Information redacted in this redacted copy of the FL ITN qualifies as confidential or trade secret information covered under Section 812. 081, Florida Statutes.

BAPTIST
Health Care Corporation

1717 North E Street, Suite 320
Pensacola, FL 32501
Phone: 850-469-2338 Fax: 850-434-4841

October 31, 2017

Office of Procurement
Agency for Health Care Administration
2727 Mahan Drive
Mail Stop #15
Tallahassee, FL 32308

Lighthouse Health Plan, LLC, a Florida Provider Service Network (PSN) is pleased to submit the attached response to the Agency for Health Care Administration's invitation to negotiate AHCA ITN 001–17/18 – Region 1. The enclosed response is for a Standard MMA Plan.

This letter serves as the document covering transmittal of the response package and includes the following information:

- **Respondent's Name:**
  - Lighthouse Health Plan, LLC

- **Respondent's Address:**
  - 1717 North E Street, Suite 320
    Pensacola, FL 32501

- **Respondent's Federal Employer Identification Number:**
  - 82-3182832

- **The names of the respondent's official contact person and an alternate who have the authority to bind the respondent to a Contract, along with both individuals' title, address, telephone number, email address, and official signature.**

  - Official Contact Person:
    Mike Gleason
    President, Lighthouse Health Plan, LLC
    1717 North E Street, Suite 320
    Pensacola, FL 32501
    850-469-7643
    Mike.Gleason@bhcpns.org

- Alternate Contact Person:
  Scott Raynes
  Vice President, Lighthouse Health Plan, LLC
  1717 North E Street, Suite 320
  Pensacola, FL 32501
  850-469-2338
  Scott.Raynes@bhcpns.org

- **A statement authorizing release of the redacted version of the response in the event the Agency receives a public records request.**
  - Lighthouse Health Plan, LLC authorizes the release of the redacted version of this response in the event that the Agency receives a public records request.

Sincerely

Mike Gleason
President, Lighthouse Health Plan, LLC

Scott Raynes
Vice President, Lighthouse Health Plan, LLC

Enclosure

EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

RESPONDENT NAME: LIGHTHOUSE HEALTH PLAN LLC

1. IDENTIFICATION OF PLAN TYPES

I hereby certify that my company is submitting a response to AHCA ITN 001-17/18 to operate as one of the following plan types in Region 1:

☐ Comprehensive Plan

OR

☐ Long-Term Care Plus Plan

OR

☒ Managed Medical Assistance Plan

OR

☐ Specialty Plan

2. QUALIFICATION OF PLAN ELIGIBILITY

I hereby certify my company currently operates as one (1) of the following:

☐ HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one (1) Florida county.

OR

☒ PSN that possesses a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator. A copy of the Third Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation response.

In addition, the respondent shall complete **Exhibit A-2-b,** Provider Service Network Certification of Ownership and Controlling Interest.

OR

☐ Exclusive Provider Organization that meets the licensure requirements of Section 627.6472, Florida Statutes.

EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

OR

☐ Accountable Care Organization authorized under federal law.

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

Lighthouse Health Plan, LLC
Respondent Name

Michael E. Dyer
Authorized Official Signature

10/31/17
Date

Mike Gleason
Authorized Official Printed Name

President
Authorized Official Title

Failure to submit, Exhibit A-2-a, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

LIMITED LIABILITY COMPANY OPERATING AGREEMENT

This Limited Liability Company Agreement (this "**Operating Agreement**") of **Lighthouse Health Plan, LLC**, a Florida limited liability company (the "**Company**"), is made as of October 18, 2017, by and between **Baptist Hospital, Inc.**, a Florida non-profit corporation (the "**BH Member**") and **Evolent Health LLC**, a Delaware limited liability company (the "**EVH Member**").

RECITALS

WHEREAS, the Company was formed as Lighthouse Health Plan, LLC on October 18, 2017, by the filing of Articles of Organization (as amended or otherwise modified from time to time, the "**Articles of Organization**") with the Secretary of State of the Florida Department of State;

WHEREAS, each of the BH Member and EVH Member has agreed to contribute certain funding amounts to the Company, and to take the other actions set forth therein, and in consideration of their respective contributions, the Company agreed to issue to each of the BH Member and EVH Member, the number of Units (defined below) set forth on Exhibit A attached hereto, respectively;

WHEREAS, the parties hereto are forming the Company for the sole purpose of forming a Provider Service Network ("**PSN**") for the Florida Agency for Health Care Administration Statewide Medicaid Managed Care Program in Region 1 (the "**Business**"); and

WHEREAS, the parties hereto wish to enter into this Operating Agreement to, among other things, (i) admit the BH Member and EVH Member as Members (as defined below) of the Company, (ii) provide for the governance and management of the Company and (iii) set forth the respective rights and obligations of Members generally.

NOW, THEREFORE, in consideration of the agreements and obligations set forth herein and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto agree as follows:

[redacted]

(c) Upon the consummation of the Closing, each Member shall hold a number of Units representing the Membership Percentages set forth on Exhibit A hereto.

(d) The Members understand and agree that the Company, among other things, is intended to operate as a PSN and, as such, a health care provider, such as the BH Member, must maintain a controlling interest in the Company as required under Florida law and regulation for purposes of operating a PSN. The Members shall cooperate and act promptly to ensure that such controlling interest is maintained by a Member(s) who qualifies as a health care provider for purposes of maintaining a PSN under Florida law and regulation.

Section 2.02 *Name*. The name of the Company as of the date hereof is **"Lighthouse Health Plan, LLC"** and its business shall be carried on in this name with such variations and changes or in such other trade names as the Board deems necessary or appropriate. The Board shall have the power at any time to change the name of the Company in its sole discretion.

Section 2.03 *Principal Place of Business*. The principal place of business of the Company shall be located at such Pensacola, Florida location as the Board may determine from time to time. The Company may also maintain such other office or offices at such other locations as the Board may determine from time to time.

Section 2.04 *Registered Agent*. The Company's registered agent and office in Florida shall be shall be set forth in the Articles of Organization. At any time, the Board may designate another registered agent and/or registered office.

[redacted]

(d) In furtherance of the Company's stated Business purpose of operating a Florida PSN, the Company shall form a Community Advisory Board consisting of health care providers and community members appointed by the BH Member to report quarterly to the Board regarding the quality of services provided by the Company as a PSN. The Community Advisory Board shall function as an advisory committee only with no voting privileges and shall be chaired by an individual appointed by the BH Member.

(e) Notwithstanding any other language set forth herein, the Company will be managed and operated in accordance with the charitable mission of the BH Member regarding among other items, the promotion of the delivery of quality health services, and the conduct of educational programs, research activities, and any other activities designed to promote the general health, rehabilitation, and social needs of individuals in need. In no event shall the Company engage in activities that (i) jeopardize the exemption under Section 501(c)(3) of the Code of the BH Member or any of its Affiliates, (ii) are inconsistent with the charitable purposes of the BH Member. Notwithstanding any other language set forth herein, the BH Member has final-decision making authority with respect to decisions necessary to protect its exemption under Section 501(c)(3) of the Code and to ensure that the activities undertaken by the Company are not inconsistent with the charitable purposes of the BH Member.

Section 3.03 *Issuance of Units.*

(a) No Units or other Equity Securities shall be issued in respect of any Additional Capital Contribution until such Additional Capital Contribution is actually made. Further, no Units or other Equity Securities shall be issued if the Company reasonably determines that such issuance may cause the Company to no longer qualify as a PSN due to a loss of controlling interest by a Member or Members that are health care providers under Florida law or regulation applicable to PSNs.

[redacted]

ARTICLE 4
CERTAIN RIGHTS AND OBLIGATIONS OF MEMBERS

Section 4.01 *Members*. The Members and their respective numbers of Units and Membership Percentages as of the Closing are listed on Exhibit A attached hereto. The Company shall amend Exhibit A from time to time promptly following any changes in any of such information in accordance with the terms of this Operating Agreement and following a resolution passed by the Members approving such amendment. No Person may be a Member without the ownership of a Unit. The Members shall have only such rights and powers as are granted to them pursuant to the express terms of this Operating Agreement and the Act.

The Members understand and agree that the Company, among other things, is intended to operate as a PSN and, as such, a health care provider, such as the BH Member, must maintain a controlling interest in the Company as required under Florida law and regulation for purposes of operating a PSN. The Members shall cooperate and act promptly to ensure that such controlling interest is maintained by a Member(s) who qualifies as a health care provider for purposes of maintaining a PSN under Florida law and regulation.

[redacted]

[redacted]

[redacted]

[redacted]

ARTICLE 5
BOARD AND OFFICERS

Section 5.01 *Board.*

(a) Except as otherwise expressly provided in this Operating Agreement, the management of the business and affairs of the Company shall be vested in the board of directors of the Company (the "**Board**"). The Board shall be made up of the number of individuals (who need not be Members) (each, a "**Director**") as specified in this Operating Agreement and as increased or decreased by the Board in accordance with the terms hereof. Each Director shall be a "Manager" (as such term is defined in the Act) of the Company but, notwithstanding the foregoing, no Director shall have any rights or powers beyond the rights and powers expressly granted to such Director in this Operating Agreement.

(b) The Board shall be made up initially of five (5) Directors.

(c) The initial composition of the Board shall be as follows:

(i) The BH Member shall have the right to designate a total of three (3) Directors (together, the "**BH Directors**"), none of whom may be a Restricted Person.

(ii) EVH Member shall have the right to designate a total of two (2) Directors (together, the "**EVH Directors**"), none of whom may be a Restricted Person; and

(d) Each of the Company and each Member shall take all necessary action to effectuate the provisions of Section 5.01(b) and Section 5.01(c) to ensure that the Board consists of the Directors who are duly designated, elected or appointed (and/or removed pursuant to Section 5.02)) in accordance with such Section, including by promptly calling and/or voting, as applicable, in any meetings or promptly participating in an action by written consent.

(c) The secretary of the Company (the "**Secretary**") shall use commercially reasonable efforts to circulate to each Director an agenda for each meeting of the Board not less than twenty-four (24) hours in advance of any meeting of the Board. Such agenda shall include any matters that any Director may reasonably request be included on such agenda

(d) At any meeting of the Board, the BH Directors represented at the meeting shall proportionally cast a total of sixty (60) votes and the EVH Directors at the meeting shall proportionally cast a total of forty (40) votes. The intent of the foregoing provision is to ensure that, at any meeting of the Board (no matter how many Directors are actually present), the BH Directors shall cast sixty (60) votes and the EVH Directors shall cast forty (40) votes.

(e) The presence in person or by proxy of at least one (1) BH Director and one (1) EVH Director shall constitute a quorum for the conduct of business at any meeting of the Board. If a quorum is not present at any meeting of the Board, no business may be conducted at such meeting, and the Directors present shall adjourn the meeting and promptly give notice of when it will be reconvened, which shall not be more than thirty (30) days from the date of the original meeting.

(f) Directors may participate in any meeting of the Board or any committee thereof by means of a conference telephone or similar communications equipment by means of which all Directors participating in such meeting may hear one another. Participation in any meeting of the Board pursuant to this Section 5.03(e) shall constitute presence in person at such meeting for purposes of Section 5.03(d) and shall constitute a waiver of any deficiency of notice of such meeting, unless such Director objects, at the beginning of the meeting, to the transaction of any business at such meeting because such meeting was not called or convened in accordance with this Operating Agreement.

(g) The parties understand and agree that the BH Directors shall maintain a controlling interest in the operation of the Company as required for the status of a Florida PSN; provided, however, subject to Section 14.02, any amendment to this Operating Agreement may only be taken upon the approval of Directors representing a total of one hundred percent (100%) of the total votes of the Directors.

(h) The Secretary or, if he or she is not present, any individual whom the Chairman may appoint, shall keep minutes of each meeting of the Board, which shall reflect all actions taken by the Board thereat.

(i) The Board may establish other provisions and procedures relating to the governance of its meetings that are not in conflict with the terms of this Operating Agreement.

(j) Each Director shall be entitled to receive all information (including without limitation, board minutes, board books and financial reports) that is made available to any Director in such Person's capacity as such.

Section 5.04 *Action Without a Meeting.* Notwithstanding Section 5.03, with respect to any matter requiring the approval or consent of the Board under this Operating Agreement or the Act, the Board may take such action without a meeting, if a consent or consents in writing, setting forth the action to be taken, shall be signed by all of the Directors on the Board.

Section 5.05 *Chairman of the Board.* The Chairman of the Board (the "**Chairman**") shall initially be a BH Director. On January 1 of each year, the BH Member shall appoint a Chairman to serve as the Chairman during the then current calendar year; provided, for the avoidance of doubt, that at all times a BH Director or EVH Director, as applicable, shall be the Chairman. The Chairman shall preside at all meetings

of Members and the Board at which he or she is present and perform such other duties as from time to time may be assigned to him or her by the Board.

Section 5.06 *Officers; Designation and Election of Officers; Duties.*

(a) The Board shall delegate management of day-to-day operations of the Company to the Company's leadership team, which shall be led by the Chief Executive Officer of the Company (the "**Chief Executive Officer**"). The Chief Executive Officer shall be appointed by the BH Member.

(b) The Board may, from time to time, employ and retain Persons as may be necessary or appropriate for the conduct of the Company's business (subject to the supervision and control of the Board), including employees, agents and other Persons (any of whom may be a Member or Representative) who may be designated as officers of the Company, with titles including, but not limited to, "chief financial officer," "chief operating officer," "chief compliance officer," "president," "vice president," "treasurer," "secretary" and "general counsel," as and to the extent authorized by the Board. Any number of offices may be held by the same Person. The Board may choose not to fill any office for any period as it may deem advisable. Any officers so designated shall have such authority and perform such duties as the Board and the Chief Executive Officer, from time to time, may delegate to them. The Chief Executive Officer may assign titles to particular officers. Each officer shall hold office until his successor shall be duly designated or until his or her death or until he or she shall resign or shall have been removed in the manner hereinafter provided.

(c) Any officer may resign as such at any time. Such resignation shall be made in writing and shall take effect at the time specified therein, or if no time is specified, at the time of its receipt by the Board. The acceptance by the Board of a resignation of any officer shall not be necessary to make such resignation effective, unless otherwise specified in such resignation. Any officer may be removed as such, either with or without cause, at any time by the Board. Vacancies may be filled by approval of the Board. Designation of any Person as an officer by the Board shall not in and of itself vest in such Person any contractual or employment rights with respect to the Company.

(d) The officers, to the extent of their powers set forth in this Operating Agreement or in resolutions of the Board, shall be agents of the Company for the purpose of the Company's business, and the actions of the officers taken in accordance with such powers shall bind the Company. Any Person dealing with the Company may rely upon a certificate signed by any officer as to: (A) the identity of any Member, Director or officer; (B) the existence or nonexistence of any fact or facts which constitute a condition precedent to acts by Members, the Board or officers or in any other manner germane to the affairs of the Company; (C) the Persons who are authorized to execute and deliver any instrument or document of or on behalf of the Company; (D) the authenticity of any copy of this Operating Agreement and amendments hereto; (E) any act or failure to act by the Company or as to any other matter involving the Company or, solely with respect to the activities of the Company, any Member; and (F) the authority of the Board, any officer, employee or agent of the Company or the Tax Matters Member.

[redacted]

EXHIBIT A

MEMBER INFORMATION

Member	Units	Membership Percentage
Baptist Hospital, Inc.	600	60%
Evolent Health LLC	400	40%
Total	**1,000**	**100%**

FINANCIAL SERVICES COMMISSION

RICK SCOTT
GOVERNOR

JIMMY PATRONIS
CHIEF FINANCIAL OFFICER

PAM BONDI
ATTORNEY GENERAL

ADAM PUTNAM
COMMISSIONER OF AGRICULTURE

OFFICE OF INSURANCE REGULATION

DAVID ALTMAIER
COMMISSIONER

October 26, 2017

Mr. Barrie Blackley
President
Evolent Health LLC
800 North Glebe Road #1500
Arlington, VA 22203

Re: Evolent Health LLC
Florida Company Code: 32512

Dear Mr. Blackley,

Enclosed is the Certificate of Authority for Evolent Health LLC to transact the business of a Third Party Administrator in the state of Florida. This approval is granted contingent upon the conditions set forth in the attached Consent Order.

A summary of this Office's required filings for new insurers authorized to do business in Florida, including information on licensing of Florida agents, may be obtained from our website at www.floir.com.

Our Office staff will continue to be available to offer any assistance to you and your company. If you have any questions, you may call Life & Health Financial Oversight at 850-413-3148.

Sincerely,

David Altmaier

David Altmaier

DA/ps

Enclosure

FLORIDA OFFICE OF INSURANCE REGULATION

EVOLENT HEALTH LLC

Has duly qualified pursuant to Chapter 626.88-626.894, Florida Statutes for a THIRD PARTY ADMINISTRATOR CERTIFICATE OF AUTHORITY and is entitled to transact business in accordance with the authorization cited above.

Original Issuance: 10/26/2017

No. 17 - 453084136

David Altmaier
Commissioner
Office of Insurance Regulation

FILED
OCT 26 2017
OFFICE OF
INSURANCE REGULATION
Docketed by:

OFFICE OF INSURANCE REGULATION

DAVID ALTMAIER
COMMISSIONER

IN THE MATTER OF:

CASE NO.: 216275-17-CO

Application for the issuance of a
Certificate of Authority as an Insurance Administrator to
EVOLENT HEALTH LLC
_____/

CONSENT ORDER

THIS CAUSE came on for consideration upon the filing by EVOLENT HEALTH LLC (hereinafter referred to as "APPLICANT") with the OFFICE OF INSURANCE REGULATION (hereinafter referred to as "OFFICE") of an application for the issuance of a Certificate of Authority as an Insurance Administrator pursuant to the provisions of Chapter 626, Part VII, Florida Statutes (hereinafter referred to as "Application"). Following a complete review of the entire record, and upon consideration thereof, and being otherwise fully advised in the premises, the OFFICE hereby finds as follows:

1. The OFFICE has jurisdiction over the subject matter and parties to this proceeding.

2. APPLICANT has applied for and, subject to the present and continuing satisfaction of the requirements, terms, and conditions established herein, met all of the conditions precedent to be approved as an Insurance Administrator pursuant to the requirements set forth by the Florida Insurance Code.

3. APPLICANT is a for-profit corporation domiciled in the state of Maryland. APPLICANT represents that it is solely owned by Evolent Health, Inc., a publicly held company

that is domiciled in the state of Delaware and whose stock is traded on the New York Stock Exchange under the symbol "EVH". The Application represents that there are no ten percent (10%) or greater shareholders of Evolent Health, Inc. Said representations are material to the issuance of this Consent Order.

4. APPLICANT has made material representations that none of its officers or directors have been found guilty of, or have pleaded guilty or nolo contendere to, a felony or misdemeanor, other than a minor traffic violation, without regard to whether a judgment of conviction was entered by the court.

5. APPLICANT represents that it has submitted complete information on each of the individuals referenced in paragraph four (4) above and that if material information has not been provided, any such individual shall be removed as officer or director within thirty (30) days of receipt of notification from the OFFICE and replaced with a person or persons acceptable to the OFFICE.

6. If, upon receipt of such notification from the OFFICE, pursuant to paragraph five (5) above, APPLICANT does not timely take the required corrective action, APPLICANT agrees that such failure to act would constitute an immediate danger to the public and the OFFICE may immediately suspend, revoke, or take other administrative action as it deems appropriate upon the Certificate of Authority of APPLICANT without further proceedings, pursuant to Sections 120.569(2)(n) and 120.60(6), Florida Statutes.

7. APPLICANT has filed, and the OFFICE has relied upon, the representations in the Plan of Operation and supporting documents submitted with the Application. Written approval must be secured from the OFFICE prior to any material deviation from said Plan of Operation.

8. APPLICANT affirms that all information, submissions, explanations, representations, and documents provided to the OFFICE in connection with APPLICANT's Application, including all attachments and supplements thereto, are material to the issuance of this Consent Order and fully describe all transactions, agreements, and understandings regarding the operation of APPLICANT.

9. APPLICANT agrees that it will immediately surrender its Certificate of Authority to the OFFICE if:

a. None of the Provider Service Networks (hereinafter referred to as "PSNs") for which APPLICANT intends to provide administrative services, as defined in Section 626.88(1), Florida Statutes, is awarded a contract by the Agency for Healthcare Administration to participate in the Florida Statewide Medicaid Managed Care program beginning in 2019; or

b. None of the PSNs awarded a contract by the Agency for Healthcare Administration to participate in the above-referenced Florida Statewide Medicaid Managed Care program, with which APPLICANT contracts to provide administrative services, as defined in Section 626.88(1), Florida Statutes, receives a Health Maintenance Organization Certificate of Authority pursuant to Chapter 641, Part I, Florida Statutes, by January 1, 2019.

10. APPLICANT shall submit copies of any administrative agreements or management services agreements, whether with affiliates or unrelated parties, to the OFFICE for review and written approval prior to execution of such agreements and provision of administrative services under such agreements.

11. APPLICANT agrees that if it considers entering into health care risk contracts as defined in Section 641.234(4)(b), Florida Statutes, APPLICANT shall submit a copy of each health care risk contract to the OFFICE for review and approval prior to entering into such contracts.

12. Within three (3) months after the end of APPLICANT's fiscal year, APPLICANT shall file with the OFFICE full and true statements of its financial condition, transactions, and affairs, as required by Section 626.89(1), Florida Statutes.

13. APPLICANT shall comply with Section 626.89(2), Florida Statutes, which requires APPLICANT to file with the OFFICE, within five (5) months after the end of the APPLICANT's fiscal year, audited financial statements for the preceding fiscal year performed by an independent certified public accountant in accordance with United States generally accepted accounting principles.

14. All required reports and agreements referenced in paragraphs ten (10), eleven (11), twelve (12), and thirteen (13) above shall be filed via the OFFICE's Regulatory Electronic Filing System ("REFS"), at http://www.floir.com/iportal.

15. APPLICANT shall report to the OFFICE, Life & Health Financial Oversight, any time that it is named as a party defendant in a class action lawsuit within fifteen (15) days after the class is certified, and APPLICANT shall include a copy of the complaint at the time it reports the class action lawsuit to the OFFICE.

16. The deadlines set forth in this Consent Order may be extended by written approval of the OFFICE. Approval of any deadline extension is subject to statutory or administrative regulation limitations. Additionally, the various reporting requirements and any other provision or requirement set forth in this Consent Order may be altered or terminated by written approval of the OFFICE.

17. APPLICANT shall maintain an information security program for the security and protection of confidential and proprietary information under its control that complies with all applicable laws and regulations regarding information security. APPLICANT agrees it shall

continually monitor and enhance its information security program in order to mitigate data security breaches. APPLICANT further agrees that it shall notify the OFFICE within five (5) business days of identifying a data breach.

18. Within sixty (60) days from the date of the execution of this Consent Order, APPLICANT shall submit, or cause to be submitted, to the OFFICE a certification evidencing compliance with all of the requirements of this Consent Order. Any exceptions shall be so noted and contained in the certification. Exceptions noted in the certification shall also include a timeline defining when the outstanding requirements of the Consent Order will be complete. Said certification shall be submitted to the OFFICE via electronic mail and directed to the attention of the Assistant General Counsel representing the OFFICE in this matter and as named in this Consent Order.

19. Executive Order 13224 prohibits any transactions by U.S. persons involving the blocked assets and interests of terrorists and terrorist support organizations. APPLICANT shall maintain and adhere to procedures necessary to detect and prevent prohibited transactions with those individuals and entities, which that have been identified at the Treasury Department's Office of Foreign Assets Control website, http://www.treas.gov/ofac.

20. APPLICANT affirms that all representations made herein are true and all requirements set forth herein are material to the issuance of this Consent Order.

21. APPLICANT agrees that, upon execution of this Consent Order, failure to adhere to one or more the above terms and conditions contained herein may result, without further proceedings, in the OFFICE suspending, revoking, or taking other administrative action as it deems appropriate upon APPLICANT's Certificate of Authority in this state in accordance with Sections 120.569(2)(n) and 120.60(6), Florida Statutes.

22. APPLICANT expressly waives a hearing in this matter, the making of findings of fact and conclusions of law by the OFFICE, and all further and other proceedings herein to which it may be entitled by law or rules of the OFFICE. APPLICANT hereby knowingly and voluntarily waives all rights to challenge or to contest this Consent Order in any forum available to it, now or in the future, including the right to any administrative proceeding, state or federal court action, or any appeal.

23. Each party to this action shall bear its own costs and attorney's fees.

24. The parties agree that this Consent Order shall be deemed to be executed when the OFFICE has signed and docketed a copy of this Consent Order bearing the signature of the authorized representative of the APPLICANT, notwithstanding the fact that the copy may have been transmitted to the OFFICE electronically. Further, APPLICANT agrees that the signature of its authorized representative as affixed to this Consent Order shall be under the seal of a Notary Public.

WHEREFORE, the agreement between EVOLENT HEALTH LLC and the OFFICE OF INSURANCE REGULATION, the terms and conditions of which are set forth above, is APPROVED, and the Application for the issuance of a Certificate of Authority to EVOLENT HEALTH LLC, pursuant to Section 626.8805, Florida Statutes, is APPROVED.

FURTHER, all terms and conditions contained herein are hereby ORDERED.

DONE and ORDERED this 26 day of October, 2017.

David Altmaier

David Altmaier, Commissioner
Office of Insurance Regulation

By execution hereof, EVOLENT HEALTH LLC consents to entry of this Consent Order, agrees without reservation to all of the above terms and conditions, and shall be bound by all provisions herein. The undersigned represents that he or she has the authority to bind EVOLENT HEALTH LLC to the terms and conditions of this Consent Order.

EVOLENT HEALTH LLC

[Corporate Seal]

By: Seth BR

Print Name: Seth Blackley

Title: President

Date: 10/25/17

STATE OF Virginia

COUNTY OF Arlington

The foregoing instrument was acknowledged before me this 25th day of October, 2017

by Seth Blackley (Name of Person) as President (Type of Authority – e.g. officer, trustee, attorney-in-fact)

for Evolent Health (Company Name).

CHELSEA IRENE CODD NOTARY PUBLIC REG # 7737081 COMMISSION EXPIRES 2/28/2021 COMMONWEALTH OF VIRGINIA

Chelsea Irene Codd
(Signature of the Notary)

Chelsea Irene Codd
(Print, Type or Stamp Commissioned Name of Notary)

Personally Known X OR Produced Identification _____

Type of Identification Produced _____

My Commission Expires 2/28/2021

COPIES FURNISHED TO:

SETH BLACKLEY, PRESIDENT
Evolent Health LLC
800 N Glebe Road, Suite 500
Arlington, VA 22203
Email: sblackley@evolenthealth.com

CAROLYN MORGAN, DIRECTOR
Life & Health Financial Oversight
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399
Email: Carolyn.Morgan@floir.com

ALYSSA LATHROP, ASSISTANT GENERAL COUNSEL
Office of Insurance Regulation
200 East Gaines Street
Tallahassee, FL 32399
Telephone: (850) 413-4213
Email: Alyssa.Lathrop@floir.com

EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST

RESPONDENT NAME: Lighthouse Health Plan, LLC

I hereby certify that the respondent submitting this reply is a Provider Service Network ("PSN") as defined in Sections 409.912(2)(b) and 409.962(14), Florida Statutes, or 409.962(9), Florida Statutes:

> A PSN is a network established or organized and operated by a health care provider, or group of affiliated health care providers, which provides a substantial proportion of the health care items and services under a contract directly through the provider or affiliated group of providers and may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians, by other health professionals, or through the institutions. The health care providers must have a controlling interest in the governing body of the PSN network organization. Fla. Stat. § 409.912(2)(b) (2016).
>
> "PSN" means an entity qualified pursuant to Section 409.912(2), Florida Statutes of which a controlling interest is owned by a health care provider, or group of affiliated providers, or a public agency or entity that delivers health services. Health care providers include Florida-licensed health care professionals or licensed health care facilities, federally qualified health care centers, and home health care agencies. Fla. Stat. § 409.962(14) (2016)
>
> "Long-term care PSN" means a PSN a controlling interest of which is owned by one or more licensed nursing homes, assisted living facilities with seventeen (17) or more beds, home health agencies, community care for the elderly lead agencies, or hospices. Fla. Stat. § 409.962(9) (2016).

Please provide the following additional information.

1. The PSN's first year of operation: 2017

2. The Agency considers the first year of operation to begin on the date that the vendor was organized. Please provide the articles of incorporation, articles of organization, partnership agreement, certificate of limited partnership, or other formation documentation demonstrating the first year of operation of the PSN.

EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST

3. Identify (in the field below) the health care provider or group of affiliated health care providers (or licensed nursing homes, assisted living facilities with seventeen (17) or more beds, home health agencies, community care for the elderly lead agencies, or hospices) that have a controlling interest in the governing body of the PSN and the basis for such controlling interest.

   Baptist Hospital, Inc.

4. To the extent that such health care provider or group of affiliated health care providers identified above is not the ultimate owner, then identify (in the field below) such owners and the affiliates of such health care provider or group of affiliated health care providers and their ultimate owners, indicating the percentage of such ownership. Please see the Affiliation Criterion to Determine Controlling Interest for Purposes of the SMMC solicitation below.

   Baptist Health Care Corporation is the ultimate owner of Baptist Hospital, Inc. There are no affiliates that control or have the power to control Baptist Health Care Corporation.

5. Provide a detailed explanation (in the field below), with references to documentation and other information required by this section, that demonstrates how the vendor qualifies under the statutes and requirements of this solicitation to provide services as a PSN or LTC PSN providing services as a Managed Care Plan.

   Baptist Hospital, Inc., a Florida non-profit corporation, is the majority member of Lighthouse Health Plan, LLC. Baptist Hospital, Inc. employs professional health care providers throughout AHCA Region 1 including the following:
   - Baptist Medical Group, LLC
   - Baptist Physician Associates, LLC
   - Andrews Institute Rehab, LLC
   - Andrews Institute AS, LLC

   In addition, Baptist Hospital, Inc's ultimate owner, Baptist Health Care Corporation owns and operates health care facilities throughout AHCA Region 1, which include three hospitals, four medical parks, a behavioral health network, child protectives services, workplacement for persons with disabilities and an institute for orthopaedics and sports medicine.

   - Andrews Institute for Orthopaedics & Sports Medicine
   - Baptist Hospital
   - Gulf Breeze Hospital

- Jay Hospital
- Baptist Medical Park – Airport
- Baptist Medical Park – Navarre
- Baptist Medical Park – Nine Mile
- Baptist Medical Park – Pace
- Lakeview Center

As Baptist Hospital, Inc. is the majority member of Lighthouse Health Plan, LLC (PSN) with 60% ownership of the units of the PSN and appoints the majority of directors and the CEO of the PSN. While the PSN contracts with the minority member, Evolent Health LLC, to provide administrative services, Baptist Hospital, Inc. maintains control of the PSN by virtue of its control of the Board of Directors and CEO of the PSN. We have included the redacted pages from the operating agreement of the PSN demonstrating that Baptist Hospital, Inc. maintains the controlling interest in the PSN.

6. The individual that signed the Transmittal Letter or a person authorized in the Transmittal Letter to sign on behalf of the respondent as required by **Attachment A**, Instructions and Special Conditions, **Section B.**, Response Preparation and Content, **Sub-Section 2.**, Mandatory Response Content, **Item a.**, Transmittal (Cover) Letter, shall sign the responses to these requests for additional information above.

Affiliation Criteria to Determine Controlling Interest for Purposes of the SMMC Solicitation

7. For purposes of responding to the above, use the following General Principles of Affiliation to determine whether a controlling interest exists.

   a. Concerns and entities are affiliates of each other when one controls or has the power to control the other, or a third party or parties controls or has the power to control both. It does not matter whether control is exercised, so long as the power to control exists.

   b. The Agency considers factors such as ownership, management, previous relationships with or ties to another concern, and contractual relationships, in determining whether affiliation exists.

   c. Control may be affirmative or negative. Negative control includes, but is not limited to, instances where a minority shareholder has the ability, under the concern's charter, by-laws, or shareholder's

agreement, to prevent a quorum or otherwise block action by the board of directors or shareholders.

d. Affiliation may be found where an individual, concern, or entity exercises control indirectly through a third party.

e. In determining whether affiliation exists, the Agency will consider the totality of the circumstances, and may find affiliation even though no single factor is sufficient to constitute affiliation.

8. Affiliation based on stock ownership.

a. A person (including any individual, concern or other entity) that owns, or has the power to control, fifty percent (50%) or more of a concern's voting stock, or a block of voting stock which is large compared to other outstanding blocks of voting stock, controls or has the power to control the concern.

b. If two or more persons (including any individual, concern or other entity) each owns, controls, or has the power to control less than fifty percent (50%) of a concern's voting stock, and such minority holdings are equal or approximately equal in size, and the aggregate of these minority holdings is large as compared with any other stock holding, the Agency presumes that each such person controls or has the power to control the concern whose size is at issue. This presumption may be rebutted by a showing that such control or power to control does not in fact exist.

c. If a concern's voting stock is widely held and no single block of stock is large as compared with all other stock holdings, the concern's Board of Directors and CEO or President will be deemed to have the power to control the concern in the absence of evidence to the contrary.

9. Affiliation arising under stock options, convertible securities, and agreements to merge.

a. The Agency considers stock options, convertible securities, and agreements to merge (including agreements in principle) to have a present effect on the power to control a concern. The Agency treats such options, convertible securities, and agreements as though the rights granted have been exercised.

b. Agreements to open or continue negotiations towards the possibility of a merger or a sale of stock at some later date are not considered "agreements in principle" and are thus not given present effect.

c. Options, convertible securities, and agreements that are subject to conditions precedent which are incapable of fulfillment, speculative, conjectural, or unenforceable under State or federal law, or where the probability of the transaction (or exercise of the rights) occurring is shown to be extremely remote, are not given present effect.

d. An individual, concern or other entity that controls one or more other concerns cannot use options, convertible securities, or agreements to appear to terminate such control before actually doing so. The Agency will not give present effect to individuals', concerns' or other entities' ability to divest all or part of their ownership interest in order to avoid a finding of affiliation.

10. Affiliation based on common management. Affiliation arises where one or more officers, directors, managing members, or partners who control the board of directors and/or management of one concern also control the board of directors or management of one or more other concerns.

11. Affiliation based on identity of interest. Affiliation may arise among two or more persons with an identity of interest. Individuals or firms that have identical or substantially identical business or economic interests (such as family members, individuals or firms with common investments, or firms that are economically dependent through contractual or other relationships) may be treated as one party with such interests aggregated. An individual or firm may rebut that determination with evidence showing that the interests deemed to be one are in fact separate.

a. Firms owned or controlled by married couples, parties to a civil union, parents, children, and siblings are presumed to be affiliated with each other if they conduct business with each other, such as subcontracts or joint ventures or share or provide loans, resources, equipment, locations or employees with one another. This presumption may be overcome by showing a clear line of fracture between the concerns. Other types of familial relationships are not grounds for affiliation on family relationships.

b. The Agency may presume an identity of interest based upon economic dependence if the concern in question derived seventy percent (70%) or more of its receipts from another concern over the previous three (3) fiscal years. This presumption may be rebutted by

a showing that despite the contractual relations with another concern, the concern at issue is not solely dependent on that other concern, such as where the concern has been in business for a short amount of time and has only been able to secure a limited number of contracts.

12. Affiliation based on newly organized concern. Affiliation may arise where former officers, directors, principal stockholders, managing members, or key employees of one concern organize a new concern in the same or related industry or field of operation, and serve as the new concern's officers, directors, principal stockholders, managing members, or key employees, and the one concern is furnishing or will furnish the new concern with contracts, financial or technical assistance, indemnification on bid or performance bonds, and/or other facilities, whether for a fee or otherwise. A concern may rebut such an affiliation determination by demonstrating a clear line of fracture between the two concerns. A "key employee" is an employee who, because of his/her position in the concern, has a critical influence in or substantive control over the operations or management of the concern.

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EXHIBIT A-2-b
PROVIDER SERVICE NETWORK CERTIFICATION OF OWNERSHIP AND CONTROLLING INTEREST

Signature below indicates the respondent's full acknowledgement of, understanding of, and agreement with the certification identified above as written and without caveat.

Lighthouse Health Plan, LLC
Respondent Name

Authorized Official Signature

10/31/17
Date

Mike Gleason
Authorized Official Printed Name

President
Authorized Official Title

Failure to submit, Exhibit A-2-b, Provider Service Network Certification of Ownership and Controlling Interest, signed by an authorized official may result in the rejection of response.

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Electronic Articles of Organization
For
Florida Limited Liability Company

L17000216087
FILED 8:00 AM
October 18, 2017
Sec. Of State
slsingleton

Article I

The name of the Limited Liability Company is:

LIGHTHOUSE HEALTH PLAN, LLC

Article II

The street address of the principal office of the Limited Liability Company is:

1717 NORTH
SUITE 320
PENSACOLA, FL. 32501

The mailing address of the Limited Liability Company is:

1717 NORTH
SUITE 320
PENSACOLA, FL. 32501

Article III

The name and Florida street address of the registered agent is:

ELIZABETH C CALLAHAN
1717 NORTH
SUITE 320
PENSACOLA, FL. 32501

Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relating to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.

Registered Agent Signature: ELIZABETH CALLAHAN

Article IV

L17000216087
FILED 8:00 AM
October 18, 2017
Sec. Of State
slsingleton

The name and address of person(s) authorized to manage LLC:

Title: MGR
BAPTIST HOSPITAL, INC.
1717 NORTH
PENSACOLA, FL. 32501

Title: MGR
EVOLENT HEALTH LLC
800 N. GLEBE ROAD, SUITE 500
ARLINGTON, VA. 22203

Signature of member or an authorized representative

Electronic Signature: ELIZABETH CALLAHAN

I am the member or authorized representative submitting these Articles of Organization and affirm that the facts stated herein are true. I am aware that false information submitted in a document to the Department of State constitutes a third degree felony as provided for in s.817.155, F.S. I understand the requirement to file an annual report between January 1st and May 1st in the calendar year following formation of the LLC and every year thereafter to maintain "active" status.

LIMITED LIABILITY COMPANY OPERATING AGREEMENT

This Limited Liability Company Agreement (this "**Operating Agreement**") of **Lighthouse Health Plan, LLC**, a Florida limited liability company (the "**Company**"), is made as of October 18, 2017, by and between **Baptist Hospital, Inc.**, a Florida non-profit corporation (the "**BH Member**") and **Evolent Health LLC**, a Delaware limited liability company (the "**EVH Member**").

RECITALS

WHEREAS, the Company was formed as Lighthouse Health Plan, LLC on October 18, 2017, by the filing of Articles of Organization (as amended or otherwise modified from time to time, the "**Articles of Organization**") with the Secretary of State of the Florida Department of State;

WHEREAS, each of the BH Member and EVH Member has agreed to contribute certain funding amounts to the Company, and to take the other actions set forth therein, and in consideration of their respective contributions, the Company agreed to issue to each of the BH Member and EVH Member, the number of Units (defined below) set forth on Exhibit A attached hereto, respectively;

WHEREAS, the parties hereto are forming the Company for the sole purpose of forming a Provider Service Network ("**PSN**") for the Florida Agency for Health Care Administration Statewide Medicaid Managed Care Program in Region 1 (the "**Business**"); and

WHEREAS, the parties hereto wish to enter into this Operating Agreement to, among other things, (i) admit the BH Member and EVH Member as Members (as defined below) of the Company, (ii) provide for the governance and management of the Company and (iii) set forth the respective rights and obligations of Members generally.

