visit for conditions treatable by the PCP or an urgent care center (such as ear infection, sore throat, respiratory or gastrointestinal symptoms). ICT staff will complete a comprehensive evaluation of the member's risk factors and barriers to timely routine and preventive services, and develop a service plan collaboratively with the member, family/guardian or caregiver, PCP and any other treating providers.

To effectively address the additional risk for ED and other acute medical services for members with behavioral health (BH) co-morbidities, our ICT staff will include BH clinicians who will direct the management of members with BH co-morbidities and coordinate with providers of specialized BH services the member needs.

The service plan for identified members may include a variety of interventions that will reduce the likelihood of inappropriate ED use, such as: health education; motivational interviewing; self-management training; improved coordination between medical and BH providers and between member and provider; referral to community-based services; assistance with transportation; and condition-specific support from an ICT Health Coach. ICT staff will contact the member's PCP within three days of completing the assessment to share findings, including any gaps in care compared to evidence-based guideline recommendations identified by Centelligence Foresight (for example, a member has not filled a necessary prescription), and service plan recommendations, and obtain PCP input on and support for the service plan. LHC will provide our highest-risk members (with multiple co-morbidities) who lack reliable phone access with a pre-programmed direct dial cell phone at no cost to the member through our innovative Connections Plus® Program. Provision of the phone will facilitate the member's communication with ICT staff and their providers and caregivers so they can call promptly to ask questions, request assistance, and report medication side effects or new or changed needs rather than just seeking care at the ED. The phone will also be preprogrammed with other important phone numbers such as for NurseWise, our 24/7 nurse advice line, 911, and the domestic violence hotline.

NurseWise will place New Member Welcome Calls within the first 60 days of enrollment to the parents/guardians of new members under age 13 with an auto-assigned PCP who are at higher risk of ED use. The call will include, but not be limited to, focused education on appropriate use of the ED and the value of having a medical home, and the availability of 24/7 advice from NurseWise.

LHC will continuously educate our members about the importance of establishing a relationship with a PCP as a regular source of care and the value of a medical home, through the Member Handbook, information on our Member Portal, and our Member Newsletters, among other means. We will also educate members about the availability and value of NurseWise, our 24/7 nurse advice line. NurseWise staff can provide valuable, evidence-based advice about health concerns, as well as information about LHC policies. They will also be very effective in helping to appropriately redirect the member to alternative care settings, such as an urgent care center. NurseWise has a proven track record of diverting members to non-ED care when appropriate. NurseWise staff encourage members to go to the ED when appropriate, including for emergency behavioral health services, and instruct members to use 911 services

for life-threatening conditions. After NurseWise instructs a member with an emergency behavioral health condition to go to the closest ED, staff will contact the member within the next 48 hours to confirm that the member successfully obtained services. If they have not, the staff will assist with any barriers to access. Centene plans also provide aligned member incentives for the use of preventive and primary care services.

LHC will reward members with a credit on a CentAccount™ Mastercard® debit card for targeted healthy behaviors such as completing annual preventive health visits, and completing other recommended preventive health and chronic disease care screening, like appropriate diabetes testing. Members may use their CentAccount card to pay for medical copays or to purchase approved health care goods and services at many familiar retailers, such as Wal-Mart, Walgreens, Target, and CVS/Pharmacy. Rewarding members for healthy behaviors can help reduce urgent or emergent conditions that send members to the ED.

We will collaborate with PCPs and other providers to reduce the need for members to seek ED services. We will leverage our relationship with our owner-partner FQHCs to give us a “feet on the street” presence across the State of Louisiana for reaching out to identified members at high risk for ED use and those using the ED frequently and/or inappropriately. LPC&A’s 19 FQHCs, with multiple locations in both urban and rural areas throughout the state, have a long history of working effectively with Medicaid, CHIP and other low-income populations, and understand the needs of their local communities. ICT staff (co-located in some high-volume FQHC and provider sites) will coordinate with FQHC staff on outreaching to, assessing, and intervening with members.

Community Outreach. LHC will collaborate with non-profit faith-based and other community-based organizations across Louisiana to promote the early and frequent use of primary care services, thus reducing the need for inappropriate ER use. MemberConnections™ outreach staff will help organize and staff health promotion and education events, such as wellness clinics and health fairs. In each instance, they will reinforce the importance of the medical home and preventive services. We will customize our efforts to meet the needs of each community, but consistently reinforce the importance of early primary care preventive services. When we identify specific communities with high member ED utilization, we may reinforce the message with general public communications on billboards or bus signage.

Targeted Provider Interventions. LPC&A FQHCs understand that Louisiana Medicaid and CHIP members face significant barriers in obtaining specialty consultations and often use the ED as a means of obtaining consultations. LHC has already begun an aggressive specialist recruitment campaign to contract with increasing numbers of needed specialists throughout the state. Based on letters of intent we have already received, our specialty network includes over 4770 providers. This will complement the innovative steps that a number of our owner-partner FQHCs have already taken to partner with local hospitals and clinics to provide increased access, including onsite hours, to specialists. In addition, We will offer providers, including specialist providers a financial incentive for performing services that are appropriate for a member’s condition. For example, a specialist provider who performs appropriate diabetes screenings for a member would be eligible for an encounter based incentive that reimburses the provider beyond their contractually agreed upon rate. By offering this additional payment, LHC can expand access and help reduce inappropriate ED utilization by creating a financial motivation for a provider to become a LHC contracted provider. See Section F.5 for details on our plans for ensuring specialty access, particularly in rural areas and for members with disabilities.

With the majority of LPC&A FQHCs achieving Patient-Centered Medical Home recognition by the end of 2011, these partners will be capable of coordinating care and providing enhanced access to PCP services, including extended hours. From participation with DHH on Project Access, many of our partner FQHCs already offer extended hours. LHC will offer a PCP after-hours financial incentive for offering members an alternative to ED services for non-emergent conditions. We will include an ED utilization metric on our Provider Profile Overview Reports produced and distributed quarterly to PCPs. Our

Provider Overview Reports will also inform PCPs of their performance on other measures of access and timely preventive health services.

LHC will encourage the use of our Provider Portal by network hospital Emergency Departments to help them access critical information and immediately connect members with their PCPs and LHC when they visit an ED inappropriately. For example, when a member visits a network hospital ED, the ED staff will be able to log into our Provider Portal and access the member's eligibility information. Our Provider Portal will support an Emergency Department Indicator on the eligibility inquiry screen, as an optional check box. If the ED provider checks this box, an automated alert will be generated to notify the member's Case Manager via our TruCare health services management platform. In addition, the Provider Portal will generate an e-mail to the PCP, if the provider has registered on our Provider Portal with their e-mail. The e-mail will include a link back to the Provider Portal, allowing the provider to log in and retrieve notification of the Member's ED status.

In addition, ED staff viewing the member's eligibility information on our Provider Portal will also be able to access an Emergency Care Record (ECR) for the member that includes core medical history; whether or not the member has any urgent care gaps; and the member's PCP. Prior to accessing the ECR, our Provider Portal will present the ED staff user with a quick "break glass" affirmation screen; to enable our adherence to the Emergency Access provisions in the HIPAA Security Rule. ECR access is automatically captured on our Provider Portal's audit trail in compliance with HIPAA. The "break glass" action by the ED staff user will also automatically trigger an electronic alert that the member is in the ED to the Case Manager via TruCare, as well as an automated e-mail to the appropriate FQHC or hospital-based case manager and the member's PCP. This feature allows us to immediately follow-up with the member to 1) educate them about appropriate use of the ED and for non-emergent situations help them consider alternative sites for care; 2) help them schedule an appointment with the appropriate provider, and 3) help them schedule follow-up care.