NOW, THEREFORE, in consideration of the agreements and obligations set forth herein and for other good and valuable consideration, the receipt and adequacy of which are hereby acknowledged, the parties hereto agree as follows:

[redacted]

(c) Upon the consummation of the Closing, each Member shall hold a number of Units representing the Membership Percentages set forth on Exhibit A hereto.

(d) The Members understand and agree that the Company, among other things, is intended to operate as a PSN and, as such, a health care provider, such as the BH Member, must maintain a controlling interest in the Company as required under Florida law and regulation for purposes of operating a PSN. The Members shall cooperate and act promptly to ensure that such controlling interest is maintained by a Member(s) who qualifies as a health care provider for purposes of maintaining a PSN under Florida law and regulation.

Section 2.02 *Name*. The name of the Company as of the date hereof is **"Lighthouse Health Plan, LLC"** and its business shall be carried on in this name with such variations and changes or in such other trade names as the Board deems necessary or appropriate. The Board shall have the power at any time to change the name of the Company in its sole discretion.

Section 2.03 *Principal Place of Business*. The principal place of business of the Company shall be located at such Pensacola, Florida location as the Board may determine from time to time. The Company may also maintain such other office or offices at such other locations as the Board may determine from time to time.

Section 2.04 *Registered Agent*. The Company's registered agent and office in Florida shall be shall be set forth in the Articles of Organization. At any time, the Board may designate another registered agent and/or registered office.

[redacted]

(d) In furtherance of the Company's stated Business purpose of operating a Florida PSN, the Company shall form a Community Advisory Board consisting of health care providers and community members appointed by the BH Member to report quarterly to the Board regarding the quality of services provided by the Company as a PSN. The Community Advisory Board shall function as an advisory committee only with no voting privileges and shall be chaired by an individual appointed by the BH Member.

(e) Notwithstanding any other language set forth herein, the Company will be managed and operated in accordance with the charitable mission of the BH Member regarding among other items, the promotion of the delivery of quality health services, and the conduct of educational programs, research activities, and any other activities designed to promote the general health, rehabilitation, and social needs of individuals in need. In no event shall the Company engage in activities that (i) jeopardize the exemption under Section 501(c)(3) of the Code of the BH Member or any of its Affiliates, (ii) are inconsistent with the charitable purposes of the BH Member. Notwithstanding any other language set forth herein, the BH Member has final-decision making authority with respect to decisions necessary to protect its exemption under Section 501(c)(3) of the Code and to ensure that the activities undertaken by the Company are not inconsistent with the charitable purposes of the BH Member.

Section 3.03 *Issuance of Units.*

(a) No Units or other Equity Securities shall be issued in respect of any Additional Capital Contribution until such Additional Capital Contribution is actually made. Further, no Units or other Equity Securities shall be issued if the Company reasonably determines that such issuance may cause the Company to no longer qualify as a PSN due to a loss of controlling interest by a Member or Members that are health care providers under Florida law or regulation applicable to PSNs.

[redacted]

ARTICLE 4
CERTAIN RIGHTS AND OBLIGATIONS OF MEMBERS

Section 4.01 *Members*. The Members and their respective numbers of Units and Membership Percentages as of the Closing are listed on Exhibit A attached hereto. The Company shall amend Exhibit A from time to time promptly following any changes in any of such information in accordance with the terms of this Operating Agreement and following a resolution passed by the Members approving such amendment. No Person may be a Member without the ownership of a Unit. The Members shall have only such rights and powers as are granted to them pursuant to the express terms of this Operating Agreement and the Act.

The Members understand and agree that the Company, among other things, is intended to operate as a PSN and, as such, a health care provider, such as the BH Member, must maintain a controlling interest in the Company as required under Florida law and regulation for purposes of operating a PSN. The Members shall cooperate and act promptly to ensure that such controlling interest is maintained by a Member(s) who qualifies as a health care provider for purposes of maintaining a PSN under Florida law and regulation.

[redacted]

[redacted]

[redacted]

[redacted]

ARTICLE 5
BOARD AND OFFICERS

Section 5.01 *Board.*

(a) Except as otherwise expressly provided in this Operating Agreement, the management of the business and affairs of the Company shall be vested in the board of directors of the Company (the "**Board**"). The Board shall be made up of the number of individuals (who need not be Members) (each, a "**Director**") as specified in this Operating Agreement and as increased or decreased by the Board in accordance with the terms hereof. Each Director shall be a "Manager" (as such term is defined in the Act) of the Company but, notwithstanding the foregoing, no Director shall have any rights or powers beyond the rights and powers expressly granted to such Director in this Operating Agreement.

(b) The Board shall be made up initially of five (5) Directors.

(c) The initial composition of the Board shall be as follows:

(i) The BH Member shall have the right to designate a total of three (3) Directors (together, the "**BH Directors**"), none of whom may be a Restricted Person.

(ii) EVH Member shall have the right to designate a total of two (2) Directors (together, the "**EVH Directors**"), none of whom may be a Restricted Person; and

(d) Each of the Company and each Member shall take all necessary action to effectuate the provisions of Section 5.01(b) and Section 5.01(c) to ensure that the Board consists of the Directors who are duly designated, elected or appointed (and/or removed pursuant to Section 5.02)) in accordance with such Section, including by promptly calling and/or voting, as applicable, in any meetings or promptly participating in an action by written consent.

(c) The secretary of the Company (the "**Secretary**") shall use commercially reasonable efforts to circulate to each Director an agenda for each meeting of the Board not less than twenty-four (24) hours in advance of any meeting of the Board. Such agenda shall include any matters that any Director may reasonably request be included on such agenda

(d) At any meeting of the Board, the BH Directors represented at the meeting shall proportionally cast a total of sixty (60) votes and the EVH Directors at the meeting shall proportionally cast a total of forty (40) votes. The intent of the foregoing provision is to ensure that, at any meeting of the Board (no matter how many Directors are actually present), the BH Directors shall cast sixty (60) votes and the EVH Directors shall cast forty (40) votes.

(e) The presence in person or by proxy of at least one (1) BH Director and one (1) EVH Director shall constitute a quorum for the conduct of business at any meeting of the Board. If a quorum is not present at any meeting of the Board, no business may be conducted at such meeting, and the Directors present shall adjourn the meeting and promptly give notice of when it will be reconvened, which shall not be more than thirty (30) days from the date of the original meeting.

(f) Directors may participate in any meeting of the Board or any committee thereof by means of a conference telephone or similar communications equipment by means of which all Directors participating in such meeting may hear one another. Participation in any meeting of the Board pursuant to this Section 5.03(e) shall constitute presence in person at such meeting for purposes of Section 5.03(d) and shall constitute a waiver of any deficiency of notice of such meeting, unless such Director objects, at the beginning of the meeting, to the transaction of any business at such meeting because such meeting was not called or convened in accordance with this Operating Agreement.

(g) The parties understand and agree that the BH Directors shall maintain a controlling interest in the operation of the Company as required for the status of a Florida PSN; provided, however, subject to Section 14.02, any amendment to this Operating Agreement may only be taken upon the approval of Directors representing a total of one hundred percent (100%) of the total votes of the Directors.

(h) The Secretary or, if he or she is not present, any individual whom the Chairman may appoint, shall keep minutes of each meeting of the Board, which shall reflect all actions taken by the Board thereat.

(i) The Board may establish other provisions and procedures relating to the governance of its meetings that are not in conflict with the terms of this Operating Agreement.

(j) Each Director shall be entitled to receive all information (including without limitation, board minutes, board books and financial reports) that is made available to any Director in such Person's capacity as such.

Section 5.04 *Action Without a Meeting.* Notwithstanding Section 5.03, with respect to any matter requiring the approval or consent of the Board under this Operating Agreement or the Act, the Board may take such action without a meeting, if a consent or consents in writing, setting forth the action to be taken, shall be signed by all of the Directors on the Board.

Section 5.05 *Chairman of the Board.* The Chairman of the Board (the "**Chairman**") shall initially be a BH Director. On January 1 of each year, the BH Member shall appoint a Chairman to serve as the Chairman during the then current calendar year; provided, for the avoidance of doubt, that at all times a BH Director or EVH Director, as applicable, shall be the Chairman. The Chairman shall preside at all meetings

of Members and the Board at which he or she is present and perform such other duties as from time to time may be assigned to him or her by the Board.

Section 5.06 *Officers; Designation and Election of Officers; Duties.*

(a) The Board shall delegate management of day-to-day operations of the Company to the Company's leadership team, which shall be led by the Chief Executive Officer of the Company (the "**Chief Executive Officer**"). The Chief Executive Officer shall be appointed by the BH Member.

(b) The Board may, from time to time, employ and retain Persons as may be necessary or appropriate for the conduct of the Company's business (subject to the supervision and control of the Board), including employees, agents and other Persons (any of whom may be a Member or Representative) who may be designated as officers of the Company, with titles including, but not limited to, "chief financial officer," "chief operating officer," "chief compliance officer," "president," "vice president," "treasurer," "secretary" and "general counsel," as and to the extent authorized by the Board. Any number of offices may be held by the same Person. The Board may choose not to fill any office for any period as it may deem advisable. Any officers so designated shall have such authority and perform such duties as the Board and the Chief Executive Officer, from time to time, may delegate to them. The Chief Executive Officer may assign titles to particular officers. Each officer shall hold office until his successor shall be duly designated or until his or her death or until he or she shall resign or shall have been removed in the manner hereinafter provided.

(c) Any officer may resign as such at any time. Such resignation shall be made in writing and shall take effect at the time specified therein, or if no time is specified, at the time of its receipt by the Board. The acceptance by the Board of a resignation of any officer shall not be necessary to make such resignation effective, unless otherwise specified in such resignation. Any officer may be removed as such, either with or without cause, at any time by the Board. Vacancies may be filled by approval of the Board. Designation of any Person as an officer by the Board shall not in and of itself vest in such Person any contractual or employment rights with respect to the Company.

(d) The officers, to the extent of their powers set forth in this Operating Agreement or in resolutions of the Board, shall be agents of the Company for the purpose of the Company's business, and the actions of the officers taken in accordance with such powers shall bind the Company. Any Person dealing with the Company may rely upon a certificate signed by any officer as to: (A) the identity of any Member, Director or officer; (B) the existence or nonexistence of any fact or facts which constitute a condition precedent to acts by Members, the Board or officers or in any other manner germane to the affairs of the Company; (C) the Persons who are authorized to execute and deliver any instrument or document of or on behalf of the Company; (D) the authenticity of any copy of this Operating Agreement and amendments hereto; (E) any act or failure to act by the Company or as to any other matter involving the Company or, solely with respect to the activities of the Company, any Member; and (F) the authority of the Board, any officer, employee or agent of the Company or the Tax Matters Member.

[redacted]

EXHIBIT A

MEMBER INFORMATION

Member	Units	Membership Percentage
Baptist Hospital, Inc.	600	60%
Evolent Health LLC	400	40%
Total	**1,000**	**100%**

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

RESPONDENT NAME: Lighthouse Health Plan, LLC

1. ACCEPTANCE OF SOLICITATION REQUIREMENTS

I hereby certify that I understand and agree that my organization has read all requirements and Agency specifications provided in this solicitation, accepts said requirements, and that this response is made in accordance with the provisions of such requirements and specifications. By my written signature below, I guarantee and certify that all items included in this response shall meet or exceed any and all such requirements and Agency specifications. I further agree, if awarded a Contract resulting from this solicitation, to deliver services that meet or exceed the requirements and specifications provided in this solicitation.

AND

2. ACCEPTANCE OF CONTRACT TERMS AND CONDITIONS

I hereby certify that should my organization be awarded a Contract resulting from this solicitation, it will comply with all terms and conditions as specified in this solicitation and in the Agency Standard Contract (**Exhibit A-8, including Attachments II - V**).

AND

3. STATEMENT OF NO-INVOLVEMENT

I hereby certify that neither my organization nor any person with an interest in the organization had any prior involvement in performing a feasibility study of the implementation of the subject Contract, in drafting of this solicitation or in developing the subject program.

AND

4. PROHIBITION OF GRATUITIES

I hereby certify that no elected official or employee of the State of Florida has or shall benefit financially or materially from such my organization's response or subsequent Contract in violation of the provisions of Chapter 112, Florida Statutes. I understand that any Contract issued as a result of this solicitation may be terminated if it is determined that gratuities of any kind were either offered or received by any of the aforementioned parties.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

AND

5. NON-COLLUSION CERTIFICATION

I hereby certify that all persons, companies, or parties interested in the response as principals are named therein, that the response is made without collusion with any other person, persons, organization, or parties submitting a response; that it is in all respects made in good faith; and as the signer of the response, I have full authority to legally bind the prospective respondent to the provisions of this solicitation.

AND

6. PERFORMANCE OF SERVICES

I hereby certify my organization shall ensure all services, provided directly or indirectly under the Contract resulting from this solicitation, will be performed within the borders of the United States and its territories and protectorates.

AND

7. ORGANIZATIONAL CONFLICT OF INTEREST CERTIFICATION

The standards on organizational conflicts of interest in Title 48, Code of Federal Regulations, Subpart 9.5 – Organizational and Consultant Conflicts of Interest and Section 287.057(17), Florida Statutes, apply to this solicitation. A respondent with an actual or potential organizational conflict of interest shall disclose the conflict. If the respondent believes the conflict of interest can be mitigated, neutralized or avoided, the respondent shall submit a Conflict of Interest Mitigation Plan with its response, that shall, at a minimum:

a) Identify any relationship, financial interest or other activity which may create an actual or potential organizational conflict of interest.
b) Describe the actions the respondent intends to take to mitigate, neutralize, or avoid the identified organizational conflicts of interest.
c) Identify the official within the respondent's organization responsible for making conflict of interest determinations.

The Conflict of Interest Mitigation Plan will be evaluated as acceptable or not acceptable. The Agency reserves the right to request additional information from the respondent or other sources, as deemed necessary, to determine whether or not the plan adequately neutralizes, mitigates, or avoids the identified conflicts.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Pursuant to the aforementioned requirements, I hereby certify that, to the best of my knowledge, my organization (including its subcontractors, subsidiaries and partners):

Please check the applicable paragraph below. Do not check more than one of the paragraphs below.

☒ Has no existing relationship, financial interest or other activity which creates any actual or potential organizational conflicts of interest relating to the award of a Contract resulting from this solicitation.

☐ Has included information in its response to this solicitation detailing the existence of actual or potential organizational conflicts of interest and has provided a "Conflict of Interest Mitigation Plan", as outlined above.

AND

8. RESPONDENT ATTESTATION FOR EXHIBIT A-4

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Exhibit A-4**, Submission Requirements and Evaluation Criteria, including **Exhibits A-4-a, A-4-b, A-4-c and A-4-d,** including all exhibits/attachments, as applicable.

I understand the Agency may not consider supplemental response narrative for evaluation which is not contained within the Response Sections contained in **Exhibit A-4,** Submission Requirements and Evaluation Criteria.

AND

9. RESPONDENT ATTESTATION FOR ATTACHMENT C, COST PROPOSAL INSTRUCTIONS AND RATE METHODOLOGY NARRATIVE

I hereby certify that no modification and/or alteration has been made to the template, narrative and/or instructions contained in **Attachment C, Cost Proposal Instructions and Rate Methodology Narrative, including all applicable exhibits**.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

AND

10. RESPONDENT ATTESTATION REGARDING SCRUTINIZED COMPANIES LIST

I hereby certify that my company is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to Section 215.473, Florida Statutes. Pursuant to Section 287.135(5), Florida Statutes, the respondent agrees the Agency may immediately terminate the resulting Contract for cause if the respondent is found to have submitted a false certification or if the respondent is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the term of the resulting Contract.

AND

11. NAMES OF OPERATION

I hereby certify the following is a list of all names under which my organization has operated during the past five (5) years (since July 14, 2012).

Lighthouse Health Plan, LLC

AND

12. BUSINESS RELATIONSHIP

The respondent shall disclose any business relationship (as defined in Section 409.966(3)(e), Florida Statutes) with any other eligible Managed Care Plan that is a potential respondent to this solicitation. Such disclosure shall include identifying information for each Managed Care Plan, the nature of the business relationship, the current service area of each Managed Care Plan (by line of business), and the signature of the authorized representative for each Managed Care Plan.

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

The respondent must disclose any business relationship(s) in the space provided below:

Respondent does not have such a business relationship with another eligible Managed Care Plan

AND

13. COMPLETE MEDICAID PROVIDER ENROLLMENT PACKAGE SUBMISSION

I hereby certify my organization, if awarded a Contract, shall provide the Agency with an accurate and complete Medicaid Provider Enrollment Application, including all ownership and principal fingerprint cards and processing fees, within thirty (30) days after the Contract award is complete.

AND

14. REQUIRED PLAN READINESS DOCUMENTATION

I hereby certify my organization, if awarded a Contract, shall submit to the Agency all required Plan Readiness documentation within established timeframes as required in **Attachment A**, Instructions and Special Conditions, **Section E.**, Contract Implementation.

AND

15. CERTIFICATION REGARDING TERMINATED CONTRACTS

I hereby certify that my organization (including its subsidiaries and affiliates) has not unilaterally or willfully terminated any previous contract prior to the end of the contract with a State or the Federal government and has not had a contract terminated by a State or the Federal government for cause, prior to the end of the contract, within the past five (5) years (since July 14, 2012), other than those listed on **Page 6** of this Exhibit.

AND

16. LIST OF TERMINATED CONTRACTS

List the terminated contracts in chronological order and provide a brief description (half-page or less) of the reason(s) for the termination. Additional

pages may be submitted; however, no more than five (5) additional pages should be submitted in total.

The Agency is not responsible for confirming the accuracy of the information provided.

The Agency reserves the right within its sole discretion, to determine the respondent to be an non-responsible vendor based on any or all of the listed contracts and therefore may reject the respondent's reply.

Respondent Name:Respondent has not been a party to a terminated contract.

Client's Name:

Term of Terminated Contract:

Description of Services:

Brief Summary of Reason(s) for Contract Termination:

Respondent Name:

Client's Name:

Term of Terminated Contract:

Description of Services:

Brief Summary of Reason(s) for Contract Termination:

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

EXHIBIT A-2-c
ADDITIONAL REQUIRED CERTIFICATIONS AND STATEMENTS
(10-2-17)

Signature below indicates the respondent's full acknowledgement of; understanding of; and agreement with all of the certifications and statements identified above in Items 1 through 16 as written and without caveat.

Lighthouse Health Plan, LLC
Respondent Name

Authorized Official Signature **Date** 10/31/17

Mike Gleason
Authorized Official Printed Name

President
Authorized Official Title

Failure to submit, Exhibit A-2-c, Additional Required Certifications and Statements, signed by an authorized official may result in the rejection of response.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

RESPONDENT NAME: Lighthouse Health Plan, LLC

The Agency for Health Care Administration ("Agency" or "AHCA") "must avoid, neutralize, or mitigate significant potential organizational conflicts of interest (OCI) before a Contract is awarded. If the Agency elects to mitigate the significant potential organizational conflict or conflicts of interest, an adequate mitigation plan, including organizational, physical, and electronic barriers, shall be developed. [Section 287.057(17)(a)(1), Florida Statutes]

The Agency has determined that in order to evaluate proposals and negotiate a Contract that is in the best interests of the State, it is necessary to use the services of Milliman, Inc. ("Milliman") to act as an actuary and advisor throughout all stages of the "Statewide Medicaid Managed Care Program" competitive solicitation. The Agency reasonably anticipates one or more prospective respondents may also use Milliman. The Agency has determined that all reasonably anticipated OCIs relating to Milliman may be mitigated by the following mitigation plan, which has been agreed to by Milliman:

I. Milliman

a. All Milliman personnel who will perform services under the "Statewide Medicaid Managed Care Program" competitive solicitation shall be part of a separate internal Milliman working group (the "Milliman AHCA Group") with its own internal electronic and hard folders.

b. All documents or communications received or generated by the Milliman AHCA Group that relate in any way to this solicitation shall be placed only in this Group's separate files.

c. Each member of the Milliman AHCA Group shall submit **Exhibit A-3-b**, Milliman Employee Organizational Conflict of Interest Affidavit indicating they will provide actuarial services to the Agency.

d. No Milliman personnel, other than the Milliman AHCA Group personnel shall have access to the Milliman AHCA's Groups files.

e. The above-listed personnel shall not discuss any information relating to the SMMC ITN Services with any other Milliman personnel.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

II. Respondents

a. Any actual or prospective respondent who is using Milliman for this procurement must disclose this fact in its initial reply to the solicitation. Specifically, a respondent wishing to use Milliman must:

- **i.** Identify itself and its intent to use Milliman;
- **ii.** Identify the specific Milliman personnel that will be assisting the respondent in the procurement;
- **iii.** Submit **Exhibit A-3-b, Milliman Employee Organizational Conflict of Interest Affidavit** forms, completed by each identified Milliman personnel.

b. All replies submitted in response to this solicitation must include the completed declaration in **Section IV.** of this Exhibit, signed by the authorized official who signed the reply on behalf of the respondent.

c. Any actual or prospective respondent who learns there is a reasonable basis to believe there has or may have been a violation of the Milliman OCI Mitigation Plan shall, within seventy-two (72) hours, notify the Agency of the facts and circumstances of the possible violation.

III. Protests

a. **Actual or prospective respondents are advised they have a burden to diligently investigate and challenge potential OCIs relating to Milliman**.

b. All challenges to the Milliman OCI Mitigation Plan must be timely filed as a challenge to the specifications of this solicitation. Similarly, challenges to amendments to the Milliman OCI Mitigation Plan must be timely filed as specifications challenges.

c. All challenges to Milliman-related information provided by actual or prospective respondents and posted by the Agency must be timely filed as specifications challenges.

d. **All protests filed after a Notice of Intent to Award has been posted which allege a Milliman-related OCI shall be limited to alleged violations of the Milliman OCI Mitigation Plan**.

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EXHIBIT A-3-a
MILLIMAN ORGANIZATIONAL
CONFLICT OF INTEREST MITIGATION PLAN

IV. Declaration

Declaration of Mike Gleason
Authorized Official Printed Name

Pursuant to Section 92.525, Florida Statutes, Mike Gleason
Authorized Official Printed Name

declares that:

1. I am over the age of 21 and am competent to testify as to the matters stated in this declaration.

2. I declare that I have read the Milliman Organizational Conflict of Interest Mitigation Plan, and that Lighthouse Health Plan, LLC
Respondent Name

will directly and indirectly fully comply with the Milliman Organizational Conflict of Interest Mitigation Plan through all stages of the procurement.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on this 31st day of October 2017.

Authorized Official Signature

Mike Gleason
Authorized Official Printed Name

Failure to submit, Exhibit A-3-a, Milliman Organizational Conflict of Interest Mitigation Plan, certified by an authorized official may result in the rejection of response.

REMAINDER OF PAGE INTENTIONALLY LEFT BLANK

Lighthouse Health Plan, LLC is not using Milliman, Inc. for purposes of this procurement. As such, Lighthouse Health Plan, LLC is not required to, and is not, submitting an Exhibit-A-3-b.

Consolidated Financial Statements and Supplementary Information

Baptist Health Care Corporation and Subsidiaries
Years Ended September 30, 2015 and 2014
With Report of Independent Certified Public Accountants

Ernst & Young LLP

Building a better working world

Consolidated Financial Statements and Supplementary Information

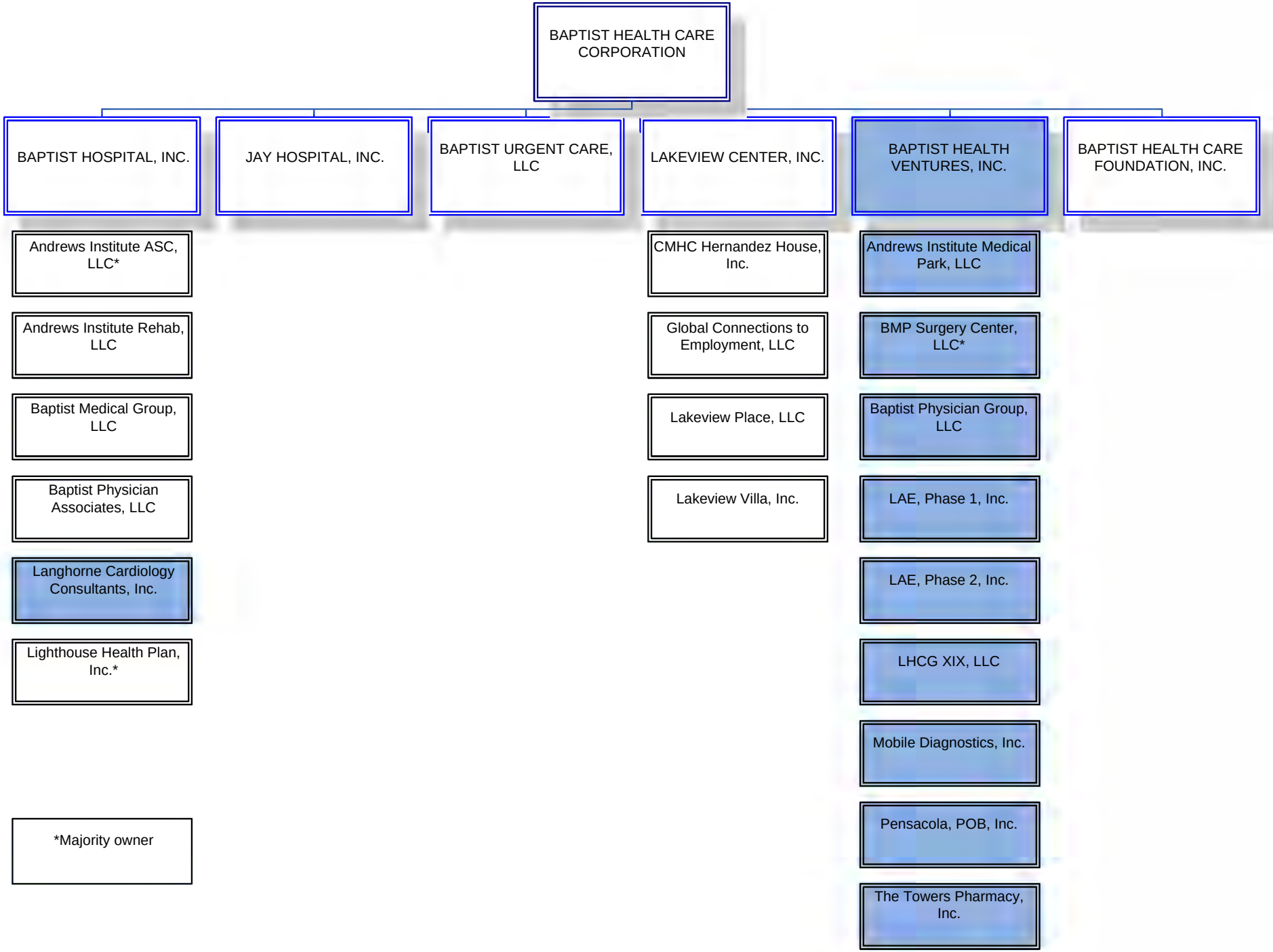
Baptist Health Care Corporation and Subsidiaries
Years Ended September 30, 2016 and 2015
With Report of Independent Certified Public Accountants

Ernst & Young LLP

Building a better working world

Baptist Health Care Corporation

2017



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Report of independent registered public accounting firm

To the Board of Directors of Evolent Health LLC:

In our opinion, the accompanying balance sheets and the related statements of operations and comprehensive loss, of changes in members' equity and redeemable preferred units and of cash flows present fairly, in all material respects, the financial position of Evolent Health LLC at December 31, 2014 and 2013, and the results of its operations and its cash flows for each of the two years in the period ended December 31, 2014 in conformity with accounting principles generally accepted in the United States of America. These financial statements are the responsibility of the Company's management. Our respons bility is to express an opinion on these financial statements based on our audits. We conducted our audits of these statements in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements, assessing the accounting principles used and significant estimates made by management, and evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

/s/ PricewaterhouseCoopers LLP
McLean, Virginia
March 2, 2015

Evolent Health LLC

Consolidated Financial Statements
As of December 31, 2016 and 2015, and for the year ended December 31, 2016 and for the period from June 4, 2015 to December 31, 2015 (Successor Company) and for the period from January 1, 2015 to June 3, 2015 and for the year ended December 31, 2014 (Predecessor Company)

Evolent Health LLC (EH)
Lighthouse Health Plan, LLC
EH – owner of 40% of Units

Insolvency Protection Account – The respondent shall describe and provide calculations used to demonstrate how it will fund the Agency Insolvency Protection Account, as specified below by Contract type. The Agency will evaluate the audited financial reports of the respondent and/or parent entity to determine the respondent's ability to fund the Agency Insolvency Protection Account. If funding for the Agency Insolvency Protection Account will come from a source other than the respondent or parent entity, the respondent shall indicate the source and provide an audit, bank statement, and/or bank letter demonstrating the ability to fund this requirement.

a) Capitated Managed Care Plans – five percent (5%) of the estimated monthly capitation amount that would be paid to the successful respondent by the Agency each month until a maximum total of two percent (2%) of the annualized total Contract amount is funded. The respondent shall provide a calculation of the five percent (5%) estimate and indicate the anticipated source and method of funding this requirement.

- The insolvency protection account will be established with a federally guaranteed financial institution licensed to do business in Florida. Required deposits will be funded by a capital contribution made in the form of cash. See the insolvency protection account calculation which provides a monthly reconciliation demonstrating the plans ability to meet the requirement per Florida statute.

Health Plan Name:	Lighthouse Health Plan, LLC
Region:	Region 1
Plan Type(s):	Managed Medical Assistance (MMA) Plan

Health Plan Name:	Lighthouse Health Plan, LLC
Region:	Region 1
Plan Type(s):	Managed Medical Assistance (MMA) Plan

Notes:

1) The income statement is presented on a pre-tax basis and excludes the health insurance provider fee
2) The balance sheet and statement of cash flows are presented on a pre-tax basis

Surplus – The respondent shall describe and provide calculations used to demonstrate how it will fund the required surplus for the particular Contract type.

a) Capitated Managed Care Plans: – The required surplus must be in the form of assets allowable as admitted assets by the Office of Insurance Regulation (OIR), and restricted funds of deposits (Agency insolvency account, OIR restricted deposits), the greater of $1.5 million, ten percent (10%) total liabilities, or two percent (2%) annualized premiums. (Section 641.225, Florida Statutes)

- The required surplus will be funded by a capital contribution made in the form of cash. See the required surplus calculation which provides a monthly reconciliation demonstrating the plans ability to meet the surplus requirement per Florida statute.

Health Plan Name:	Lighthouse Health Plan, LLC
Region:	Region 1
Plan Type(s):	Managed Medical Assistance (MMA) Plan

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Lighthouse Health Plan, LLC

A. RESPONDENT BACKGROUND / EXPERIENCE

SRC# 1 – Managed Care Experience (Statewide):

The respondent, including respondent's parent, affiliate(s) and subsidiary(ies), shall provide a list of all current and/or recent (within five (5) years of the issue date of this solicitation (since July 14, 2012) contracts for managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support).

The respondent shall provide the following information for each identified contract:

a. The Medicaid population served (such as TANF, ABD, dual eligible);
b. The name and address of the client;
c. The name of the contract;
d. The specific start and end dates of the contract;
e. A brief narrative describing the role of the respondent and scope of the work performed, including covered populations and covered services;
f. The use of administrative and/or delegated subcontractor(s) and their scope of work;
g. The annual contract amount (payment to the respondent) and annual claims payment amount;
h. The scheduled and actual completion dates for contract implementation;
i. The barriers encountered that hindered implementation (if applicable) and the resolutions;
j. Accomplishments and achievements;
k. Number of enrollees, by health plan type (e.g., commercial, Medicare, Medicaid); and
l. Whether the contract was capitated, FFS or other payment method.

In addition, the respondent shall describe its experience in delivering managed care services (e.g. medical care, integrated medical and behavioral health services, transportation services and/or long-term services and support), to Medicaid populations similar to the target population (such as TANF, ABD, dual eligible) identified in this solicitation.

For this SRC, the respondent may include experience provided by subcontractors for which the respondent was contractually responsible, if the respondent plans to use those same subcontractors for the SMMC program.

Response:

Throughout this proposal we will highlight the experience of Lighthouse Health Plan, LLC and the experience of our affiliates, Access Behavioral Health (ABH) and Evolent Health, in describing our plan to deliver superior services to Region 1 Medicaid beneficiaries.

Lighthouse Health Plan was created to address the shortage of managed care options available to low income residents in Region 1. Although a new Provider Service Network, our affiliates have extensive experience serving Florida residents and offer an integrated physical and behavioral health model.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Lighthouse Health Plan's objective is to enhance care delivery and the coordination of services by building a local health plan specifically designed to serve Region 1 Medicaid beneficiaries. Our parent company, Baptist Health, has been serving the Northwest Florida community since 1951 when it opened Baptist Hospital. Today, Baptist Health has grown to include a team over 6700 clinicians and professionals, many that reside in Region 1. In 2016, Baptist Health accounted for nearly a quarter of the total Inpatient and Outpatient services in Region 1. Today, Lighthouse Health Plan and its affiliates serve 188,858 members across Florida with over 100,000 of those members participating in Medicaid through Access Behavioral Health.

We are committed to increasing and enhancing Medicaid access in Region 1. In 1994, Baptist Health Care joined with Sacred Heart Hospital Pensacola (SHHP) to form Healthy Community Partnership, a 501c3 corporation focused on conducting community health status assessments and advancing the health and quality of life of residents in Northwest Florida. Through the 2016 Community Health Status Assessments, Baptist identified that between 2013 and 2016 housing costs had increased, high school graduation rates decreased, and more children were living in poverty in the region. Residents who participated in the 2016 survey reported difficulty in navigating the healthcare system. Lighthouse Health Plan is Baptist Health's response to the need for increased access to care and enhanced care coordination for low income residents in Region 1.

Access Behavioral Health (ABH) is an affiliate of Baptist Health, has operated in Region 1 since 2001 and today manages over 100,000 Medicaid members through full risk capitation arrangements with Humana and Molina. In fact, based on the experience and superior clinical coordination capabilities provided by ABH, they are now the single source Behavioral Health managed care organization serving Medicaid recipients in Region 1.

Evolent is a nationally-recognized organization that serves approximately 1.4M Medicaid Beneficiaries nationally and specializes in operating provider-owned Medicaid health plans. Evolent brings experience and resources that will reside in Region 1 and support Lighthouse Health Plan, LLC with health plan operations, IT and system platforms, population health technology, NCQA audited policies and procedures, and practices that have been successfully implemented across six State Medicaid programs including Kentucky, Indiana, Maryland, Illinois, Texas and the District of Columbia.

Evolent currently serves 75,000 Florida residents that receive care through a CMS Medicare Accountable Care Organization and Commercial Self-Funded product.

Our local approach to health care, includes locating clinical and operational health plan capabilities in Region 1. Unlike existing Region 1 Medicaid MCOs, we are a health plan built by the providers that serve Florida Medicaid beneficiaries every day. As a result, our community-based model includes a complete array of provider supports and superior physician engagement that creates behavior change, improved healthcare outcomes, and lower costs while engaging members personal responsibility for improving their health.

As a provider sponsored network, Lighthouse Health Plan, LLC, has built a network that has served Medicaid recipients for decades. This includes clinicians that work and live in Region 1, who understand the gaps and challenges with existing Medicaid managed care networks, and are committed to enhancing and integrating care coordination and provider access.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

In demonstrating our experience serving like Medicaid populations we present the types of populations served, members enrolled, and years of experience in managing/delivering medical and behavioral health (BH) services.

CONTRACT 1 – LAKEVIEW CENTER, INC., DBA ACCESS BEHAVIORAL HEALTH AND HUMANA MEDICAL PLAN

a. Population Served:

Medicaid MMA eligible populations

b. Name and Address of the Client:

Humana Medical Plan
500 W. Main St.
Louisville, KY 40202

c. Name of Contract:

Lakeview Center, Inc., DBA Access Behavioral Health and Humana Medical Plan

d. Start and End Dates of Contract:

August 1, 2014 – January 2019

e. Narrative Description:

Access Behavioral Health (ABH) manages the mental health and substance abuse services for Medicaid recipients and for residents of Region 1. ABH offers a network of providers who focus on the core principles of recovery: strengths-based, person-centered, individualized treatment and support for people with mental illness and substance use disorders. Our scope of services includes claims payment, utilization management, care management, eligibility verification, HEDIS and quality, managing the provider network, and provider reimbursement, and encounters.

ABH has a Managed Behavioral Health Organization (MBHO) contract to manage the Medicaid mental health and substance abuse benefits for MMA population enrolled in Humana Medical Plan in Region 1. ABH is delegated by Humana to perform utilization management and care coordination services, quality management and improvement services, network management and contracting, credentialing, claims processing, and call center functions. The covered populations include all eligible populations in the Attachment II-A MMA state HMO contract.

The covered benefits include all eligible services in the Attachment II-A MMA state HMO contract. The services are outlined in the following Medicaid handbooks: The Behavioral Health Overlay Services Coverage and Limitations Handbook, Community Behavioral Health Services Coverage and Limitations Handbook, Mental Health Targeted Case Management Handbook, Specialized Therapeutic Services Coverage and Limitations Handbook, and Statewide Inpatient Psychiatric Program Coverage Policy.

f. Use of Subcontractors:

ABH does not utilize other subcontractors for this scope of work.

g. Annual Contract Amounts:

In this contract, we have shown the ability to manage Behavioral Health dollars, capitation, member benefits, provider networks, reporting and meet the health plan's contracted performance measures. We have met the State contract performance metrics.

h. Scheduled and Actual Implementation:

Scheduled Completion of Contract Implementation: August 1, 2014
Actual Completion of Contract Implementation: August 1, 2014

i. Barriers and Resolution:

During this Contract Period, the early barriers encountered were understanding and educating all staff about member benefits and ensuring all staff dealing directly and indirectly with members were trained on every aspect of covered services. Providers also required training about the eligible members and benefits covered by the MMA plans. By mid-September, everyone was cognizant of the requirements.

j. Accomplishments and Achievements:

Through contracting, monitoring, network management and quality improvement efforts, ABH improved the coordination, integration and management of delivery services to those with emotional, mental or addictive disorders. ABH currently has three (3) licensed social workers credentialed to serve members with Escambia Community Clinic (ECC), an FQHC; this includes clinical services to ABH members in pediatrician's and PCP offices that are associated with ECC. One of ABH's High-Volume Providers, Chautauqua HealthCare Center, has placed a remote LCSW in Walton County Health Department to see ABH members while they are also receiving medical services. ABH plans to pursue credentialing for at least one therapist in all FQHCs in Regions 1.

Value-based Contracting –

ABH contracts with the large community behavioral health systems in the region on a capitated basis. These behavioral health systems are called Regional Care Centers (RCCs). Under the capitated financial system, ABH and a participating RCC enters into a contract to provide the full range of Medicaid benefits to enrollees in the RCCs capitated geographic areas. RCCs receive a per-member-per-month payment to cover all the required Medicaid services and bear the financial risk for their patients for the specified services. The capitation rate reflects the behavioral health services required by Florida Medicaid and provides the incentive for a fully integrated delivery of Medicaid services. This approach incentivizes investments in care coordination, quality improvement efforts, and efficiency across the full continuum of care, and including the coordination of care with hospitals, and multi-specialty provider groups. The value-based model establishes a reimbursement system especially designed to manage Medicaid members who have persistent complex behavioral health conditions. ABH requires by contract that the RCCs to

be accountable for the full range of behavioral health services based on clinical outcome oriented services, rather than simply utilization of services. Overall, this capitation model payment methodology offers the following:
• Alignment of incentives;
• Flexibility for providing behavioral health services;
• Improves quality of and access to behavioral health care services for enrollees; and
• Controls costs

Increase Access to Services via Telehealth Expansion –

ABH currently offers Telemedicine as well as individual, group, and family therapy via telehealth. This improves doctor/patient ratios as well as access to services for those who live in more rural areas, which subsequently also reduces inpatient services for those members.

Reduction of Potentially Preventable Readmissions –

ABH readmission rates for hospitalization within 30 days are below the state averages for adults and children. This can be attributed to the value-based contracting model, coordination of care, improved access to services through telemedicine in rural areas and intensive community based models of service.

k. Number of Enrollees, by health plan type:

MMAC - 56,000 Lives

l. Payment method:

The Medicaid Contract is Capitated.

CONTRACT 2 – LAKEVIEW CENTER, INC., DBA ACCESS BEHAVIORAL HEALTH AND MOLINA HEALTHCARE OF FLORIDA

a. Population Served:

Medicaid MMA eligible populations

b. Name and Address of the Client:

Molina Healthcare of Florida
8300 NW 33rd St. Suite 400
Miami, FL 33122

c. Name of Contract:

Lakeview Center, Inc., DBA Access Behavioral Health and Molina Healthcare of Florida

d. Start and End Dates of Contract:

November 1, 2015 to January 2019. ABH was contracted with Integral Health Plan August 1, 2014 – October 31, 2015. Molina purchased the assets of Integral, and the ABH and Integral contract was assigned to Molina effective November 1, 2015.

e. Narrative Description:

Access Behavioral Health (ABH) manages the mental health and substance abuse services for Medicaid recipients and for residents of Region 1. ABH offers a network of providers who focus on the core principles of recovery: strengths-based, person-centered, individualized treatment and support for people with mental illness and substance use disorders. Our scope of services includes claims payment, utilization management, care management, eligibility verification, HEDIS and quality, managing the provider network, and provider reimbursement, and encounters.

ABH has a Managed Behavioral Health Organization (MBHO) contract to manage the Medicaid mental health and substance abuse benefits for MMA populated enrolled in Molina Medical Plan in Region 1. ABH is delegated by Molina to perform utilization management and care coordination services, quality improvement services, network management and contracting, credentialing, claims processing, and call center functions. The covered populations include all eligible populations in the Attachment II-A MMA state HMO contract.

The covered benefits include all eligible services in the Attachment II-A MMA state HMO contract. The services are outlined in the following Medicaid handbooks: The Behavioral Health Overlay Services Coverage and Limitations Handbook, Community Behavioral Health Services Coverage and Limitations Handbook, Mental Health Targeted Case Management Handbook, Specialized Therapeutic Services Coverage and Limitations Handbook, and Statewide Inpatient Psychiatric Program Coverage Policy.

f. Use of Subcontractors:

ABH does not utilize other subcontractors for this scope of work

g. Annual Contract Amount:

In this contract, we have shown the ability to manage Behavioral Health dollars, capitation, member benefits, provider networks, reporting and meet the health plan's contracted performance measures. We have met the State contract performance metrics.

h. Scheduled and Actual Implementation:

Scheduled Completion of Contract Implementation: November 1, 2015
Actual Completion of Contract Implementation: November 1, 2015

i. Barriers Encountered and Resolutions:

During this Contract Period, the early barriers encountered were understanding and educating all staff about member benefits and ensuring all staff dealing directly and indirectly with members were trained on every aspect of covered services. Providers also required training about the eligible members and benefits covered by the MMA plans. By mid-September, everyone was cognizant of the requirements.

j. Accomplishments and Achievements:

Through contracting, monitoring, network management and quality improvement efforts, ABH improved the coordination, integration and management of delivery services to those with emotional, mental or addictive disorders. ABH currently has three (3) licensed social workers credentialed to serve members with Escambia Community Clinic (ECC), an FQHC; this includes clinical services to ABH members in pediatrician's and PCP offices that are associated with ECC. One of ABH's High-Volume Providers, Chautauqua HealthCare Center, has placed a remote LCSW in Walton County Health Department to see ABH members while they are also receiving medical services. ABH plans to pursue credentialing at least one therapist in all FQHCs in Region 1.

Value-based Contracting –

ABH contracts with the large community behavioral health systems in the region on a capitated basis. These behavioral health systems are called Regional Care Centers (RCCs). Under the capitated financial system, ABH and a participating RCC enters into a contract to provide the full range of Medicaid benefits to enrollees in the RCCs capitated geographic areas. RCCs receive a per-member-per-month payment to cover all the required Medicaid services and bear the financial risk for their patients for the specified services. The capitation rate reflects the behavioral health services required by Florida Medicaid and provides the incentive for a fully integrated delivery of Medicaid services. This approach incentivizes investments in care coordination, quality improvement efforts, and efficiency across the full continuum of care, and including the coordination of care with hospitals, and multi-specialty provider groups. The value-based model establishes a reimbursement system especially designed to manage Medicaid members who have persistent complex behavioral health conditions. ABH requires by contract that the RCCs to be accountable for the full range of behavioral health services based on clinical outcome oriented services, rather than simply utilization of services. Overall, this capitation model payment methodology offers the following:

- Alignment of incentives;
- Flexibility for providing behavioral health services;
- Improves quality of and access to behavioral health care services for enrollees; and
- Controls costs

Increase Access to Services via Telehealth Expansion –

ABH currently offers Telemedicine as well as individual, group, and family therapy via telehealth. This improves doctor/patient ratios as well as access to services for those who live in more rural areas, which subsequently reduces inpatient services for those members.

Reduction of Potentially Preventable Readmissions –

ABH readmission rates for hospitalization within 30 days are below the state averages for adults and children. This can be attributed to the value-based contracting model, coordination of care, improved access to services through telemedicine in rural areas and intensive community based models of services.

k. Number of Enrollees, by health plan type:

MMAC - 52,000 Lives

l. Payment Method:

The Medicaid Contract is capitated.

CONTRACT 3 – BAPTIST HEALTH SYSTEM HEALTHCARE PLAN

a. Population Served:

Baptist Employee and Dependents through ASO Plan

b. Name and Address of the Client:

Baptist Health Care Corporation
1717 N E Street, Suite 320
Pensacola, FL 32501

c. Name of Contract:

Baptist Health System Healthcare Plan

d. Start and End Dates of Contract:

January 1, 2016-December 31, 2018

e. Narrative Description:

Baptist Health has been managing their employees and dependents health expenses through a self-funded insured plan. They currently manage 5,858 members. Baptist selected this path so they could design a health benefit plan to address specific employee needs, as well as company objectives. Baptist Health has gained valuable risk management experience through designing flexible benefits that help promote clinical programs specifically designed for their membership. Continuous analysis of plan expenses has allowed Baptist Health to make the plan design changes needed to manage costs. Experience gained includes strategies to better manage utilization, network provider contracts, and assuring appropriateness of care, all of which encourage wellness and provide efficient utilization of services. The covered population includes commercial – ASO. Covered benefits include:

- Medical
- Pharmacy
- Hospitalization
- Mental Health.

f. Use of Subcontractors:

Baptist Health utilizes Blue Cross and Blue Shield of Florida, Inc as their TPA administrator who is accountable for claims payment and operations maintenance.

g. Annual contract and claims payment amounts:

• Annual Premium Amount – 2012 / 1,359,815.22
• Annual Claims Payment Amount – 2012 / 1,359,815.22
• Annual Premium Amount – 2013 / $1,088,940.25
• Annual Claims Payment Amount – 2013 / $1,088,940.25
• Annual Premium Amount – 2014 / $1,018,689.74
• Annual Claims Payment Amount – 2014 / $1,018,689.74
• Annual Premium Amount – 2015 / $1,063,533.35
• Annual Claims Payment Amount – 2015 / $1,063,533.35
• Annual Premium Amount – 2016 / $1,008,324.40
• Annual Claims Payment Amount – 2016 / $1,008,324.40

h. Scheduled and Actual Completion Date of contract implementation:

i. Barriers Encountered and Resolutions:

j. Accomplishments and Achievements:

Baptist Health has decreased medical expenses 30% over the period 2012 to 2016. Baptist Health has gained valuable risk management experience since taking accountability for designing how benefits, provider data management, and promotion of clinical programs specifically designed for their membership. Continuous analysis of plan expenses has allowed Baptist Health to make plan design changes needed to manage costs. Experience gained includes strategies to better manage utilization, network provider contracts, and assuring appropriateness of care, all of which encourage wellness and provide efficient utilization of services

k. Number of Enrollees, by health plan type:

Commercial ASO – 5,858 lives including 1,946 Children

l. Payment Method:

The Contract is Self-Funded by Baptist Health.

CONTRACT 4 – Kentucky Medicaid Managed Care (Evolent)

a. Populations Served:

• Kentucky TANF
• CHIP
• ABD
• Foster Care
• Dual-Eligible Enrollees
• Former Foster care
• Expansion Adults
• Newborn

b. Name and Address of the Client:

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Passport Health Plan – Contract with Kentucky Health and Family Services Office of the Secretary
275 E. Main Street
Frankfort, KY 40621

c. Name of Contract:

SFY18 -1H Medicaid Managed Care Contract

d. Start and End Date of Contract:

July 1, 1997 – December 31, 2017

e. Narrative Description:

Passport provides full risk managed care services for 310,000 Medicaid recipients participating in the TANF, ABD, Foster Care, and Dual-Eligible populations. Expanded from 15 counties in 2013, Passport is a full-risk managed care organization now serving all 120 Kentucky counties. Since 2013, Passport has grown from 170,000 to 310,000 members. There are over 400 clinical and operations staff located in Kentucky that support the health plan Coordinated benefits include:

• Alternative Birthing Center Services
• Ambulatory Surgical Center Services
• Behavioral Health Services – Mental Health and Substance Abuse Disorders
• Chiropractic Services
• Community Mental Health Center Services
• Dental Services, including Oral Surgery, Orthodontics and Prosthodontics
• Durable Medical Equipment, including Prosthetic and Orthotic Devices, and Disposable Medical Supplies
• Early and Periodic Screening, Diagnosis & Treatment (EPSDT) screening and special services
• End Stage Renal Dialysis Services
• Family Planning Services in accordance with federal and state law and judicial opinion
• Hearing Services, including Hearing Aids for Members Under age 21
• Home Health Services
• Hospice Services (non-institutional only)
• Independent Laboratory Services
• Inpatient Hospital Services
• Inpatient Mental Health Services
• Meals and Lodging for Appropriate Escort of Members
• Medical Detoxification, meaning management of symptoms during the acute withdrawal phrase from a substance to which the individual has been addicted.
• Medical Services, including but not limited to, those provided by Physicians, Advanced Practice Registered Nurses, Physicians Assistants and FQHCs, Primary Care Centers and Rural Health Clinics
• Organ Transplant Services not Considered Investigational by FDA
• Other Laboratory and X-ray Services
• Outpatient Hospital Services
• Outpatient Mental Health Services
• Pharmacy and Limited Over-the-Counter Drugs including Mental/Behavioral Health Drugs

• Podiatry Services
• Preventive Health Services, including those currently provided in Public Health Departments, FQHCs/Primary Care Centers, and Rural Health Clinics
• Psychiatric Residential Treatment Facilities (Level I and Level II)
• Specialized Case Management Services for Members with Complex Chronic Illnesses (Includes adult and child targeted case management)
• Specialized Children's Services Clinics
• Targeted Case Management
• Therapeutic Evaluation and Treatment, including Physical Therapy, Speech Therapy, Occupational Therapy
• Transportation to Covered Services, including Emergency and Ambulance Stretcher Services
• Urgent and Emergency Care Services
• Vision Care, including Vision Examinations, Services of Opticians, Optometrists and Ophthalmologists, including eyeglasses for Members Under age 21

Extra benefits provided to Passport members include:
• Expanded dental services for children
• Gift cards for health behaviors

f. Use of Subcontractors:

Passport uses the following subcontractors for the indicated scopes of work:
• Evolent Health performs claims administration, utilization management, pharmacy utilization management, physical and behavioral health care management, eligibility and encounter processing
• Beacon Health manages behavioral health claims administration and utilization management
• Avesis performs dental and vision benefit management
• CVS provides PBM network and claims administration

g. Annual contract and claims payment amounts:

• Annual Premium Amount – 2012: $798,189,387
• Annual Claims Payment Amount – 2012: $767,942,949
• Annual Premium Amount – 2013: $687,029,939
• Annual Claims Payment Amount – 2013: $647,064,538
• Annual Premium Amount – 2014: $1,293,066,980
• Annual Claims Payment Amount – 2014: $1,102,107,375
• Annual Premium Amount – 2015: $1,656,424,912
• Annual Claims Payment Amount – 2015: $1,512,545,962
• Annual Premium Amount – 2016: $1,752,378,468
• Annual Claims Payment Amount – 2016: $1,663,794,132

h. Scheduled and Actual Implementation:

Scheduled Completion of Contract Implementation: July 1, 2016
Actual Completion of Contract Implementation: July 1, 2016

i. Barriers and Resolution:

As there was no Medicaid stratification model available via the State, Passport built a stratification model to identify Medicaid members requiring care management support. Passport also developed the statewide network required for seven new expansion regions. Passport contracted a statewide network that met state access standards within 90 days.

j. Accomplishments and Achievements:

Passport is consistently ranked one of the top 20 Medicaid health plans in the country by NCQA since receiving 'Excellent' accreditation status in the first NCQA Survey in 2004. We currently have hundreds of community relationships across the state and have over 50 community-sponsored events each year, including back pack events, healthy hoops, state and local-based fairs, and 2 annual zoo events (1 for the homeless population and 1 for grandparents raising their grandchildren). Passport is developing new west end campus that will integrate social determinants of health and operates under the governance of the community through a 31-member Partnership Council, which includes representation from members, providers, the Kentucky Health Department, school systems, advocacy groups, and state health policy officials. Additionally, Passport's iHOP (innovative Health Outcomes Program) grant program sets aside funding on an annual basis for the research and development of programs that would improve the quality, access, efficiency, and cost of health care delivered to those who receive Medicaid benefits.

k. Number of Enrollees, per health plan type:

• TANF and CHIP – 156, 643 lives
• SSI (ABD) – 22,520 lives
• Foster Care – 4,336 lives
• Dual Eligibles – 11,836 lives
• Medicaid Expansion – 114,264 lives
• TOTAL – 309, 599 lives

l. Payment Method:

The Medicaid Contract is capitated.

CONTRACT 5 – County Care

a. Population Served:

• ICP – Integrated Care Program is for seniors and persons with disabilities who are eligible for Medicaid but not eligible for Medicare
• FHP – Family Health Plan includes families with children under the age of 19; pregnant woman; and adults ages 19-64 with income up to 138 percent of the federal poverty level.
• ACA – Affordable Care Act allows states to expand Medicaid programs to cover most low-income individuals through the federal health insurance marketplace.
• LTSS –Long Term Services and Supports includes new rules about property transfers and penalties that affect anyone going into a skilled care nursing facility, supportive living facility or receiving in-home care supports to allow the person to remain in their home.

b. Name and address of the client:

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GENERAL SUBMISSION REQUIREMENTS
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Cook County Health and Hospitals System (CCHHS)
1900 W. Polk Street
Suite 220C
Chicago, IL 60612

c. Name of the Contract:

State of Illinois Contract Between the Department of HealthCare and Family Services and County of Cook, a Body Politic and Corporate, By and Through Its Cook County Health and Hospitals System for Furnishing Health Services by a County Managed Care Community Network

d. Start and End Dates of the contract:

April 1, 2016 - March 31, 2019. This is the start date of the contract between Evolent and CCHHS. The original contract award from IL Medicaid to County Care was October 2012. Through the 2016 re-procurement efforts, County Care will continue to serve and expand its number of covered lives through 2022.

e. Narrative Description:

CountyCare entered into this contract with the state of Illinois to deliver integrated and quality managed care to Enrollees, supporting Seniors, Persons with a Disability, Families and Children, Special Needs Children, and adults qualifying for the HFS Medical Program under the Affordable Care Act (ACA Adults). Evolent Health performs the following for CountyCare: TPA services including claims processing, call center, member and provider services, credentialing, provider relations, utilization management, compliance, fraud waste and abuse/SIU. Covered services include:

• Genetic radiology services
• Genetic counseling and testing
• Home health agency visits
• Hospital emergency room visits
• Hospital inpatient services
• Hospital ambulatory services
• Laboratory and x-ray services
• Medical supplies, equipment, prostheses and orthoses, and respiratory equipment and supplies
• Mental health services provided under the Medicaid Clinic Option, Medicaid Rehabilitation Option, and Targeted Case Management Option
• Nursing care for enrollees under age 21 not in the HCBS waiver for individuals who are MFTD
• Nursing care for the purpose of transitioning children from a hospital to home placement or other appropriate setting for enrollees under age 21
• Nursing facility services
• Optical services and supplies
• Optometrist services
• Palliative and hospice services
• Pharmacy services (drugs used in the treatment of hepatitis C are covered only if dispensed in accordance with coverage criteria approved by the Illinois Department of Healthcare and Family Services)

• Physical, occupational, and speech therapy services
• Physician services
• Podiatric services
• Post-stabilization services
• Practice visits for enrollees with special needs
• Pregnancy termination if medically necessary as defined by Illinois law
• Renal dialysis services
• Respiratory equipment and supplies
• Services to prevent illness and promote health
• Subacute alcoholism and substance abuse services, residential day treatment, and detox day treatment
• Transplants using transplant provider certified by HFS
• Transportation

f. Use of Subcontractors:

CountyCare delegated TPA and population health functions, as well as ongoing management and administration to Evolent Health. MCO delegated services include claims processing, state encounter submission, customer and provider services, provider data loading, provider relations, member and provider call center, utilization management, clinical and financial analytics, finance, accounting, compliance, FWA/SIU, TPL, Grievances and Appeals, enrollment and eligibility, credentialing and implementation of state-of-the-art population health. CountyCare uses the following subcontractors for the indicated scopes of work:

• Evolent Health for TPA services including claims processing, call center, member and provider services, credentialing, provider relations, utilization management, compliance, fraud waste and abuse/SIU
• Health Dialog for the Nurse-line
• Purple Group for Marketing Material Development
• Sage for Communication and Content Development
• MPX Online for Fulfillment
• Change Healthcare for Claim Clearinghouse
• First Recovery Group for Third Party Liability/Subrogation
• Optum Analytics for Fraud, Waste and Abuse Analytics/ Special Investigative Unit
• Avail for Behavioral Health Hotline
• SPH Analytics for Healthcare surveys
• 3WON for Provider Credentialing

g. Annual contract and claims payment amounts for the past five years are:

• Annual Premium Amount – 2013: $ N/A
• Annual Claims Payment Amount – 2013: $ N/A
• Annual Premium Amount – 2014 6 months: $357,723,569
• Annual Claims Payment Amount – 2014 6 months: $208,828,480
• Annual Premium Amount – 2015: $916,043,815
• Annual Claims Payment Amount – 2015: $ 661,949,043
• Annual Premium Amount – 2016: $1,227,714,526
• Annual Claims Payment Amount – 2016: $903,283,482.00
• Annual Premium Amount – 2017 9 months: $599,943,074

• Annual Claims Payment Amount – 2017 9 months: $371,594,966.00

h. Scheduled and Actual Implementation:

Scheduled completion by Evolent Health: April 1, 2016
Actual completion date: April 1, 2016.

i. Barriers and Resolution:

Because of the abrupt termination of the initial TPA, IlliniCare, there was a need to expedite contracting and implementation with current TPA, Evolent Health. A 6-8-month implementation in scope was successfully executed and implemented in 93 days.

j. Accomplishments and Achievements:

CountyCare coordinated a multi-disciplinary team of subject matter experts, sub-delegated vendors, clinicians, compliance and data experts, technologists, medical, care management entities, and healthcare business operations professionals in the successful collaboration and implementation of a complex suite of healthcare services in a remarkably short period of time. The AIDS Foundation of Chicago (AFC) released a report that praises Cook County leaders for implementing CountyCare. The new program implements early a provision of the Affordable Care Act (ACA) that allows states to expand Medicaid programs to cover most low-income individuals. “CountyCare is an unprecedented opportunity for people with HIV to obtain more comprehensive, life-extending health care,” said David Ernesto Munar, President/CEO of AFC. “We strongly support this early expansion of Medicaid in Cook County, which will give HIV-affected populations and the organizations that assist them a keyhole view of the larger system changes coming next year. AFC has been at the forefront of advocacy on Medicaid expansion for over a decade, so it is especially gratifying to witness CountyCare’s rollout.” AFC’s report, CountyCare & the Ryan White Program: Working Together to Optimize Health Outcomes for People with HIV, outlines the importance of CountyCare and the role it can play in improving access to health services for people with HIV. It also contains a number of policy recommendations for the city and state departments of public health, Cook County, and the federal government. “We have worked for the last 18 months to make sure CountyCare would be implemented successfully for people with HIV,” Munar said. “We face significant challenges to coordinate CountyCare with the Ryan White Program. We are grateful for the extensive hard work that county officials – including Dr. Ram Raju, who heads the County health system – have done to make CountyCare and the Ryan White Program work together.” The federally-funded Ryan White Program provides HIV medical care, medications, and supportive services to low-income people with HIV. The program is a payer of last resort, meaning all other sources of payment must be accessed before Ryan White Program funds can be used to cover needed services for people with HIV/AIDS.

k. Number of enrollees, by health plan type:

Medicaid: 151,196 lives:
-FHP/ACA: 146,454 lives
-ICP: 4,742 lives

l. Payment Method:

The contract is capitated.

CONTRACT 6 – Indiana Family and Social Services Administration (FSSA)

a. Population Served:

• Hoosier Health Wise (HHW) –Children under 18 from low income families and pregnant women
• Healthy Indiana Plan (HIP) – Adults 19-64 whose household income does not exceed 138% of the federal poverty level and do not have access to one of the other Medicaid programs (this is the Indiana Medicaid Expansion population)

b. Name and Address of client:

MDwise Inc.
1200 Madison Avenue Suite 400
Indianapolis, IN 46225

c. Name of the contract:

The Indiana Family and Social Services Administration (FSSA) contract with MD Wise

d. Start and End dates of the contract:

January 1, 2017 - December 31, 2021

e. Narrative Description:

MDwise is a local, Indiana-based nonprofit Medicaid health care company. The health plan was founded in 1994 by the Health and Hospital Corporation of Marion County and Indiana University Health to help vulnerable populations needing health coverage in Indiana. MDwise works with the State of Indiana and Centers for Medicare and Medicaid Services to serve the Hoosier Healthwise and Healthy Indiana Plan health insurance programs. MDwise has a large network of doctors, specialists and hospitals throughout the State of Indiana. Healthy Indiana Plan (HIP) covers 122,781 lives and Hoosier Health Wise covers 224,024 lives.

f. Use of Subcontractors:

MDwise uses the following subcontractors for the indicated scopes of work:
• BC Forward for Medicaid helpline
• Dentaquest for Dental third-party administrator
• Evolent Health for Third party administrator
• Health Care Fraud Shield for Fraud and abuse system
• HealthX Portal for Member/Provider web portal for eligibility
• HMS for TPL Processing
• Medimpact for Pharmacy claim processing
• MUGS for Frailty assessment
• RideRight for Transportation Vendor
• Sirona for Nurse on Call
• VSP for Vision third party administrator

g. Annual Contract Amounts:

The annual contract amount (payment to the respondent) and annual claims payment amount Annual contract and claims payment amounts for the past five years are:
• Annual Premium Amount – 2012: $445,445,000
• Annual Claims Payment Amount – 2012: $360,231,000
• Annual Premium Amount – 2013: $449,853,000
• Annual Claims Payment Amount – 2013: $363,526,000
• Annual Premium Amount – 2014: $583,769,000
• Annual Claims Payment Amount – 2014: $480,516,000
• Annual Premium Amount – 2015: $1,033,233,000
• Annual Claims Payment Amount – 2015: $923,288,000
• Annual Premium Amount – 2016: $1,433,651,000
• Annual Claims Payment Amount – 2016: $1,364,768,000

h. Scheduled and Actual Implementation:

The re-procurement contract became effective with the state on January 1, 2017 and Evolent's services began on January 1, 2017.

i. Barriers and Resolution:

The largest challenge of the implementation was the expedited timeframe. Evolent was contracted on July 2016 and therefore had six months to complete implementation. Aggressive project management was used with all key stakeholders to manage to the target go live date.

System configuration for Provider Service Networks was also a challenge. MD Wise is comprised of 7 different provider delivery networks that assume financial risk for the members health system partnered with their primary care providers. Each network has its own provider network. As a result, Evolent implementation actually included working through the complexity of configuring seven different provider networks and seven different payment schedules to ensure accuracy of provider data and in the format needed, we deployed Evolent provider management personnel to work on site with MD Wise. Additionally, we applied provider data scrubbing techniques, e.g. application of USPS data base to MD Wise data to normalize data. Finally, we compared previously received x12 837 claim files and their provider information to the provider file extract we received. All discrepancies identified were reviewed and in load file adjusted if appropriate. Additionally, we implemented automated logic to identify providers from claims submitted as PAR by TIN according to delivery system specific network rules.

Another challenge was the eligibility system. The state's FFS Medicaid agency, transitioned to a new MMIS system. The state MMIS system provides the x12 834 files to all the MCOs. Therefore, MD Wise ran two tracks of testing, e.g. implementation testing and eligibility testing from the new system.

j. Accomplishments and Achievements:

MDwise was honored as Bronze Stevie® Award Winner in 2017 American Business Awards. MDwise was awarded a Bronze Stevie® Award in the Customer Service Department of the Year

in the Health Products and Services category. 2017 Stevie winners were celebrated and presented their awards on Tuesday, June 20.

MDwise earned the award based partly on feedback received in a member survey conducted by the organization. In the survey, 97 percent of members said they would recommend MDwise to a friend or family member. Additionally, 95 percent of members reported being treated with courtesy and respect by customer service.

The American Business Awards are the nation's premier business awards program. All organizations operating in the U.S. are eligible to submit nominations – public and private, for-profit and non-profit, large and small. More than 3,600 nominations from organizations of all sizes and in virtually every industry were submitted this year for consideration in a wide range of categories, honoring achievement in every aspect of work life, from customer service and management to public relations and product development., among others. And more than 190 executives worldwide participated in the judging process to select this year's Stevie Award winners.

k. Number of enrollees, by health plan type:

• HIP (Adults 19-64 whose household income does not exceed 138% of the federal poverty level and do not have access to one of the other Medicaid programs (this is the Indiana Medicaid Expansion population)) – 122,781 lives
• HHW (Children under 18 from low income families and pregnant women) – 224,024 lives
• Commercial Market Place – 29,897 lives

l. Payment Method:

The contract is capitated.

Evaluation Criteria:

1. The extent of the respondent's experience with providing integrated medical and behavioral health services.

2. The extent of the respondent's subcontractors' experience in coordinating or providing services to Medicaid recipients.

3. The extent to which the barriers to implementation experienced by the respondent have clear resolutions outlined.

4. The extent to which the respondent has listed accomplishments and achievements that are relevant to this solicitation.

5. The extent to which the respondent's Medicaid populations served are similar to the populations served by the SMMC program.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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SRC# 2 – Florida Experience (Regional):

The respondent shall provide documentation of the extent to which it has experience operating as a Florida Medicaid health plan in the region in which it plans to provide services or in any other region in the State of Florida. If applicable, the respondent shall provide the Agency Contract number and the regions of operation to show it has experience providing managed care services and/or LTC services in Florida. The respondent shall provide documentation of any Medicare Advantage Plan contracts for counties in the State of Florida.

Response:

Lighthouse Health Plan was founded in 2017 by one of the largest health systems serving Region 1 Medicaid recipients today. Despite being a new provider service entity, Lighthouse Health Plan has a long history of addressing the healthcare needs of Floridians and especially Medicaid recipients. The founding organization, Baptist Health Care, has served the State's population since 1951.

Our parent organization and affiliates are well experienced since they provide over 20% of all Medicaid hospital care in Region 1. In addition, Baptist Health Care's experience includes Access Behavioral Health who has managed Medicaid behavioral health services on a capitated basis for over 10 years.

For our parent founder, organizing into Lighthouse Health Plan was a natural extension of their current mission to serve Medicaid beneficiaries. As a provider-sponsored network plan, we intend to create value for the state of Florida, the Division of Medicaid, providers across the state, and Medicaid beneficiaries by offering high quality, efficient, and accessible health care. Further, by virtue of introducing a new model that operates on principles different from for-profit coordinated care organizations, we will encourage competition and positive clinical outcomes. As Lighthouse Health Plan is led by providers, we will achieve a greater degree of physician engagement that will result in improvements, not only for Medicaid beneficiaries enrolled with Lighthouse Health Plan, but also to all beneficiaries served by our providers, including those enrolled with other managed care organizations. This system-wide impact commonly achieved by Provider Sponsored Networks will create a greater value to the State.

Evaluation Criteria:

For the Managed Care Plan that is proposing to provide services under this solicitation, whether the respondent has:

- An existing SMMC Contract in that region;
- An existing SMMC Contract in another region in the State of Florida; or
- A Medicare Advantage Plan contract in that region.

Score: This section is worth a maximum of 30 raw points as outlined below.

1. 20 points if the respondent already has an SMMC Contract in the region that it plans to provide services (MMA, LTC and/or Specialty).

2. 10 points if the respondent has an SMMC Contract in other regions in the State.

3. 5 additional points will be awarded if the respondent has a comprehensive (MMA & LTC) SMMC Contract in the region that it plans to provide Medicaid services.

4. 5 additional points will be awarded if the plan has a Medicare Advantage Plan in the region that it plans to provide services.

5. 0 points will be awarded if the plan does not have an SMMC Contract in Florida or a Medicare Advantage Plan contract in the region.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 3 – Statutorily Required Florida Presence (Statewide):

The respondent shall provide information regarding whether each operational function, as defined in Section 409.966(3)(c)3, Florida Statutes, will be based in the State of Florida, and the extent to which operational functions will be conducted by staff in-house or through contracted arrangements, located in the State of Florida. This includes:

a. Specifying the location of where the respondent's corporate headquarters will be located (as defined by Section 409.966(3)(c)3, Florida Statutes);

b. Indicating whether the respondent is a subsidiary of, or a joint venture with, any other entity whose principal office will not be located in the State of Florida; and

c. Identifying the number of full-time staff, by operational function (as defined in Section 409.966(3)(c)3, Florida Statutes), that will be located in the State of Florida and out of state.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

LOCATION OF CORPORATE HEADQUARTERS

Should Lighthouse Health Plan, LLC ("Lighthouse") be awarded a contract for the SMMC Managed Medical Assistance Program, our corporate headquarters will be in Pensacola, Florida, Region 1.

Lighthouse will soon open our headquarters in Ft. , which is centrally located to the majority of Medicaid Enrollees and providers that serve Region 1. As a result, nearly all Lighthouse functions as defined in 409.966(3) (c)3 will be performed in our Pensacola office with support provided from our Evolent Health national support staff located in Louisville, KY.

FLORIDA-BASED FUNCTIONS

As Lighthouse has observed, locating services and functions within close proximity of Enrollees and providers is the best method for improving clinical outcomes and achieving quality results in our local community. As a local entity focused on Region 1 Medicaid Enrollees, Lighthouse recognizes the importance of and value brought by locally placed operations. We will perform the following functions in the State of Florida:

• Claim Processing: Florida-based services include provider data capture for system configuration and research for inquiries/ claims adjustment
• Enrollee Services
• Provider Relations
• Utilization Management (including Prior Authorization): Florida-based services will include staff performing concurrent utilization management.
• Case Management, Disease Management, and Transitions of Care
• Quality Improvement

• Lighthouse Health Plan Administration

SUBSIDIARY STATUS

Lighthouse Health Plan is a limited liability company with two members. The sixty percent (60%)] majority member of the company is Baptist Hospital, Inc. As the majority member, Baptist Hospital, Inc. maintains a controlling interest in the company as required for companies operating as provider service networks in Florida Medicaid. Baptist Hospital, Inc. maintains its corporate headquarters at 1717 North "E" Street, Suite 320, Pensacola, FL 32501. The minority member is Evolent Health LLC, which maintains its corporate headquarters at 800 North Glebe, Arlington, VA 22203.

Lighthouse subcontracts with Evolent Health LLC to provide health plan operational and management services. The following functions will be performed by Evolent in Florida: Executive/Administrative, Clinical Operations, Provider Relations, Enrollee and Provider Services, Finance, Quality, and Behavioral Health Management. These functions will be performed in Florida due to our commitment to a high quality, local interaction with Florida Medicaid recipients, providers, Region 1 community leaders and the Agency for Health Care Administration. Additionally, the State of Florida benefits from Lighthouse being headquartered in Region 1 and Evolent Health's national support model that offers operational cost efficiencies and economies of scale.

STAFFING BY OPERATIONAL FUNCTION

Lighthouse Health Plan's organization and staffing approach will offer an executive leadership team, health plan operations, and Population Health team. Our clinical teams will be 100% located in Region 1 to maximize Enrollee engagement and strengthen our Care Managers' relationships with Enrollees. We will staff to provide extensive outreach to providers, advocates, and community-based organizations in order to address the unique health needs in Region 1. Finally, we will incorporate the clinical experience of our health system parent to further innovative clinical programs, engage physicians, and assist in such matters as identification and resolution of access gaps. This innovative approach is built around the health systems and human capital that are already caring for the SMMC population and will deliver improved care to Enrollees, enhanced support to providers, and value to the state of Florida

As established by 409.066(3)(c)3, the number of current and projected full-time staff by operational function that will be located in Florida and out of the State of Florida are provided below. Please note that all projected staff are based on membership assumptions disclosed within the ITN.

Lighthouse staffing assumptions account for 117 Health Plan FTE's with 87 being located within Florida. The number of projected staff does not include an estimated 75 FTEs that provide national support services to Lighthouse.

Below are the number of FTEs, by operational function, that will be located in the State of Florida assuming projected year one membership is reached:

Claim Processing
• Staff Located In Florida = 1

• Staff Located Out of State = 11

Enrollee Services
• Staff Located In Florida = 12
• Staff Located Out of State = 0

Provider Relations
• Staff Located In Florida = 11
• Staff Located Out of State = 3

Utilization Management, including Prior Authorization
• Staff Located In Florida = 1
• Staff Located Out of State = 5

Case Management, Disease Management, and Transitions of Care
• Staff Located In Florida = 38
• Staff Located Out of State = 0

Quality Improvement
• Staff Located In Florida = 2
• Staff Located Out of State = 1

Finance and Other Administration
• Staff Located In Florida = 22
• Staff Located Out of State = 10

Evaluation Criteria:

1. Whether the respondent's corporate headquarters will be located in Florida (it is not a subsidiary of or a joint venture with any other entity whose principal office will be located outside of Florida).

2. The extent to which operational functions (claims processing, enrollee/member services, provider relations, utilization and prior authorization, case management, disease management and quality functions, and finance and administration) will be performed in the State of Florida.

Score: This section is worth a maximum of 15 raw points. Each of the above components is worth a maximum of 5 points each as described below. 5 additional points will be awarded if respondent meets Items 1(a) and 2(a) below.

For Item 1:

(a) 5 points for corporate headquarters in Florida and no parent or joint venture organization outside Florida;
(b) 0 points if no relevant corporate headquarters in Florida.

For Item 2:

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(a) 5 points if all functions will be performed in Florida;
(b) 4 points for 6-7 functions to be performed in Florida;
(c) 3 points for 4-5 functions to be performed in Florida;
(d) 2 points for 2-3 functions to be performed in Florida;
(e) 1 point for 1 function to be performed in Florida;
(f) 0 points for no functions to be performed in Florida;
(g) 0 points if only community outreach, medical director and State administrative functions will be performed in Florida.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 4 – Contract Performance (Statewide):

The respondent shall state whether, in the past five (5) years (since July 14, 2012), it has voluntarily terminated all or part of a managed care contract under which it provided health care services as the insurer; has had such a contract partially or fully terminated before the contract end date (with or without cause); has withdrawn from a contracted service area; or has requested a reduction of enrollment levels. If so, describe the contract; the month and year of the contract action; the reason(s) for the termination, withdrawal, or enrollment level reduction; the parties involved; and provide the name, address and telephone number of the client/other party. If the Contract was terminated based on the respondent's performance, describe any corrective action taken to prevent any future occurrence of the problem leading to the termination. Include information for the respondent as well as the respondent's affiliates and subsidiaries and its parent organization and that organizations' affiliates and subsidiaries.

Response:

In the past five years, neither Lighthouse Health Plan, LLC nor any of our affiliates and subsidiaries nor our parent organization or its affiliates and subsidiaries (collectively, Lighthouse Health Plan), have voluntarily terminated all or part of a managed care contract under which we provided health care services as the insurer.

Lighthouse Health Plan has not had such a contract fully or partially terminated, with or without cause, before the end date in the past five years. Lighthouse Health Plan has also not withdrawn from a contracted service area nor requested a reduction of enrollment levels.

Evaluation Criteria:

1. The extent to which the respondent or parent or subsidiary or affiliates have requested enrollment level reductions or voluntarily terminated all or part of a contract.

2. The extent to which the respondent or parent or subsidiary or affiliates has had contract(s) terminated due to performance.

3. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to patient care rather than administrative concerns (e.g., reporting timeliness).

4. The extent to which the respondent or parent or subsidiary or affiliates had terminations for performance issues related to provider network management, claims processing or solvency concerns.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each as described below.

For Item 1:

(a) 5 points for no voluntary termination of all or part of a contract, no requests for enrollment level reduction and no service area withdrawals;

(b) 0 points for any voluntary terminations, requests for enrollment level reductions, or service area withdrawals.

For Item 2:

(a) 5 points for no involuntary terminations;
(b) 0 points for any involuntary termination based on performance.

For Item 3:

(a) 5 points for no contract terminations related to patient care;
(b) 0 points if termination related to patient care.

For Item 4:

(a) 5 points for no contract terminations related to provider network management, claims processing or solvency concerns;
(b) 0 points if termination related to performance issues related to provider network management, claims processing or solvency concerns.

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B. Agency Goals

SRC# 5 – Disease Management (DM) Program (Statewide):

The respondent shall describe its proposed approach to implementation of specific disease management programs and how they will be used to advance the Agency's goals as stated in **Attachment A**, Instructions and Special Conditions, **Section A.,** Overview, **Sub-Section 15.**, Program Objectives and Goals, of this solicitation. The respondent's description shall include:

a. A description of each proposed disease management program;

b. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

c. A description of the evidence-based guidelines utilized in the approach;

d. A description of how disease management programs are integrated with case management/care coordination programs; and

e. A description of performance metrics used to evaluate the efficacy of the disease management program, including cost-savings, increase in treatment adherence, and measurement of the impact on potentially preventable events, including relevant experience to provide support for the use of the specific performance metrics.