How the proposed PIP will expand quality improvement services

This project will expand the amount and timeliness of data that PCPs receive about member utilization and behavior and give them direct or indirect access to predictive modeling risk estimate reports for their members.

The project will also encourage PCPs to measure and assess their performance for all patients, a critical quality improvement skill for PCPs as they move toward Patient-Centered Medical Home Recognition

How the proposed PIP will improve the health care status of the Louisiana Medicaid population

Louisiana has a high rate of poverty with poor access/poor utilization of preventive health services that result in high rates of ED utilization. Louisiana Medicaid members have a high rate of ED utilization. Services provided by EDs, particularly for non-emergent conditions, are expensive, disrupt continuity of care and the medical home relationship, and may have less expertise for pediatric patients than primary care providers. This PIP will attempt to identify and outreach to members at risk for inappropriate ED utilization, identify and remove barriers to accessing timely preventive care, collaborate with PCPs and ensure that members with chronic and/or special healthcare needs receive the preventive and specialty care services they need to prevent exacerbation of their condition. In addition, this project will provide near real time data to ICT staff that will enable them to intervene quickly to identify and address barriers to obtaining services, particularly primary care services, in more appropriate settings. ICT staff will also be able to more effectively facilitate the medical home/member linkage.

Our Chief Medical Director will lead the evaluation of LHC's membership, service patterns, utilization differences and needs in order to effectively implement the PIP interventions. These interventions will combine Centene's assets - nationally proven best practices, expert staff, state of the art technology, and emphasis on assuring access to primary care - with local innovation driven by our partnership with LPC&A FQHCs. Nationally, FQHCs have demonstrated their ability to reduce ED utilization by low-income patients. Centene also has a proven ability to improve ED utilization.

As an example of the effectiveness of our interventions, our NurseWise advice line has a proven track record of redirecting members to more appropriate care. During the 12 months prior to Q3 2010, over 81% of all members whose conditions did not indicate the need for ED care heeded NurseWise advice to seek care alternatives. Our ICT asthma management program achieved statistically significant reductions of 24.6% in child asthma-related ED visits and 12.5% in adult asthma-related ED visits, compared to matched member non-participants, during CY2008 through CY2010.

Through this PIP, we will identify high-risk members, encourage them to seek services through their PCPs, and encourage PCPs to provide enhanced access for members and coordinate all services that their members need to maintain or improve health status. Expanding primary and specialty access and linking the members to their PCPs will be a key factor in improving quality and health care outcomes of the Louisiana Medicaid and CHIP populations.

Rationale for selecting the PIP

Visits to the ED for non-urgent and preventable conditions are common and growing. Medicaid and CHIP recipients have a rate of ED visits twice that of the U.S. population as a whole (8.2 compared to 4.1 visits per 100 individuals) and constituted 26% of all ED visits in 2006.²³ The ED visit rate in Louisiana for Medicaid was 32% higher than for the U.S. overall in 2009²⁴ although the HEDIS Ambulatory Care (ED Admissions) measure of ED visits not leading to an inpatient admission for CommunityCARE in 2009 was slightly better than the national 2010 Medicaid NCQA 50th percentile (66.37 compared to 67.74 per 1,000 member months). Medicaid patients are seeking care in the ED for non-urgent and preventable conditions, in part, because of a lack of an available and regular source of primary care.²⁵ Improved access to primary care may reduce the use of the ED for non-urgent conditions.

LHC selected this PIP due to the need to improve ED utilization for this population, and to address DHH's priority and goal to decrease ED utilization per 1000 to at or below the HEDIS 2011 Medicaid 50th percentile.

PIP #2: Well Child Visits in the First 15 Months of Life – The percentage of children in the denominator that received at least 6 well child visits in the first 15 months of life.

Measurable Goals

Increase the rate of well child visits in the first 15 months of life (6 or more visits) to the 2011 national Medicaid NCQA Quality Compass 75th percentile or above.

System Interventions

Targeted Interventions with Members. LHC will identify members who are due or overdue for a well child visit using monthly reports from our Centelligence Foresight platform, and will contact parents/guardians with reminders through outbound automated or in-person calls and targeted mailings of reminder postcards. Reminders will explain how to obtain help scheduling appointments and arranging for transportation, and remind members that they are eligible to receive an incentive for each visit (up to six) through our CentAccount member incentive program for timely receipt of these services. We will reward members with a credit on a CentAccount™ Mastercard® debit card for targeted healthy behaviors like completing well child visits. Members may use their CentAccount card to pay for medical co-pays or to purchase approved health care goods and services at many familiar retailers.

Our outreach to parents will start before birth. Our Start Smart for Your Baby® comprehensive pregnancy and postpartum management program will provide health education to all of our pregnant members,

²³ Goodel S, De Lia D, and Cantor JC, *Emergency Department Utilization and Capacity*, The Synthesis Project. Policy Brief #17, July 2009 www.rwjf.org accessed 6/14/2011

²⁴ www.statehealthfacts.org Kaiser Family Foundation

²⁵ *Reducing Inappropriate Emergency Room Use among Medicaid Recipients By Linking Them to a Regular Source of Care*, Partnership for Medicaid, www.thepartnershipformedicaid.org accessed 6/14/2011

including information about timely well child visits for new babies and the importance of accessing recommended well child care. New members will receive information about EPSDT services in New Member Welcome Packets and New Member Welcome Calls. Members will continue to receive such information in the Member Handbook, on our Member Portal, and in Member Newsletter articles, for example.

LHC also will implement Centene's MemberConnections intensive member outreach and education program to support our efforts. MemberConnections Representatives (MCRs) are health outreach workers hired from within the communities we serve to ensure that our outreach is culturally competent and conducted by people who know the unique characteristics and needs of the local area. MCRs will conduct targeted outreach, including home visits, to parents we have been unable to contact with infants overdue for well child care. They will also provide general information on the importance of timely preventive care during local health fairs and other community events.

MCRs will assist other plan staff in supporting Health Check Health Days (HCHD). For HCHD, LHC will partner with FQHCs and other PCP offices to identify members who have missed well child visits (or other preventive health services such as immunizations and lead screening). Staff will contact the parents/guardians of identified members to offer them an appointment for the needed service on a certain day set aside by the practice, and to arrange transportation for the appointment with our transportation vendor. MCRs will attend the event to assist the provider's office staff with check-in, reinforce the importance of preventive care, and answer questions about the member's health plan benefits. Our partner FQHCs will capitalize on their existing relationships with many members; existing community outreach programs/activities; increasing capabilities as medical homes, and collaboration with LHC staff to ensure that infants receive timely well care.

LHC's Member Relationship Management (MRM) system will help us coordinate member outreach. For example, if ICT or other staff are attempting to contact a member's parent because of non-compliance with needed EPSDT services, they will document the gap in care in TruCare. That information is passed to MRM, so that Member Services or other staff can receive alerts any time that they are in touch with that member.

Targeted Interventions with Providers. LHC will facilitate all PCPs' efforts with well child compliance through repeated training and updates starting with new provider orientation and continuing with information and tools available on the Provider Portal, in Provider Manual and Newsletters, and through webinars, for example. Provider Services staff will assist non-compliant PCPs with practical toolkits containing, for example, well child visit and immunization periodicity schedules, registration materials for the state immunization registry, and guidelines for prevalent conditions. To facilitate accountability, we will supply PCPs with monthly HEDIS Reports that include all of their linked members who are due for a well visit the following month, as well as members who are past due for services. This report will be available through our online Provider Portal as well as by mail. We will use Care Gaps, our innovative technology solution to alert providers to a member's potential need for well care and other recommended services when checking member eligibility or their Member Panel Roster on the Provider Portal. We also will distribute Provider Report Cards quarterly to PCPs/Medical Homes that include performance indicators such as Well Child Visits in the First 15 Months of Life as required by DHH. Performance reporting increases provider awareness of performance, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of improvement actions.