Response:

Baptist Health, as the provider sponsored organization for Lighthouse Health Plan (Lighthouse), brings multiple hospitals and clinics, and physician networks together with Evolent Health, a leading Population Health expert, to offer the best in local care supported by nationally recognized, evidence-based health care management, including disease management. Baptist Health provides vital care as the only locally owned, not for profit health care system in the Pensacola area investing in the community and supporting organizations that help individuals with chronic conditions, such as the Bear, Levin, Studer YMCA; the Northwest Florida Chapter of the American Cancer Society; and the American Heart Association. Lighthouse will build on the many high-quality programs offered through Baptist, such as the Baptist Cancer Institute, accredited by the by the American College of Surgeons Commission on Cancer and Association of Community Cancer Centers (ACCC), enhancing coordinated and complimentary care for enrollees across the care continuum.

For enrollees stratified low or moderate risk, Lighthouse will offer seven disease management programs (referred to as Condition Care) targeting nine conditions:
• Asthma for children and adults
• Cancer for children and adults
• COPD for adults only
• Heart Failure for adults only
• Diabetes for children and adults
• Hypertension/CAD for adults only
• Behavioral health diagnoses of anxiety, depression or substance use for children and adults

We will also offer enrollee incentives designed to promote completion of specific health and wellness activities. Enrollees may earn $25 per qualifying activity up to a maximum of $50 a year distributed on a reloadable card. Qualifying activities of particular relevance to enrollees with chronic conditions are:

- Care gap closure (must have all necessary care gaps closed based on age, gender, race)
- Completion of comprehensive diabetes care (must be compliant with appropriate care for diagnosis: eye exam, foot exam, HbgA1c)
- Medication compliance for people with asthma (if identified as asthmatic through care programming, must be compliant with medication regimen including provider visits)
- Compliance with psychotropic medication regimen (if identified through care programming must be compliant with medication regimen including provider visits)
- Participation and graduation from specific care management program
- Successful participation in a medically-approved smoking cessation
- Successful participation in a medically directed weight loss program
- Successful participation in a medically approved alcohol or substance abuse recovery program

Condition Care delivers highly coordinated and evidence-based health education, care coordination, including care gap closure, close collaboration with the enrollee's primary care physician (PCP) and aligned, local care management team. Centralized Condition Care health coaches work in partnership with the enrollee to address needs holistically through outreach calls, health education and care gap closure. Health Coaches activate the local care management team community health workers or other team members when needed, to provide in-person visits for enrollees who need additional help managing their chronic condition or addressing other issues such as social determinants of health.

Health Coaches will work closely with our network providers, including Patient Centered Medical Homes (PCMHs) such as Escambia Community Clinics (ECC), that is certified as a Level 2 PCMH. ECC has implemented standardized order sets to streamline testing and referrals for patients with certain diseases, such as diabetes, and is conducting daily huddles to identify patients with care gaps, ED use or who have been discharged from the hospital. The combination of Lighthouse's and ECC's chronic condition clinical management will enable us to rapidly engage Lighthouse enrollees in multidisciplinary care that includes highly coordinated physician treatment and Condition Care disease management. In addition, Lighthouse's local community health workers (CHWs) will work in the community with hard to reach or hard to engage enrollees, coordinating their outreach efforts with vital community providers like ECC.

We propose exploring the use of Congregational Liaisons. The Congregational Health Network at Methodist Le Bonheur Healthcare in Memphis educates parishioners from the African-American community to serve as volunteer health liaisons helping fellow parishioners discharged from the hospital who need post-discharge support. The Congregational Liaison is teamed with a hospital navigator who completes the transition plan and initial visits post discharge. The volunteer helps follow-up on scheduling appointments and services. In addition to connecting enrollees with Congregational Liaisons post-discharge, we believe the liaisons can serve a valuable role locating and helping us to engage enrollees who may otherwise be reluctant to speak to us.

LOW RISK ENROLLEES

Enrollees stratified as low-risk receive targeted condition-specific informational materials and health coaches monitor the enrollee's service use to identify care gaps, intervening with the enrollee and his or her provider to close these gaps. In addition, the health coach makes outreach calls to low-risk enrollees when they identify a change in the enrollee's health status, such as an inpatient admission, to determine the need for more intensive intervention and support.

MODERATE RISK ENROLLEES

Health coaches work telephonically with enrollees stratified as having moderate risk, their caregivers and family members, PCP and other providers as applicable, delivering evidence-based interventions that:
• Educate enrollees on their targeted conditions, overall health and self-management
• Support the enrollee's behavior change
• Reduce the incidence of complications
• Improve physical functioning
• Improve emotional well-being
• Support the provider/enrollee relationship
• Emphasize and reinforce provider's use of clinical practice guidelines

The health coach:
• Delivers self-management training through personalized enrollee interventions documented in an enrollee Action Plan
• Collaborates with the enrollee's PCP and specialists to reinforce treatment plans
• Provides feedback to enrollees and the enrollee's PCP and other treating providers on specific chronic management issues and successes
• Coordinates referrals to other clinical programs when enrollees experience heightened acuity
• Collaborates with the local, multidisciplinary care management team to coordinate access to community-based resources and to provide in-home health education and support when needed
• Identifies available community evidence-based support programs, such as the Stanford Chronic Disease Self-Management Program (CDMSP).

The health coach works with an extended team of nurse care managers, BH specialists, nutritionists, and pharmacists who provide consultation and support as needed. In addition, the health coach coordinates the enrollee's self-management and related interventions with the local, geographically-aligned care management team aligned with the enrollee's PCP. The team includes licensed RN and BH care managers, community health workers (CHWs), dietitians, pharmacists and health educators hired from the local community who collaborate to make sure enrollees are connected to their PCP and care is closely coordinated for maximum effectiveness. When the health coach determines an enrollee would benefit from an in-home assessment or other outreach visit, he or she coordinates outreach from the local CHW, nurse care manager or BH care manager, depending on the enrollee' specific needs. The local care management team may also help identify and coordinate access to community resources that support the enrollee's Condition Care Action Plan.

Coordination among health coaches and the extended Condition Care team, local care management team members, utilization management and other internal staff is supported by our sophisticated technology platform, Identifi, that aggregates all available data, to provide authorized users, including the enrollee's PCP with a comprehensive enrollee profile and real-

time health management platform. The data can also seamlessly integrate into the provider's electronic medical record system.

HIGH-RISK ENROLLEES

Enrollees with targeted chronic conditions, including comorbid conditions, stratified as high risk or having "rising risk" are enrolled into Complex Care unless another care management program is more appropriate to their condition and risk level (such as High Need BH Care Management or Care Management for Enrollees with Special Health Care Needs). These enrollees are high risk for a future inpatient admission or emergency room (ER) visit that can be avoided with the additional support from a nurse or behavioral health care manager, as applicable. Enrollees stratified at this level are able to learn and use self-management skills.

All of our care management programs include the essential elements of disease management including enrollee education, self-management support and coordination in support of the provider's treatment plan.

ENROLLEE IDENTIFICATION AND STRATIFICATION

We systematically evaluate enrollee data against a set of identification and stratification criteria for each of the condition-specific programs using both automated (rules-based) and manual (query and clinical referral based) processes from numerous data sources. We include social and demographic data in this process, recognizing that the risk of poor health outcomes is magnified when enrollees live in food deserts, have few options for nearby employment or are homeless, for example. Our algorithm is highly sensitive to the challenges Medicaid enrollees face daily and is described in detail later in this section.

Once identified, we stratify enrollees considering care gaps, comorbid conditions, and social factors, to determine the appropriate level of intervention based on enrollee identified need and status. Enrollees may have more than one chronic condition. In this case, we apply a hierarchy to ensure the enrollee is targeted for the appropriate program.

We stratify enrollees with targeted chronic conditions into three risk levels:

1. Enrollees with a low risk score based on our proprietary predictive modeling, have two paid claims for evaluation and management visits and a targeted primary diagnosis with no significant care gaps.
2. Enrollees with a moderate risk score have at least one of the following:
a) A condition-related inpatient admission within six months
b) A condition-related ER visit within three months
c) No PCP or condition related specialist visit within twelve months
d) No prescription(s) for a condition-related medication.
3. Enrollees with a high risk score are most likely to incur a disease-specific adverse event. Some of the covariates used to project a likely adverse event include: co-existing chronic conditions, prior service utilization, change in service utilization rates, drugs that indicate disease progression or severity, specific medical equipment use and gaps in care.

The stratification is condition specific and the process runs at least monthly. However, re-stratification may occur anytime in between based on new information obtained during the

enrollee screening or assessment or additional information that becomes available during enrollee interactions.

PROGRAM ENROLLMENT

We enroll enrollees into Condition Care and confirm enrollment during the first program outreach. Enrollees who agree to remain enrolled receive a program enrollment letter that includes a program brochure that includes:
• Information on how to use program services
• How the enrollee became eligible to participate
• Health coach contact information and how to access their care manager or health coach
• The importance of completing routine visits to the PCP for preventive care and disease-specific follow-up
• Enrollee rights and responsibilities
• How to provide feedback on the program or communicate a complaint
• Whom to contact in an urgent situation
• How to opt-out should they prefer not to participate

We re-contact enrollees who decline participation six months later when they meet the criteria for the program again to attempt enrollment. Enrollees who do not want to be contacted again are placed on a do not call list. We notify all enrolled enrollees and their PCPs of care gaps on an ongoing basis and help close these gaps.

Enrollees stratified as low risk receive outreach when the enrollee has unplanned care, gaps in care or is identified for another program such as Transitions of Care. We use technology to support outreach to our low risk enrollees when able, via secure text messaging, patient engagement applications tied to our care management IT platform, IVR calls, as well as educational mailings.

For enrollees stratified as medium risk the health coach completes a condition-specific health screening, and develops an action plan with the enrollee focusing on self-management of the enrollee's chronic condition(s), and self-management support, health education and coaching to improve knowledge and self-management skills. The screening includes questions about the enrollee's:
• Primary language
• Vision
• Hearing
• Educational level
• Caregiver support
• Personal goals
• Understanding and beliefs about their condition
• Condition-specific questions – for example, for an enrollee with asthma, use of a peak flow meter
• Medications and adherence
• PCP and PCP engagement
• Other health conditions
• Health behaviors, including smoking

The screening incorporates other evidence-based screening tools, including:
• PHQ2 Screening

• PHQ9 screening

In addition, the screening tool prompts completion of referrals based on an enrollee's responses. Examples include to care management if an enrollee needs help identifying a specialist to help manage their condition, to a dietitian for help with nutritional education and planning, or to a pharmacist for help with medication education and management.

The health coach makes a minimum of one outreach call every three weeks during program enrollment (typically 90 days) unless requested otherwise by the enrollee or enrollee's physician, to determine if the enrollee is progressing with self-management, has additional needs or questions.

Action Plans --

We focus all of our clinical programs on teaching and supporting enrollees' self-management, focusing first on the conditions and needs of priority concern to the enrollee. Interventions are not limited to addressing the enrollee's targeted chronic condition (such as diabetes). In fact, if the enrollee's most pressing issue is a social need, the health coach first intervenes to help the enrollee meet this need. If the enrollee has co-morbid conditions, such as asthma and obesity, and the condition that triggered program enrollment (asthma) is not the enrollee's primary concern but he or she identifies obesity as the primary concern, we begin with obesity.

Interventions are specific to the enrollee's condition and circumstances and address the following:
• Condition monitoring, including self-monitoring (e.g., foot and skin care for diabetics, or a relapse prevention plan for substance use) and reminders about self-administered or provider ordered tests
• Adherence to treatment plans and wellness recovery plans (including medication adherence) and tracking mechanisms
• Communication with practitioners about the enrollee's health conditions, self-management and condition monitoring activities and care plan goals and progress (example – what to do before a visit to a physician or therapist – writing down most important issues)
• Additional resources external to the organization, as appropriate (e.g., community programs, national organizations such as the American Diabetes Association or National Alliance on Mental Illness, and useful Web sites)

All care management programs align with our provider-facing tool, Identifi Practice. Using this tool providers can see which of their patients are enrolled in clinical management programs, or who have received program outreach, or have gaps in care, as well as each patent's recent service use and risk stratification level.

Condition-Specific Information --

We offer all enrolled enrollees, either during an encounter with the health coach and/or through the enrollment letter, a condition-specific health education booklet from the "Take Control, Live Better" series for the enrollee's specific condition. Healthwise booklet content includes condition-specific education, detailed planning tools for self-management, and symptom management information. Additional information in the workbook includes:
• Physician visits and pre-visit planning
• Identifying and avoiding triggers

• Managing medications
• Urgent and emergent symptoms and actions

Examples of condition-specific information include:
• Developing and following an Asthma Action Plan
• Using a Peak Flow Meter and keeping an Asthma Diary

Health Coaches answer enrollees questions about using these tools, help the enrollee develop goals related to the information in the tools and incorporate these goals into the enrollee's Action Plan. Health coaches also refer enrollee to relevant websites specific to the enrollee's primary chronic condition, such as the American Lung Association and the National Asthma Education and Prevention Program.

Health Behaviors –

Enrollees with chronic conditions may need help addressing behaviors that negatively impact their chronic conditions such as being overweight, smoking or having a sedentary lifestyle. Health coaches educate enrollees about healthy diets, exercise, and smoking cessation and refer enrollees to support lines, community classes and support groups such as:
• AHEC (Area Health Education Center) smoking cessation classes
• The state's Tobacco Free Florida website and Quit Coach support line
• Baptist Health onsite tobacco cessation classes
• Chronic Disease Self-Management Programs
• Healthiest Weight –free nutrition based cooking classes at the Northwest Florida YMCA

If an enrollee needs additional help and encouragement with healthy behaviors, the coach makes a referral to the local care management team Community Health Worker who contacts the enrollee by phone or in-person to provide this assistance, such as arranging participation in classes and access to transportation and helps coordinate care.

The health coach also helps enrollees access covered benefits that support self-management such as smoking cessation products, medications and equipment, such as nebulizers or inhalers. The coach works with the enrollee's PCP and, when prior authorization is required, UM staff.

Symptom Management --

Health coaches include symptom management as part of the enrollee's health education and self-management skills training and provide materials to support symptom management, such as the "Take Control, Live Better" condition-specific workbook, the Sick Day plan for diabetics, and an Asthma Action Plan. "Red Flag" education helps enrollees with early identification of symptoms and self- management

Medication Support --

Medication support is a major focus of our program. Health coaches review an enrollee's medication compliance and understanding of medication use, dosage, and side effects during the enrollee's screening. Coaches help enrollees identify ways to remember to take their medications as scheduled and access automated medication delivery systems that include prompts to ensure timely refills. The coach consults with the extended care team nurse or pharmacist when needed

to provide enrollees with more in-depth information or support. Enrollees are made aware of automated delivery systems through the CVS directly independent of the PBM. Those patients being touched by pharmacists through a clinical program can educate the enrollee as well.

Enrollees also receive the Health Wise suite of behavioral health educational programs. Inclusive of content on depression, anxiety, panic disorder, sleep disorder, bipolar disorder, how to find a support group that meets your needs, medication adherence strategies, stress management, and substance use disorder, among other content.

Emotional Support --

Health coaches screen enrollees for psychosocial issues that may impact their ability to effectively manage their chronic condition and support the enrollee's ability to feel confident in self-management. They perform standard screens to measure improvement in depression and anxiety.

Behavior Change --

We train health coaches in motivational interviewing, an evidence-based approach that helps people with chronic conditions make positive behavioral changes. Self-management education includes but is not limited to assessing the enrollee's understanding of his/her treatment plan, educating the enrollee with the assistance of disease specific educational materials about testing, medication adherence, managing symptoms, and when to contact their provider. The health coach works with the enrollee to develop and execute personal goals related to their overall health or disease state such as weight loss and exercise.

Enrollees demonstrate their progress through teach back, verbalizing confidence and progress on both clinical guideline goals and personal goals. The health coach ensures that care is coordinated with the enrollee's local care team and PCP and encourages the enrollee to share relevant health information with the team and with their provider.

Provider Communication --

We notify providers and the extended care team of enrollee engagement in the program as soon as possible, but no later than 45 days of an enrollee's enrollment into Condition Care. This information, as well as periodic updates, is provided through Identifi messaging, including direct notification into the providers EHR, telephonic outreach, by fax, email, or mail. Toll-free telephone and fax numbers are also available.

When an enrollee declines enrollment or graduates from the program we notify the provider within seven days.

Health coaches work to close an enrollee's care gaps through coordination of needed services, enrollee education and help accessing and completing specific appointments or refilling medications, and through collaboration with the enrollee's PCP and specialist(s). The enrollee's PCP also receives care gap alerts and urgent notifications when an enrollee's condition indicates a need for an urgent care visit with the PCP or treating provider. Periodic reports, as well information provided through the local care management team or embedded care managers, also helps keep PCPs up-to-date on their patient's progress. Messaging transmitted to the providers

EHR or by fax, alerts the PCP and specialist the enrollee's Action Plan is available in Identifi or by hard cop upon request.

Educating Providers About Condition Care Programs --

Condition Care program information is distributed to providers annually. Evidence-based clinical practice guidelines are provided annually, or sooner if updates to the guidelines are made prior to annual distribution, and distributed through the provider newsletter, provider websites, and web portals, and in provider manuals, training materials and during provider orientation. All communication to practitioners includes contact information for provider feedback or comment on the guidelines.

Program materials include information on:
• Available services for enrollees and practitioners and how to use services
• How the enrollees become eligible to participate
• The evidence-based clinical, behavioral health and preventive health guidelines
• The program content information and the existing clinical practice decision support tools consistent with the guidelines
• Program staff contact information and access, regular business hours and after-hours access
• How program staff works with enrollees

PROGRAM GOALS ALIGN WITH THE STATE'S GOALS

As a provider-sponsored health plan, we will bring the strength of Evolent's population health programs to our aligned providers, combining clinical supports and community resources to help enrollees make meaningful gains in self-management. Condition Care programs use the latest innovative and evidence-based approaches to help enrollees, or families and their children, manage chronic conditions, improve their overall health and functioning, and avoid inpatient and other high cost service use. These programs are part of our care management continuum that in combination with our provider programs will reduce potentially preventable inpatient and outpatient hospital events, and unnecessary ancillary services use through close collaboration with the enrollee and his or her PCP and other treating providers.

CONDITION-SPECIFIC IDENTIFICATION, STRATIFICATION AND INTERVENTIONS

ASTHMA

We identify enrollees for enrollment into Asthma Condition Care who have a primary diagnosis of asthma in all past claims history and for enrollees stratified as low-risk, have two paid claims for evaluation and management visits.

For enrollees stratified as moderate risk, in addition to the low-risk criteria, these enrollees have:
• An asthma related inpatient admission within six months
• An asthma related ER visit within three months
• No PCP or asthma related specialist visit within twelve months
• Lack of a prescription for a long-acting inhaler

We offer all enrolled enrollees, either during an encounter with the health coach and/or through the enrollment letter, the Health Wise "Asthma - Take Control, Live Better" booklet. The booklet

content includes asthma education, detailed planning tools for self-management, and symptom management information. Additional information in the workbook includes:
• Physician visits and pre-visit planning
• Developing and following an Asthma Action Plan
• Using a Peak Flow Meter and keeping an Asthma Diary
• Identifying and avoiding Triggers
• Managing Medications
• Urgent and Emergent symptoms and actions

Health coaches also refer enrollee to the following websites for additional educational resources and tools:
• American Lung Association (smoking cessation)
• National Asthma Education and Prevention Program

We also refer enrollees who smoke to the state's Tobacco Free Florida website and Quit Coach support line and to local Quit Smoking Now and other community-based classes and supports. Health coaches also help enrollees access covered nicotine replacement products.
Health coaches encourage enrollees through educational materials and telephone interactions to communicate regularly with their PCP about their asthma and their treatment plan. We stress the importance of enrollees taking an active role in their care and include enrollee "teach back", to confirm appropriate understanding.

Asthma is often associated with various comorbidities. According to the NIH, frequently reported asthma comorbid conditions include rhinitis, sinusitis, and gastro esophageal reflux disease (GERD). The health coach educates enrollees to avoid lung irritants and triggers for asthma attacks and provides educational materials on asthma triggers to test the enrollee's knowledge retention.

If the health coach identifies any of the following urgent care opportunities during an interaction with an enrollee, he or she alerts the enrollee's PCP of the enrollee's status via telephone, secure email, or EHR where available, within one business day.
• Increasing use of rescue inhaler over two days or more than two to three times a day
• Difficulty with usual activities for two consecutive days
• Decreased peak flow reading for two consecutive days

A written protocol helps the health coach identify urgent care opportunities.

CANCER

Cancer is a complex condition that often requires multiple interventions provided by a variety of health professionals over prolonged periods of time. Excluding cancer-specific treatment, the numbers of hospitalizations for cancer patients are often significantly higher than in the general population. For example, chemotherapy and radiotherapy can impair immune function, increasing risks of infectious complications and sepsis. In patients with other medical comorbidities, such as diabetes or heart disease, holistic management of these diagnoses with cancer therapy minimizes the risk of preventable complications. In addition, enrollees with cancer experience a range of emotions, fears, and concerns. When these emotions are inadequately understood and addressed, they become less engaged in their care and are less likely to adhere to therapy or manage other comorbid conditions.

Identification of Enrollees for the Cancer Support program (CSP) –

We identify the majority of enrollees with cancer enrolled in the Cancer Support Program (CSP) through daily utilization management (UM) authorizations for enrollees admitted to the hospital. Enrollees may also be referred to the program or identified from paid claims data, including pharmacy claims. Baptist's Cancer Institute offers free annual cancer screening clinics (for skin, head and neck, and lung cancers) and will now be able to connect screened individuals of concern who are Medicaid-eligible with the local care management team for assistance and if applicable, treatment at the Institute and enrollment into the CSP.

CSP Goals –

The CSP's primary goal is to support the implementation of the enrollee's specialist treatment plan to prevent avoidable readmissions, reduce unnecessary emergency room (ER) visits, manage the enrollee's pain and remove barriers that may prevent the enrollee and his/her caregiver from adhering to his/her treatment plan.

Multidisciplinary Care Team –

The CSP is implemented by a multidisciplinary care team that includes a registered nurse care manager, health coach, registered dietitian, social worker and pharmacist, working in close collaboration with the enrollee's PCP and oncologist. We do not stratify enrollees enrolled in the CSP. Rather, enrollees receive individualized interventions through the combined resources of the team.

The nurse care manager performs a comprehensive enrollee assessment and develops a care plan that includes the enrollees short and longer-term goals, identified needs and interventions, which include:
• Care coordination and care management
• Enrollee education and self-management support
• Caregiver support
• Coordination of resources and services
• Ongoing telephonic contacts and in-home and hospital visits if necessary
• Ongoing physician communication
• Case management services if the enrollee is admitted to the hospital

The primary goals include:
• Minimize acute-care service use
• Decrease the incidence of side effects that increase the risk of infection or delay enrollees' ability to receive standard therapies
• Educate enrollees and their families about the phases of cancer treatment (e.g., active, palliative, and hospice care) and provide support through every phase of their treatment, from initial care to end of life

Evolent uses current, applicable, evidence-based clinical guidelines from nationally recognized sources for the basis of its CSP. Evidence-based, medical society and national industry standards are referenced for the development, ongoing maintenance, and updates to the program. Nationally recognized clinical guidelines are reviewed and updated as appropriate, at least every

two years or at the time any new scientific evidence or national standards are published; or revised information, or changes to the guidelines are made available.

Baptist Cancer Institute offers a cancer support group and cancer navigator who helps guide individuals through their cancer treatment from admission through discharge. Navigators and Health Coaches will work together so that enrollees receiving treatment at the Institute will transition to an appropriate care management program on discharge, such as the Cancer Support (DM) Program.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD)

We identify enrollees for enrollment into COPD Condition Care who have a primary diagnosis of COPD in all past claims history and for enrollees stratified as low-risk, have two paid claims for evaluation and management visits. For enrollees stratified as moderate risk, in addition to the low-risk criteria, these enrollees have at least one of the following:
• A COPD related inpatient admission within six months
• A COPD related ER visit within three months
• No PCP or COPD related specialist visit within twelve months
• Lack of a prescription for a long-acting inhaler

We offer all enrolled enrollees, either during an encounter with the health coach and/or through the enrollment letter, the Health Wise “COPD - Take Control, Live Better” booklet. The booklet content includes COPD education, detailed planning tools for self-management, and symptom management information. Additional information in the workbook includes:
• Physician visits and pre-visit planning
• Developing personal action plan for quitting smoking
• Using a metered-dose inhaler with spacer
• Identifying and avoiding triggers
• Managing medications
• Oxygen use
• Pulmonary rehabilitation
• Urgent and emergent symptoms and actions

Health coaches also refer the enrollee to the following websites for additional educational resources and tools:
• American Lung Association
• National Asthma Education and Prevention Program

We also refer enrollees who smoke to the state’s Tobacco Free Florida website and Quit Coach support line and to local Quit Smoking Now and other community-based classes and supports. Health coaches also help enrollees access covered nicotine replacement products.
COPD is often associated with various comorbidities. Some of these may include pneumonia, musculoskeletal problems, osteoporosis, and gastro esophageal reflux disease (GERD). Enrollees with multiple and complex comorbidities are referred to a nurse care manager who identifies an appropriate Care Management program to meet the enrollee’s needs.

If the health coach identifies any of the following urgent care opportunities during an interaction with an enrollee, he or she alerts the enrollee’s PCP of the enrollee’s status via telephone, secure email, or EMR, where available, within one business day.

• Increased cough or productive cough, chest tightness, breathlessness,
• Increasing O2 from baseline (air hunger) over 2 days or use of more than 4L
• Increased use of rescue inhalers/nebulizers over 2 days

HEART FAILURE (HF)

Risk Stratification –

We identify enrollees for enrollment into HF Condition Care who have a primary diagnosis of HF in all past claims history and for enrollees stratified as low-risk, have two paid claims for evaluation and management visits.

HF - Moderate Risk (Condition Care): Members with two paid claims for evaluation and management visits with the primary diagnosis of heart failure, AND at least one of the following:
• A heart failure related inpatient admission within six months
• A heart failure related ER visit within three months
• No PCP or heart failure related specialist visit within twelve months
• Patient's heart failure and hypertension prescription adherence is less than 80%

HF – High Risk (Complex Care): Members with HF most likely to incur a disease-specific adverse event. Criteria for the moderate risk level are expanded to include:
• Co-existing chronic conditions
• Prior utilization, over past twelve months, that takes into account admissions, emergency room visits, PCP visits and specialist visits
• Drugs that indicate disease progression or severity
• Medical equipment (e.g., home oxygen)
• Gaps in care

HF Interventions --

All high risk members with HF receive a Heart Failure, "Take Control, Live Better" educational booklet, unless they decline. Moderate and low risk members are offered, either through an encounter with the nurse care manager and/or through the enrollment letter, an opportunity to request the educational booklet. Members are encouraged to communicate regularly with their practitioner about their heart failure and their treatment plan through educational materials and telephone interactions. The program stresses the importance of members taking an active role in their care. The educational booklet content includes Heart Failure education, detailed planning tools for self-management, and symptom management information. Additional information includes:
• Physician visits and pre-visit planning
• Schedule for tests and screenings
• Symptoms of heart failure and keeping a symptom record
• Treatments for heart failure
• Self-care
• Exercise planning form
• Heart healthy eating
• Urgent and Emergent symptoms and actions

Additional resources provided to members include the following web sites:

• American Heart Association
• American Lung Association (for smoking cessation)

HF Comorbidities and Other Health Conditions --

HF is often accompanied by various comorbidities. These comorbid conditions may include diabetes, hypertension, kidney disease, chronic obstructive pulmonary disease, obesity and sleep disordered breathing. Members with multiple comorbidities are stratified at a higher risk level and managed by RNs who address the comorbid conditions in collaboration with the members' practitioner. Members receive information addressing their comorbid conditions, including behavioral health referral, if appropriate. Additionally, members receive information on healthy eating, salt restriction, blood pressure control, exercise, etc. Members with complex care needs are screened for cognitive deficits and referred to the BH care manager if appropriate.

Urgent Notification Alerts --

If the nurse identifies any of the following urgent care opportunities, during an interaction with a patient, he or she alerts the patient's practitioner of the patient's status via telephone, secure email, or EMR, where available within one business day.

• Weight Gain: 2-5 pounds within 24-48 hours
• Increasing Shortness of breath or dyspnea on exertion that persists over 2 days (unable to walk as far as usual)
• Sputum or persist cough (possible signs of pulmonary edema)

HYPERTENSION/CAD

Hypertension is one of the most prevalent chronic conditions in existence, with 30 percent of the population affected and only half well-controlled. It is more prevalent in lower socioeconomic classes and is closely linked with heart attacks, strokes, and kidney failure. Hypertension is highly behavior dependent - on diet, smoking, weight loss, and medication adherence. According to the National Institutes for Health, even in the short term (15 months), reduction in uncontrolled hypertension can reduce cardiovascular events by 16 – 20 percent.

Hypertension - low risk enrollees have two paid claims for evaluation and management visits with the primary diagnosis of hypertension in all past claims history. These enrollees receive care coordination. Monthly re-stratification or referral may result in enrollment into Condition Care, Complex Care or another clinical program based on the identified needs.

Hypertension - moderate risk enrollees have two paid claims for evaluation and management visits with the primary diagnosis of hypertension, AND at least one of the following:
• A hypertension related inpatient admission within six months
• A hypertension related ER visit within three months
• No PCP or hypertension related specialist visit within twelve months
• An adherence rate to antihypertensives of less than 80%

Enrollees receive health education and coaching and care coordination.

Hypertension -Specific Interventions –

All enrolled high-risk enrollees receive a Coronary Artery Disease "Take Control, Live Better" booklet, unless they decline. Moderate and low risk enrollees are offered, either through an encounter with the health coach and/or through the enrollment letter, an opportunity to request the booklet. Enrollees are encouraged to communicate regularly with their practitioner about their hypertension and their treatment plan. This is communicated through educational materials or, in high and moderate risk enrollees, through educational materials and telephone interactions.

Additional interventions include SMS reminders to take prescribed medication, which can double adherence rates; and identification of enrollees on multiple antihypertensives with pharmacist collaboration with PCPs to promote cost-effective prescribing and patient adherence, including minimizing the number of pills, providing 90 day prescriptions to minimize refill issues, encouraging combination therapy, if appropriate, minimizing use of NSAIDs and addressing social determinants that may be obstructing the enrollee's hypertension management.

The program stresses the importance of enrollees taking an active role in their care. The booklet content includes CAD education, detailed planning tools for self-management, and symptom management information. Additional information includes:
• Physician visits and pre-visit planning
• Schedule for tests and screenings
• Managing angina
• Treatments for CAD
• Managing medications
• Exercise planning form
• Heart healthy eating
• Urgent and Emergent symptoms and actions

Additional resources provided include the following:
• American Heart Association website
• Smoking Cessation tools
• YMCA Information - a national resource for fitness facilities

Hypertension - Comorbidities and Other Health Conditions –

Enrollees receive information addressing their comorbid conditions, including behavioral health referral, if appropriate. Additionally, enrollees will receive information on healthy eating, salt restriction, blood pressure control, exercise, and more. Enrollees with hypertension often present with hyperlipidemia, and are at higher risk for depression. Enrollees with multiple comorbidities are stratified at a higher risk level and enrolled in Complex Care.

Hypertension - Urgent Notification Alerts –

If the nurse care manager or health coach identifies any of the following urgent care opportunities, during an interaction with an enrollee, he or she alerts the enrollee's practitioner of the enrollee's status via telephone, secure email, or EMR, where available within one business day or sooner if symptoms are more emergent.
• Chest pain or pressure, squeezing, fullness or pain in chest that lasts more than a few minutes or goes away and comes back

• Aspirin and anticoagulant therapy with increased bruising, bleeding gums, bloody stool, or hematuria.
• Statin therapy with muscle or joint pains (may affect medication adherence, Lipitor, etc.)

DIABETES

The Condition Care diabetes intervention is intended to help guide the care of enrollees with diabetes to improve the quality of their care, their adherence to treatment, and to control health care costs. Supporting the practitioner-patient relationship and plan of care, the diabetes program emphasizes the prevention of the exacerbations and complications of diabetes through evidence-based practice guidelines.

Stratification of Enrollees with Diabetes --

Diabetes - low risk enrollees have two paid claims for evaluation and management visits with the primary diagnosis of diabetes in all past claims history.

Diabetes - moderate risk enrollees have two paid claims for evaluation and management visits with the primary diagnosis of diabetes, AND at least one of the following:
• A diabetes related enrollee inpatient admission within six months
• A diabetes related ER visit within three months
• No PCP or diabetes related specialist visit within twelve months
• Last HbA1c test was greater than twelve months ago

Diabetes Program Interventions --

All enrolled high-risk enrollees receive a diabetes Health Wise “Take Control, Live Better” booklet, unless they decline. Moderate and low risk enrollees are offered, either through an encounter with the health coach and/or through the enrollment letter, an opportunity to request the booklet. Enrollees are encouraged to communicate regularly with their practitioner about their diabetes and their treatment plan. This is communicated through educational materials or, in high and moderate risk enrollees, through educational materials and telephone interactions. The program stresses the importance of enrollees taking an active role in their care. The booklet content includes diabetes education, detailed planning tools for self-management, and symptom management information. Additional information includes:
• Physician visits and pre-visit planning
• Schedule for tests and screenings
• Managing diabetes
• Managing medications
• Exercise planning form
• Diet and diabetes
• Urgent and Emergent symptoms and actions

Additional resources provided to enrollees include the following:
• American Diabetes Association website
• American Heart Association website
• YMCA Information

Diabetes Program Urgent Notification Alerts –

If the nurse care manager or health coach identifies any of the following urgent care opportunities, during an interaction with an enrollee, he or she alerts the enrollee's practitioner of the enrollee's status via telephone, secure email, or EMR, where available within one business day.
• Hypoglycemia that occurs at least 2 days per week - blood sugars before meals <70 or 2 hours following meals <100
• Hyperglycemia that occurs at least 2 days per week - blood sugars before meals >120 or 2 hours following meals >180
• Open wounds or sores that are not healing

BEHAVIORAL HEALTH: ANXIETY, DEPRESSION AND SUBSTANCE USE

We enroll enrollees who have behavioral health diagnoses of anxiety, depression or substance use and who are identified as being at risk for a BH-related event, into the Behavioral Health program. A BH care manager provides health education, self-management support and care coordination, consulting with a RN care manager as needed, to address the enrollee's physical health needs. The BH care manager works with the enrollee, their providers, caregivers and community-based support services to increase the enrollee's knowledge and understanding of their behavioral health conditions and improve access to BH specialty providers, community-based resources and support services.

Identification and Stratification of Enrollees with Targeted BH Conditions - Anxiety, Depression and Substance Use –

We identify enrollees for enrollment into Behavioral Health based on a combination of service use, diagnoses, and risk factors. These enrollees can have a diagnosis of anxiety, depression or substance use with the following characteristics and are not otherwise identified for another, more intensive care management program.

Identification and stratification considers:
• Related ER or inpatient, specialist and PCP visits
• Related MRI/ PET scans, and other diagnostics
• Behavioral health related medication prescriptions
• Specific social determinants of heath such as lack of employment, lack of access to public transportation, or advancing age

Enrollees are stratified on a continuous risk score scale.

BH Program Enrollee Screening and Assessment –

The BH care manager completes a comprehensive psychosocial assessment that includes modules such as Mood, Personal Safety, Anxiety, and Substance Use; and evidence based screening tools such as the PHQ2 and 9, GAD-7 and CAGE-AID. Screenings are repeated within 30 days to assess improvement in functioning and symptomology.

Interventions –

The BH Care Manager focusses on:
• Psychotropic medication education

• Education about the enrollee's specific condition, interaction with co-morbidities, and "what to watch for" / relapse planning
• Collaborative Self-management plans, including when to contact the doctor
• Ensuring adequate caregiver support and appropriate resources at home
• Arranging follow-up appointments, including an appointment with the primary care physician and Behavioral Health providers
• Linkage to community-based and peer supports

For enrollees with substance use, the BH Care Manager coordinates outreach from the local care management team CHW to support the enrollee's access to local resources, including methadone clinics and the Ziboxone clinic.

BH Program Urgent Notification Alerts –

If the BH care manager identifies any of the following urgent care opportunities during an interaction with an enrollee, he or she alerts the enrollee's practitioner of the enrollee's status via telephone, secure email, or EHR, where available within one business day.

ALGORITHM SUPPORTING ENROLLEE STRATIFICATION

Our algorithm supporting enrollee stratification begins with analysis of a comprehensive set of data sources that includes physical and behavioral health claims data and social data, combined with health risk assessment data, to accurately identify enrollees risk for future events. Our model uses predictive analytics to forecast the probability of a specific outcome while also determining if we can change it. We then design targeted interventions to avoid the occurrence or lessen the impact of the risks on the enrollee instead of providing a "one size fits all" intervention.

Our model's predictive reliability is higher than industry standards with a c-statistic of 0.82 (a frequently cited measure of predictive performance). For example, our model's c-statistic is higher than that of the:
• Johns Hopkins Adjusted Clinical Groups Model
• Chronic Comorbidity Counts Model
• Minnesota Tiering Model
• Charlson Comorbidity Model

Our predictive modeling has been validated and tested with Medicaid enrollees by capturing the Medicaid population specific characteristics and service utilization patterns. We strengthen our predictive models through access to our provider's Electronic Health Record (EHR) data.

Data Sources: Clinical Data –

We build our predictive models from many data sources. These include medical and pharmacy claims, EHR data, laboratory and other diagnostic data, self-reported data, health assessment data (including American College of Obstetrical and Gynecological assessment data in the context of enrollees with high risk pregnancies), and data supplied by the state Health Information Exchange. This data integration allows for comprehensive view of enrollees' health, integrating disparate medical datasets to describe disease severity, enrollee health trajectory, and/or engagement. Because different data sources can generate complementary insights, we leverage them together. An example of this is utilizing medication orders and pharmacy claims fill

information from provider EHRs, made possible through our close relationship with providers as a Provider-Sponsored Health Plan.

Data Sources: Social and Demographic Data –

Due to the importance of psychosocial and socio-economic issues on health outcomes we leverage a variety of publicly available data sources to determine a population's social determinants of health. The American Community Survey (ACS) from the U.S. Census Bureau tracks over 100 data elements on education, poverty and housing status by neighborhood. We leverage the location affordability index, walkability index, food access and supermarket availability from U.S. Department of Transportation, as well as the Environmental Protection Agency's Smart Location Database to supplement social economic and environmental information. We also apply U.S. Department of Agriculture food desert tracks to our risk scoring determination. We incorporate data at the census block level and at the individual address level when this data exists (such as the use of federal subsidized housing or shelter data). We take advantage of the recent developments in the "Internet of Things", leveraging Google technology (like the technology that allows users to locate amenities in Google Maps), to calculate distances to the nearest pharmacy, grocery store, physician's office, and hospital which may identify potential gaps in the community's health care access.

In addition to the monthly identification process, enrollees can be referred to a clinical program by physicians, caregivers, hospital discharge planners, UM and CM staff, the 24/7 Nurse Line and by enrollee self-referral. We encourage enrollees, families/caregivers, providers, and Lighthouse team members to make referrals for care management at any time.

Stratification –

The proprietary analytic predictive modeling tool generates multiple paths and algorithms in identifying and stratifying patients, for example, using 1) prior emergency room or hospital visits, 2) pharmacy prescriptions, 3) social determinant data and 4) gaps in care. Enrollees are assigned a risk score according to the risk level. Basic scoring rules are applied to available data sources and, as additional data sources become available, then altered accordingly. Scores are refreshed every time client eligibility is received and/or at least monthly. Stratification is a dynamic process, and a stratification level can change as an enrollee's condition changes, linking to the appropriate level of risk and corresponding intervention.

The stratification process identifies enrollees for enrollment into specific clinical programs using the combination of risk stratification and program eligibility criteria and generates an enrollee roster at the physician level, which includes the physician's panel of enrollees; identified program; referral source, if other than through predictive modeling; and current status indicators, such as engaged, closed, or unable to reach. The algorithm and risk level is unique to each identified program.

Because we run multiple algorithms an enrollee may identify for enrollment into more than one program. In this situation, we use an enrollment hierarchy matching the enrollee to the program that provides the highest level of support.

We re-stratify the membership at least monthly or as data becomes available to proactively identify enrollees with rising risk and intervene early.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

EVIDENCE-BASED GUIDELINES

We use current, applicable, national evidence-based clinical guidelines from recognized sources and employ national industry standards during development, ongoing maintenance, and updates of our DM and CM programs. Our programs employ the Stanford-developed Chronic Disease Self-Management Program (CDMSP) that is culturally and linguistically adaptable as the foundation for our Chronic Condition management interventions.

Nationally recognized clinical guidelines are reviewed and updated as appropriate, at least every two years or at the time any new scientific evidence or national standards are published or a change to the guideline is made available. If the national guidelines have not been developed, reviewed or revised by the recognized source within the past five years certified practitioners specializing in care for the condition review and attest to the relevancy and accuracy of the proposed guideline.

Our primary condition-specific guidelines by condition include:

Asthma
• Guidelines for the Diagnosis and Management of Asthma: Clinical Practice Guidelines, NIH Publication N. 97-4051, July 2007. National Institutes of Health, National Heart, Lung and Blood Institute.
• National Asthma Education and Prevention Program, Partners Putting Guidelines into Action, Partners Putting Guidelines into Action Guidelines Implementation Panel Report for: Expert Panel Report 3—Guidelines for the Diagnosis and Management of Asthma NIH Publication No. 09-6147 December 2008.

Heart Failure
• ACC/AHA Guidelines for the Evaluation and Management of Chronic Heart Failure in the Adult, 2013.

Hypertension
• American College of Cardiology/American Heart Association. 2013 ACC/AHA Guideline on the Lifestyle Management to Reduce Cardiovascular Risk.
• American College of Cardiology/American Heart Association. 2013 ACC/AHA Guideline on the Assessment of Cardiovascular Risk.
• American College of Cardiology/American Heart Association. 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults.

Cancer
• Cancer guidelines from the US Preventive Services Task Force.
• Choosing Wisely campaign papers from the American Society of Clinical Oncology
• Health Care Costs for Patients with Cancer at the End of Life. Journal of Oncology Practice.
• Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. NIH.

COPD
• Global Strategy for the Diagnosis, Management and Prevention of COPD, Global Initiative for Chronic Obstructive Lung Disease (GOLD) Updated 2017.

Diabetes
• American Diabetes Association, Standards of Medical Care in Diabetes—2017
• Case Management Society of America, Guidelines for improving member-centered care for Diabetes, 2015.

Behavioral Health
• IMPACT Collaborative Care Model. AIMS Center University of Wisconsin.
• Kate Lorig's Self-Management Support. Stanford University.
• Guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices.

INTEGRATION WITH CASE MANAGEMENT AND CARE COORDINATION

Our model is holistic and includes close coordination with the local care management team aligned with specific PCPs, their patients and local hospitals. Our care management teams include RNs, licensed behavioral health clinicians, CHWs, care coordinators, dietitians, pharmacists and health educators. Our model also fully integrates behavioral and physical health in our clinical programs, so that the care team can meet enrollees' varied needs with a multidisciplinary team approach.

Health coaches collaborate with the local care management team to deliver personalized interventions. The care management team is available to provide needed in-person outreach and interventions to enrollees, coordination of in-home services when indicated, and coordination with the enrollee's medical home, other treating providers and programs that support the enrollee's total needs. Health coaches may also refer an enrollee for enrollment into a more intensive care management program such as Complex Care or Catastrophic Care through referral to a care manager via Identifi.

When an enrollee enrolled in Condition Care is enrolled in an episodic care program such as our Maternity Care program high risk component or transitional care for enrollees in an inpatient setting at risk of readmission, we suspend Condition Care enrollment. When the enrollee completes the episodic program, Lighthouse re-stratifies the enrollee to identify their ongoing care coordination and care management needs. Enrollees re-stratified into Condition Care are referred to the health coach with whom they worked previously, when available, and the episodic program nurse or BH care manager provides current clinical and demographic information to the health coach to support the enrollee's reengagement.

Because all of our clinical staff and care management team members are supported through our single technology platform and the Identifi Care module, referrals are managed electronically in near real-time and all available clinical and claims information is accessible to support the referral. If possible, transition to a care management program uses a case conference, bringing together all relevant care team members including health coaches, care managers, the enrollee's PCP, and others involved in the enrollee's management, to identify the most appropriate program enrollment. We engage the enrollee through telephonic outreach and in-person through a Community Health Worker visit or when the enrollee is at their PCP's office where we have embedded care managers. In situations where an enrollee declines enrollment into a more intensive care management program, the care team will continue to meet the enrollee's needs

through the Condition Care program supplementing interventions with in-person outreach from the local care management team.

MEHTODOLOGY FOR EVALUATING IMPACT AND RESULTS

Throughout the year, we collect, track and analyze at clinical quality measures and, on an annual basis, we document the data and program information, including any relevant interventions, activities, identified barriers and opportunities, for review by the Care Management Quality Committee. Program components are enhanced, if appropriate, based on the analysis.

The Quality Measures meet the following criteria:
• The measures capture a relevant process or outcome.
• There is a quantitative result.
• There is a benchmark or performance goal.
• The data and methodology are valid for the process or outcome measured.
• Measurement results are analyzed in comparison with a benchmark and/or goal.
• The measure is population based

Quality improvement activities include measuring, trending, and analyzing results against performance goals and/or benchmarks identified for the overall Program and/or specific to each of the chronic conditions. Performance data is tracked and reviewed by the Quality Management Committee.

Data gathered and presented for analysis may include:
• Condition Care Performance Metrics (Claims Driven Data)
• Average length of stay
• Bed Days/1,000
• Admissions/1,000
• Denied Days
• 30 Day Readmission Rates
• Emergency Room visits/1,000
• PCP visits/1,000
• Specialist visits/1,000
• Inpatient Utilization
• Outpatient Utilization
• All cause unplanned 30-day readmission rates

Areas of focus across our care management programs include identifying or refining our strategies designed to help reduce potentially preventable events.

At least annually, we evaluate Program effectiveness using enrollee clinical outcome measures, and through enrollee experience reported from the satisfaction survey and enrollee complaints. We obtain feedback through surveys sent to enrollees that measures 1) overall satisfaction with the Program, 2) improvements in enrollee's ability to manage his/her health, 3) helpfulness of the team members, 4) usefulness of information disseminated, and 5) areas of the Program and the support that was most helpful and least helpful.

Practitioner feedback is also collected and analyzed using data from the practitioner satisfaction surveys, feedback and complaints, if any. Clinical operations health plan staff also review this

data to identify areas to improve and enhance the services and training for DM program staff. We also measure program participation.

EXAMPLE OUTCOMES

A study of Medicare Advantage patients identified for Condition Care between January 1, 2015 and December 31, 2015 comparing those who enrolled with those who did not, demonstrated the effectiveness of Condition Care interventions. Patients were matched on demographic characteristics, 12-month historical utilization and disease severity using a propensity score methodology. Multivariable regression was used to examine the association between engagement in Condition Care and outcomes, when appropriate.

Preliminary findings demonstrate:
• Patients enrolled in Condition Care had significant increases in PCP and specialist visits
• Among patients who had a PCP or specialist care gap, patients enrolled in Condition Care had a higher gap closure rate of 81 percent compared to 53 percent for those not enrolled
• Patients enrolled in Condition Care were significantly less likely to be subsequently identified for Complex Care through either stratification or referral – 15 percent compared to 28 percent.

CONDITION-SPECIFIC MEASURES

We use the following condition-specific measures, in addition to measures of inpatient admission/readmission, ED use and cost of care, to evaluate the impact of the program.

Asthma –

• HEDIS - Use of Appropriate Medications for People with Asthma: Enrollees identified as having persistent asthma and who were appropriately prescribed an asthma controller medication.
• HEDIS - Medication Management for People with Asthma (MMA): Enrollees with persistent asthma who were dispensed appropriate medication and remained on an asthma controller medication for at least 75% of their treatment period.
• Asthma Ambulatory Care Sensitive Condition Admissions (ACSC): The number of ACSC Admissions for enrollees with Asthma/Total Number of Enrollees Identified with Asthma

Cancer –

• Efficacy measures include: Cancer screening rates, ER Visit rates, inpatient admission rates
• Overall measures include: average stage at diagnosis, deaths in the hospital, hospice enrollment 1 and 3 months before death, treatment adherence, calls to 24/7 Nurse Line
• Cost Savings include: chemotherapy spending, total cost of care at 6 months, 3 months and the last 30 days, percentage of spending for inpatient services, at 6 months, 3 months and the last 30 days

Hypertension –

• For those who LDL-C Testing may be indicated: Enrollees 18-75 years of age with cardiovascular conditions who received an LDL-C screening.
• Medication Adherence for Cholesterol (Statins): Enrollees 18 years of age with a proportion of days covered (PDC) of at least 80% for statins during the measurement period.

• CAD Ambulatory Care Sensitive Condition Admissions (ACSC): The number of ACSC Admissions for Enrollees with CAD/Total Number of Enrollees Identified with CAD
• CAD: ACE/ARB Therapy: Enrollees 18 years of age and older with a diagnosis of CAD and Diabetes or current or prior LVEF < 40% who were dispensed ACE inhibitors of ARB therapy.
• Adults 18-59 years of age whose blood pressure was <140/90 mm Hg
• Adults 60-85 years of age, with a diagnosis of diabetes, whose blood pressure was <140/90 mm Hg
• Adults 60-85 years of age, without a diagnosis of diabetes, whose blood pressure was <150/90 mm Hg

COPD –

• Pharmacotherapy Management of COPD Exacerbation (PCE): COPD exacerbation for enrollees 40 years or older who had an acute inpatient or ED discharge and dispensed a bronchodilator within 30 days of the event.
• Use of Spirometry Testing may be indicated: The percentage of enrollees 40 years of age and older with a new diagnosis of COPD or newly active COPD, who received spirometry testing to confirm the diagnosis
• COPD Ambulatory Care Sensitive Condition Admissions (ACSC): The number of ACSC Admissions for enrollees with COPD/Total Number of enrollees Identified with COPD

Diabetes Program Quality Measures –

• Comprehensive Diabetes Care: Hemoglobin A1c HbA1c Testing - Enrollees 18-75 years of age with Diabetes who had an HbA1c testing.
• Medication Adherence for Diabetes Medications - Enrollees 18 years and older with a Proportion of Days Covered (PDC) of 80% or over across classes of diabetes medications during the measurement period.
• Diabetes Ambulatory Care Sensitive Condition Admissions (ACSC): The number of ACSC Admissions for Enrollees with Diabetes/ Total Number of Enrollees Identified with Diabetes

Behavioral Health Program Quality Measures –

• Number and percent of enrollees engaged each week with PHQ 2 or 9 and GAD 7 completed
• Antidepressant Medication Management - (AMM)
• Follow-up Care for Children Prescribed ADHD Medication – (ADD)
• Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - (IET)

Evaluation Criteria:

1. The extent to which the respondent proposes an innovative and evidence-based approach to disease management for the following conditions:

(a) Cancer (Section 409.966, Florida Statutes);
(b) Diabetes (Section 409.966, Florida Statutes);
(c) Asthma;
(d) Hypertension;
(e) Mental health; and

(f) Substance abuse.

2. The adequacy of the respondent's description of how its respective disease management programs will be incorporated into its overall approach to advance the Agency's goals.

3. The extent to which the respondent's algorithm and risk stratification approach is well defined and describes the data sources that will be utilized.

4. The adequacy of the respondent's description of how its disease management programs will be integrated into case management/care coordination programs.

5. The extent to which the respondent's disease management programs include the following components:

(a) Symptom management;
(b) Medication support;
(c) Emotional support;
(d) Behavior change; and
(e) Communication with providers, including the PCP/specialists.

6. The extent to which the respondent has described a methodology for evaluating the impact of the disease management programs and provided results/data based on previous experience that supports the reduction of potentially preventable events.

Score: This section is worth a maximum of 75 raw points with each component being worth a maximum of 5 points each.

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SRC# 6 – HEDIS Measures (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. The respondent shall include, in table format, the target population (TANF, ABD, dual eligible), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-a-1**, General Performance Measurement Tool to provide results for the following HEDIS measures:

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Response:

Lighthouse Health Plan's experienced subcontractor has achieved quality standards and quality improvements for HEDIS measures for health plans in Kentucky, Maryland and Illinois (the three largest Medicaid contracts based on membership) for the following populations.
• In Kentucky, total approximately 171,400 enrollees, operating 18 years, including: TANF Adult (28,808 enrollees), Child (123,167 enrollees); Foster Care (4,077 enrollees); and SSI Adult (15,387 enrollees)
• In Maryland, total approximately 87,700 enrollees, including: TANF Families, CHIP, pregnant women (to 250% FPL), Foster Care, ACA expansion population, SSI below age 65
• In Illinois, total approximately 150,900 enrollees, operating three years, including: TANF Family and ACA expansion population (146,454 enrollees), Seniors and people with disabilities excluding Medicare (4,472 enrollees)

Attachment SRC 6-1: Exhibit A-4-a-1 provides the requested HEDIS measures from Kentucky and Maryland during calendar years 2015 and 2016, and from Illinois during calendar year 2016 (the first reporting year).

Over the past two years (calendar year 2015 to 2016), these plans have exceeded national and regional Medicaid means and achieved improvements in numerous HEDIS and other performance measures. Among the measures delineated in this SRC, the plans have achieved the following:

Antidepressant Medication Management - Acute Phase:
• In Kentucky, we exceeded the national mean in CY 2015, and exceeded the regional mean in CY 2015 and CY 2016.

Comprehensive Diabetes Care - HbA1c Control (<8%):
• In Kentucky, we exceeded the national mean in CY 2016, and exceed the regional mean in CY 2015 and in CY 2016. We showed improvement of 5.49 percentage points from CY 2015 to CY 2016.
• In Maryland, we exceeded the national and regional means in CY 2015 and CY 2016.

Controlling High Blood Pressure:
• In Kentucky, we exceeded the national mean in CY 2016, and exceeded the regional mean in CY 2015 and CY 2016. We showed improvement of 6.19 percentage points from CY 2015 to CY 2016.
• In Maryland, we exceeded the national and regional means in CY 2015 and CY 2016.

Follow-Up After Hospitalization for Mental Illness (7 day):
• In Kentucky, we exceeded the national mean in CY 2015 and in CY 2016, and exceeded the regional mean in CY 2015 and in CY 2016. We showed improvement of 4.74 percentage points from CY 2015 to CY 2016.

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation Total):
• In Kentucky, we showed improvement of 4.74 percentage points from CY 2015to CY 2016.
• In Illinois, we exceeded the national and regional means in CY 2016.

Medication Management for People with Asthma (75% Compliance – Total):
• In Kentucky, we exceeded the national mean in CY 2015, and exceeded the regional mean in CY 2015.

Child and Adolescents' Access to Primary Care Practitioners, 12-24 months:
• In Kentucky, we exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Maryland, we exceed the national mean in CY 2015.
• In Illinois, we exceeded the national and regional means in CY 2016.

Children and Adolescents' Access to Primary Care Practitioners, 25 months – 6 years:
• In Kentucky, we exceeded the national mean in CY 2015 and in CY 2016, and exceeded the regional mean in CY 2015 and in CY 2016.
• In Maryland, we exceeded the national and regional means in CY 2015.

Children and Adolescents' Access to Primary Care Practitioners, 7-11 years:
• In Kentucky, we exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and in CY 2016.
• In Maryland, we exceeded the national mean in CY 2015.

Children and Adolescents' Access to Primary Care Practitioners, 12-19 years:
• In Kentucky, we exceeded the national mean in CY 2015 and in CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.

• In Maryland, we exceeded the national mean in CY 2015 and CY 2016.

Adults' Access to Preventive/Ambulatory Health Services (Total):
• In Kentucky, we exceeded the regional mean in CY 2015 and CY 2016.

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 160 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 150 points as described below:

Exhibit A-4-a-1, General Performance Measurement Tool, provides for seventy-two (72) opportunities for a respondent to report prior experience in meeting quality standards (twelve (12) measure rates, three (3) states each, two (2) years each).

For each of the measure rates, a total of 10 points is available per state reported (for a total of 360 points available). The respondent will be awarded 2 points if their reported plan rate exceeded the national Medicaid mean and 2 points if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 2 points for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 150 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 360 points, the final score will be 150 points (100%). If a respondent receives 324 (90%) of the available 360 points, the final score will be 135 points (90%). If a respondent receives 36 (10%) of the available 360 points, the final score will be 15 points (10%).

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SRC# 7 – HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Adults' Access to Preventive/Ambulatory Health Services (Total);
- Child and Adolescent Access to PCPs (all 4 age bands reported as separate rates);
- Medication Management for People with Asthma (75% - Total);
- Controlling High Blood Pressure;
- Comprehensive Diabetes Care – HbA1c Control (<8%);
- Follow-up after Hospitalization for Mental Illness (7 day);
- Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation – Total);
- Antidepressant Medication Management – Acute Phase; and
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia.

Response:

The experiences described below exemplify comprehensive, multifaceted approaches to improving HEDIS and other performance standards when Lighthouse Health Plan fails to meet goals, and when goals are met but improvement is desired.

ACTIONS TAKEN TO IMPROVE DIABETES-RELATED HEDIS PERFORMANCE MEASURES

The Lighthouse Health Plan team recognized the need to improve diabetes care for enrollees in a Kentucky Medicaid managed care plan after failing to achieve the plan's goal to meet the 2016 Quality Compass 90th Percentile for HbA1c Control (<8.0%). To drive improvement, a Diabetes Program was designed and implemented in 2016, resulting in a 5.49 percentage point increase in the measure from 45.42% in CY 2015 to 50.91% in CY 2016. Using ER data and risk stratification to identify high risk enrollees, interventions focused on enrollee engagement and incentives, and provider and community engagement.

Enrollee Engagement and Incentives --

Enrollee education on the importance of screenings/tests are conducted through face-to-face, telephonic, and mail outreach, enrollee newsletters, on-hold SoundCare messages, Lighthouse's website, and targeted enrollee educational materials. The Care Coordination Department has Case Managers in high volume practices to educate and encourage enrollees to complete screenings. Three separate attempts are made to contact the enrollee.

The Diabetes Care Program received daily facility-specific ER and readmission reports, from which staff identified enrollees diagnosed with diabetes. These enrollees received targeted mailings and telephonic outreach. Enrollees who are newly diagnosed with diabetes received a detailed educational booklet about diabetes, describing the importance of screenings/tests based on the ADA Standards of Care. High risk enrollees also received telephonic outreach and individualized mailings based on assessment by the Diabetes Disease Managers. The Diabetes

Care Program collaborated with the plan's ER Navigators for targeted face-to-face, mailing and telephonic outreach to enrollees who had an ER visit. A Care Connector Program assisted enrollees with urgent issues related to diabetes. The plan's Vision Program increased outreach to enrollees delinquent in obtaining their DRE Exam.

An enrollee incentive program is geared to increase enrollee and clinician awareness of ADA Standards of Care for completing recommended screenings/tests, including HbA1c testing, blood pressure, foot inspection, DRE, influenza vaccinations, microalbumin, and weight with BMI. Similar to what we propose to implement in Florida, enrollees who receive the recommended screenings/tests for comprehensive diabetes care return their incentive form receive a gift card. In 2016, 188 enrollees received gift cards for completing their screenings/tests.

Enhancements to the program included enrolling individuals with diabetes in the Stay Healthy at Home Program to assist enrollees with recognizing glucose readings and symptoms of hyper or hypoglycemia, and developing educational materials targeting children 9-17 years of age to help with understanding and knowledge of the disease process and management. Auto-dialing technology engaged enrollees in diabetic care gap reminders. On an ongoing basis, enrollees with diabetes who are assessed as high risk receive care management through Complex Care, or a special transitions program if being discharged. Low risk enrollees receive diabetes-related mailings annually.

Provider and Community Engagement --

Clinicians received status updates on enrollees enrolled in the Diabetes Care Program and were provided reference information on the ADA Standards of Care on Passport's website. Program staff collaborated with Provider Relations to educate clinicians during all site visits to improve compliance with ADA Standards of Care recommendations. Embedded Case Managers educated clinicians regarding available monthly Care Gap Reports that identify enrollees who need an LDL-C screening, HbA1c test and microalbumin.

The plan increased community awareness regarding the diagnosis, appropriate treatment, and appropriate self-management skills for persons with diabetes by distributing educational materials at health fairs and events. Community engagement also included collaboration with the Kentucky Diabetes Symposium, Kentucky Diabetes Network (KDN), and local departments of health, and other community agencies and statewide initiatives to increase awareness, and gain knowledge and information about the latest treatment options and procedures and new medications available. The plan collaborated with pharmacies to distribute enrollee education when dispensing the preferred testing meter, and with other community partners to provide supportive services to enrollees/families who need advanced illness management services. The plan also works with community resources to assist enrollees in getting corrective lenses, if needed.

Monitoring and Ongoing Improvement –

During 2016, an average of 10,135 enrollees were enrolled in the Diabetes Care Program, an 89% increase from 2015. A Diabetes Enrollee Satisfaction Survey is sent to enrollees enrolled in the Diabetes Care Program, and outreach is conducted to those enrollees who indicate "fair" or "poor" responses on their survey. All new enrollee materials are evaluated to ensure each piece is clear and concise. The plan administers the PHQ-2, PHQ-9 (for adults) and PSC-17 (for children ages 4-17) to prescreen and screen for depression in diabetic enrollees and referred enrollees to

the BH team as needed. Surveys and data are monitored for trends and to provide feedback to individual staff and address any identified areas that needed improvement.

The combination of efforts resulted in an increase in HEDIS performance. HbA1c Control <8% increased 5.49 percentage points in MY 2016 compared to the previous year. Quality Compass (QC) percentile increased from the 33rd percentile in MY 2015 to the 50th percentile in MY 2016. The MY 2016 rate of 50.91% was 0.82 percentage points below the QC 67th percentile. MY 2016 rate greatly exceeded both the Regional mean (43.19) and the State mean (45.41).

ACTIONS TAKEN TO IMPROVE HEDIS SCORES WHEN STANDARDS WERE MET BUT IMPROVEMENT WAS DESIRABLE

While ranked above the Regional Mean for all age bands for the HEDIS measure Children and Adolescent Access to Primary Care Practitioners (CAP), a culture of continued quality improvement and a decline in rates from 2015 to 2016, prompted the Kentucky plan to intensify efforts to improve access to primary care practitioners as well as EPSDT screenings for this population. An observed decline in HEDIS rates from 2015 to 2016 resulted in implementation of an EPSDT Screening and Participation PIP.

Interventions in 2016 –

Actions focused on provider and enrollee engagement and education, support for office staff, and care coordination and collaboration:

Provider Engagement activities:
• Educated clinicians on the required age appropriate elements of an EPSDT screen through clinician site visits, clinician mailings, and available tools on the plan's website
• Encouraged the use of available tools that identify age-appropriate screen and assist in completion of the required elements of an age appropriate EPSDT screen through review and demonstration of the available tools at clinician site visits
• Distributed the EPSDT resource binder for education/training purposes to clinicians who performed EPSDT screenings
• Distributed the Kentucky Department of Health Lead Risk Assessment and Testing Guidelines and Verbal Lead Risk Assessment Tool to all EPSDT providers via ENEWs
• For providers scoring low on Lead Testing and Risk Assessment on audit, supplemented the targeted education with the Department of Health Lead Testing and Risk Assessment materials
• Conducted EPSDT provider webinars to educate on the American Academy of Pediatrics Recommendations for Preventative Care Guidelines.

Enrollee Engagement activities:
• Conducted outreach to parents to relay information so they will understand the importance of preventative care
• Published an article in each issue of My Health My Life regarding EPSDT
• Continued to provide education to enrollees on EPSDT periodicity schedule including tools for self-management via telephonic outreach and community events
• Developed enrollee education material specific to AAP/Bright Futures Standards of Care Guidelines and recommendations

• Leveraged the auto-dialing technology and Rapid Response Outreach Team (RROT) to engage enrollees, in need of assistance making appointments, during auto dialer campaigns to increase EPSDT screenings and immunizations
• Educated enrollees/caregivers about the importance (benefits and positive effects) of EPSDT screenings through telephonic outreach, enrollee newsletters, on-hold SoundCare messages, Passport Health Plan's website, enrollee educational material, and face-to-face outreach
• Conducted outreach and education to enrollees referred for special services as a result of an EPSDT Screen
• Encouraged enrollees to participate in corporate-sponsored events, i.e., healthy hoops, SCORE
• Referred non-compliant enrollees to the home visit program for outreach and education (On behalf of the health plan, Departments of Health (DOH) conducted 589 successful home visits providing education)
• After verifying claims, provided incentives to 1,133 adolescent enrollees that self-reported receiving an age-appropriate EPSDT screens.

An evaluation of enrollee engagement rewards on improving both screening and participation rates found that among telephonic outreach to 11,074 enrollees, 3,315 enrollees were provided education on the importance of EPSDT screens, a 30% success rate. Among 29,066 outbound automated call reminders to enrollees needing a well-child visit, 8,245 enrollees attended their visit, a 28% success rate.

Support for Office Staff to Identify Needed Screenings:
• Engaged Lighthouse's Embedded Case Managers to identify enrollees in currently in the clinician office scheduled for other services and educate on the importance of EPSDT. Embedded nurses work in partnership with the office staff to schedule same day or follow up appointments for age-appropriate EPSDT screens
• Increased internal community engagement staff for outreach and education to non-compliant enrollees in all age groups
• Provided additional enrollee identification tools to clinicians to assist with identifying those enrollees due for screenings
• Provided Screens and Immunizations Due reports to clinicians on a monthly basis to capture immunizations due utilizing the defined periodicity schedule.

Care Coordination and Collaboration:
• Partnered with EPSDT Coordinator to combine efforts to increase EPSDT Screening and Participation rates as well as EPSDT compliance
• Quality Improvement department aligned with Provider Enrollment and Provider Relations to deliver all necessary EPSDT education at the time of provider on-boarding.
• Formed connections with community agencies, to improve screening and participation, enrollee education and compliance with EPSDT services
• Collaborated with Asthma Disease Management to include EPSDT information in a mass mailing directed to children/caregivers
• Increased intermittent chart audits on sick visits for well care criteria as needed
• Developed and facilitated a cross-functional EPSDT workgroup team to look at ways to improve the performance and effectiveness of the EPSDT Program.

2017 and Beyond –

The Kentucky health plan continues efforts to monitor the success of their telephonic outreach and to increase incentives to adolescent enrollees to encourage appropriate EPSDT screenings. Lessons learned from the EPSDT Program Evaluation and the observed decrease in the HEDIS rates resulted in the implementation of an EPSDT Screening and Participation PIP. Baseline measurements were completed in December 2016, Interim measurement are due December 2017, and Final measurements in December 2018. With results pending, the health plan continues to identify barriers to achieving improvement, to implement interventions to overcome these barriers and to hone our approach in hopes of making an impact. Interventions for the current PIP are listed below.

Provider Engagement:
• Provide education to PCP's regarding AAP & EPSDT guidelines and proper coding for services via plan outreach channels (eNews)
• Educate Department of Health (DOH) providers regarding their role in providing EPSDT services and billing to the plan via email to DOH sites
• Develop EPSDT care gap reports for high volume PCP groups to encourage outreach by the PCP office
• Use group level EPSDT QI audit to identify provider groups with low EPSDT documentation compliance who fail to meet the passing audit score of 90% and provide supplemental education tools to providers
• Distribute "best practices" tip sheet to PCPs with pediatric enrollees regarding prevention and management of "no show" appointments, and cultural sensitivity for non-English speaking patients

Enrollee Engagement:
• Live agent telephonic outreach with three attempts (change from normal cadence of one attempt) campaigns
• Home visit outreach to enrollees unable to reach via live agent telephonic campaign.
• Continued evaluation of enrollee engagement rewards on improving both the screening and participation rates.

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 8 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Robert, a 50-year-old man, was diagnosed with chronic obstructive pulmonary disease (COPD) five (5) years ago. His symptoms have been worsening recently, and he has presented at the emergency department three (3) times during the past thirty (30) days. Robert previously smoked twenty-five (25) cigarettes per day for thirty (30) years, but cut down to ten (10) cigarettes per day after his first COPD exacerbation two (2) years ago. He has attempted to quit smoking on several occasions without any success. Robert is prescribed several regular medications for his COPD, as well as for hypertension and hypercholesterolemia. He is pre-diabetic and obese with a BMI of 35. His last appointment with his specialist was ten (10) months ago. Robert has difficulty taking his medications regularly, as he is sometimes unable to get his prescriptions in his rural community and he lacks transportation. After his last visit to the emergency department, Robert was prescribed oxygen treatments and a new medication; however, he has not filled these orders. Robert lives with his 15-year old son and is a single parent. Robert and his son have been on Medicaid for the last four (4) years since he lost his job. Robert has been a member of the plan since December 2016.*

The respondent shall describe its approach to coordinating care for an enrollee with Robert's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Baptist Health, as the provider sponsored organization for Lighthouse Health Plan (Lighthouse), is committed to identifying enrollee's like Robert before his condition worsens and to intervene quickly with enrollee's who have escalating health care services use, including emergency department (ED) visits that might be avoided through more closely coordinated medical treatment and care management support. Evolent's analytics, suite of care management programs, and multidisciplinary care teams have proven to be effective with enrollees like Robert. Lighthouse will implement this effective population health approach that has achieved significant reductions in inpatient admissions and emergency department (ED) visits among enrolled participants.

• For example, a mature provider-led Medicare Advantage plan with more than 10,000 enrollees including dual eligibles, enrolled high-risk enrollees in Complex Care and reduced inpatient admissions by 38 percent and ED visits by 51 percent during the 2015 study period. The focus on enrollees with "rising risk" (enrollees likely to incur higher future costs) distinguished this approach from the approach used previously.
• Similarly, a newly launched, previously unmanaged Next Generation ACO population with over 29,000 enrollees achieved a 66 percent reduction in inpatient admissions and a 51 percent reduction in ED visits following enrollment into Complex Care.

While the degree of the reductions in inpatient and ED use may be less among Medicaid enrollees who typically have greater unmet social needs than Medicare enrollees, the program design and implementation is the same and similar positive outcomes are expected.

Complex Care is a care management program for enrollees of all ages who have chronic conditions and who are high risk or likely to incur a diagnosis-specific inpatient admission or readmission for a medical or behavioral health condition based on such factors as: chronic condition progression or severity; a high impact utilization pattern predicted to continue or increase in future; and/or complicated medication regimens. Enrollees identified as high impact are those likely to engage in care management and, based on predictive modeling, likely to have further service use within the next twelve months.

Enrollees are identified through referrals and risk stratification, leveraging:
• claims and pharmacy data
• Data from the enrollee enrollment file including existing authorizations when available
• Results of health risk screening and health risk assessment

Once identified, these enrollees are assigned to an appropriately qualified nurse or behavioral health care manager. This care manager introduces the enrollee to the care management program, secures their agreement for participation and discusses their current needs. They work together to complete a comprehensive enrollee assessment and develop an individualized care plan with the multidisciplinary care team, enrollee, PCP, specialist(s) and others involved in the enrollee’s care. Any relevant condition-specific educational materials are mailed to the patient, and the care manager provides care coordination, including coordinating referrals to service providers and community-based programs and resources. As the enrollee makes progress toward specific, personalized graduation goals, the care manager supports them, reassessing and revising the care plan as appropriate.

The local care management teams align with an enrollee’s PCP to help us reinforce and support the close relationship between the enrollee, PCP and specialty providers, improving the health status of enrollees with complex needs.

All care team members have visibility into the enrollee’s care plan through Identifi, our web-based platform that integrates care management, utilization management and provider information.

NEW ENROLLEE IDENTIFICATION

Enrollees with COPD and two paid claims for evaluation and management visits with the primary diagnosis of COPD in all past claims history are stratified as low risk. Enrollees who also have at least one of the following are stratified as moderate risk:

• A COPD-related inpatient admission within six months
• A COPD-related ED visit within three months
• No PCP or COPD-related specialist visit within twelve months
• Lack of a prescription for a long-acting inhaler

These enrollees are identified for COPD Condition Care (DM). Condition Care delivers highly coordinated and evidence-based health education, care coordination, including care gap closure, close collaboration with the enrollee's primary care physician (PCP) and aligned, local care management team. Centralized Condition Care health coaches work in partnership with the enrollee to address needs holistically through outreach calls, health education and care gap closure. Health Coaches activate the local care management team community health workers or other team members when needed, to provide in-person visits for enrollees who need additional help managing their chronic condition or addressing other issues such as social determinants of health.

Enrollees stratified as low-risk receive targeted condition-specific informational materials and health coaches monitor the enrollee's service use to identify care gaps, intervening with the enrollee and his or her provider to close these gaps. In addition, the health coach makes outreach calls to low-risk enrollees when they identify a change in the enrollee's health status, such as an inpatient admission, to determine the need for more intensive intervention and support.

Health coaches work telephonically with enrollees stratified as having moderate risk, their caregivers and family members, PCP and other providers as applicable, delivering evidence-based interventions that:
• Educate enrollees on their targeted conditions, overall health and self-management
• Support the enrollee's behavior change
• Reduce the incidence of complications
• Improve physical functioning
• Improve emotional well-being
• Support the provider/enrollee relationship
• Emphasize and reinforce provider's use of clinical practice guidelines

The health coach works with an extended team of nurse care managers, BH specialists, nutritionists, and pharmacists who provide consultation and support specific to Condition Care as needed. In addition, the health coach coordinates the enrollee's self-management and related interventions with the local, geographically-aligned care management team aligned with the enrollee's PCP. The team includes licensed RN and BH care managers, community health workers (CHWs), dietitians, pharmacists and health educators hired from the local community who collaborate to make sure enrollees are connected to their PCP and care is closely coordinated for maximum effectiveness. When the health coach determines an enrollee would benefit from an in-home assessment or other outreach visit, he or she coordinates outreach from the local CHW, nurse care manager or BH care manager, depending on the enrollee' specific needs. The local care management team may also help identify and coordinate access to community resources that support the enrollee's Condition Care Action Plan.

Enrollees like Robert stratified as high risk are those with COPD who are most likely to incur a disease-specific adverse event. These enrollees are enrolled into Complex Care. In addition to the moderate risk criteria these enrollees also have:
• Co-existing chronic conditions

• More frequent inpatient admissions, ED, PCP and specialist visits
• Drugs that indicate disease progression or severity
• Medical equipment use (e.g., home oxygen)
• Gaps in care

The stratification process runs monthly. However, re-stratification may occur anytime in between based on the enrollee's screening or assessment or additional information that becomes available during interaction with the enrollee.

When Robert first became an enrollee of our health plan in 2016, we identified him for enrollment into our Complex Care program based upon the results of our predictive modeling and risk stratification process using the historical claims data we received in the transition file combined with social data sets. Specific data elements driving this initial identification included:
• COPD-related drug claims
• Hypertension and high cholesterol-related drug claims
• Co-existing chronic conditions – hypertension, hypercholesterolemia and obesity
• Department of Labor data for Robert's rural community indicating healthcare disparities and lack of economic opportunity

Robert participated in the Complex Care program, which provides nurse-led self-management coaching and support for enrollees with chronic and comorbid conditions who are stratified as high risk. We address enrollees' physical health, behavioral health, and social needs through our integrated care management approach and include disease management interventions for targeted conditions. The nurse also works closely with the local, multidisciplinary care management team aligned with Robert's PCP. These local teams of nurse care managers, BH care managers, community health workers (CHWs), dietitians and pharmacists support Complex Care interventions, helping to connect or reconnect enrollees to their PCP, access community resources in support of the enrollee's care plan goals, and provide in-person outreach, assessment, and care coordination when needed to make sure the enrollee's total needs are met.

By June of 2017, Robert had achieved several of his goals: he was now compliant with his medication regimen and had successfully cut back on smoking, had no ED use, had seen his specialist and was connected with his PCP. Because of his progress, Robert "graduated" from Complex Care and transitioned to COPD Condition Care (DM).

However, in September of 2017, Robert's care coordinator received an alert notifying her of his ED visits via ADT feeds integrated with Identifi Care. The Care Coordinator completed a notification in Identifi to Robert's previous Complex Care nurse care manager within 24 hours of notification, who phoned Robert to learn why he used the ED and if the visit was avoidable. The care manager gathered information about Robert's chief complaint and time of day when he presented in the ED and asked Robert if he called his PCP and if so, had he requested an appointment and was unable to get one.

The nurse care manager learned that Robert's son was at home for the summer and he and his son were arguing frequently, leading to an increase in Robert's stress level and his smoking, accompanied by increasing shortness of breath. In addition, his son would normally pick up Robert's medication from the pharmacy on his way home from school but with the onset of summer, Robert said he had no way to get his medication from the pharmacy.

Robert was re-stratified as high risk based on his more recent ED use and gaps in care (failure to fill his oxygen and new medication order or to see his specialist recently or following his ED visits), with his previously identified risk factors.

HEATH RISK ASSESSMENT

Once an enrollee is stratified as high risk, as Robert was, a local Care Manager conducts a comprehensive assessment of their total needs to confirm their risk level and identify the most appropriate care management program to meet their needs.

The assessment tool is housed in Identifi and includes, but is not limited to, the following elements:
• Home/living situation
• Clinical history, including medications
• Health status, including medical and behavioral health condition-specific issues
• Current providers
• Activities of daily living and cognitive functions, needs, preferences and barriers
• Mental and social-economic health status needs, preferences and barriers
• Life-planning activities such as living will, advance directives, and power of attorney when applicable to the enrollee and his or her situation
• Cultural and linguistic needs, preferences, or limitations
• Visual and hearing needs, preferences or limitations
• Health beliefs and behaviors including smoking, diet and exercise
• Available covered and non-covered services and community resources
• Personal safety

In Robert's case, the nurse care manager reached him via telephone within three business days of identification and, based on his previous experience with the program, he readily agreed to re-engage. Even though he had participated in the Complex Care program previously, a full re-assessment was done within 24 hours of reaching him to identify any changes in his circumstances since the first assessment. The assessment included identification of the enrollee's needs, barriers, and preferences to inform the development of a personalized care plan. His earlier answers were available to the nurse care manager through Identifi Care so that changes could easily be identified.

As noted above, the care manager gathered information about Robert's chief complaint and time of day when he presented in the ED and his ability to access his PCP. She also learned that Robert's son was at home for the summer and he and his son were arguing frequently, leading to an increase in Robert's stress level and his smoking, accompanied by increasing shortness of breath. In addition, his son would normally pick up Robert's medication from the pharmacy on his way home from school but with the onset of summer, Robert said he had no way to get his medication from the pharmacy.