How the proposed PIP will expand quality improvement services

This project will expand the amount and timeliness of data that PCPs receive about members' well care visit status, and will strongly support their member outreach capabilities. This initiative also will encourage them to measure and assess their performance for all patients, a critical quality improvement skill for PCPs as they move toward Patient-Centered Medical Home Recognition.

How the proposed PIP will improve the health care status of the Louisiana Medicaid population

Timely preventive care is critical for prevention, early diagnosis and treatment of physical and developmental disorders. Louisiana's infants and children receive well care visits less frequently than the U.S. as a whole. Increasing access and utilization of preventive health services for infants and young children will improve their health status through the rest of their lives by permitting early medical, behavioral and social interventions for timely diagnosed conditions.

We will use a multi-faceted approach to member engagement through outreach and education and a collaborative approach with our providers to improve compliance. Our Chief Medical Director will lead the evaluation of LHC's membership, service patterns, utilization differences and needs in order to effectively implement the PIP interventions. These interventions will combine Centene's expertise with local innovation driven by our partnership with LPC&A.

Centene has been successful in improving the rate of well child visits and preventive screening and services, such as immunizations. For example, from 2008 to 2009, Centene plans (consolidated) improved performance on the HEDIS measure Well Child Visits in the First 15 Months of Life (6 or more visits) by a statistically significant 7.6% (from 50.9% to 54.8%; $p = 0.0254$).

Rationale for selecting the PIP. Louisiana children age 0-17 years have a medical and dental preventive visit rate below the national average (69.6% compared to 72.0%).²⁶ The child death rate (1-14 years) exceeds the national average (29 compared to 19 per 100,000). Though the rate of well child visits in the first 15 months (6 or more visits) has improved recently for Louisiana Medicaid from 43.05% in 2006 to 53.70% in 2009²⁷ (54.69% for CommunityCARE), it is still below the national Medicaid NCQA 50th percentile. Barriers to improved compliance include: parents' lack of understanding of the value of preventive services; concern about the number of visits and services recommended for their infants; lack of transportation; care of other children; and work hours.

LHC has selected this PIP because of the need in the Louisiana Medicaid population for improved rates of child preventive health services and DHH's priority and goal to increase performance to meet or exceed the national Medicaid NCQA 50th percentile.

PIP #3: Breast Cancer Screening – The percentage of women 40-69 years old that received a breast cancer screening.

Measurable Goals

Improve the rate of breast cancer screening of women 40-69 years to or above the most current Medicaid NCQA Quality Compass 75th percentile.

System Interventions

Targeted Interventions to Members. LHC will identify members who are eligible and due or overdue for breast cancer screening using monthly reports from our Centelligence Foresight platform. Because of the critical role providers play in members compliance with this screening, we will outreach through postcard and automated telephone reminders to those identified members to explain how to obtain help scheduling appointments for well care visits and mammograms and arranging for transportation. We also will remind members that they are eligible to receive an incentive through our CentAccount program for timely well visits and screening.

New members will receive information about recommended preventive services in New Member Welcome Packets and New Member Welcome Calls. Members will also receive educational information and reminders in the Member Handbook, on our Member Portal and in Member Newsletter articles, for

²⁶ www.statehealthfacts.org Kaiser Family Foundation

²⁷ DHH, <http://new.dhh.louisiana.gov>

example. Our MemberConnections Representatives will disseminate information regarding breast cancer screening to age-appropriate members during health fairs and community events.

LHC's Member Relationship Management (MRM) system will help us coordinate member outreach. For example, if ICT or other staff is attempting to contact a member because of non-compliance with breast cancer screening, they will document the care gap in TruCare, our integrated health services management system. That information then flows to MRM, which alerts Member Services or other staff to discuss scheduling an appointment for breast cancer screening any time that they are in touch with that member in person or on the phone.

We will improve convenient access to mammography for our members by arranging for mobile mammography services such as those provided by Women's Hospital in Baton Rouge, Union General Hospital in Farmersville and others. We will partner with churches or other community centers, as well as FQHCs and other high-volume PCPs, to host mobile mammography units. We will determine where to locate these mobile units by generating GeoAccess maps and identifying locations where concentrations of non-compliant members are located. Quality Improvement staff will notify identified members when the mobile unit will be in their vicinity and provide contact information for Member Services and MemberConnections Representatives to help them schedule appointments during convenient hours, which will include weekend hours. Qualified radiologists will read the mammograms and return the reports to the member's PCP.

Targeted Interventions to Providers. LHC will facilitate PCP involvement in increasing breast cancer screening compliance through repeated training and updates starting with new provider orientation and continuing by providing information in the Provider Manual, on the Provider Portal, in Provider Newsletters, and through webinars, for example.

To facilitate accountability, we will supply PCPs with monthly reports from Centelligence Foresight that will include all of their linked members who are due for screening as well as members who are past due for services. This report will be posted on our Provider Portal as well as mailed. In addition, Quality Improvement and Provider Relations staff will outreach to PCPs with 20 or more non-compliant linked members. We will support these targeted outreach efforts with lists of these members; chart stickers to prompt recommendation of mammography; and a "fax-back" form with which the provider can notify us of members who are not eligible for screening. Online Care Gaps, also powered by Centelligence Foresight, will alert providers to a member's potential need for breast cancer screening and other recommended services when checking member eligibility on our Provider Portal, or reviewing their Member Panel Roster.

LHC will distribute quarterly provider report cards to PCPs as part of our Provider Profiling Program. These quarterly report cards will include a Breast Cancer Screening performance indicator, as required by DHH. Performance reporting increases provider awareness of performance, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of improvement actions.

Our partner FQHCs will capitalize on their existing relationships with many members, as well as their community outreach, increasing capabilities as medical homes, and collaboration with LHC staff to ensure that women receive timely screening.

How the proposed PIP will expand quality improvement services.

This project will expand the amount and timeliness of data that PCPs receive about a member's recommended preventive health screening status which will support their member outreach and education activities. The project will also encourage providers to measure and assess their performance for all patients, a critical quality improvement skill for PCPs as they move toward Patient-Centered Medical Home Recognition.

How the proposed PIP will improve the health care status of the Louisiana Medicaid population

Compliance with recommended breast cancer screening will increase early diagnosis and treatment of breast cancer which can lead to better outcomes. Timely mammography screening among women aged 40 or older could prevent 15-30% of all deaths from breast cancer. Stage 1 breast cancer (early lesions, discovered by breast exam or mammography) has a 95% survival; stage IV (late stage) is incurable with current treatments.²⁸ Improving the rate of breast cancer screening in the Louisiana Medicaid population will increase the early identification of breast cancer and could lead to improved outcomes for Louisiana women (enrolled in Medicaid) diagnosed with this disease. Mobile mammography screenings will expand member access to these critical preventive services to improve outcomes.

Centene has been successful in improving the breast cancer screening rates in Medicaid and other low-income women with similar initiatives. For 2008 to 2009 Centene plans (consolidated) improved performance on the HEDIS measure Breast Cancer Screening by a statistically significant 9.0% (from 43.1% to 47.0%; $p < 0.0001$). In addition, our Wisconsin affiliate achieved increases of 25% – 40% in screening rates for women 40-49 years and 50-59 years between 2006 and 2007.

Rationale for selecting the PIP

The proportion of Louisiana women 40 years or older who had a mammography within the previous two years (2008) was about the same as the national average (75.9% compared to 76.0%). However, the screening rate for women in CommunityCARE was 44.43% in 2009, over 14% lower than the national Medicaid NCQA 50th percentile, and 41.5% lower than for all Louisiana women in 2008. The incidence of breast cancer in Louisiana (2007) was lower than the national average (117.2 compared to 120.4 per 100,000 women), but the incidence in African American Louisiana women was higher (121.3 per 100,000 women). The breast cancer death rate for Louisiana women (2007) was 23.8 per 100,000 women, only slightly higher than the national average. However, the death rate for African American Louisiana women was almost 28% higher than the overall national average, likely related to late stage diagnosis.

Two recent studies of Medicaid managed care members non-compliant with breast cancer screening indicated that frequent reasons were lack of physician recommendation, mammography not being a priority for the member, transportation difficulties, lack of convenient appointment times, and fear of finding something wrong.^{29 30} LHC has selected this PIP because of this need and DHH's priority and goal to increase performance to meet or exceed the national Medicaid NCQA 50th percentile.

PIP #4: Cervical Cancer Screening - The percentage of women 24-64 years old in the denominator that received a cervical cancer screening.

Measurable Goals

Improve the cervical cancer screening rate to or above the most current Medicaid NCQA Quality Compass 75th percentile.

System Interventions

Interventions Targeted to Members. LHC will identify members who are eligible and due or overdue for cervical cancer screening using monthly reports from our Centelligence Foresight platform, and will contact members through targeted mailings of reminder postcards. Reminders will explain how to obtain help scheduling appointments and arranging for transportation, and remind members that they are eligible to receive an incentive through our CentAccount program for timely screening.

²⁸ Louisiana Breast and Cervical Health Program, www.labchp.lsuhscc.edu/information.htm accessed 6/16/2011

²⁹ Parkington SR et al, Barriers to Breast Cancer Screening In a Managed Care Population, *Managed Care* Apr 2009 34-45

³⁰ Ahmed NU, Fort J, Malin A, Hargreaves M, Barriers To Mammography Screening In A Managed Care Population, *Public Administration & Management* 2009 13; 3, 7-39

New members will receive information about recommended preventive services in New Member Welcome Packets and New Member Welcome Calls. Members will also receive educational information and reminders in the Member Handbook, on our Member Portal, and in Member Newsletter articles, for example.

Our Start Smart for Your Baby comprehensive pregnancy and postpartum management program will provide health education to all of our pregnant members that includes information about, and the importance of, timely and ongoing cervical cancer screening. Our MemberConnections Representatives will disseminate information about the importance of Pap smears to age-appropriate members during health fairs and community events.

Our MRM system will help us coordinate member outreach. For example, if ICT or other staff are attempting to contact a member because of non-compliance with cervical cancer screening, they can document the care gap in TruCare, our integrated health services management system. That information will then flow to MRM, which alerts Member Services or other staff to discuss scheduling an appointment for a Pap smear any time that they are in touch with that member in person or on the phone.

Targeted Interventions to Providers. LHC will facilitate PCP involvement in increasing cervical cancer screening compliance through repeated training and updates starting with new provider orientation and continuing by providing information in the Provider Manual, on the Provider Portal, in Provider Newsletters, and through webinars, for example.

To facilitate accountability, we will supply PCPs with monthly reports from Centelligence Foresight that include all of their linked members who are due for a Pap smear the following month as well as members who are past due for services. This report will be posted on our Provider Portal and mailed. Online Care Gaps, also powered by Centelligence Foresight, will alert providers to a member's potential need for cervical cancer screening and other recommended services when checking member eligibility on our Provider Portal, or reviewing their Member Panel Roster. We will distribute quarterly Provider Report Cards to PCPs with Cervical Cancer Screening as one of the performance indicators measured, as required by DHH. Performance reporting increases provider awareness of performance, identifies opportunities for improvement, and facilitates plan-provider collaboration in the development of improvement actions.

Our partner FQHCs will capitalize on their existing relationships with many members, as well as their community outreach, increasing capabilities as medical homes, and collaboration with LHC staff to ensure that women receive timely screening.

How the proposed PIP will expand quality improvement services. This project will expand the amount and timeliness of data that PCPs receive about a member's recommended preventive health screening status, which will support their member outreach and education activities. The project will also encourage providers to measure and assess their performance for all patients, a critical quality improvement skill for PCPs as they move toward Patient-Centered Medical Home Recognition.

How the proposed PIP will improve the health care status of the Louisiana Medicaid population. Improving the rate of cervical cancer screening in the Louisiana Medicaid population will increase the early identification of cervical cancer and could lead to improved outcomes for Louisiana women (enrolled in Medicaid) diagnosed with this disease. Regular cervical cancer screening will improve a member's chances of having cervical cancer diagnosed at an early stage. The 5-year relative survival rate for cervical cancer is 93% for women with an initial diagnosis of localized disease. For women initially diagnosed with disseminated disease, the survival rate is only 13%.³¹

Centene has been successful in improving the cervical cancer screening rates in Medicaid and other low-income women with similar initiatives. For example, our Georgia affiliate, Peach State Health Plan

³¹ Louisiana Breast and Cervical Health Program, www.labchp.lsuhscc.edu/information.htm accessed 6/16/2011

increased their screening rate by 20% (to 65.5%) between 2007 and 2009. Our Arizona affiliate, Bridgeway Health Systems increased their screening rate in an SSI population by 36.5% (to 51.3%) between 2009 and 2010.

Rationale for selecting the PIP. Louisiana has a low rate of cervical cancer screening and a high cervical cancer death rate. The proportion of Louisiana women who had a Pap smear within the previous three years (2008) was 76.6%, compared to 82.8% for the U.S. The screening rate for women in CommunityCARE was 55.18% in 2009, almost 19% lower than the national Medicaid NCQA 50th percentile. Yet the incidence of cervical cancer in Louisiana (2007) was 8.8 per 100,000 women, over 11% higher than for the U.S. The incidence in African American Louisiana women was even higher at 11.9%. The cervical cancer death rate for Louisiana women (2007) was 3.2 per 100,000 women, a full 33.3% higher than the national average. The death rate for African American Louisiana women was 145.8% higher than the overall national average, and 37.2% higher than the national average for African Americans.³²

Research has found that of U.S. women who had visited a doctor in the past year but had not had a recent Pap smear, 87% reported that their doctor did not suggest that they have it done.³³ This would suggest that lack of physician recommendation contributes greatly to the under-utilization of Pap smear testing. Other reasons identified as to why some women do not routinely get screened for cervical cancer include: did not feel it was needed; just put it off; too painful, unpleasant, or embarrassing; or never thought about it. Other risk factors include less than a high school education, older age, poverty, and certain racial and ethnic minority groups.³⁴

LHC has selected this PIP because of this need and DHH's priority and goal to increase performance to meet or exceed the national Medicaid NCQA 50th percentile.

- How your will keep DHH informed of PIP program actions, recommendations and outcomes on an ongoing and timely manner.