The nurse care manager determines through the assessment that Robert is experiencing stress and therefore completes the PHQ2 and 9 tools that are integrated in Identifi, to identify possible underlying depression and anxiety. She also assesses Robert's medication adherence.
The assessment results help the nurse care manager confirm the enrollee's initial stratification level and determine whether the recommended CM program is appropriate (or identify the alternative CM program assignment based on identified needs) and forms the basis for the development of Robert's personalized care plan.

CARE COORDINATION/CASE MANAGEMENT

Robert's assessment results drive development of an automated, preliminary care plan in Identifi Care that is customized by the care manager to reflect his personal needs and goals. This preliminary care plan is developed based upon the assessment and is completed within five days. The care manager contacts Robert's PCP and other treating providers to obtain current information on Robert's providers' treatment plans and Robert's identified needs, including any unmet needs. The care manager may also schedule a care conference with Robert's providers, other members of the local care management team, and Robert when needed, to discuss more complicated care needs. This would occur, for example, if Robert is participating in care management but starts visiting the ED again or is admitted to the hospital.

Program participation is voluntary: if the enrollee declines Complex Care or another care management program for which he is eligible the local team implements Care Coordination to help the enrollee access prescribed drugs, transportation, and community resources, keep him connected to his PCP and specialist, and to monitor any gaps in care. The CHW escalates any issues of concern, including care gaps, to the local care management team for intervention.
The enrollee's PCP is notified as soon as possible, but within 45 days of his engagement in the program. Notification may be through a letter, secure email, fax, provider's EHR or phone call to the responsible physician. If the enrollee declined to participate in Complex Care we would work with his PCP to encourage participation and reinforce with the enrollee that this program provides help to manage his health conditions and other service and social support needs at no cost.

Robert's nurse care manager works in collaboration with enrollees of the local care management team to address all his identified needs. For Medicaid recipients like Robert, adequately addressing social determinants of health makes a huge impact on the ability to achieve improved health status. His nurse care manager and community health worker (CHW) focus on:
• Connections to school-based, community, and state agency resources to address social determinants of health
• Health behaviors - interventions encourage enrollees to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use).
• Psychosocial issues – interventions address factors that impact an enrollee's adherence to the healthcare plan, such as social, emotional, or financial barriers.
• Caregiver support – interventions support caregiver's emotional resources, providing external/ community based resources such as caregiver support groups, respite, and development of coping skills.

Outreach for enrollees enrolled in Complex Care is a minimum of every 10 business days unless otherwise requested by the enrollee or his or her physician. Because Robert has significant stressors and recent ED use as well as gaps in care, Robert's nurse care manager schedules outreach every five business days for the first three weeks, followed by every 10 business days until Robert reaches his graduation goals.

SERVICE PLANNING

In Robert's case, he has not seen his specialist and is disconnected from his PCP. The nurse care manager selects related problems such as:
• Patient with COPD - clinic visit may be indicated.

• Gap Closure - Completion of Required PCP or Relevant Specialist Visit

Identifi populates the following goals:
• Patient actively works with his/her doctor(s) on treatment plan
• Patient attends planned/wellness visits and conducts necessary testing/examinations as directed by doctor

And the following interventions:
• Provide Education on Treatment Plan and Office Visit Schedule
• Provide Education and Materials on making the most of physician visit
• Contact Provider
• Assist with Appointment Scheduling
• Verify Medical Record Documentation

If Robert has not seen his doctor because of access issues, access-related and care coordination PGIs will populate his initial care plan.

Robert's nurse care manager selects additional problems in Identifi, which include (but are not limited to):
• Medication management – non-adherence
• Tobacco use
• Limited transportation
• Self-management difficulties
• Social concern (employment)
• Caregiver strain (son)
• Anxiety

Related goals and interventions populate the preliminary care plan.

Robert's Service Needs & Interventions --

The nurse care manager identifies those needs that can be met through care management and coordination of covered services, non-covered (carved out) services, and community supports or a combination of these. For example, smoking cessation is addressed through a combination of nurse care manager-delivered health education, access to smoking cessation products, and referral to smoking cessation resources in the community.

Robert's nurse care manager helps Robert identify self-management goals using motivational interviewing and learns that one of Robert's priorities is spending time with his son while getting healthier, which he will implement by taking walks together.

Other interventions and strategies include:
• The nurse care manager coordinates oxygen delivery from a network DME provider
• Robert's obesity, hypertension, and high cholesterol trigger a referral to the local care management team registered dietician to provide nutritional counseling and development of a weight control plan. The CHW works with a community group that helps people who lack transportation with weekly grocery shopping.
• The nurse care manager reviews the health plan's coverage of nicotine replacement therapy and if Robert agrees, contacts Robert's PCP to coordinate Robert's access to a smoking

cessation product. She also provides information about local cessation resources, including local smoking cessation support groups.
• The nurse care manager also provides strategies to help Robert with his stress management.
• Robert gets assistance scheduling a PCP visit and a specialist visit and arranging transportation to help ensure that he will attend these appointments.
• She offers to work with Robert to find a pharmacy vendor that can offer services such as home delivery to ensure that transportation to the pharmacy is no longer a barrier to medication adherence.
• The nurse care manager completes a referral to the CHW:
• For assistance helping Robert identify and participate in community smoking cessation classes
• To explore local summer employment options for Robert's son. The CHW connects Robert and his son to programs for summer employment. Program information is added to Robert's care record.

As part of the nurse care manager's review process, she identifies those services requiring prior authorization including Robert's oxygen and coordinates review with a UM clinical reviewer. The reviewer gathers additional information from his specialist and nurse care manager about Robert's oxygen needs to establish medical necessity. Following authorization, the nurse care manager coordinates access to the services and equipment working with providers as needed.
Nicotine replacement therapy is a covered benefit and prior authorization is not required. The nurse care manager provides education about nicotine replacement therapy use and adherence. The nurse care manager contacts the provider via phone, the provider's EHR, or in person (for example, if a nurse is embedded in the practice) for services requiring physician oversight or orders (e.g., DME, medications, physical therapy, emergent/urgent medical concerns, changes to care plan, etc.).

Because Robert needs a timely PCP and specialist visit as soon as possible to avoid additional ED visits, the nurse care manager works with the PCP's and specialist's office staff with Robert on the phone to identify a date and time that works for Robert. She then calls the transportation vendor, also by three-way call, to arrange transportation to these appointments. As part of the referral process, Robert's nurse care manager shares Robert's care plan with the PCP and specialist notifying them through the EHR, fax or mail.

The nurse helps Robert obtain the prescription needed from his provider and coordinates with the local pharmacy as needed.

The referral to the CHW is created in Identifi and the CHW uses their extensive knowledge of community activities and classes to help connect Robert to these resources.

In addition, standard communication protocols include Urgent Notification Alerts. If the nurse care manager identifies any of the following urgent care opportunities when working with an enrollee who has COPD, he or she alerts the enrollee's treating provider of the enrollee's status via telephone, secure email, or EHR where available, within one business day.
• Increased cough or productive cough, chest tightness, breathlessness,
• Increasing O2 from baseline (air hunger) over 2 days or use of more than 4L
• Increased use of rescue inhalers/nebulizers over 2 days

We have defined urgent alert criteria for other chronic conditions including hypertension, diabetes and asthma. The nurse is responsible for informing the enrollee's PCP and treating provider of any significant decline or symptom exacerbation of symptoms.

Supporting Robert's Compliance with His Care Plan --

Robert's nurse care manager implements the following interventions to facilitate compliance with Robert's care plan:
• Mails Robert a COPD education booklet after reviewing this with Robert during a contact that includes health education within two days of their initial call.
• Contacts Robert every five days to check-in on his progress and newly identified needs, providing supportive counseling and asking Robert to teach back specific self-management skills.
• Informs Robert of enrollee incentives for participation in approved tobacco cessation and weight loss programs and arranges access to these programs if Robert wants to participate.
• Educates Roberts about use of the Identifi Engage app - an innovative mobile application available to enrollees in care management that includes tracking of key health metrics, positive reinforcement that promotes care plan adherence and tools for enrollees to communicate with their care team.

Through our proposed member incentive program, Robert would be eligible to earn $25 per qualifying activity up to a maximum of $50 a year distributed on a reloadable card. Qualifying activities relevant to Robert's assessed needs are:
• Care gap closure (must have all necessary care gaps closed based on age, gender, race)
• Comprehensive diabetes care (must be compliant with appropriate care for diagnosis: eye exam, foot exam, HbgA1c)
• Participation and graduation from a specific care management program
• Successful participation in a medically-approved smoking cessation
• Successful participation in a medically directed weight loss program

The nurse care manager also monitors enrollee's gaps in care and avoidable ED visits and inpatient hospital admissions from ADT feeds and claims data.

Supporting Robert's Access to Providers --

A primary feature of our care management model is promoting and supporting the relationship between Robert and his PCP and specialists and ensuring Robert has access to the specialty care providers he needs. Our Provider Network Specialists continually monitor the network to make sure provider capacity is adequate based on the size and needs of our membership. When the local care management team becomes aware of a potential provider access concern they work closely with the Provider Network team to identify the cause and correct or ameliorate this. For example, if Robert was unable to get an appointment with his pulmonologist, Robert's care manager would:
• Call the pulmonologist to discuss why the pulmonologist is unavailable
• If the pulmonologist states he can longer see Robert, help Robert locate, select and schedule an appointment with another available in-network pulmonologist
• If there is no in-network pulmonologist available within the required travel distance/time, locate an out-of-network (OON) pulmonologist willing to see Robert and coordinate OON authorization with the utilization management team

• Coordinate the access issues with the Provider Network team, who will follow-up with Robert's original pulmonologist to learn why he can no longer see Robert and identify a solution if feasible (such as helping the specialist expand his capacity)
• The Provider Network team will also offer a contract to the out-of-network pulmonologist and look for other ways to grow network capacity

DISCHARGE/TRANSITION PLANNING

A primary objective of our care management approach is supporting and helping enrollees develop self-management skills, and for children, helping families develop skills that meet their child's care coordination needs, and support achievement of each child's developmental milestones. We have established graduation goals for each program and an anticipated program length of enrollment. However, CM program enrollment continues as long as needed and enrollees may transition to less intensive programs, such as Care Coordination, as they achieve their self-management goals and when their health is stable. For example, the anticipated length of Robert's enrollment in Complex Care is about 120 days.

Graduation goals are created as part of the care planning process and progress toward those goals are tracked over time. These graduation goals can be customized as needed per program and additional patient-specific goals can be created. Goals can be prioritized and targeted as patient or provider-led goals. Ongoing progress tracking of care team member assignments and goal completion is provided. Once graduation goals are achieved, the enrollee can be discharged or transitioned to a lower-level program.

Robert's graduation goals are:
• Robert takes an active role in self-managing condition
• Robert adheres to prescribed medication regimen
• Robert actively works with his/her doctor(s) on treatment plan
• Robert understands and has a plan for managing symptoms and knows when to contact physician
• Robert has been educated and provided information on Advance Directives
• Robert had no avoidable hospitalizations in 60 days
• Robert had no avoidable ED visits in 60 days

Robert is working toward graduation with his nurse care manager and is feeling more in control of his COPD and his stress level. Once he graduates from the Complex Care Program, he will transition to the COPD Disease Management program. He also knows that if he needs more intensive help in the future, he will have a number of resources available to him through Lighthouse and the community resources that have been identified to support him.

DISEASE MANAGEMENT

All care management programs include the essential elements of disease management including enrollee education, self-management support and coordination in support of the provider's treatment plan. Additionally, enrollees with a single, primary chronic condition or those who have successfully completed a high-risk program, such as Complex Care, and are no longer at high-risk, are enrolled in our DM program, Condition Care. Health coaches educate enrollees about their condition and support self-management, help close care gaps and promote compliance with the provider's treatment plan. We offer Condition Care for enrollees with a primary single

diagnosis of: asthma, cancer, COPD, diabetes, heart failure, hypertension or who have a BH diagnosis of anxiety, depression or substance use.

Once Robert graduates from the Complex Care program, he is eligible to participate in the COPD Condition Care (DM) program. In this program, the nurse schedules calls and in-person visits with Robert as well as visits from the CHW to provide verbal coaching and help Robert develop his self-management plan. Disease specific coaching includes, but is not limited to, assessing Robert's understanding of his/her treatment plan, educating Robert with the assistance of disease specific educational materials on testing, medication adherence, managing symptoms, and when to contact his PCP and specialists. The nurse care manager helps the enrollee develop and execute personal goals such as losing weight or quitting smoking related to their overall health or specific disease state.

Through motivational interviewing she homes in on the goals that are most important to Robert making sure these goals are a primary focus of Robert's care plan. Robert's social determinants of health must be addressed first before gains can be made in other areas. Enrollees like Robert may need help locating and arranging stable housing or accessing community transportation to purchase healthy food. The nurse care manager works closely with the local care management team to identify and help enrollees access local resources.

Robert receives a Healthwise "Take Control, Live Better" COPD booklet and the nurse care manager encourages Robert to communicate regularly with his PCP and specialists about his COPD and treatment plan. The nurse care manager and CHW provide education and support to Robert stressing the importance of taking an active role in his care. They review the booklet content, including COPD education, detailed planning tools for self-management, and symptom management information, including:
• Scheduling physician visits and completing pre-visit planning
• Developing a personal action plan for quitting smoking
• Using a metered-dose inhaler with spacer
• Identifying and avoiding triggers
• Managing medications
• Oxygen use
• Pulmonary rehabilitation
• Urgent and emergent symptoms and actions

These materials are provided by a national vendor, Healthwise, and meet the contract requirements for literacy, health literacy and language.

Because Robert and his son use the Internet, the nurse care manager also provides him with relevant internet resources. For example, the American Lung Association website, which provides online education and smoking cessation tools.
The nurse care manager helps Robert demonstrate his progress through teach back, including helping Robert explain the clinical guideline goals and his personal goals.

Provider Decision Support --

We provide semi-annual Care Opportunity Reports to providers alerting them to potential care opportunities for their patients with COPD. Using claims data, we identify missed lab work, medication fills and other key disease-specific activities. For example, we will notify Robert's PCP

of needed spirometry testing or the enrollee's non-adherence to appropriate bronchodilator or corticosteroid medications. The Care Opportunity Report is consistent with national clinical practice guidelines adopted for our COPD disease management programs and for Robert's other chronic conditions using nationally recognized guidelines.

UTILIZATION MANAGEMENT

As part of the nurse care manager's review process, she identifies those services requiring prior authorization including Robert's oxygen and coordinates review with a UM clinical reviewer. The reviewer gathers additional information from his specialist and nurse care manager about Robert's oxygen needs to establish medical necessity. Following authorization, the nurse care manager coordinates access to the services and equipment working with providers as needed.
Nicotine replacement therapy is a covered benefit and prior authorization is not required. The nurse care manager provides education about nicotine replacement therapy use and adherence. The nurse care manager contacts the provider via phone, the provider's EHR, or in person (for example, if a nurse is embedded in the practice) for services requiring physician oversight or orders (e.g., DME, medications, physical therapy, emergent/urgent medical concerns, changes to care plan, etc.).

GRIEVANCE AND APPEALS

We implement an established and compliant grievance and appeals process that includes the appeal process whenever a service is denied or authorized in an amount less than requested (i.e., is an adverse benefit determination). Denials may only be made by the Medical Director.

If Robert's requested services were determined not medically necessary, or were authorized, but in an amount less than requested, the request and related documentation would be provided to the Medical Director for final review and determination.

The UM team would inform Robert of the determination process and his rights, to appeal the adverse determination and if the appeal was not decided in his favor, the right request a Medicaid Fair Hearing from the Agency. Denial of a service, in whole or in part, triggers written notification of the reason for denial and Robert's right to appeal and request a Medicaid Fair Hearing, and to be assisted in filing their request, in accordance with the contract.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes;

e. Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;

f. Application of discharge and aftercare planning protocols that facilitate a successful transition;

g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;

h. Description of the assessment of provider capacity to meet the specific needs of enrollees;

i. Identification of strategies that promote enrollee self-management and treatment adherence;

j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and

k. Application of strategies to integrate enrollee information across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative and evidence-based processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provides evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative and evidence-based strategies to integrate information across all systems/processes into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

C. RECIPIENT EXPERIENCE

SRC# 9 – Expanded Benefits (Regional):

Based upon the expanded benefits listed in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent shall identify the benefits it proposes to offer its enrollees for all eligible populations (TANF, ABD, dual eligible, and LTC populations). **Exhibit A-4-a-2**, Expanded Benefits Tool outlines specific expanded benefits, including category, procedure code descriptions and procedure codes. When electing to offer expanded benefits included in **Exhibit A-4-a-2**, Expanded Benefits Tool, the respondent must offer the benefit in its entirety, including all procedure codes (and minimum quantity limits) listed in **Exhibit A-4-a-2**.

Response: The respondent shall select the following expanded benefits it will offer, as listed in **Exhibit A-4-a-2**, Expanded Benefits Tool (Respondent shall check all that apply):

☒ Dental benefits for adults
☒ Over-the-counter benefits
☒ Occupational Therapy benefits for adults
☒ Physical Therapy benefits for adults
☒ Hearing benefit for adults
☒ Vision benefit for adults
☒ Prenatal benefit
☒ Respiratory Therapy benefit for adults
☒ Speech Therapy benefit for adults
☒ Additional Primary Care services benefit
☒ Newborn Circumcision benefit

Evaluation Criteria:

Score: This section is worth a maximum of 190 raw points as outlined below.

(a)	Election of the Dental benefit for adults:	50 pts
(b)	Election of the Over-the-counter benefit:	25 pts
(c)	Election of the Occupational Therapy benefits for adults:	20 pts
(d)	Election of the Physical Therapy benefit for adults:	20 pts
(e)	Election of the Prenatal benefit:	20 pts
(f)	Election of the Hearing benefit for adults:	10 pts
(g)	Election of the Vision benefit for adults:	10 pts
(h)	Election of the Respiratory Therapy benefit for adults:	10 pts
(i)	Election of the Speech Therapy benefit for adults:	10 pts
(j)	Election of the Additional Primary Care services benefit:	10 pts
(k)	Election of the Newborn Circumcision benefit:	5 pts

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 10 – Additional Expanded Benefits (Regional)

The respondent shall identify each additional expanded benefit that it proposes to offer its enrollees by eligible population (TANF, ABD, dual eligible, and LTC populations). For the purposes of this SRC, the respondent must not select expanded benefits that are included in **Exhibit A-4-a-2,** Expanded Benefits Tool described in SRC# 9. The respondent shall include the name of the benefit, procedure code descriptions, procedure codes and any limitations (frequency/duration, etc.).

The respondent shall submit documentation that includes the calculations used to determine the per-member-per-month (PMPM) cost and the data source used for the calculations (e.g. previous SMMC experience, commercial experience). The submitted PMPM cost must be developed on a "total member" basis, rather than a "per user" or "per benefit eligible" basis (e.g., if the benefit is for adults only, do not submit the expected monthly cost per adult but rather the expected cost per member; or, if the benefit is for the household, its expected monthly cost must be converted to the expected cost per member) and should exclude administrative costs. The respondent shall submit **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

Response:

Lighthouse Health Plan will offer our Enrollees additional expanded benefits as outlined in Attachment SRC 10-1: Exhibit A-4-a-3. These additional benefits were selected based on their value in supporting the needs of our Enrollees. Documentation of our calculation methodology for determining PMPM costs, including data sources used is included below:

CALCULATION METHODOLOGY FOR DETERMINING PMPM COSTS

The Lighthouse team utilized the services of Wakely Consulting to assist in pricing of Expanded Benefits, which included coverage for adult vaccines, home health care, expanded physician visits and respite care.
The Expanded benefit offering was first selected for the plan and primarily based on value of these offerings to Medicaid members. We utilized the services of Wakely Consulting to assist in pricing of Expanded Benefits which included coverage for adult vaccines, home health care, expanded physician visits and respite care. Wakely provided us with details used in their pricing including the use of 2015 Truven commercial data for the State of Florida adjusted for Medicaid population and utilization patterns. We took into consideration reimbursement differences, network and access issues to adjust our pricing assumptions. The final pricing results were checked for reasonableness using Milliman's table of maximum/minimum/average PMPMs that was provided from the previous rate period. We used Milliman provided values for the following benefits since we did not have good data for pricing: Art and/or Pet Therapy, Medically-Related Lodging & Food & Post-Discharge Meals.

Wakely provided us with details used in their pricing. Broadly, Wakely based the pricing on utilization from the 2015 Truven Medicaid dataset. The description of each expanded benefit calculation is provided below:

Adult Vaccines --

For each of the three adult vaccines – flu, pneumonia and shingles – Wakely used the Truven dataset to calculate an adult utilization rate, defined as the percent of unique adults (age 21 or older) utilizing the vaccine during a one-year period. These vaccines were assumed to be provided only once per year, an assumption that was corroborated by review of the Truven dataset. The unit cost was assumed as 100% of the Florida Medicaid fee schedule for the corresponding CPT code. In cases where the expanded benefit encompassed multiple CPT codes, the Truven dataset was used to derive a distribution of utilization across codes. Finally, the Florida ITN databook was used to determine the percentage of members over age 21, which is the covered population for the benefit. The final PMPM for each benefit was calculated as:
• Percent of Adults Utilizing the Vaccine multiplied by
• The Average Unit Cost of the Vaccine multiplied by
• The Proportion of the Population that are Adults divided by 12.

Home Health Care --

To price home health care for non-pregnant adults, Wakely used the Truven dataset to calculate an adult utilization rate, defined as the percent of unique adults (age 21 or older) utilizing the benefit during a one-year period, and a frequency per utilizing member, defined as the number of visits during a one-year period for benefit-utilizing adults. The unit cost was assumed as 100% of the Florida Medicaid fee schedule for the corresponding CPT code; the Truven dataset was used to derive a distribution of utilization across CPT codes. Finally, the Florida ITN databook was used to determine the percentage of members over age 21, which is the covered population for the benefit. The final PMPM for Home Health Care was calculated as:
• Percent of Adults Utilizing Home Health Care multiplied by
• The Frequency per Utilizing Adult multiplied by
• The Average Unit Cost multiplied by
• The Proportion of the Population that are Adults divided by 12.

Expanded Physician Visits --

To price expanded physician visits, Wakely used the Truven dataset to calculate an adult utilization rate, defined as the percent of unique adults (age 21 or older) utilizing the benefit during a one-year period, and a frequency per utilizing member, defined as the number of visits during a one-year period for benefit-utilizing adults. The unit cost was assumed as 100% of the Florida Medicaid fee schedule for the corresponding CPT code; the Truven dataset was used to derive a distribution of utilization across CPT codes. Finally, the Florida ITN databook was used to determine the percentage of members over age 21, which is the covered population for the benefit. The final PMPM for Expanded Physician Visits was calculated as:
• Percent of Adults Utilizing Expanded Visits multiplied by
• The Frequency per Utilizing Adult multiplied by
• The Average Unit Cost multiplied by
• The Proportion of the Population that are Adults divided by 12.

Respite Benefit –

For respite care, Wakely used a utilization rate that was based on client discussions, reasonable expectations and needs of this population. Wakely also made an assumption around the proportion of respite benefit utilizers who would use facility-based vs. home-based care, as well as a split between high-intensity and low-intensity home-based care. Utilizing families were

assumed to use respite care twice per year, the benefit limit. The unit cost was assumed as 100% of the Florida Medicaid fee schedule for the assumed level of home care and $100 per day for hospital care (a research-based assumption). The final PMPM for respite care was calculated as:
• Percent of Families Utilizing Respite Care multiplied by
• Two Uses per Year multiplied by
• The Sum of the Percentage of Families Utilizing the Respite Care Setting multiplied by
• The Average Unit Cost of the Specific Respite Care Setting
• Divided by 12.

We took into consideration reimbursement differences, network and access issues to adjust our pricing assumptions. The final pricing results were checked for reasonableness using Milliman's table of maximum/minimum/average PMPMs that was provided from the previous rate period.

Evaluation Criteria:

a. The extent to which the respondent identifies the expanded benefits it will provide and the information included in **Exhibit A-4-a-3**, Additional Expanded Benefits Template (Regional).

Score: This section is worth a maximum of 5 raw points with the above component being worth a maximum of 5 points.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

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SRC# 11 – Online Provider Directory (Statewide):

The respondent shall describe the provider search function for the online provider directory, including submission of:

a. A description outlining the transparency and accessibility of the online provider directory, including the parameters upon which enrollees may search. Include whether or not the online provider directory is mobile friendly.

b. Screen shots for each mouse click required from the start of the respondent's home page to actual search results for a provider, using durable medical equipment providers and zip code as the search elements.

c. A list of performance indicators the respondent will include for each provider type listed in its provider directory.

d. A description of the respondent's process for verification of provider information in the online provider directory, including delegated subcontractor provider information, and the method(s) the respondent uses to ensure the weekly network file submission to the Agency is accurate.

Response:

Lighthouse Health Plan will develop and maintain an online Provider Directory meeting all state-specified requirements building on Evolent and its partners' Provider Enrollment Team's nearly 20 years of experience developing and maintaining Medicaid provider directories. Our Provider Directory will include information for all types of network providers, including, but not limited to primary care providers (PCPs), hospitals, specialists, providers of ancillary services, behavioral health/substance use disorder clinicians and facilities, and pharmacies.

The web-based platform housing the online Provider Directory complies with all required accessibility requirements. The online Directory will comply with the criteria as outlined in 42 CFR 438.10(c)(6)(i)-(v) and will be made available in a machine-readable file and format in compliance with 42 CFR 438.10(h)(4). We will make a printed Directory available to potential enrollees or enrollees who prefer this option at no cost on the Lighthouse website and this will be available in alternative formats, including large print, in compliance with 42 CFR 438.10.42 CFR 438.10.

TRANSPARENT AND ACCESSIBLE ONLINE PROVIDER DIRECTORY

Lighthouse, through our IT and Provider Data teams, will host and ensure that we maintain an online Provider Directory available to Enrollees 24 hours a day, 7 days a week, 365 days a year. Our online provider directory will not require a login or password to be able to locate and view our contracted providers.

Enrollees will be able to search the online provider directory by:
• Provider name
• Provider type
• Distance from the Enrollee's address

• County and state
• Zip code
• Whether the provider is accepting new patients
• Street address
• City and state

Enrollees may also search the online Provider Directory using:
• Category of provider (i.e., Primary Care Physician, Specialist, Behavioral Health provider, Hospital, etc.)
• Specialty (i.e., Family Practice, Pediatrics, Cardiology, etc.)
• Group Name
• Facility Name
• Other options, such as:
• Gender
• Board Certification
• Languages Spoken

The online directory will be designed to make navigation intuitive for users of all ability levels. HealthSparq, our vendor for testing, conducts usability testing using industry-accepted testing methods that incorporates all NCQA requirements no less than every three years. This testing occurs more frequently if the user interface changes.

The Directory will meet specified language requirements, including:
• Use a font size no smaller than 12 points
• Have a readability score at or below 4th grade reading level
• Use an easily understood language and format
• Comply with other state and federal accessibility guidelines

MOBILE CAPABILITIES

We will make the searchable Provider Directory available through our Identifi Engage mobile app that is supported on both Android and iOS platforms. Using this app, Enrollees can access full search functionality within the provider directory. In addition to Identifi Engage, the Lighthouse website is optimized for viewing on mobile devices. Enrollees who don't use Identifi Engage can access the provider directory by using the web browser on their mobile device.

SEARCH RESULTS SCREEN SHOTS

Attachment SCR11-1 provides four screen shots for a DME provider search at the zip code level for a Medicaid plan in Kentucky supported by the same tools that will be used to build the Lighthouse online provider directory. The screenshots are meant to be illustrative of our team's online provider directory capabilities. The actual Lighthouse online provider directory will be built to Florida specifications and will be reviewed with the Agency during the readiness review process.

DIRECTORY LISTING OF PROVIDER PERFORMANCE INDICATORS

All providers will be assigned a quality score using an internal algorithm that draws on a combination of factors. We will display high quality providers first in the online Provider Directory

search display and will include an indicator identifying each provider that is “high quality”. We will indicate those providers who practice at PCMHs.

Quality factors such as those listed below will be used to generate a provider score:

Access Measures
• Proportion of enrollees seen at least once per year
• Average wait time to schedule an appointment
• Proportion of new Enrollees seen within 90 days of enrollment
• Proportion of Enrollees with chronic conditions seen at least twice per year

Enrollee Patient Safety Scores
• Proportion of Enrollees with provider preventable conditions
• Incidence of Sentinel Events

Quality and Outcome Measures
• HEDIS measure performance (including preventive services measures)
• Proportion of Enrollees with avoidable hospital admissions/ readmissions
• Proportion of Enrollees with avoidable ER visits
• Audit compliance performance

Enrollee Experience Satisfaction
• Enrollee-rated quality
• CAHPS results
• Enrollee grievances
• Disenrollment survey outcomes

MONITORING THE ACCURACY OF THE PROVIDER DIRECTORY

Lighthouse provider data is regularly audited to ensure accuracy. Our IT department partners with a combination of business operations, credentialing and enrollment teams to conduct the audits. We audit the data manually on an ongoing basis using both a random sample and systematic comparisons. We also utilize daily, weekly, and monthly reports to review data accuracy and consistency in underlying systems that feed the directories. We audit provider directories through a combination of random sample manual validation and proprietary algorithmic calculations that identify potential errors. These findings are then investigated and records are updated. Audits also take place when the updates are received by the Enrollment team and during the credentialing process.

We audit provider information at multiple stages in the process for data quality and consistency, utilizing relational algorithms for precision. For example, we audit the information loaded into the repository using comparisons to both what was expected to be loaded and compared to other information in the repository. We then audit again as compared to state & federal records of provider information, and also as compared to ongoing independent sources. The effectiveness of these audit methods was recently demonstrated in Kentucky where the Lighthouse team utilized them to assist Passport Health Plan in obtaining the highest level of accuracy among all Medicaid Managed Care Organizations on an EQRO Provider Data Directory ad-hoc audit.

Providers are expected to notify the health plan of any changes to their demographic data such as new addresses, different phone numbers, changes in new patient acceptance, etc. The health plan also uses data sources such as Enrollee feedback, review of the State's master data file, returned mail, claims information and input from provider relations specialists to identify inaccuracies in provider data. In this latter case, provider relations specialists will prepare a roster of the providers they are meeting with to verify that the demographic information is correct. When an inaccuracy is identified, the provider relations specialist will obtain a communication from the provider with the necessary corrections and that is provided to the enrollment team. As needed, outbound calls are made.

DAILY UPDATES TO THE PROVIDER DIRECTORY

The online provider directory will be refreshed daily to ensure that Enrollees have access to the most updated version of the directory. Provider demographic updates will be loaded into the system of record within five (5) business days which then updates the online directory on a daily basis and will simultaneously be used in future iterations of the printed directory as well. We prioritize updates that have the greatest impact on Enrollees such as provider terminations, additions, or significant demographic changes. We will also give special attention and focus to updates that have the potential to impact the quality and safety of Enrollees' care such as sanctions, restrictions and urgent correspondence from regulators.

Lighthouse will partner closely with the Agency to keep the state apprised of changes to the health plan, its network of healthcare providers and to ensure that all requirements are sufficiently complied with. This is accomplished through regular reporting as well as ad hoc contact with the state.

Evaluation Criteria:

1. The extent of the respondent’s search functions for the respondent’s online directory and ease of access for enrollees’ navigation of the online provider directory, including whether or not the online directory is mobile friendly.

2. The extent to which the number of clicks it takes recipients to access the search results, as indicated by the screen shots provided, is less than five (5).

3. The extent and relevance of the performance indicators available in the respondent’s provider directory for each provider type listed.

4. The extent of the respondent’s efforts to ensure information in the respondent’s online provider directory is accurate, including type and frequency of monitoring activities, and delegated subcontractor provider information. Include the frequency of outreach efforts to remediate incorrect provider demographic information and accepting new patient status.

5. The extent to which the respondent’s online provider directory updates are performed daily and the extent to which the updates are communicated to the Agency as required to ensure the information the respondent displays on its website align with the Agency’s information.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 12 – Enrollee Grievance and Appeal System (Statewide):

The respondent shall provide a flowchart and written description of how the respondent will execute its enrollee grievance and appeal system, including identifying, tracking and analysis of enrollee complaints, grievances, appeals and Medicaid fair hearing data. The respondent shall include in the description detail regarding how data resulting from the grievance and appeal system are used to improve the operational performance of the respondent.

Response:

Lighthouse Health Plan, LLC ("Lighthouse") has a fully operational process and system for identifying, tracking and analyzing enrollee complaints, grievances, appeals, and Medicaid Fair Hearings. Lighthouse recognizes that complaints, grievances, and appeals represent areas of enrollee dissatisfaction or disagreement with Lighthouse processes, services, and decisions. While we have always worked closely with our Enrollees and providers to address any concerns that come to our attention, we understand that Enrollees and providers sometimes do not agree with our decisions. Our current grievance and appeal (G&A) process is an effective tool for fairly and quickly resolving these issues and ensuring every Enrollee and provider receives equal consideration for any concerns. Our process is fully compliant with all applicable federal, state and contractual requirements. The process and system are customizable to meet the requirements of the Agency.

To ensure access to the grievance and appeal system, we educate and promote the submission of complaints, grievances, and appeals via multiple modalities, including telephonic, written, electronic, and in person (as applicable). Complaints, grievances, and appeals may be filed by Enrollees, guardians, caretaker relatives, providers, care managers, or any authorized individual the Enrollee appoints to represent them. Lighthouse has bilingual (English/Spanish) Customer Service staff, and utilizes translation lines, TTY, TDD, and relay services to assist Enrollees who speak other languages, or have vision or hearing difficulties. All translation and assistance is free of charge to the Enrollee. Customer Service is available to assist with understanding instructions and filling out forms. Any barriers to filing complaints, grievances, and appeals are investigated and resolved as soon as possible. In addition to the narrative below, please see Attachment SRC 12-1 G&A Flowcharts and Workflows for the Grievance Policy Flowchart, Appeals Policy Flowchart, screenshots of the Complaints workflow, and screenshots of the Appeals workflow for illustrations of the grievance and appeals process.

GRIEVANCE AND APPEAL SYSTEM PROCESS

Intake and Complaint Process –

Receipt of complaints, grievances and appeals may be made verbally, electronically, by facsimile, or in writing. All turnaround times begin upon receipt of the complaint, grievance or appeal by Lighthouse, regardless of mode of transmission. Lighthouse Health Plan maintains a system to track, investigate, and communicate all complaints, grievances, and appeals. The system also maintains the documentation to support external review of grievances and appeals and source-of-truth files for Medicaid Fair Hearings. The system allows for complete reporting to meet regulatory and accreditation requirements.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

When a Customer Service representative receives a verbal or emailed complaint, grievance or appeal from an Enrollee, the following initial procedure is initiated:
• The substance of the issue is recorded in the system. All entries are date and time stamped and permanently entered into the Enrollee file.
• Appeals are immediately transferred to the Grievance and Appeals department (see below for Appeals process and workflow).
• The representative seeks to resolve the issue on the call. If it can be resolved on the call, it is categorized as a Complaint. Examples of issues/complaints and on-call resolutions include: changing PCPs, referral to care coordination, assistance with finding a specialist or making an appointment, billing/claims issues, or duplicate ID card distribution.
• All actions taken on the call are documented in the system.
• If the representative is not able to resolve the complaint on the call, the call may be forwarded to a supervisor for further review and action.
• The following categories of grievances and appeals are always referred immediately to the Grievance and Appeals department: for grievances, Quality of Care, Quality of Office Site, BH Quality of Care, BH Quality of Office Sit, grievances regarding vendor services; and for appeals, all appeals which are any matters related to a service denial, suspension, reduction, or termination.
• The supervisor has up to one business day from receipt of the call to resolve the issue. If the issue cannot be resolved within the one business day by either the representative or the supervisor, it is marked as a Grievance, and forwarded to the Grievance and Appeals department for handling. All actions, including transfers, are documented in the system.
• Upon ticket closure, the complaint is categorized by type (types are pre-populated in the system and are configurable based on analysis and reporting needs) and disposition (resolved on call, resolved with supervisor, referred to Grievance and Appeals).

When a written or faxed complaint, grievance or appeal is received from an Enrollee, the following procedure is initiated:
• The received document is scanned and stored in the system.
• A G&A representative triages all documents received according to whether they are complaints/grievances or Appeals. Written complaints/grievances are treated as grievances and referred directly to the Grievance and Appeals department. Individual tickets are opened in the Grievance and Appeals tracking system for each request.

Grievance Process –

Once the case has been determined to be a Grievance, the case is transferred to the Grievance and Appeals department and entered into the departmental system. An acknowledgement letter is sent to the Enrollee/grievant within five calendar days. The system is fully customizable, according to the needs of the State Medicaid partner and State regulations. All entered fields are designed to be reportable to help in root cause analysis, assessment of barriers, and development of opportunities for improvement. At a minimum, the following information is collected:
• Enrollee's ID number and demographic information
• Provider/practitioner TIN/NPI number and demographic information
• The caller's name, relationship to the Enrollee, and phone number
• Dates tracked: received, incident occurrence, acknowledgement notification, resolution notification
• The type of grievance being filed (customizable)
• Nature of the grievance

• All research/investigation details
• All correspondence, including notification and decision letters, and documents received by the Enrollee and/or providers for investigation in the case
• Final decision, including ability to track place of grievance

In describing the nature of the grievance, a full narrative description of the issue will be documented with specific details pertaining to the issue, such as dates, provider name and provider ID number when available. A full investigation is completed, which may include (but is not limited to) Enrollee/provider contact, systems research (claims, eligibility, finance, configuration), and referrals to specific departments or outside vendors for resolution. All referrals are tracked and monitored in the system to ensure timely and appropriate closure of the grievance or appeal.

All grievances related to the following are routed to Quality of Care for a nurse review, including PCP change requests that are based on care concerns like:
• Clinical Concerns: Any aspect of clinical care, including diagnosis and treatment concerns. This includes medical/behavioral/pharmaceutical issues.
• Environmental Concerns: condition of office, office equipment, office parking lot, office odors, uncomfortable temperature in waiting area or patient exam rooms, and equipment malfunction.
• Safety Concerns: medication errors, and accident or injury while at the provider's office, improper disposal of biohazard materials, and poor or no infection control practices.

Quality of Care investigations are conducted under peer review protection and may include corrective actions for the provider or facility. Substantiated quality of care grievances are reported to the Credentialing Committee.

All grievances related to the following are routed to Compliance for review:
• HIPAA Privacy Concerns: other patient medical records in view, any loud conversations overheard about patients or disclosure of information to an unauthorized person.
• Potential HIPAA/PHI violations
• Allegations of fraud, waste, or abuse

Grievances may be routed to additional departments, including medical management, care coordination, network services, claims, configuration, enrollment/eligibility, finance, customer service, or marketing, as needed to fully investigate and resolve. The Grievance and Appeals department works with any vendors or subcontractors to resolve grievances.