LHC will submit the QAPI reports annually that will include all current quality improvement activities, planned new or continuing improvement activities, and an assessment of the effectiveness of the QAPI program. We also will submit all required administrative and clinical performance measures at required intervals and upon request by DHH. In addition, within three months of contract execution and at the beginning of each contract year thereafter, LHC will submit to DHH, in the required format, both a general and a detailed description of each PIP for review and approval. LHC will also submit to DHH the performance measures for these PIPs and all other Level I Performance Measures quarterly, in aggregate and as part of the individual PCP provider profiling Overview Reports. This will allow DHH to monitor the effectiveness of and sustained improvement from our PIPs in an ongoing, timely manner.

- How the proposed PIPs may include, but is not necessarily, limited to the following:
 - New innovative programs and processes.

The success of our QAPI Program and of these proposed PIPs will be enhanced both by our innovative processes and our relationship with our LPC&A FQHC partners. Descriptions of several of these innovative approaches follow.

LHC will be supported by CentelligenceTM, Centene's proprietary, innovative, and comprehensive family of integrated decision support and health care informatics solutions. Our Centelligence enterprise

³² Kaiser Family Foundation, www.statehealthfacts.org accessed 6/15/2011

³³ Mitchell JB, Utilization of Health Care Services Related to Cancer Prevention for Women in the Medicaid Program; Final Report, Health Economics Research Inc. February 2002 www.cms.gov

³⁴ Louisiana Breast and Cervical Health Program, www.labchp.lsuhscc.edu/information.htm accessed 6/16/2011

platform continually integrates and analyzes an enormous amount of transactional data (e.g. claims, lab test results, authorizations) from multiple sources and produces *actionable* information. Centelligence Foresight, our integrated suite of predictive modeling applications, will identify members with specified risk factors, at increased risk for increased future utilization of specific types, or with gaps in recommended preventive care services. This will greatly enhance our ability to identify members who may be over-utilizing emergent services or in need of preventive care visits or screening. Centelligence Insight will produce plan and provider-level HEDIS and utilization-based measures to assess effectiveness of the PIPs as well as provider performance. Frequent, comprehensive performance reporting is essential for improvement by LHC and our providers. Our Provider Portal will provide ready access to this reporting. It will also enhance information-sharing and coordination among LHC clinical staff, PCPs and other providers such as ED staff. We will creatively use our GeoAccess[®] capabilities, such as strategically placing and scheduling mobile mammography units in location where concentrations of members need this service.

LHC's multidisciplinary Integrated Care Team approach will combine case and disease management staff and will include Registered Nurse Case Managers, BH clinician Case Managers, Program Specialists (Social Workers), Health Coaches (Disease Management), and Program Coordinators. We will co-locate all staff on an ICT together to maximize coordination of their efforts and integration of all services a member receives, including services provided through LHC, carved out Medicaid services, non-Medicaid services and services provided through community organizations. We will hire ICT staff from the communities we will serve in Louisiana to ensure they are familiar with the unique local characteristics of members and providers. We will also locate ICT staff in our regional offices as well as in our partner FQHCs and other high volume provider offices, enhancing their ability to provide personal service and work closely with members and providers to coordinate and manage care particularly for those with co-morbid conditions, unmet needs and barriers to timely and appropriate care.

LHC's innovative CentAccount[™] member incentive program will promote personal healthcare responsibility and ownership by rewarding members for targeted healthy behaviors. Eligible members can earn rewards for completing well visits and other recommended preventive health screening, such as breast and cervical cancer screening. The reward will be loaded onto an LHC-issued CentAccount MasterCard[®] debit card. Members can use this card at many merchants they already use every day, such as Walgreens, CVS, Rite-Aid stores, supermarkets such as Albertson's, Winn-Dixie, Piggly Wiggly, Safeway, Kroger's, Sam's and Wal-Mart, and other stores throughout the state. Members will be able to use the card to buy a wide variety of health-related items, including some over-the-counter medications not covered by Medicaid. Goods and services will qualify for card purchases if they are recognized by U.S. Internal Revenue Service as health care expenses for a Flexible Spending Account and flagged by the retailers' Inventory Information Approval System.

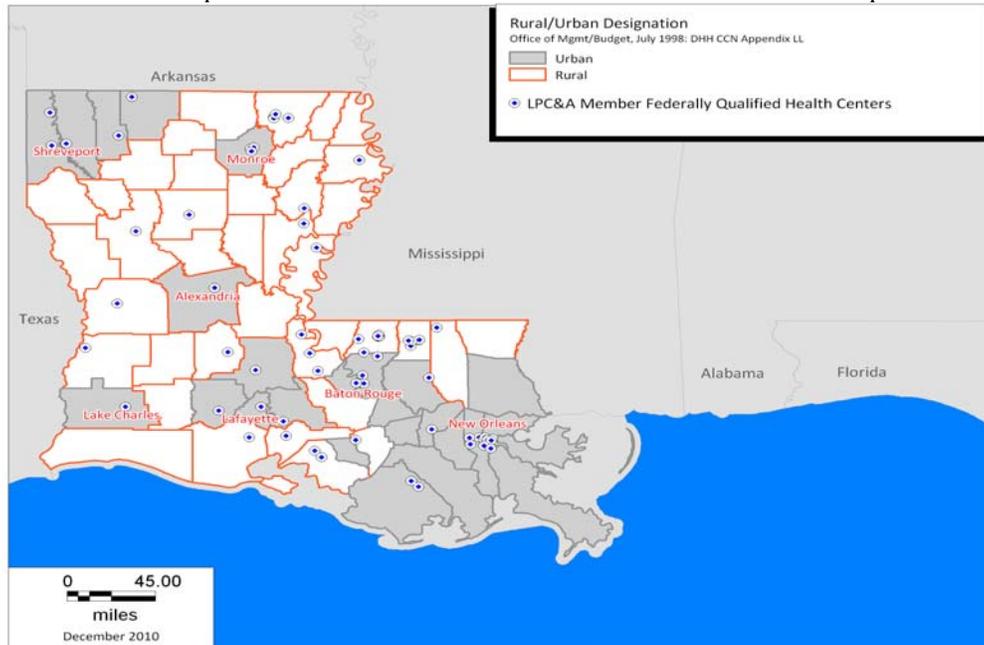
- Contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts and/or School Based Health Clinics.

LHC is a joint venture between Centene and the Louisiana Partnership for Choice and Access (LPC&A), which is comprised of 19 FQHCs. For more than 28 years, FQHCs have been an integral component of the health delivery system in Louisiana, providing nearly 632,000 visits for almost 203,000 patients in 2010.³⁵ LPC&A's owner-FQHCs understand the needs and preferences of Louisiana Medicaid recipients and Medicaid providers, and how they differ across the various regions of the state. LPC&A FQHC members have close ties to their communities and a spirit of accountability for the health status of these residents. They will provide members with an alternative to ED care for non-emergent problems, and actively outreach to members to ensure timely preventive care and screening.

The graphic below shows the multiple site locations LPC&A's 19 FQHCs bring to the table throughout Louisiana. Given the excellent coverage in urban, rural and remote areas of the state, LHC is well positioned to create unique solutions for expanding access for members living in these areas. These

³⁵ 2010 UDS Site Summary, U.S. Department of Health and Human Services, Bureau of Primary Health Care.

traditional Medicaid/CHIP providers not only have clinics physically located in these areas, they also have established relationships with both Medicaid and CHIP beneficiaries and other providers in the area.



The 19 FQHC's of LPC&A offer a broad spectrum of primary care and wellness services including 11 school based clinics as well as mobile units. For example, Primary Care Providers for a Healthy Feliciana has 4 school based clinics located in East Feliciana and is actively working to expand their services into West Baton Rouge and other surrounding parishes to offer mental health services in their school systems. Additionally, our partner FQHCs David Raines Community Center and Innis community Health Center both have mobile units providing dental screenings, sealants, and some restorative treatment at local schools.

For Start Smart, well child care, and healthy lifestyle community education programs and events, we will leverage the current relationships of our FQHC partners with local Women, Infants, and Children (WIC) programs, Head Start, and School Based Health Clinics (some of which are run by an FQHC), either to jointly schedule and participate in events, or to coordinate scheduling, with the goal of maximizing outreach. For example, with Head Start and school events, we will help provide immunizations and examinations that children need prior to program or school enrollment. Community events such as these also help identify unenrolled children who may be Medicaid or LaCHIP-eligible and provide a chance to educate parents on the benefits of a medical home and follow-through on EPSDT screenings. In addition, LHC will collaborate with School Nurses and School Based Health Clinics to provide education on asthma.

Question J.6

Utilizing Feedback from Members
and Providers to Drive Changes and
Improvements

J.6 Describe how feedback (complaints, survey results etc.) from members and providers will be used to drive changes and/or improvements to your operations. Provide a member and a provider example of how feedback has been used by you to drive change in other Medicaid managed care contracts.

LHC will emulate the best practices of our affiliate Centene health plans and use a variety of methods such as analysis of grievances and appeals, satisfaction surveys, program satisfaction assessments, direct feedback (both formal through advisory committees and informal through Member and Provider Services calls), enrollment/disenrollment activity, and turnover to assess member and provider satisfaction. Our Quality Management (QM) staff monitors multiple aspects of member and provider satisfaction and report regularly to our Quality Assessment Performance Improvement Committee (QAPIC). The QAPIC refers recommendations for interventions related to adverse trends to our Performance Improvement Team (PIT), a **multi-departmental**, cross-functional quality improvement team that facilitates the ongoing integration of quality improvement throughout the organization. It directly manages or coordinates all improvement projects or initiatives. We measure performance of member services and other functions against established benchmarks or goals, and at intervals reflecting when improvement is expected to occur. We re-measure data at these intervals to allow us to monitor progress and make adjustments to corrective actions. This process can sometimes result in service improvement initiatives that test a pilot program or an innovative approach that, if successful, can be implemented across all Centene affiliates. These initiatives are designed to improve the quality of our members' and providers' experience with the plan and the CCN-P Program.

How Member Feedback is Used to Drive Operational Changes or Improvements

Member Satisfaction Surveys. LHC will conduct annual Consumer Assessment of Healthcare Providers and Subsystems (CAHPS) surveys and methodology to assess the quality and appropriateness of care to members. To this end, we will extend the contract with the Myers Group, an NCQA-certified CAHPS vendor with whom existing Centene affiliate health plans current contract, to conduct CAHPS[®] 4.0H Medicaid Adult and 3.0H Medicaid Child Surveys of a random sample of our population that will include

- Getting needed care
- Getting care quickly
- How well doctors communicate
- Health plan customer service
- Global ratings

We will report each survey's results, separately and by CCN GSA within 120 days after the end of the plan year.

Example 1. Our AZ affiliate, Bridgeway Health Solutions (Bridgeway), completed member satisfaction surveys for our Arizona Long Term Care System (ALTCS) members in 2008 and 2010 using similar but not identical survey instruments. The surveys assessed satisfaction with the plan and specifically with **case management services**. The surveys were mailed to a sample of members in both contracted GSAs with a response rate that improved from 16% in 2008 to 23% in 2010. Bridgeway's leadership team reviewed and presented the Survey results to the QAPIC for recommendations. An item on both surveys stated: 'My Case Manager has taken time to explain' four specific covered services. In 2008, positive responses (agree and somewhat agree) for the four services ranged from 63% to 77% in Maricopa and 89% to 96% in Yuma. As a result, QM staff reviewed the discrepancy in results between Maricopa and Yuma with Case Management staff, and provided retraining in cultural competency and the importance of ensuring members understand covered services. Case management leadership added focused training in these areas in the department's periodic scheduled training. In 2010, positive responses improved from **90% to 96%** in Maricopa and from **92% to 98%** in Yuma.

Example 2. Superior HealthPlan, our Texas affiliate, conducted a root cause analysis of the 2008 Child CAHPS Getting Care Quickly composite score and identified concerns about Provider understanding of,

or compliance with, appointment availability standards and Texas HealthSteps (EPSDT) requirements; and about Member lack of understanding of how to access NurseWise, their 24-hour nurse advice line. Interventions included provider education through *Superior Providers*, their provider newsletter, *PartnerSHP*, their monthly provider eblast, and the *Primary Care Update*, their monthly PCP posting on the Provider Portal; targeted feedback to Providers who failed appointment and after hours availability audits; 60-day re-audits; and, for some, referral to the QIC for non-compliance. Their CAHPS Getting Care Quickly composite score improved from 2008 to 2010 for both STAR (70.1% to 87.1%) and CHIP (72.8% to 86.1%) members. They also experienced a downward trend from 2009 to 2010 in complaints related to access and availability of Providers, (0.58 per 1000 Members to 0.41 per 1000 Members).

Example 3. Based on 2007 CAHPS survey results, Peach State Health Plan, our Georgia affiliate, instituted quarterly customer service training; an employee recognition campaign for excellent customer service; and an initiative to improve access by recruiting additional providers in specific geographic areas. Their 2008 Child CAHPS survey showed improvement in Customer Service (72.6% to 77.4%), Getting Care Quickly (78.6% to 86.9%) and overall Rating of the Plan (78.5% to 86.8%) over the 2007 CAHPS results.

Member Advisory Council and other Direct Member Feedback. Like other Centene affiliates, LHC will establish a Member Advisory Council. LHC's Member Advisory Council will promote a collaborative effort to enhance the service delivery system in local communities while maintaining member focus and allow participation in providing input on policy and programs. In short, we will provide a forum and members to have a **“meaningful voice”** in the development and continuous improvement of our delivery model. LHC's Council will be chaired by Jamie Schlottman, LHC's Health Plan President, and will meet at least quarterly and include broad representation of members/families/significant others and member advocacy groups that reflect the population and community served. Members, their families/significant others and member advocacy groups will comprise at least 50 per cent of the membership. LHC will provide council orientation and ongoing training for council members to ensure they have adequate information and understanding to fulfill their role on the council. At those orientations, LHC will provide and review the Member Advisory Council Plan including the schedule of meetings and our goals for the council. We will include member perceptions in the development of our goals and submit the plan to DHH within 30 days of contract execution and annually thereafter. Centene values the collaborative relationships we establish with our State clients and LHC will include DHH in any correspondence to the council including the agenda and minutes. We will also post all agenda and minutes on our LHC website.

Example 1. Managed Health Services (MHS), our Wisconsin affiliate has gathered member feedback from focus groups and community forums that has resulted in a number of improvement initiatives, including the following:

- After hearing that members were not inclined to open or read MHS mailings because the information and format did not “grab their attention,” they revamped their quarterly member newsletters to be more diverse in content, address more member interests and appear more aesthetically pleasing. We also began **hand addressing** important mailings, such as HealthCheck reminders, to be more personal and attention-getting.
- Feedback also indicated that members were not aware of MHS' website, though the web was their preferred method of receiving information. In response, MHS updated their Member Portal by adding a Contact Us feature, so members can communicate with the plan via e-mail; simplifying the provider look-up feature; and posting their Member Handbook in Spanish, English, Hmong and Russian. They added children's activities and more preventive health and safety information and convenient online PCP selection, health risk assessments, and notification of pregnancy functions.
- During one Member and Community Advocate Advisory Committee meeting a member spoke of personal success with Botox[®] treatment for spasticity. This input prompted the Chief

Medical Officer to further research this therapy for case-by-case approval for other members not responding to more conventional therapies.