After investigation has been completed, the ticket will be checked for completion, including all required fields, and a resolution letter will be sent to the grievant. The letter will be distributed within 90 calendar days, or sooner, based on the needs of the Enrollee. The resolution letter includes, but is not limited to the following:
• Issue summary
• Findings and conclusions based on investigation
• Disposition of the grievance
• Additional rights, as applicable
• Tracking information

Appeals Process

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

An appeal is a request for review of an action or decision related to covered services or services provided (an Adverse Benefit Determination). An Adverse Benefit Determination is defined as the denial or limited authorization of a requested service, including but not limited to:
• The type or level of service; reduction, suspension, or termination of a previously authorized service
• A denial, in whole or in part, of payment for a service; failure to provide services in a timely manner
• Failure to act within specified timeframes
• A denial of a request to obtain services outside the network for specific reasons

Appeals may be requested orally or in writing, and all turnaround times start on the day of receipt of request. All appeals are tracked in a central system. The system is fully customizable, according to the needs of the Agency and State regulations. All entered fields are designed to be reportable to help in root cause analysis, assessment of barriers, and development of opportunities for improvement.

At a minimum, the following information is collected:
• Enrollee's ID number and demographic information
• Provider/practitioner TIN/NPI number and demographic information
• The caller's name, relationship to the Enrollee, and phone number
• Dates tracked: received, incident occurrence, acknowledgement notification, resolution notification
• The type of appeal being filed (expedited, standard, post service)
• Nature of the appeal
• All research/investigation details, including all aspects of clinical care
• Clinical guidelines/medical policies used to determine outcome
• All correspondence, including notification and decision letters, and documents received by the Enrollee and/or providers for investigation in the case, and clinical review documents
• Final decision, including ability to track place of appeal

An acknowledgement letter is sent to the appellant within five business days of receipt of request. Additional information is requested at that time. The Appeals coordinator will review all submitted information and contact the provider for additional information as needed. Appeals are reviewed by same/similar specialty match practitioners, who did not make the original denial decision, and are not subordinate to the person who made the initial decision. All details of the decision, including any applicable documentation, are maintained in the appeals system.
Resolution letters are distributed to the Enrollee and provider, within 30 calendar days of the appeal, or sooner depending on the health needs of the Enrollee. The letters indicate who made the decision, the clinical guidelines used, an explanation of the decision in Plain Language, and all applicable further appeal and grievance rights including the Subscriber Assistance Program (SAP) and Fair Hearing information.

During a timely filed appeal, and upon the Enrollee's request, the Enrollee's benefits will be continued if the appeal involves a previously authorized treatment, the services were ordered by an authorized service Provider and the time period covered by the original authorization has not expired. The Enrollee may make a written request for continuation of benefits within ten calendar days of notice of Adverse Benefit Determination, pending the determination of a State Fair Hearing.

The Enrollee, or representative of the Enrollee with Enrollee written consent, may examine or request copies of the Enrollee's appeal case file free of charge. The Appeal decision is final and completes all appeal options available through the plan. In a detailed resolution letter, we inform Enrollees of their right to request a review through SAP or a State Fair Hearing through the Agency with notification of the appeal decision.

Expedited Review –

Lighthouse provides an expedited review when we determine or the provider indicates that taking the time for a standard resolution could jeopardize the Enrollee's life, health, or ability to attain, maintain, or regain maximum function. Expedited appeals are available for prospective and concurrent services. An expedited appeal is not available for requests that are made retrospectively. For all expedited appeals, the same process as Standard Appeals is followed, including same/similar specialty match provider review. A decision is made and communicated within 72 hours from receipt of the appeal request.

Subscriber Assistance Program (SAP) –

Lighthouse informs Enrollees of the process for requesting review of a grievance or appeal decision from the Subscriber Assistance Program. Enrollees may file a request to review the decision up to one year from receipt of the final decision letter. Enrollees may not have SAP review the case if they have already filed for a State Fair Hearing. We will continue all requested benefits while the SAP is conducting its review, if requested by the Enrollee or representative within 10 calendar days of determination. If the action is upheld, Lighthouse may recover the costs of any services furnished because of the continuation of benefits. Lighthouse will implement the decision made by the SAP as soon as possible.

State Fair Hearing Process –

After exhausting the appeal process, an Enrollee (or the Enrollee's authorized representative) is entitled to request a State Fair Hearing if an Appeal of an Adverse Benefit Determination is not resolved wholly in the Enrollee's favor. The request must be made within 120 calendar days of the date of the appeal notice of resolution. We will adhere to all regulatory and contractual requirements and time frames and comply with the Agency's ruling in such cases. Lighthouse will bear all costs associated with the State Fair Hearing in the event it results in a reversal of the Adverse Benefit Determination.

ACCESS TO GRIEVANCES & APPEALS

Lighthouse Health Plan offers a well-established, user-friendly, and timely Enrollee Complaint, Grievance and Appeal process that complies with all applicable federal, Agency, and contractual requirements. Our grievance and appeals process also meets NCQA standards. The process is led by our Grievance and Appeals department and is designed to quickly identify issues that one or more of our Enrollees may be experiencing and resolve Grievances to ensure that every Enrollee receives the services to which they are entitled.

Enrollees and designated personnel can file complaints, grievances, and appeals through multiple modalities, including: verbally, written, electronically, facsimile, and in person. Enrollees are informed of the right to file complaints, grievances and appeals, and the process for doing so, in

the Enrollee Handbook and on the Lighthouse website. Reminders to review this information are provided annually to all Enrollees in the Enrollee Newsletter. In addition, any area that has potential contact with Enrollees (care management, care coordination, utilization management, inpatient care management, customer service) receives training on how to assist Enrollees in filing complaints, grievances, and appeals.

To assist Enrollees who speak languages other than English, and to ensure that they can quickly and easily access and file grievances and appeals, including Fair Hearings, Lighthouse promotes the following strategies:
• All written communications to Enrollees include a pull-out action that directs Enrollees to call Customer Service if they have difficulty understanding the information or need assistance with translation.
• Enrollee Handbooks, Newsletters, and other Lighthouse documents are produced in English, Spanish, and any additional language for which Lighthouse has reached a threshold of Enrollees. Information is also translated into English, Spanish, and other threshold languages on the website. Languages spoken by Enrollees are assessed at least annually to ensure that all threshold languages are captured in all applicable materials and the website.
• Lighthouse maintains a contract with telephonic language translation services for over 100 languages. The service is used “on demand” by Lighthouse staff to have real time conversations with Enrollees.
• The Customer Service and Grievance and Appeals departments prioritize hiring bilingual staff (Spanish/English) and will hire additional bilingual staff in other languages as needed.

To ensure Enrollees with disabilities have full access to the Grievance & Appeals system, Lighthouse implemented the following strategies:
• The Customer Service number is accessible through toll-free, collect, TTY, TDD, and national relay services (711).
• Enrollee Handbooks may be produced in large font and Braille upon request.

TIMELINESS AND TIMELINES

Lighthouse Health Plan has current experience with two state Medicaid programs. All required acknowledgement and resolution letters for complaints, grievances, and appeals are resolved in timelines that are less than those specified in federal and State requirements.

From June 2016 to July 2017, Medicaid Health Plan A completed 1,104 appeals, 100% within the state’s required time frame. From July 2016 to June 2017, Medicaid Health Plan B received and resolved 1,741 grievances. The average turnaround time for resolution notification was 17.6 calendar days. For the 189 standard appeals received and resolved, the average turnaround time for resolution notification was 15.1 calendar days.

Lighthouse will meet all required State Medicaid timelines for acknowledgement, notification, and closure for complaints, grievances, and appeals. Workflows are monitored daily to ensure turnaround time compliance. Barriers are addressed if timeframes are in jeopardy of being missed, and root cause analysis conducted to ensure processes are effective and efficient. Cases may be expedited to ensure timeliness as appropriate to each Enrollee’s health needs and circumstances.

LEVERAGING DATA FOR ACTION

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The system used to maintain and report complaints, grievances, and appeals is password protected and accessible only to staff who need information to investigate and resolve cases. Protection of Enrollee privacy is maintained at all times and no personal health information is discussed in meetings or other potentially public forums. All staff who work with complaints, grievances, and appeals are required to take annual HIPAA and PHI protection training. Signed employee documentation of the training is retained in employees personnel file. Any incidents or potential breaches of PHI data are reported immediately to Compliance and investigated per policy.

All complaints, grievances and appeals are tracked within our system, which is used to track the timeliness of each step, for reporting purposes, and for identifying trends that may need to be addressed. For tracking and monitoring purposes, we group complaints and grievances into customizable categories, based on regulatory and accreditation needs. Current categories in the system include:

- Access to Care
- Attitude/Service
- Billing/Financial
- Case/Care management
- Dental
- HCBS Waiver Services
- LTC Waiver Services
- Medical Necessity
- Pharmacy
- Transportation
- Quality of Care
- Quality of Office Site
- Vision
- Other

Complaints, grievances, and appeals are also categorized as Behavioral Health or Non-Behavioral Health. The system is fully customizable to capture all required information, in all required categories. Categories can be added or deleted to the system as needed.

All data captured in the system, which includes complaints, grievances, appeals, and Medicaid Fair Hearing cases, is available for reporting and analysis. The Director of Grievance and Appeals works with the analytics department to develop and review reports based on the State required templates, as well as internal and client needs. These reports are assessed to identify barriers, investigate root cause of issues, identify opportunities for improvement, prioritize actions, take action, and re-assess the data for improvements. Analysis and prioritization activities take place within the Quality Improvement Committee, an interdisciplinary oversight committee to better incorporate complaint, grievance, and appeal findings within all impacted areas of the health plan.

Reports include, but are not limited to the following information:

- Complaints: Number received, category breakdown
- Grievances: Number received, number resolved, rates per 1000 Enrollees, turnaround times (percent meeting goal and averages or acknowledgement and resolution), breakdown of numbers by state category, quantitative and qualitative analysis within each category, behavioral health breakdown

• Appeals: Number received, number resolved, rates per 1000 Enrollees, turnaround times (percent meeting goal and averages or acknowledgement and resolution), overturn rates, breakdown by type of appeal filed and place of service, behavioral health breakdown
• Fair Hearing: Number received, number resolved, overturn rate, assessment of provider and type of service

CORRECTION ACTION PLAN TIMELINES AND EFFECTIVENESS

Reports are compiled monthly, quarterly, and annually, based on Medicaid and State requirements. Reports include analyses of complaints, grievances, and appeals, to determine if there are trends and to identify barriers to address. Information is disseminated to the appropriate internal departments or vendors/subcontractors to conduct further assessment and develop corrective action plans as needed. For example, if we found multiple grievances for a specific provider, we would notify the Provider Network Management department, and in turn they would follow their internal policy to determine if a Corrective Action Plan (CAP) was necessary and impose needed time frames.

The Grievance and Appeal department tracks all Corrective Action Plans, and requests updates on deliverables at 30, 60, and 90-day increments. It is expected that all CAPs are resolved within 90 days of identification of the issue. Following notification of closure of a Corrective Action Plan, the Director of Grievances and Appeals will review the original problem, identified barriers, and action taken to determine if the actions fully addressed the identified issues. If it is determined that the issues were not fully addressed, the Corrective Action Plan will not be accepted and will be sent back to the appropriate department for revision. Grievances and appeals will be monitored over time to ensure that corrective actions resolved the issues.

Reporting, corrective action plans, and outcomes of Fair Hearings are reporting to the Quality Improvement Committee. The Committee determines if the outcomes reveal an opportunity for improvement in any aspect of our process and, if so, implements a process improvement plan.

TRACKING MULTI-SOURCE COMPLAINTS AND GRIEVANCES

All complaints, grievances, and appeals are tracked in separate workflow tasks to provide more detailed tracking and reporting according to the requirements for each type of ticket. Complaints are tracked in the Customer Service module within the Identifi HPA system. All calls to Customer Service are documented in this system. Representatives are required to complete fields for each call that indicate whether the issue was an “inquiry” or a “complaint.” Complaints are further categorized using established NCQA categories (customizable for State requirements). Prior to closing the ticket, the representative must complete a field that notes whether the issue was resolved, referred to a supervisor, or escalated for resolution. Complaints closed at the representative level are reported as complaints; complaints closed by a supervisor within one business day are also reported as complaints. Escalated issues are referred using an established template and workflow to the Grievance and Appeals department.

All complaints submitted by the Agency or any vendors/subcontractors are entered directly into the tracking tool by the Director of Grievances and Appeals. They are tracked and can be reported separately or as part of the larger category of complaint. Subcontractors are provided limited access to the tool, which only allows them access to complaints, grievances, and appeals that are assigned to them. This protects PHI and allows secure and efficient communication between

Lighthouse and its subcontractors. All information, investigation details, resolution language, and attachments are maintained within the system and available for review by the Agency or other auditors as requested.

G&A-SOURCED OPERATIONAL IMPROVEMENTS

Grievance and appeal system data is integral to our ongoing efforts to improve service to both enrollees and our provider partners. Complaint, grievance and appeals data is compiled, reviewed, and reported monthly and quarterly. Grievance and Appeals reports are submitted to State Medicaid agencies, as required. Complaints, grievances and appeals are reported on the Quality Work Plan, which is reviewed by the Quality Improvement Committee (QIC) on a quarterly basis and outlines goals, timetables, individual accountability per task and status. The Quality Improvement Committee charter includes, but is not limited to, analyzing and reviewing individual and aggregate referred Enrollee grievances, appeals, sentinel events and other quality of care and patient safety concerns. The QIC also tracks provider audit data and design plans of correction. As appropriate, the Annual QI Evaluation details studies, methodologies, results, improvement actions and overall impact. If there is a Quality of Care or Quality of Service concern for a provider, the issue is also sent to Credentialing and their minutes are also submitted to QIC. Examples of how grievance and appeals data has resulted in operational performance follow.

Grievance Example #1: State Medicaid Plan A –

The provider network management organization structure for our Kentucky Medicaid plan is designed to facilitate close relationships with our provider partners. Providers have access to a specific Provider Network Management representative, who is their primary contact for assistance with many inquiries and concerns. As a result, deliberate attention is given to the assignment of provider network staff to providers. This organizational structure extended to the investigation of grievances which were forwarded to the designated provider network team member assigned to the provider. While this supported our commitment to excellent service to our provider partners, it often resulted in more than one provider network team member coordinating grievances. While we continue to employ our personal relationship based approach to provider relations, we streamlined the process of handling grievance investigations by routing grievances requiring provider network involvement to only one (1) Provider Network team member. This designated team member works closely with the Provider Network representatives(s) assigned to the provider to resolve the grievance and serves as the sole contact for the G&A department – enhancing the tracking of grievances requiring investigation by our Provider Network Management department, as well as improving accountability for follow-up.

Grievance Example #2: State Medicaid Plan B –

During a quarterly analysis of grievance data, it was noted that the highest category was Billing/Financial. Drill down data indicated there were two key drivers of grievances:
1. Balance Billing: Providers were receiving payment on their claims from the health plan and were billing Enrollees the balance of charges.
2. Full Billing: Providers were not submitting claims to the health plan and were billing the Enrollee the full charge.

Drill down analysis of the balance billing grievances indicated that out of network providers and ancillary services providers accounted for most of the issues. The following actions were taken:

1. Developed a “Cease Billing” letter to be distributed to providers, noting the regulations that prohibit balance billing of Medicaid Enrollees.
2. Posted the cease billing information on the provider website and distributed it to the provider offices during Provider Relations visits.
3. Worked with large ancillary groups to update group IDs and billing code issues that were causing systemic balance billing.

Drill down analysis of the full billing grievances indicated that Enrollees were being billed because the providers did not know they were insured by the health plan or had not verified eligibility. The following actions were taken:
1. Developed a script, template, and training for Customer Service to use when an Enrollee called in with a full billing issue. The script encouraged the Enrollee to call their provider and tell them they were part of the health plan and provide correct claims filing information. Customer Service representatives informed Enrollees that they must present their Enrollee ID card to the provider office at each visit to ensure that the office had the correct information.
2. Grievance and appeals staff called provider offices to verify that providers had the correct clearinghouse code for submission of claims.
3. Provider Relations Representatives were asked to remind providers, on every visit, how to check eligibility in the system, and to verify the clearinghouse code and process for claims submission.
4. A reference guide was placed on the website for providers to explain appropriate addresses and access codes for written and electronic claims submissions and correct claims submission, including addresses and clearinghouse information.

Results revealed a decrease in full billing grievances from 3rd Quarter 2016 through 1st Quarter 2017, following implementation of new scripting. Use of the new billing template by Customer Service improved operational workflow, reducing incomplete grievance information and improving filing time of grievances. Balance billing issues decreased for large ancillary groups following identification and remediation of system errors. Through our efforts, we continue to identify specific sub-issues and develop new processes to address them.

Appeals Example #3: State Medicaid Plan B –

During a quarterly analysis of appeals data, it was noted that one third of appeals were related to denials of inpatient behavioral health services. Drill down data indicated that there were three key drivers of these appeals:
1. Initial denial did not include complete clinical information.
2. Providers expressed disagreement with the health plan’s clinical review guidelines.
3. Appeal of complete stay, including components that had not been requested to be reviewed, when a part of the stay was denied.

Actions taken to improve operational processes:
1. The health plan Medical Director conducted in-person meetings with clinical leadership at the facilities. During these meetings, the following topics were reviewed and discussed: relevant clinical guidelines; medical management processes, including documentation needed for clinical review of requests and timeframes for receipt of requests; and requirement to conduct prior authorization on all inpatient requests.

2. The health plan created a single point of contact for facilities to work with to resolve appeals. This person is a licensed clinical counselor with extensive experience in both Medicaid and knowledge of the service area.
3. Routine meetings were scheduled between the point of contact and the facilities to quickly resolve issues and to continue to improve processes.

Evaluation Criteria:

1. The extent to which the respondent's grievance and appeal system flowchart reflects ease of access for individuals with complaints, grievances and appeals, including ease of access for persons with disabilities or who speak other languages.

2. The extent to which the respondent's timelines for acknowledging and responding to complaints, grievances and appeals are less than those specified in federal and State requirements.

3. The extent to which the respondent's complaint, grievance and appeal and Medicaid Fair Hearing data are aggregated so that results are actionable, protect enrollee privacy and are reviewed by the appropriate staff or committee for analysis and prioritization of corrective action and/or improvement initiatives.

4. The extent to which the respondent's complaint, grievance and appeal process imposes deadlines on completion of corrective action plans implemented as a result of verified complaints, grievances or appeals and have set quality controls in place to review outcomes.

5. The extent to which the respondent is able to ensure all complaints (including those submitted to the respondent by the Agency or respondent's subcontractors) are tracked and resolved as part of the respondent's established complaint, grievance and appeal process.

6. The extent to which the respondent's grievance and appeal system data resulted in operational improvements of the respondent.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 13 – Social Media (Statewide):

The respondent shall describe its approach for engaging enrollees by using innovative communication methods and technologically advanced resources, including, but not limited to the use of social media, texting and smartphone application platforms.

Response:

Lighthouse Health Plan engages Enrollees across multiple channels as part of our comprehensive Enrollee communication strategy supporting general health and wellness, care management and care coordination, and increased Enrollee awareness of the services and benefits available from Lighthouse. Our approach includes the use of technology to connect with Enrollees in ways that best fit their lifestyles, including through social media, texting, and mobile applications. Studies have shown that using technology to communicate with Enrollees can be more effective than traditional outreach methods. Our experience with innovative communication methods is consistent with the conclusions of the studies which are cited throughout this response.

Lighthouse Health Plan's social media and technology-enabled enrollee engagement approaches will also seek to integrate and leverage established programs available through our sponsor, Baptist Health. Baptist's current efforts in this area include:
• Traditional social media—Facebook, Twitter, Instagram which will promote Lighthouse posts when appropriate.
• Physician appointment text message reminders that will augment Lighthouse's texting programs described below.
• EasySchedule— Accessible by smart phone, the Baptist web site allows individuals make appointments online, receive text confirmation
• Patient portal — Accessible by smart phone—allows enrollees who receive services at a Baptist facility to check test results, request medication refills, send messages to their providers about appointments or ask medical questions.

All of our patient engagement services incorporate evidenced-based content and best practices to deliver highly effective and engaging solutions. Our Enrollee communications strategy includes the following components:

Smart Phones provided by Tracfone through the Lifeline program --

We also propose to provide free cell phones to qualified Enrollees via TracFone. In 2016, we distributed 48,000 free cell phones and sent over 768,000 text messages to Enrollees. We will offer all adult Enrollees TracFone Wireless services that include:
• Up to 250 minutes of service per month, with 500 free minutes for the first four months
• Ability to communicate with care team without using plan minutes
• A free phone
• Unlimited text messages

Enrollees may apply online, fill out an application and mail it back, or call TracFone directly to apply for a phone. We are excited that TracFone now offers Android smart phones and data plans supporting mobile applications that empower Enrollees to better manage their health and engage with their care teams through smart phone technology.

Engaging Enrollees via Text Message --

According to the Pew research center, 91 percent of American adults own a cell phone and more than 80 percent communicate using text messaging. This rate of use is consistent even among lower income groups. The Pew survey found that 78% of cell phone owners with household incomes less than $30,000/yr. use their phones for texting. Furthermore, marketing experts estimate that 98 percent of text messages received are opened. These findings reinforce the potential of using text messaging as an important communication channel with our Enrollees.

We will utilize an electronic texting service, CareMessage, to communicate health information to our Enrollees. CareMessage's programs deliver personalized, interactive health information via text messaging. The programs include reminders for recommended exams, screenings, and vaccinations, as well as developmental milestones. We can also inform Enrollees about services and benefits and send administrative alerts (e.g. re- enrollment reminders) via text message. Independent evaluations of the services have demonstrated improved outcomes on several HEDIS and EPSDT quality measures such as immunization compliance and appointment attendance.

In addition to the CareMessage texting program, Lighthouse will offer Child Development, a free texting program, for new mothers designed to provide more information about caring for and giving their babies the best possible start in life. Child Development supports mothers by providing accurate, text-length health information and resources in a format that is personal and timely, using a channel she knows and uses. The moms receive text messages through Child Development programs from birth until the child is three-years old. Topics addressed include, nutrition, exercise, oral health, immunizations, birth defect prevention, developmental milestones, safe sleep, family violence, injury prevention, mental health, substance abuse, car seat safety, and more.

Our Enrollees will also be able to use text messaging to access healthcare services. Lighthouse's Pharmacy Benefits Manager, CVS Caremark, offers Enrollees an easy way to order refills of their medications through the Text to Refill program. Enrollees text the word "Refill" to CVS-TXT (287-898), when prompted they enter the prescription number and pharmacy phone number (located on the prescription label) and choose a preferred pick up time. Enrollees will then receive a confirmation text letting them know that their refill has been ordered. We will promote this option in our Enrollee communications, and as part of initiatives targeted at medication adherence.

Robust Enrollee-facing Mobile Applications --

Lighthouse will provide our Enrollees with access to our comprehensive Enrollee-facing Mobile application, Identifi Engage. Identifi Engage is a secure mobile application that encourages convenient communication between patients and care teams while limiting interruptions in patients' daily lives. Identifi Engage will be used to

- Locate a Network Provider
- Schedule Appointments with Providers
- Receive timely counsel from members of their care team
- Enable care teams to proactively communicate with Enrollees
- Foster prompt coordination among the extended care team; case managers, nutritionists, pharmacists, etc.
- Support secure communications between care teams and Enrollees

• As a supplemental communication channel for Enrollees (especially those that are harder to reach via telephone / mail).

The goals of Identifi Engage are to increase care management program completion, improve Enrollee satisfaction and skill in managing their conditions, reduce delays in scheduling appointments and increase Enrollee attendance at scheduled appointments, and improve the effectiveness of the care team, and our care management approach.

Additionally, our Enrollees will have access to the CVS app through CVS Caremark, our pharmacy benefits manager. Because Enrollees fill prescriptions through multiple channels (mail service pharmacy, retail pharmacy stores, and/or specialty pharmacies) CVS Health offers their Integrated Pharmacy Experience, where Enrollees can manage all of their prescriptions in a comprehensive manner, regardless of whether they use the Caremark or CVS retail digital channels.

Enrollees engaged digitally also have secure, reliable, real-time access to their confidential pharmacy benefits, valuable health information and opportunities to save with lower cost medication options. The digital products will take into consideration, and be reflective of, where the Enrollee is within their benefit year and how the plan design works at all points within that year. In addition, the opportunity and personalized service information available to Enrollees through the digital applications is the same information that our Customer Care representatives have access to and would communicate to an Enrollee calling in for assistance.

Our maternity app, through Lucina's Firefly technology, will enable ongoing communication between the OB nurse and care team, and the Enrollee. The app consists of SMS/text functionality and the content in either the care management platform or the Enrollee app feeds bidirectionally to ensure up to date information on the antepartum and post-partum period. The functionality consists of gestational age and condition specific educational content, questionnaires that allow for feedback and alerts to the OB nurse and care team. If an alert is sent to the care team, it will appear in their work list, so they recognize to make additional outreach to an Enrollee as necessary. In addition, based on the Enrollee's response to the questionnaire, the tools provide real time updating of the clinical risk score and propose adjustments to the care plan.

Social Media Presence --

Lighthouse will establish a Facebook page, Twitter and You Tube accounts. These social media channels will be used to communicate general health education information as well as information about the plan. Through social media, Lighthouse will promote relevant community events, timely health topics including back to school health, Flu Shot information and information about the Zika virus. Facebook and Twitter will also use National Health Observances to promote health awareness and education. For example, April is Alcohol Awareness month, during this month Lighthouse will promote information about alcohol abuse and treatment through our social media channels. Additionally, we will leverage our social media presence in the following ways:
• Twitter will be used to Share health promotion, health education, and community activities quickly and to a large audience via 140 character messages with linked hashtags that organize the message into relevant categories that allow users to more easily access information threads related to the topic they're interested in i.e. #lowsodiumrecipes or #growingvegetables. Links can direct users to multiple types of media i.e. Health Tip fact sheets, educational videos, important diagrams, surveys, sign-up sheets for health promotion programs, etc. We will also use Twitter

to launch health goal or health education campaigns i.e. #5000StepsADayChallenge, #HbA1CEducationWeek. Enrollees can interact with our Twitter content by re-tweeting posts, and sending the author of the post a Direct Message (DM).
• Facebook will be used to Improve health literacy, self-management efficacy, peer support, and health promotion through creating health promotion communities where patients can; Find information related to their conditions, health goals, and community health promotion activities i.e. healthy cooking & exercise classes, Join peer-support communities related to their health goals and interests, and Interact with their provider and find out new information of new programs and activities they can get involved in. We will also use Facebook to launch health goal or health education campaigns i.e. #5000StepsADayChallenge. Enrollees can interact with our Facebook contact by sending us a direct message via Facebook messenger, "liking" our posts, and sharing our posts with their network. We will also utilize Facebook to host educational events using Facebook Live to broadcast streaming presentations on topics of interest to our Enrollees and the community at large. These broadcasts will be available for viewing after the live broadcast and will focus on health education topics relevant to the Agency's goals.

Our Social Media presence will comply with the requirements and prohibitions contained in Section X.C.12 of the model contract.

Online Community Resource Repository --

We recognize that a growing body of research demonstrates the important link between health outcomes and social factors such as income, educational attainment, and access to food and housing. We will therefore deploy the Healthify social and community resource solution designed specifically to address Enrollees' social determinants of health. Healthify will provide our care managers and care navigators with access to a powerful database of social and community resources. Care Managers will search the Community Resource Network to find new services, filter through the resource and eligibility taxonomies, and ultimately refer patients to the best programs and community services for managing their social and behavioral health needs.

We will work with Healthify to provide Enrollee access to the database enabling Enrollees to locate the community-based resources they need. This value-added benefit will be available to Enrollees 18 years of age and older with computer or smart phone access.

The Healthify solution will also support referral tracking and reporting. All participants of an Enrollee's care team will be able to track referrals and identify those that are the most effective in meeting the Enrollee's social needs. Healthify will specifically enable the care team to build a support network of community agencies and social services, send eReferrals to trusted partners and participating organizations, and track successful referrals and implement interventions with non-compliant cases. The ability to track patient referrals and ensure whether or not they have been successfully completed is essential to coordinating care around the social determinants of health

IMPROVING HEALTH LITERACY AND PROMOTING IMPROVED OUTCOMES

By engaging Enrollees through innovative communications channels Lighthouse will improve health literacy and promote improved health outcomes. Texting and mobile apps will be used to promote health literacy by improving the usability of and access to health information, using patient feedback to evaluate the usability of the health information presented, and targeting and

tailoring communication using a user-centered design approach. This includes writing messages in simple text, personalizing messages based on patient's health literacy level, providing interactive communication opportunities that facilitate back and forth between the Enrollee and the care team, and collecting patient feedback via text and mobile app surveys. Specifically, the short form nature of text messages supports communication with Enrollees who may have low literacy and health literacy levels. As with our written/printed Enrollee communications, messages through texting and social media will be written at a 4th grade level.

Studies have shown that health education and promotion via social media and texting makes a difference in improving health outcomes. A study by the Medical Journal of Australia documented a 10 percent reduction in no-shows for Enrollee appointments as a result of text reminders. Also, the International Journal of Medical Informatics published a study in 2012 showing medication adherence increased from 10-30 percent as a result of texted re-fill reminders.

Texting programs have also shown proven educational value related to disease management. A texting program similar to what Lighthouse proposes to implement was deployed with diabetics at a large safety net hospital in Los Angeles resulting in better HbA1c control and a 16 percent reduction in ED visits.

We will replicate these results with our texting and mobile application offerings.

EVIDENCE OF SUCCESS

Our innovative Enrollee communications strategies have demonstrated results. The impact that these approaches have on outcomes is described below.

Care Message Results: Engaging Enrollees via text message has resulted in outcomes that exceed traditional Enrollee communication channels including telephonic outreach. The CareMessage program, for example, was used by an FQHC in Southern California to engage with patients who were due for a preventive visit. Using CareMessage, the FQHC reached 51,784 patients, and of those 11,943 (more than 23%) scheduled an appointment. CareMessage text messaging resulted in higher rates of appointment scheduling compared to other outreach methods (23% of those contacted via text scheduled an appointment as compared to only 6% of those contacted by phone). Of those who scheduled appointments, 24% were new patients and 76% existing patients. Using Care Message, the FQHC was able to decrease patients without visits from 37% to 31%.

Care Message has also been used to address gaps in care. An FQHC in Florida used CareMessage to reach out to women who were due for a cervical cancer screening. Texts were sent to 3,085 women and of those 846 (27%) scheduled a cervical cancer screen.

Our direct experience with Care Message has also demonstrated the following results: Decreasing cases closed because the Enrollee was lost to follow-up (unable to be reached) from 15% to 8%; Reducing missed calls from 48% to 35% and increasing the number of Enrollees who fulfill their care plan goals by 15%.

For our pharmacy texting programs and the CVS app, digitally engaged Enrollees are showing a 1% higher Medication Possession Ration (MPR) resulting in up to 10% better medication adherence; meaning Enrollees are leading healthier lives by following their medication regimens.

CVS Health studies have also found an average of $23 PMPY health care cost avoidance when Enrollees are digitally engaged.

ACCESS ACROSS DEVICES/OPERATING SYSTEMS

Our technology-enabled Enrollee communications channels are designed to maximize accessibility. Our text messaging services are compatible with any mobile device that can receive SMS texts, including subsidized mobile phones obtained through the lifeline program. For Enrollees who don't have a mobile phone, CareMessage can deliver messages to landline phone numbers as well.

Our mobile application is available on IOS and Android operating systems and is optimized for low data consumption. Phones available through Lifeline use the Android operating system. Data plans include 500MB of data. Additionally, in recognition of the fact that oftentimes Enrollee's primary access to the internet is through a mobile device, Lighthouse's website, including the Healthify online community resource database, is optimized for mobile to facilitate easy viewing.

Our strategy also includes the integration of our digital Enrollee communications initiatives. Planned enhancements to Identifi Engage will increase its compatibility with other platforms via Application Programming Interface (API) integration.

TRACKING ENROLLEE USAGE TRENDS

One of the benefits of technology-enabled Enrollee engagement is the enhanced data that is available for tracking usage trends and engagement. For example, the CareMessage platform includes dashboard reporting to:
-Response rate
-Engagement rate
-User retention
-User activation.

The dashboard allows for monitoring and outcomes tracking which can then be used to optimize future campaigns that leverage the platform.

The Identifi Engage mobile application tracks usage metrics including daily logins, daily and monthly active users, repeat users, and frequency of use. Adoption of the mobile app is promoted by our Enrollee Services team, Care Managers, and at community outreach events. Usage trends indicate the features of the app that are used most often and are an indicator of how useful the app is to our Enrollees. Identifi Engage also tracks and monitors:
• User activity data (message exchange quantity, frequency, time/date stamp, and category)
• User satisfaction rating
• User activation score (message exchange quantity & frequency)
• Message type categorization (scheduling, care team communication, general education)

Our social media messages through Facebook, Twitter and YouTube are measured in terms of views, likes, and subscribers.

Evaluation Criteria:

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent described how these technology investments will be used to improve health literacy and promote improved health outcomes.

2. The extent to which the respondent provides data that supports the efficacy of the proposed approach in achieving the intended goals/health outcomes (e.g., increase in appointment compliance) for the target population.

3. The extent to which the respondent describes how social media, texting and smartphone app(s) will be mobile friendly and made available on all operating systems (iOS, Android, Windows, etc.) and interoperable with other technologies currently used by the Medicaid population (e.g., Lifeline).

4. The extent to which the respondent is able to provide routine performance data to support enrollee usage trends.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 14 – CAHPS Results (Statewide):

The Respondent (including respondents' parent, affiliate(s), or subsidiary(ies)) shall include in table format, the target population (TANF, ABD, dual eligible) and the respondent's results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid Contracts (as measured by number of enrollees). If the Respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent's largest Contracts. If the Respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported. Respondents shall provide the data requested in **Exhibit A-4-a-4**, Standard CAHPS Measurement Tool, to provide results for the following CAHPS items/composites:

a. Health Plan Rating;
b. Health Care Rating;
c. Getting Needed Care (composite);
d. Getting Care Quickly (composite); and
e. Getting Help for Customer Service (composite).

Response:

Lighthouse Health Plan's experienced subcontractor has achieved quality standards and quality improvements for CAHPS measures for health plans in Kentucky and Illinois (the largest Medicaid contracts based on membership) serving the following populations:

• In Kentucky, total approximately 171,400 enrollees, operating 18 years, including: TANF Adult (28,808 enrollees), Child (123,167 enrollees); Foster Care (4,077 enrollees); and SSI Adult (15,387 enrollees)
• In Illinois, total approximately 150,900 enrollees, operating three years, including: TANF Families and ACA expansion population (146,454 enrollees), Seniors and people with disabilities excluding Medicare (4,472 enrollees)

Attachment SRC 14-1: Exhibit A-4-a-4 provides the requested 2017 Adult and Child CAHPS measures for the Kentucky and Illinois plans.

In the 2017 CAHPS, the health plans exceeded national Medicaid means in numerous CAHPS other performance measures. Among the measures delineated in this SRC, the health plans have achieved the following:

• Health Plan Rating: Exceeded the national mean for 2017 Adult CAHPS in Kentucky and Illinois; exceeded the national mean for 2017 Child CAHPS in Kentucky

• Health Care Rating: Exceeded the national mean for 2017 Adult CAHPS in Kentucky and Illinois; exceeded the national mean for 2017 Child CAHPS in Kentucky

• Getting Needed Care (composite): Exceeded the national mean for 2017 Adult CAHPS in Kentucky; exceeded the national mean for 2017 Child CAHPS in Kentucky

• Getting Care Quickly (composite): Exceeded the national mean for 2017 Adult CAHPS in Kentucky and Illinois; exceeded the national mean for 2017 Child CAHPS in Kentucky

• Getting Help for Customer Service (composite): Exceeded the national mean for 2017 Adult CAHPS in Kentucky and Illinois; exceeded the national mean for 2017 Child CAHPS in Kentucky

Evaluation Criteria:

1. The extent to which the respondent exceeded the national Medicaid mean for each CAHPS survey item/component reported.

Score: This section is worth a maximum of 20 raw points as described below.

Exhibit A-4-a-4, Standard CAHPS Measurement Tool, provides for thirty (30) opportunities for a respondent to report prior experience in providing desirable experiences with health care (five (5) measures, three (3) states each, adult population for each, and child population for each). For each of the five (5) measures, a total of six (6) points are available.

The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean, for each available state, for adults and for children, respectively. An aggregate score will be calculated and respondents will receive a final score of 0 through 20 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 30 points, the final score will be 20 points (100%). If a respondent receives 27 (90%) of the available 30 points, the final score will be 18 points (90%). If a respondent receives 3 (10%) of the available 30 points, the final score will be 2 points (10%).

D. PROVIDER EXPERIENCE

SRC# 15 – Provider Engagement Model (Statewide):

The respondent shall describe in detail its provider engagement model. The respondent shall include the following elements in its description, at a minimum:

a. The respondent's staff that play a role in provider engagement;
b. The presence of local provider field representatives and their role;
c. The mechanism to track interactions with providers (electronic, physical and telephonic);
d. How the respondent collects and analyzes utilization data and provider feedback, including complaints received, to identify specific training needs;
e. The metrics used to measure the overall satisfaction of network providers with the respondent; and
f. The approach and frequency of provider training on respondent and Agency requirements.

Response:

As a Provider Sponsored Health Plan, provider engagement is at the very core of Lighthouse Health Plan's model and starts at the highest levels of leadership. We recognize that a positive provider experience, focused on solid communication and provider satisfaction, directly impacts the experience of our Enrollee population. We emphasize regular and active engagement with our provider network to ensure an informed provider network, strong relationships, regular feedback and continuous quality improvement.

The Board of Directors, which is comprised primarily of providers in the community, ensures that providers and their patients are at the forefront of our processes and drives everything we do. We engage providers in a myriad of ways, including through:
• Network provider inclusion in our provider-based quality improvement committees
• Consultations and peer-to-peer discussions with our Medical Directors
• Regional meetings to share best practices and discuss specific community and population needs
• Onsite and in-person to assist with operational issues and share actionable data
• Training and orientation of new providers, and periodic retraining
• Weekly face-to-face or telephonic huddles for our highest risk, poorly engaged Enrollees
• Our provider service call center for questions and complaints
• A standardized annual provider satisfaction survey
• Provider complaints and grievances
• Representation in operational and quality-focused workgroups
• Monthly in-person or webinar workshops with Provider Relations staff
• Provider Newsletter, targeted messages, resource guides and other resources posted on the provider portal

LEADERSHIP INVOLVEMENT WITH PROVIDER ENGAGEMENT

The Board of Directors, which is comprised primarily of providers in the community, ensures that providers and their patients are at the forefront of our processes and drives everything we do. The Board oversees our Quality Improvement (QI) program, which is built on an established and highly functional staffing and quality management committee structure including direct interaction

with providers through several provider-based committees. These committees, chaired by our senior leadership and comprised of providers in the community, include:

• Quality Management Committee (QMC): The QMC provides direction, oversight, and management of the clinical care and quality of care provided to Enrollees. The QMC is chaired by the Medical Director and is composed of seven participating providers (including medical and behavioral health providers) appointed on an annual basis, along with representatives from non-clinical areas.
• Physician Advisory Committee (PAC): Chaired by board selected physician leader and include representation from local providers, the PAC is responsible for approving the Quality and Access Scorecard and ensuring fair and reasonable scoring thresholds. The PAC identifies potential operational challenges to be addressed through local plan or provider plan sponsor activities. This committee would also recommend local initiatives to address quality or cost opportunities.
• Credentialing Committee: Chaired by the Medical Director and including representation from community providers approved by the Board of Directors, the Credentialing Committee is responsible for oversight of the credentialing and re-credentialing process.

These committees represent the voice of the provider and ensure that voice is heard by plan leadership and is the foundation of our quality improvement activities.