Example 2. At Bridgeway's December 2008 Council meeting, a Maricopa member mentioning that often caregivers received their training in English; however, she felt that providing training in Spanish would prove to be beneficial to Spanish-speaking caregivers. Bridgeway's Network Management staff investigated and found that AccentCare provided training in both English and Spanish and that they were willing to serve as a resource for other agencies. Subsequently we were able to assist a local attendant care agency with providing training in Spanish for Spanish-speaking caregivers that also addressed cultural sensitivity.

Grievances and Appeals. LHC's Grievance and Appeal (G & A) staff will log, track, and trend all member grievances. Tracking categories include, but are not limited to, availability and accessibility of services and providers, utilization and case management services, quality of care, and covered benefits. Each month the G & A Manager will review all member grievances and discuss them with LHC's Senior Leadership Team. If the G & A Manager identifies adverse trends from quarter to quarter, she will convene the Grievance and Appeal Committee, composed of representatives from all departments. The Committee performs a **root cause analysis** to identify underlying causes and recommends corrective actions to the QAPIC, which monitors subsequent complaint data for improvement. If we determine through further analysis that a quality of care issue exists, the grievance is forwarded to our QM Department for further investigation. The QAPIC will monitor all grievance data quarterly. During the annual QM program evaluation process, the G & A staff and the QAPIC will assess grievance data by category to identify trends, identify plan or provider level improvement opportunities, and develop interventions for the annual work plan. The G & A Manager will also present the grievance data to the Member and Provider Advisory Councils each quarter for input.

LHC's Finance, Case Management, and Provider Services Departments will jointly review member enrollment, disenrollment and 'request to disenroll' data each month, looking for trends within GSAs as potential indicators of member satisfaction or dissatisfaction. They will present their analysis to the QAPIC to supplement grievance and appeal trend analysis. This type of data can often drive change in network recruitment processes.

Example 1. In CYE 2007, Bridgeway's grievances related to transportation spiked to 43 (60% of all grievances). All originated in the Maricopa GSA and were related to the same provider. Bridgeway revised their contractor oversight process and recruited additional contractors for the GSA. Transportation-related grievances declined to five in CYE 2008 and have remained low ever since. They also revised their Member Handbook to provide additional information regarding the transportation benefit, including appropriate use of the benefit, how to access services, and contact information for assistance in scheduling transportation.

Example 2. During routine monitoring of member grievance data for CYE 2009, Bridgeway's Leadership Team noted an upward trend in grievances related to providers billing members. There were 94 such grievances constituting 81% of all grievances for the year. The G & A Committee was convened to investigate and perform a root-cause analysis. They identified a major underlying barrier to be provider offices not having accurate member eligibility information. The QMPIC provided recommendations and approved enhancements to the Member Services tracking database, increasing the number of grievance categories to facilitate increased identification and reporting of these grievances. They used the database to coordinate efforts by Case Management staff to ensure that their assigned members' providers had accurate member eligibility information and by Network Management staff to identify non-contracted providers in the database already seeing our members for targeted recruitment efforts. As a result, only 42 grievances related to provider billing were filed in CYE 2009, and only 17 such grievances (47% of all grievances) were filed in 2010. They are continuing to implement interventions to sustain this improvement trend.

Example 3. MHS identified transportation problems as a cause for frequent grievances. Members were frustrated regarding cab availability and resulting missed appointments. The Milwaukee market has one major transportation vendor that is used by all of the Medicaid health plans. MHS began conducting monthly meetings with this vendor to discuss member feedback and determine appropriate corrective action. As a result, the company increased its fleet and gave MHS access to its dispatch system. This resulted in member grievances related to transportation decreasing 70% from 2007 to 2008.

In 2009 MHS received several member complaints about cabs not showing up and lost cab orders. To address these issues, MHS reinstated quarterly meetings with the vendor to review trends, discuss member issues and concerns, and look for ways to improve timeliness and member satisfaction. Their staff reduced the risk of lost orders by batching the orders, which were initially faxes, but now time- and date-of-receipt-stamped emails. To improve the cab ordering process, we worked with the vendor to place one of their **staff onsite** at our call center five days a week for quick and accurate transport information.

How Provider Feedback is Used to Drive Operational Changes or Improvements

Provider Satisfaction. LHC will use provider satisfaction survey data to drive change. LHC will conduct annual provider satisfaction surveys utilizing a tool that, following DHH approval, will assess satisfaction with provider enrollment, provider communication, provider education, provider complaints, claims processing, claims reimbursement and utilization management processes, including medical reviews and support toward Patient Centered Medical Home implementation. No later than 120 days after the end of the plan year, LHC will submit a provider satisfaction survey report to DHH that summarizes the survey methods and findings and provides analysis of opportunities for improvement.

Example. In 2008 Bridgeway conducted provider satisfaction surveys prompted by the implementation of a major systems update that required modification of several claims and prior authorization processes, including processes for Case Manager authorized services. The survey questions focused on satisfaction with those processes. Bridgeway sent the survey to 67 network long term care and home and community-based providers, with a 55% response rate. Based on the survey results, the QAPIC implemented changes including a temporary increase in staffing, and process redesign encompassing systems analysis, supplemental software and improved accountability. Demonstrated improvement included increases in positive responses from 2008 to 2009: timeliness of claims payments from 65% to 75%; prior authorizations process from 61% to 85%; ability to receive information from Member Services about eligibility from 79% to 94%; and assistance received from Case Managers from 86% to 95%.

Direct Provider Feedback. LHC will implement a Provider Advisory Committee (PAC) as a formal mechanism to solicit provider input regarding our operations, policies and customer service. The PAC is composed of the Medical Director, network practitioners from across the contracting area, the Director of Contracting and Network, and Provider Relations staff as appropriate. The Medical Director chairs the Committee. The Committee provides input on LHC's provider profile and incentive programs, and other administrative practices, and supports development of the physician scorecard indicators, useful analyses of the data, and effective means of helping Providers improve their performance. Based on the experience of our affiliate Centene health plans we also anticipate receiving direct feedback from providers on network issues through the secure email on our Provider Portal.

Example 1. Superior HealthPlan, Inc. (Superior), our affiliate Texas health plan, presented changes to Provider profiling metrics to their Quality Committee and received invaluable insight to a proposed measure regarding follow-up after an emergency room visit. Practitioners expressed their difficulty in knowing when one of their patients has been to the emergency room. Superior was able to partner with some of its high-volume hospitals to obtain daily listings of members who had been to the emergency room on the previous day and developed a process to share this information with their provider network in order to facilitate continuity of care and follow-up with the medical home after an emergency room visit.

Example 2. At the December 2010 Council meeting of our Arizona affiliate, Bridgeway’s QM staff presented a comprehensive review and update of their performance improvement projects, including a project to increase member use of advanced directives and their advocacy of the Five Wishes[®] form. A Provider Council member related his difficulty in obtaining the Five Wishes form for his patients. To supplement the distribution of the forms to members by our Case Managers, we implemented a link to the 5 Wishes forms on the Bridgeway Provider Portal within one week of the meeting. We also implemented a dedicated toll-free “live person” provider inquiry line for authorization and claim status in response to Provider Council members’ request for a single point of contact at the plan.

Provider Complaints and Appeals. At Centene affiliate plans, a majority of provider complaints received have been appeals of actions to deny or reduce authorizations for services. The G&A staff log and track the appeals in addition to reporting them to our state partners. LHC’s G&A staff will monitor appeals and Medical Management staff will also monitor the frequency and types of actions as additional indicators of potential provider dissatisfaction. Tracking this data may also identify possible changes in practice patterns within the network, or inconsistencies in how Medical Management staff applies medical necessity criteria. LHC’s G&A staff will present action and appeal data each quarter to the Member and Provider Councils and the QAPIC for review and recommendations. Provider complaint data can, for example, drive changes in the process of adopting clinical criteria or practice guidelines, as well as changes in the criteria or guidelines themselves. They can also change the process of provider education regarding criteria and the process of training and testing inter-rater reliability for Medical Management staff.

Example 1. In March 2010, a Bridgeway network provider submitted a complaint about repeated denials of prescriptions for medication for hepatitis C. Bridgeway’s prospective pharmacy utilization criteria required that confirmation of hepatitis C should include a positive HCV RNA. The provider's position was that a positive HCV RNA was superfluous if the member had a documented positive liver biopsy and an elevated viral load. Using the provider's input and a review of the evidence base, the Bridgeway Pharmacy and Therapeutics Committee revised their criteria for this medication and removed the requirement for HCV RNA confirmation when the patient had a positive biopsy and viral load.

Example 2. As a result of routine monitoring of provider appeals by the G&A staff in 2009 and of direct feedback from network hospitals, Bridgeway’s Medical Management/Utilization Management Committee noted an upward trend in denials, appeals and overturned denials of ALTCS members’ inpatient stays. Assessment by the Committee determined that the major contributors were poor communication with and insufficient information from the inpatient facilities to their Concurrent Review staff. The corrective action approved by the Committee was the implementation of onsite Concurrent Review Nurses at higher volume network hospitals. Concurrent Review Nurses promptly coordinated with hospital staff to arrange access to workspace, patient records, and hospital clinical staff. In some cases, they have received hospital authorization to interact directly with hospitalized members to facilitate transition of care planning for hospital discharge. As a result of this change, the number of denied inpatient admissions has steadily declined from a total of 17 in the fourth quarter of 2009 (4% of admissions) to eight in the fourth quarter of 2010 (1% of admissions). For example, Yuma Regional Medical Center had six denials in the fourth quarter of 2009, but has averaged three per quarter since then; the John C. Lincoln Hospitals in Phoenix had two denials in the fourth quarter of 2009 and none since. Bridgeway is continuing onsite concurrent review to maintain this improvement.

Provider Turnover. Our relationships with and retention of our providers is a hallmark of Centene’s success in administering programs like the CCN-P. LHC Provider Services staff will monitor contract terminations as well as retention of individual and organizational providers. QM staff will record reasons for provider departures from the network in the credentialing tracking database using reason codes. QM staff will also monitor turnover among facility and agency staff such as home health nurses and personal care attendants. The QAPIC will regularly review turnover data, with input from the Member/Provider Advisory Council(s), and develop recommendations to improve network consistency and promote network provider retention.

Question J.7

HEDIS Measure Results for State Medicaid Contracts

J.7 Provide, in Excel format, the Proposer's results for the HEDIS measures specified below for the last three measurement years (2007, 2008, and 2009) for each of your State Medicaid contracts.

- If you do not have results for a particular measure or year, provide the results that you do have.
- If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.
- If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).
- If you do not have HEDIS results for five states, provide the results that you do have.
- In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.

Provide results for the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services
- Comprehensive Diabetes Care- HgbA1C component
- Chlamydia Screening in Women
- Well-Child Visits in the 3,4,5,6 years of life
- Adolescent well-Care.
- Ambulatory Care - ER utilization
- Childhood Immunization status
- Breast Cancer Screening
- Prenatal and Postpartum Care (Timeliness of Prenatal Care and Postpartum Care)
- Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents

Include the Proposer's parent organization, affiliates, and subsidiaries

Please see **Attachment J.7: Centene Health Plan HEDIS Scores** which contains the HEDIS scores for measurement years (MY) 2007 through 2009 for all Centene Medicaid plans that reported scores. Scores were not reported for plans before they were operational or when continuous enrollment during start-up was insufficient for reporting. The attachment includes data for the following plans:

- Absolute Total Care (South Carolina)
- Buckeye Community Health Plan (Ohio)
- Managed Health Services (Indiana)
- Managed Health Services (Wisconsin)
- Peach State Health Plan (Georgia)
- Sunshine State Health Plan (Florida)
- Superior Health Plan (Texas)

Each of the plan reports in **Attachment J.7** indicates where the Plan used hybrid methodology and explains each instance in which a measure is not reported for a specific year.

We have included the results for each state contract included in Section B.16. Centene affiliate plans followed HEDIS technical specifications for small numbers as a guide, and did not report data if the denominator used to calculate the measure was smaller than 30. The following table summarizes any exceptions associated with the measures reported in **Attachment J.7**:

Contract State Name	Exceptions
Absolute Total Care (ATC)	ATC began operations in December 2007; therefore HEDIS rates were not reported for MY 2007. In MY 2008, ATC did not adequate enrollment to report Adults Access to Preventive/Ambulatory Health Services (AAP); Comprehensive Diabetes Care – HbA1C component (CDC); Chlamydia Screening in Women (CHL); or Breast Cancer Screening (BCS). ATC did not conduct medical record review for their first year of business and was not required to report the measure per the State contract, so chose not to report Childhood Immunization Status (CIS). ATC also chose not to report Weight Assessment and Counseling for Nutrition and Physical Activity in Children/Adolescents (WCC) since it was their first year of business and it was a first year measure.
Buckeye Community Health Plan (BCHP)	BCHP reported HEDIS rates for MY 2007 through 2009. BCHP reported an NR for CDC Good Control <7 as this was not a required reporting component per the State contract.
Bridgeway Health Solutions (BHS)	BHS has not publicly reported Medicaid HEDIS rates as it is not required of their State contract and due to the high proportion of dual-eligible members with incomplete claims data. Bridgeway monitors and trends HEDIS scores for conducting improvement projects and focus studies in order to improve member health status.
CeltiCare Health Plan (CeltiCare)	CeltiCare has not yet begun HEDIS reporting; they did not begin enrolling members until October 2009.
IlliniCare Health Plan (Illinicare)	IlliniCare has not yet begun HEDIS reporting; they did not begin enrolling members until May 1, 2011.
Magnolia Health Plan (Magnolia)	Magnolia has not yet begun HEDIS reporting; they did not begin enrolling members until January 1, 2011.
Managed Health Services – IN (MHS-IN)	MHS – IN reported all HEDIS rates for all years with the exception of the measures noted on the table that had a denominator less than 30.
Managed Health Services – WI (MHS-WI)	MHS-WI did not publicly report HEDIS scores in MY 2008 as it was not a requirement of their State contract. MHS-WI monitors and trends HEDIS scores for conducting improvement projects and focus studies in order to improve member health status. MHS-WI did not report the age breakdown for WCC, only the total rate for all members in the measure.
Peach State Health Plan (PSHP)	PSHP reported all measures when applicable except CDC Good Control <7 as this was not a required reporting component per the State contract.
Sunshine State Health Plan (SSHP)	SSHP began enrolling members on February 14, 2009. SSHP only reported the State contract required measures in 2009 since it was the first year of plan operations.
Superior Health Plan (SHP)	SHP did not publicly report HEDIS scores in MY 2008 as it was not a requirement of their State contract. SHP monitors and trends HEDIS scores for conducting improvement projects and focus studies in order to improve member health status. In MY 2009, SHP did not report CDC Good Control <7 as this was not a required reporting component per the State contract.