Our Medical Directors will be available to providers for consultation, peer-to-peer discussions regarding treatment plan or service authorization requests and other patient care questions or concerns. The medical directors offer outreach either by teleconference or in-person upon request. Our network providers play a critical role in driving health outcome improvements and will join the Lighthouse Medical Directors via regional meetings the share best practices, discuss specific community and population needs and participate in the provider quality committees.

LOCAL PROVIDER FIELD REPRESENTATIVES

Lighthouse will have a robust, local, in-person provider support network that includes full-time field-based Provider Representatives who work on improvement opportunities and issue resolution, Population Health Managers who will provide in-person support to meet PCP's and Practice Manager's immediate needs and embedded Care Managers for high volume or high-risk practices.

Field-based Provider Representatives are a key conduit for communication between network providers and Lighthouse Health Plan. They will work in conjunction with field based Population Health Managers to improve Enrollee experience and cost of care through sharing of actionable data. This may include sharing a care gap report with a physician practice and work with a practice on workflows, data, reports, analytics on how to better close care gaps and improve access and patient outcomes. Field-based Provider Representatives responsibilities shall include, but is not limited to:
• Help providers with operational issues, including claims submission and payment
• Work with Network Management to identify gaps in the network and ensure network stability as it applies to terminations and panel closures
• Facilitate collection of credentialing and re-credentialing documents
• Ensure access and availability for Enrollees and network providers
• HEDIS training, education and monitoring
• Provider data integrity and demographic changes

- Site visits to address Enrollee concerns and adherence to policies and procedures
- Root cause analysis and resolution of load and billing issues
- Liaise between provider and Lighthouse departments
- Training and orientation of new providers
- Web training

The ratio of local field representative to providers will be 1:550 unique providers. This ratio will be evaluated on a quarterly basis to ensure that we are meeting the needs of the provider community from a local perspective. If we find that this ratio is insufficient, we will ramp up staff accordingly.

The presence of Population Health Managers boosts the ratio of Lighthouse staff focused on provider engagement. While the local field representatives are focused on operational issues such as claims payment and network contracting, Population Health Managers will analyze PCP practice data and identify opportunities to improve performance; help PCPs make full use of data available through the provider portal and EHR to help drive care enhancements by supporting practices' workflow improvements via PDSA cycles.

Our Provider Field Representative team also works diligently with our specialist providers to ensure that they remain committed to serving our Enrollees. Tactically, this starts by assigning experienced Provider Relations team to high priority specialists. This team works to communicate the administrative ease of working with Lighthouse (examples include electronic referral process, available Provider Services Call Center, defined authorization services, accessible UM team members and prompt claims payment through Electronic Funds Transfer). These features have been identified as critical by our specialist providers in previous provider satisfaction surveys. As a result of consistent communication with our specialist providers, our provider relations approach has achieved a retention rate exceeding 99% in other Medicaid markets.

Embedded Care Managers work with Enrollees and providers at the point of care. To address the needs of high risk Enrollees, we will schedule weekly face-to-face or telephonic huddles with provider practice staff led by the Enrollee’s Care Manager to review the status of highest risk, poorly engaged Enrollees enrolled in care management. In addition, ad-hoc case conferences will be scheduled upon provider request to review and coordinate strategies to meet Enrollees’ complex care needs or Enrollees with slower progress to self-care.

TRACKING INTERACTIONS WITH PROVIDERS

We employ a single module, Identifi Network that seamlessly combines electronic, physical and telephonic communications with providers, allowing for a comprehensive view of all provider transactions. Telephonic interactions with providers will be tracked through our call tracking system and integrated with our Customer Relationship Management program within Identifi Network. All calls are logged and tracked, and if issues cannot be resolved on the phone then an issue will be escalated in the system. Escalated issues enter a workflow designed to manage the issue through resolution. If the call is a tagged as a complaint, the issue will be logged in our Complaints and Grievances module and routed to the appropriate field representative for resolution. Field representatives can document and track tasks in this module and assign follow up to other team members. In-person interactions will also be logged in the Identifi Network system so we have one aggregate view of all physician interaction.

On a monthly basis, the Network Management leadership team reviews all provider call information along with all issues logged from calls and field representatives to identify trends and patterns across categories (i.e., clinical, administrative). For example, we may look at call volumes related to claim questions or payment questions to identify possible claim payment issues ahead of time. For clinical, we may evaluate call volumes related to certain pre-authorization question to identify gaps or process improvement areas. The Network Management and Operations teams will then deploy a Lean 6 Sigma approach to identifying root causes and implementing systemic solutions for clinical and administrative problem areas.

DATA-DRIVEN PROVIDER FIELD REPRESENTATIVE TRAINING

Our field-based Provider Representatives undergo a comprehensive training and retraining program that is initiated as a new hire. The training will be provided by the Network Manager and senior field representatives in the office and in the field. The provider representative will be trained on the following:

- Field Provider Representative responsibilities
- Managed Medical Assistance
- Credentialing and re-credentialing requirements; including delegation oversight and delegated credentialing
- Website overview
- HEDIS and Pay-for-performance programs
- Reporting – including but not limited to, Medicaid PCP performance reports, ER Frequent Flyer reports
- Customer Service Management system
- Navigating a provider contract
- Claims, appeals, claims payment disputes overview
- Pre-Call Planning, Meeting Etiquette and Provider Visit Strategy
- Provider Orientations
- Authorizations/UM

An example of retraining would occur when it is identified that there is a trend in delayed response time to provider inquiries. We would retrain provider representatives with the expectation for email and phone follow up from a provider inquiry.

Lighthouse utilizes the Identifi platform and its enterprise data warehouse along with a reporting and analytics module to analyze data. This data is aggregated at the health plan level and with drill-down capabilities to the practice and provider level for outlier analysis and any performance improvement opportunities. This includes Care Gaps, utilization outliers (both good and bad), referral patterns, and several other methodologies. This data is used to improve the consistency and quality of care delivered to patients via provider sponsored committees charged with driving results. An example of this may include a Specialist Committee focused on referral protocols for appropriate utilization of specialists and ancillary services, or a Physician Advisory Council charged with improving the closure the care gaps or improving clinical program engagement rates for a provider/practice.

When warranted, our continuous quality improvement processes to address aberrant trends will include identification of retraining needs. An example of a need for retraining is occurs after notification of a trend in increased cost in home based care and therapies. We would retrain all provider service staff on the appropriate use of these services and how to discuss individual

practice patterns with the PCPs. This would include training on appropriate prior authorization criteria, highly effective vendors in the community.

MEASURING PROVIDER SATISFACTION

Our Provider Network Manager manages provider satisfaction using the results of a standardized, annual provider satisfaction survey, provider service call center trends, provider complaints and grievances, and direct feedback received through the provider relations representatives or providers themselves during community interactions. These feedback channels help identify opportunities for increasing provider satisfaction. The Lighthouse team has used this approach for over 20 years to conduct and act on opportunities to improve provider satisfaction. Provider satisfaction surveys have consistently reflected high satisfaction ratings from providers in our affiliates in other states. For example, this past year the plan that our team supports in Kentucky was ranked first in overall provider satisfaction among the five Kentucky Medicaid managed care plans, far exceeding the rating for the second highest rated plan. This high level of satisfaction was the result of improvement efforts made based on the results of the provider satisfaction survey in the previous year. This success demonstrates the effectiveness of our approach and drives our continuous efforts to improve even further.

Annual Satisfaction Survey:

We conduct an annual Provider Satisfaction Survey using the SPH Analytics (SPHA) Provider Satisfaction Survey tool, an industry-leading analytical tool with validated methodologies and proven results. SPHA is an NCQA certified survey vendor. The survey collects composite scores in the areas of overall satisfaction, identifies issues with provider services, identifies factors impacting satisfaction and plan loyalty, and provides comparison to other plans. Our Provider Satisfaction Survey tool would conform to FL specifications and would utilize a four-point Likert scale. The tool shall include the following domains:

- Provider relations and communication;
- Clinical management processes;
- Authorization processes including denials and appeals;
- Timeliness of claims payment and assistance with claims processing;
- Complaint resolution process; and
- Care coordination/ case management support.

The survey will assess varying areas of health plan effectiveness and service to ensure that as a provider service network we are creating the optimal provider experience. Those areas we will assess in the survey and analyze for any improvement opportunities are: a) Provider relations and communication; b) Authorization processes, including denials and appeals; c) Timeliness of claims payment and assistance with claims processing; d) Complaint resolution process; and e) Care coordination/case management support.

SPHA utilizes a “one-wave mail and Internet with phone follow-up” survey methodology to administer the Provider Satisfaction Survey. Results of the survey and defined action plans derived from these results will be submitted to the Agency by July 1 of the Contract year.

Provider satisfaction Survey Responsible Parties –

Our Quality Improvement department will be responsible for developing and conducting the Provider Satisfaction Survey. Our Provider Relations and Provider Services teams will be responsible for implementing program improvements identified through the Provider Satisfaction Survey and the other reports and feedback mechanisms. These teams will work together to develop strategic initiatives and plans with their assigned providers to continue to build a strong health plan-provider partnership. The results of these activities are reported and reviewed by the Quality Management Committee (QMC) and the Board of Directors, who are ultimately responsible for provider satisfaction ratings.

Additional Provider Satisfaction Assessment Metrics –

In addition to the Provider Satisfaction Survey we continuously seek provider feedback through inbound calls and provider participation in workgroups and webinars. In our Provider Service call center, the Provider Services Data Analyst produces a dashboard showing monthly trends in call reasons and identifying providers with higher than average call volumes. The Provider Services Manager shares this dashboard with the Provider Network Manager. Together these leaders identify opportunities for provider outreach. Recently this dashboard was utilized in Kentucky to identify a PCP who was contacting the plan multiple times per day to request Enrollee assignment for new patients. Outreach was conducted to the provider and a process was established to handle Enrollee assignment issues in batches. This resulted in the provider office spending less time on the phone with the plan, and more time focused on delivering care to our Enrollees.

As a PSN we encourage providers to give input through representation on workgroups, including workgroups on communications, operations (ex. Claims), Quality, Provider Relations and Provider/Enrollee Services. Providers will also have opportunities to provide feedback during the frequent training sessions, workshops and webinars we will provide through the year.

Using Provider Satisfaction Findings for Quality Improvement –

If we identify opportunities for improvements through the Provider Satisfaction Survey or the other satisfaction assessment methods, our Provider Relations team works to develop and implement improvement plans. For example, based on feedback indicating the need for improved communication and communication channels, EPSDT requirements, etc. from a provider satisfaction survey in Kentucky, our team recently introduced an electronic newsletter for providers and began distributing pocket quick reference cards to provider offices. Quality Improvement initiatives that result from our monitoring of provider satisfaction are managed by our Quality Department, tracked as part of our Quality Workplan and are reported to the QMC.

PROVIDER EDUCATION AND TRAINING

Provider education and training is a critical component of our onboarding process for new network providers, which will be provided by the Provider Field Representative in person within the first month following the provider's effective date. Provider Field Representatives will also provide ongoing training to the entire provider network quarterly or as needed in person, telephonically and via webinar. We also provide education to providers, when relevant, through our Provider Newsletter, and in targeted messages sent to providers. We also have quick reference guides, resource guides and job aids available on the web portal.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Each provider approved for network participation by Lighthouse receives a welcome letter which includes the Provider Handbook that describes our service authorization policies and guidelines. Field-based Provider Relations Representatives train new providers in person within 30 days of contracting and on an ongoing basis as needed. During this new provider orientation session, Provider Relations staff review the Provider Manual and establish themselves as points of contact for the provider on issues. Training includes

- Review of available resources,
- Covered services and benefits,
- Provider responsibilities,
- Quality improvement,
- Billing procedures,
- Claims processing,
- Payment timeframes,
- Care management and disease management,
- Appeals and grievances,
- Pharmacy services,
- Service authorizations, and
- Compliance

We utilize multi-modal training options and will survey providers following training in a continual training improvement and enhancement process. Provider training also includes information about the dispute resolution process, including how providers have 90 days from the date of a final determination to file a written complaint as well as the timeframes for our responses to complaints. Lighthouse will provide notice of the status of complaints in accordance with contract requirements, providing written notice of status every 15 days resolving complaints within 60 days. Providers are also notified that they can contact the Provider Services call center with any questions or issues. Due to the high touch nature of our Provider Relations Representatives, providers would be provided business card/personal information to support providers with ongoing questions or issues.

We revise provider materials to incorporate new or revised policies and procedures, including service authorization procedures and CPGs, for example. These provider updates are distributed through the provider portal.

During subsequent site visits, the Provider Relations Representative reviews and works to resolve any issues or difficulties experienced by the provider. These meetings also serve to collect information about issues providers are facing so that Lighthouse can evaluate its processes to address provider concerns. When our reporting shows a more widespread issue, Provider Relations will host webinars or in person workshops provide clarification to multiple providers. Monthly in person education and training for the top five (5) specific provider types identified by the Plan will review common claims submission errors and how to avoid those going forward. We will facilitate this process through analyzing claims trends and reports of which errors are occurring most frequently, by NPI. This will help us identify both the most common causes of errors as well as the providers having the most challenges with claim submission. We will also conduct a monthly webinar open to all participating providers to address new authorizations, health plan requirements, current topics, and provide an open forum for questions. The webinar will be offered at least twice monthly to accommodate providers' needs and schedule.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The extent to which plan leadership are involved in provider engagement.

2. The extent to which local provider field representatives are incorporated into the model, including the ratio of local provider representatives to providers.

3. The extent to which the method the respondent uses to track interactions with providers is capable of producing meaningful data the respondent will use to address both clinical and administrative problem areas.

4. The extent to which the method the respondent uses to track interactions with providers addresses potential provider field representative training needs.

5. The extent to which the metrics used produce actionable data for measuring provider satisfaction, increasing provider performance, improving the provider engagement model, and identifying areas of improvement for provider related communications or written materials.

6. The extent to which the training includes service coverage guidelines, service authorization requirements, billing procedures, claims processing, payment timeframes, and respondent's dispute resolution process and timeframes, including corresponding requirements in scope of services.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 16 – Dispute Resolution (Statewide):

The respondent shall describe in detail its provider dispute resolution process.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Lighthouse Health Plan employs a holistic approach to resolving provider issues. We are committed to fully investigating and providing swift resolution for our providers who have concerns or express dissatisfaction. Our successful track record is largely due to our responsiveness to provider issues and our frequent and careful monitoring of grievances.

PROVIDER DISPUTE PROCESS

The Lighthouse team has been effectively implementing our grievance process for over 20 years. All grievances are resolved within State required timeframes. Our focus on customer service and first call resolution to our providers sets us apart from other health plans. Identifi Health Plan Administration (HPA) provides all the information needed by our in-house provider service representatives (PSRs) to answer inquiries, questions and concerns from providers regarding Enrollee eligibility status; the transfer of Enrollee medical records among providers; prior authorization and referral procedures; claims payment procedures; coordination of out-of-network services with our UM and Provider Network Management departments, etc. For example, the team member may work in coordination with our Provider Relations team if a face-to-face visit is needed to best resolve the issue.

Our Provider Claim Services Unit (PSCU), a dedicated provider claims call center, is part of our Provider Services department and answers all claims related calls from providers and resolves more than 80% of claims related inquiries in one call over the telephone - routinely re-processing claims during the call. The PCSU team member is adept at understanding the claim processing system, provider contracting, State Medicaid reimbursement, and other payment processes important to resolving claims disputes. For more complex claims issues, PCSU team members coordinate the resolution of the issue. With a focus on root cause resolution, issues are investigated, reviewed by a multi-disciplinary team for input and approval of the proposed solution and managed to resolution.

Our proposed process for claims-related disputes will comply with the requirements outlined in Section VIII. 5 Provider Complaint System, including but not limited to:
• Allowing providers 90 days from the date of final determination of primary payer to file a written complaint
• Acknowledging the complaint verbally or in writing within 3 business days of receipt along with the expected date of resolution
• Notifying the Agency and the provider of the complaint status within 15 days of receipt
• Providing written requests to the Agency within 3 business days of receipt of the complaint if additional time is required to research the complaint. The notification will include an explanation of the need for an extension and the expected time needed beyond the 15 days for research and response.
• Receiving Agency approval of any extension

• Providing written notice of the status to the provider every 15 days
• Resolving the complaint within 60 days of receipt
• Providing written notice of the disposition and the basis for the resolution to the provider within 3 business days of the resolution

Non-claims related complaints are handled by PSRs who are committed to fully investigating and providing swift resolution for our providers who have concerns or express dissatisfaction. The Provider Services Team maintains a one call resolution standard for non-claims related complaints. For our Kentucky plan, more than 98% of calls were resolved within 1 business day. Complaints are documented in the Identifi Health Plan Administration (HPA) call documentation system, as well as the Grievance and Appeals system for tracking, trending and reporting.

Our process for non-claims issues within the Florida Statewide Medicaid Managed Care Program will comply with the requirements outlined in Section VIII. 5 Provider Complaint System, including but not limited to:
• Giving providers 45 days from date the issue occurred to file a written complaint
• Acknowledging the complaint verbally or in writing within 3 business days of receipt
• If warranted, documenting why the complaint is unresolved after 15 days of receipt and providing written notice of the status to the provider every 15 days
• Resolving the complaint within 90 days of receipt
• Providing written notice of the disposition and basis for resolution to the provider within 3 business days of resolution

Providers may seek an appeal through the Grievance and Appeal department within 90 days of a claims denial for lack of prior authorization, services exceeding the authorization, insufficient supporting documentation or late notification. Upon receipt of a written service appeal, the Grievance and Appeals Coordinator logs the appeal in the tracking system and processes the appeal request. The Grievance and Appeals Coordinator issues a standardized acknowledgement letter within 5 business days that advises the Enrollee and the provider that the appeal decision will be made within 30 days from the date the appeal was filed, and the provider is instructed to provide applicable information necessary for review. A 14-day extension may be requested. The Grievance and Appeals Coordinator reviews the appeal for completeness and to determine clinical specialty, routes the request and all pertinent information, and assigns the case to a board-certified physician with clinical expertise in treating the enrollee's condition or disease.

At the time of the physician assignment, the Grievance and Appeals Coordinator also reviews the case to ensure that the physician was not involved in the initial denial. The physician reviewer evaluates the case and issues a decision. The Grievance and Appeals Coordinator sends the provider a decision letter. If the decision is not wholly in favor of the provider, the letter will include notification to the provider that he/she may submit a request to the Agency for a State Administrative Hearing. The case file is updated with the decision and date of notification.

Lighthouse will provide an expedited review when the Grievance and Appeals Coordinator determines or the provider indicates that taking the time for a standard resolution could jeopardize the enrollee's life, health, or ability to attain, maintain, or regain maximum function. For all expedited appeals, a physician other than the physician rendering the original decision reviews the appeal request, and a decision is communicated to the provider within 72 hours from our receipt of the appeal request or as expeditiously as the enrollee's health condition requires.

Providers are educated on the provider complaint system and process via the provider manual, web-site, educational sessions, and onsite visits. The process will also be available to non-participating providers on the website or upon request. An Agency approved complaint form will be provided on Lighthouse's web site to assist providers if they choose to use this method. In addition to being able to the manual, providers will have online access to topic-specific guidelines for billing, claims resubmission, duplicate claims, general info, etc. The Billing Guidelines are created specifically to address when Lighthouse sees claims issues, or when new guidance comes out that has the potential for claims issues (new codes, new provider specific guidelines, etc.).

IDENTIFYING CLAIMS RELATED DISPUTE TRENDS

Data elements tracked in our Grievance and Appeals system include receipt date of the complaint, date the complaint is acknowledged, the nature of the complaint, name of the provider filing the complaint, name of the staff recording the complaint, team member assigned to investigate the complaint, disposition, corrective action required, if applicable, and the date the resolution letter is mailed to the provider. Complaint data is routinely reviewed and used to make program improvements. All elements of the Provider Complaint Report will be captured and reportable to the Agency as required. The Lighthouse PCSU receives claims disputes via phone or mail correspondence. Trends are identified through multiple sources, which include information from providers, business analyst identification through reports, and the reimbursement/ audit team through their reviews. Our comprehensive grievance and appeals system generates state-required monthly and quarterly reports, as well as our own internal reports.

Once a trend is identified by PCSU, research is completed by PCSU Root Cause Analysts and/or the Reimbursement team. Depending on findings, appropriate action is taken. Our First Alert process supports our approach to identifying claims related disputes trends. This weekly meeting of PCSU, Provider Reimbursement and other health plan staff is a well-established, clear and defined process for reporting claims reimbursement issues and requesting and implementing system updates or changes. Some examples of improvements from other programs where the Lighthouse team has deployed this process include:

• Improved process to resolve provider inquiries. Previously, the Provider Reimbursement and Provider Claim Services teams received requests from numerous queues, and e-mails. Opportunities for trending and root cause resolution were not optimized. Under a new process, all works requests and inquiries are submitted on a designated form and routed directly to a Claims Coordinator or the Root Cause Review Team. The Root Cause Review team member serves as the lead and works with the Reimbursement, Contracting, Claims and Provider Enrollment departments, etc. to identify the root cause of the issue for complete resolution for all affected providers. This improvement streamlined the process and has enhanced accountability.

• Ensured UM department receives medical appeals documentation in the most timely manner. Although the Lighthouse team meets or exceeds all State Medicaid timeframes for medical appeals, UM department staff raised concerns regarding the efficiency of the process. Specifically, UM often received and reviewed correspondence that resembled medical appeals documentation but upon closer inspection was not. Also, the Provider Claims Service Unit (PCSU) did not receive notification of the outcome of medical appeals – resulting in additional calls from affected providers. The process improvement solution included additional training on identifying and forwarding true medical appeals correspondence, utilizing technology to transmit appeals

documentation, and communication by the UM appeals staff to PCSU regarding appeal outcomes enabling PCSU to quickly identify claims requiring re-processing based on the appeal decision.
• Reduced Newborn Claim Denials. The claim system was configured to require a prior authorization for all inpatient claims. As a result, claims for newborns were denying for no authorization. The Root Cause Review Team identified this trend and implemented a process improvement whereby denied newborn claims were pended to a special queue each day and promptly auto adjudicated.
• Reduced Non-Emergent Claim Denials. As many emergency department (ED) visits are for non-urgent conditions, a revision was made to the reimbursement policy for ED claims – reimbursing these claims in accordance with a contracted triage rate. As a result, a large amount of correspondence was received from providers intended to support their request for a higher-level payment. A health plan physician was engaged to review the correspondence and claims. It was determined the vast majority of the claims warranted a higher payment. We removed the non-emergent logic, resulting in timelier payment as well as reduced claims re-processing.
• Improved authorization configuration. The system was configured to review specific therapy claims based on daily visit increments. However, providers billed these services in units based on 15 minute increments – resulting in inappropriate denials. We changed the system to reflect provider billing processes – reducing these denials.

Our comprehensive grievance and appeals database and tracking system allows us to generate state-required monthly and quarterly reports, as well as our own routine and ad-hoc reports. Our Provider Services and Grievance and Appeals teams have significant experience working with state Medicaid agencies to provide regular reports on complaints, grievance, and appeals. We are committed to partnering with our providers to refine the complaint and appeals processes to meet their needs. This commitment has helped our team in Kentucky achieve provider satisfaction scores that are higher than all other Medicaid managed care plans operating in the state. During 2016, our KY Grievance and Appeals team completed 1,104 appeal requests, 610 were Enrollee appeals and 494 were provider appeals. Of the 610 Enrollee appeals, 15 were expedited. Appeals and denials are highly audited and we have met or exceeded all requirements for EQRO, State, NCQA and our internal audits. This process has been audited and consistently found to be 100% compliant.

Calls and correspondence designated as provider disputes (written claims related complaints, requests related to third party reviews) are forwarded to the Grievance and Appeals team for resolution. The team reports to the Sr. Director of Utilization Management and Clinical Programs and includes the Grievance and Appeals Managers and six (6) full-time Grievance and Appeals Coordinators. The Grievance and Appeals Coordinator is responsible for resolving the issue or coordinating the response to the dispute with other areas as appropriate. All disputes are documented in the Grievance and Appeals system. The Grievance and Appeals Manager provides daily oversight and works with the team to proactively review cases before they are finalized. Daily monitoring ensures timeliness of all disputes. Department audit staff also review complaints, appeals, and third-party review requests. Monthly reporting supports monitoring activity and includes information on the appropriateness of plan dispute determinations, timeliness of payments to providers post resolution decision and timeliness of the claims dispute process. The Director and Manager reviews reports to identify trends as well as opportunities for improvement. Results are also reported on the QI Workplan and shared with the Quality Management Committee for their feedback.

DISPUTE RESOLUTION OVERSIGHT

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Provider satisfaction is paramount to our success as a provider services network. Lighthouse understands very well the important role and impact claim payment timeliness, accuracy of claims processing, and resolution of claims payment problems or disputes have on provider satisfaction. Our team works hard to achieve excellent results in all of these areas. In fact, for 2017, 99.66% of clean claims are being paid within 30 days and 99.99% of all original claims have been paid within 90 days. For 2016 – 99.75% of clean claims were paid within 30 days and 99.99% of original claims were paid within 90 days. Our provider dispute process will be fully compliant with federal, state and Florida Medicaid program requirements and comply with the requirements outlined in Section VIII. 5 Provider Complaint System.

Our one-call resolution standard will continue to drive our commitment to resolving claims related complaints as quickly as possible. Through PSCU, more than 80% of claims related inquiries are resolved in one call over the telephone through, routinely re-processing claims during the call.

The Grievance and Appeals Coordinator is responsible for resolving the issue or coordinating the response to the dispute with other areas as appropriate. All disputes are documented in the Grievance and Appeals system. The Grievance and Appeals Manager provides daily oversight and works with the team to proactively review cases before they are finalized. Daily monitoring ensures timeliness of all disputes. Department audit staff also review complaints, appeals, and third-party review requests. Monthly reporting supports monitoring activity and includes information on the appropriateness of plan dispute determinations, timeliness of payments to providers post-resolution decision and timeliness of the claims dispute process.

LIGHTHOUSE RESPONSE TO AGENCY REQUESTS

The Lighthouse team has maintained an exemplary record responding to State Medicaid Programs' record requests. Experience includes responding to annual External Quality Review Organization (EQRO) reviews, ad hoc Program Integrity requests, appeals documentation, legislative inquiries, care management evaluation requests involving Enrollees or providers requiring an expeditious response based on the Enrollee's health condition and complaint resolution inquiries. Our employees will receive comprehensive training on the Florida Statewide Medicaid Managed Care Program including requirements pertaining to Agency requests.

Our Compliance Officer will serve as the Agency's primary point of contact for all Agency requests. The Compliance Officer or their designee will acknowledge receipt of all Agency requests. Written, oral and electronic requests will be received, logged and monitored using a dedicated compliance email box to ensure compliance with the FL Medicaid Managed Care Program responsiveness requirements, the Agency and all state and federal laws and regulations. The Compliance Officer or their designee will direct the request to the Grievance and Appeals department who will document the request in the Grievance and Appeal system, assess the request, confirm that it can be fulfilled within the Agency's prescribed timeframe, or provide justification for a request for extension which may only be granted by the Agency at its discretion. The assigned business owner will provide the response to the Grievance and Appeals Coordinator who will submit the response to the Compliance Officer for transmission to the Agency.

The Grievance and Appeals department will provide timely monthly reports to the Agency on provider complaints in accordance with Section XIV, Reporting Requirements and the Managed Care Plan Report Guide as noted in Section VIII 5 of the model Contract. As required, the monthly Provider Complaint Report will specify the date of receipt for each complaint as well as date of

disposition. Agency requests will be reflected in our reporting. Routine internal reports help the Grievance and Appeals team to ensure all requirements related to timeliness are met such as date of acknowledgement to provider or date status letter to provider. This information will be available to the Agency. Our provider grievance and appeals reporting package will include Provider Grievance Summary and Detail, Provider Appeals Summary and Detail, Behavioral Health Provider Grievance Summary and Detail and Behavioral Health Provider Appeals Summary and Detail. Additionally, Lighthouse will provide, as requested by the Agency, internal reports used to monitor, identify trends, and improve processes. These will be provided to the Sr. Director, who in turn will review and submit to the Agency.

INTEGRATION OF COMPLAINTS

We understand data is the foundation for process improvement and we seize every opportunity to collect valuable data to inform our efforts. In addition to complaints received via the Agency and the independent third-party reviewer, we are well prepared to document and track all registered complaints – those through Provider Services (Provider Service Representatives, PCSU), a Provider Network representative, UM staff, external meetings and events, etc. All provider complaints, appeals and third-party review requests regardless of referral source will be documented in the Grievance and Appeals system. Documenting all the complaints in one system allows us to capture the "complete picture" of the issues affecting our provider partners and drives the development and implementation of improvements to alleviate these issues. This comprehensive approach is conducive to our focused efforts on root cause analysis versus treating the symptoms associated with a specific provider's issue.

Calls are documented in the Identifi Health Plan Administration (HPA) call documentation system and are visible across the Identifi Platform (i.e. an Enrollee's Care Manager will be able to view complaints, grievances and appeals to help them better support the enrollee). Written complaints are documented in the Grievance and Appeals system for tracking, trending and reporting. Our "high touch" process allows providers to speak directly with one of our staff through our Provider Service call center. In 2016, 85% of provider complaints handled through this system were resolved during the initial conversation, 95% were resolved within 24 hours by the Provider Services Team and 100% were resolved by the Grievance Coordinator within 30 days. Complaints received either verbally or in writing by the plan are escalated to the complaint/ grievance coordinator for investigation.

PARTICIPATION IN AGENCY'S CLAIMS DISPUTE RESOLUTION PROGRAM

Lighthouse will participate and comply with all of the Statewide Provider and Health Plan Dispute Resolution Program requirements. Providers may request a review of their original appeal by the State's contracted independent review organization Maximus. The Grievance and Appeals team will be responsible for coordinating Maximus requests by documenting these requests in the Grievance and Appeals database and designating them as Statewide Provider and Health Plan Dispute Resolution Program requests, facilitating analysis, and trending specific to these requests but inclusive of other provider grievance and appeal data.
The Grievance and Appeals Coordinator will submit all requested supporting documentation to the independent review organization within 15 days upon request and coordinate payment of all review payments and orders as a result of the review. As with all provider related issues, these cases are aggregated to continuously identify trends and potential process improvements/system

enhancements and have included claim processor education/training, clam system re-configuration, and corrections to provider contracts.

When appropriate, Lighthouse will work with Maximus on claims disputes that meet the minimum thresholds and are not related:
• Exclusively to late payment, including claim dispute filed more than 12 months after the final determination by provider or health plan
• Interest payments
• To an open internal grievance in a Medicare Managed Care organization or that qualify for a Medicare reconsideration appeal
• A part of a Medicaid fair hearing
• That are the basis for an action pending in state or federal court

The Grievance and Appeals team is staffed to ensure that proper documentation and timely responsiveness is affected to comply with Final Orders from Maximus. Lighthouse can confirm that we will comply with the final orders that are issued by the Agency and that all related claims will be reprocessed within prompt pay guidelines (30 days). The 2017 history of 99.66% of clean claims being paid within 30 days and 99.99% of all original claims paid within 90 days. For 2016 – 99.75% of clean claims were paid within 30 days and 99.99% of original claims were paid within 90 days.

Through internal monthly reports, Lighthouse will work with Claims, Medical Directors, IT /TPA (system enhancements), Finance, Compliance (Policy Review/validation), Provider Relations (communications) to update system following Arbitrated cases.

To promote transparency, providers will have online access to documents that identify current or recently completed Claims and Configuration projects. The reports will outline project description, impacted providers, expected resolution, current status, and expected ETA, when available. Lighthouse will comply with all prompt pay final orders issued by the Agency related to claims arbitration determinations.

Evaluation Criteria:

1. The extent to which the respondent's process identifies claims related dispute trends and initiates process improvement activities/system enhancements.

2. The extent to which the respondent's process includes oversight to ensure appropriate plan dispute determinations are made, timely payments are made, and claims disputes resolved within required timeframes.

3. The extent to which the respondent's process incorporates timely response to Agency requests related to complaint resolution in accordance with the scope of services.

4. The extent to which the respondent integrates all complaints, regardless of the complaint referral source (e.g., Agency, third party).

5. The extent to which the respondent's resolution process includes the respondent's participation in the Agency's claims dispute resolution program authorized in Section 408.7057, Florida Statues, as well as includes the following:

(a) Responding to requests for information from the State contracted independent dispute resolution organization;

(b) A global process for analysis of arbitrated cases for possible identification of process improvement/system enhancements; and

(c) Prompt payment of final orders issued by the Agency related to claims arbitration case determinations.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 17 – Claims Processing and Payment Process (Statewide):

In a manner suitable for the provider community, the respondent shall submit key components of its claims processing and payment process, addressing both paper and electronic claims submissions for both participating and non-participating providers.

The response shall include detailed information on the metrics to be employed by the vendor to track timeliness and accuracy of claims adjudication and payment for claims submitted by participating providers and how these metrics will be used by line level and management staff to improve processes and provide for rapid cycle improvement.

The response shall also include a detailed description of how the respondent will make data and metrics regarding claims and payment available to the Agency and will ensure that network providers have access to real-time and trend data regarding claims processing and payment by the respondent and all applicable proposed subcontractors.

Note: Pursuant to Section 409.966(3)(c)6., Florida Statutes, response to this submission requirement will be considered for negotiations.

Response:

Lighthouse Health Plan recognizes the need for an extensive and accurate claims processing system to ensure accurate and timely payment of claims to providers and support access to care for our enrollees, and will leverage the Identifi Health Plan Administration (HPA) platform to accomplish this objective. This highly configurable claims processing operation is currently in use by 14 provider-aligned health plans and full risk- bearing entities supporting over 1.72 million covered lives across Medicaid, Medicare and Commercial programs. The claims processing system currently adjudicates more than ten million Medicaid claims each year. Highlighted performance metrics for HPA claims processing from existing Medicaid lines of business are as follows:

Timely payment: 63% of claims are paid within 7 days, 65% within 10 days and 95% within 20 days. The average turn-around time for clean claims is 8 days.

Accuracy: Claims are processed with financial and procedural accuracy in excess of 99%. Claims accuracy metrics are described in more detail below.

Within the HPA claims processing system, we can configure complex benefit structures and pricing schedules of all types. During the various stages of the adjudication process, the system interacts with membership eligibility, third party liability data, product benefit parameters, provider pricing agreements, medical management requirements, and clinical editing information to provide accurate and highly automated adjudication of claims and/or encounter submissions. Claims processing uses diagnosis codes and procedure codes to read service-based rules, and includes parameters for handling benefit limitations, deductibles, copays, and coordination of benefits (COB) situations. Our powerful software engine:

- Adapts to rapidly changing business and regulatory environments.
- Automates business processes;
- Enhances efficiency;

• Provides the flexibility to administer diverse plan designs; and
• Integrates with third party solutions;

The claims payment process for non-participating providers is identical to the process for participating providers but requires prior authorization for out of network care as described elsewhere in the proposal. Claims from non-participating providers are paid based on the appropriate fee schedule or the payment terms of any applicable single case agreement.

The HPA platform accommodates, and currently administers all major payment methodologies including Fee-for-Service, Capitation, Case Rates, Per Diems, DRG, percentage of billed, UCR, percentage of UCR, RBRVS with GPCI, Bundling, per diems, tiered per diems, lesser of billed and calculated rates, treatment case and many more. Today, the system receives and processes updates to over 1000 Medicaid fee schedules.

The HPA platform is extremely flexible and will enable us to administer highly customized requirements specific to the Florida Medicaid contract including benefits, eligibility, fee schedule and provider service location configuration.

KEY COMPONENTS OF OUR CLAIMS PROCESSING AND PAYMENT PROCESS

Summary of the Claims Lifecycle

Claims Submission: Providers may submit paper claims or electronic claims. We encourage our participating providers to submit claims through Electronic Data Interchange (EDI) powered by the claims clearinghouse, Change Health, which allows faster, more efficient and cost-effective claims submission for providers. EDI, performed in accordance with nationally recognized standards, supports the health care industry's efforts to reduce administrative costs. Currently, approximately 95% of the claims handled by HPA are submitted electronically.

Paper claims submitted by providers (by mail or by fax) are inventoried, scanned and compiled into an electronic file (known as an x12 837 file) for processing alongside electronically submitted claims. All claims, regardless of the submission method, are date stamped with the date of receipt and that date is captured within the claims processing system. Throughout the adjudication process the system is continually capturing processing dates so that inventory can be properly managed and reported.

All claims are reviewed automatically to verify that they include all required information (WEDI SNIP validation Levels 1 and 2 edits). Claims are returned to providers through the clearinghouse if they are missing required information without having to be loaded into our claims system. Claims that include all required information are routed for auto-processing or manual review based on configured business rules.

Auto-Adjudication Process: Claims that can be automatically adjudicated proceed through the claims edits described below prior to arriving at the check run/remittance advice stage. Claims that require manual review are routed to claims workflows as described below. Currently, 75 percent of HPA current claims volume is adjudicated automatically through the rules engine and 25 percent require manual review/processing. Our Process Improvement Team reviews manual claims queues continuously to identify opportunities to improve our auto-adjudication rates, this

continuous process improvement effort leads to steadily improving auto-adjudication rates over time.

Comprehensive Claims Editing: HPA utilizes a comprehensive set of claims edits including (NCCI) Claim Editing guidelines. During claims editing, the system automatically checks each claim for errors, omissions, and questionable coding relationships by testing the data against an expansive database containing millions of government and industry rules, regulations, and policies governing health care claims. The system automatically detects coding errors related to unbundling, modifier appropriateness, diagnoses, and duplicate claims. Medical necessity edits are also provided to help health plans detect procedures billed without supporting diagnoses or not medically necessary based on National and Local Coverage Determinations. The editing software maintains coding edits specific to Medicaid, which are separated by Professional, Inpatient, and Outpatient services. Those claims identified with edit issues are either forwarded to the Manual Claims Review process or returned to the provider for correction and resubmission.

An example of a claims edit that ensures proper claims payment is the requirement that skilled nursing facility (SNF) claims include documentation of a completed Pre-admission Screening and Resident Review (PASRR). SNF claims with dates of service prior to the completion date on the PASRR will be denied. Lighthouse will comply with all agency requirements specific to reporting denied SNF claims and supports the enhanced monitoring of claims for this level of service.

Manual Claims Review: Claims that cannot go through the auto-adjudication process enter a workflow queue and are manually reviewed. Manually reviewed claims include, but are not limited to, the following:

- Coordination of Benefits situations that cannot be processed automatically
- Out of Network Claims
- Transplant Claims
- Complex Multiple Surgical Procedures
- Select Preauthorization Claims
- Grace Period Claims
- Newborn Claims when Submitted with Mom's Enrollee ID
- Complex Eligibility with Date Spans and Gaps in Coverage
- Corrected and Late Billings
- Adjusted Claim Activity
- Complex Anesthesia Claims

Our manual claims adjudication is performed by staff who are stratified by skill level which corresponds to the complexity of the claims that they review. The process is supported by rigorous training and referenceable policy and procedures to ensure consistent processing. Claims Review Team members are assigned to either claims inventory or post adjudication activities, allowing the teams to focus and ensure claims are finalized timely and in accordance with service level agreements for their assigned areas of responsibility. Claims that require manual review for like or similar reasons are routed to the same work queue to allow processing efficiency. Work queues are monitored for patterns and trends and teams continuously assess claims inventory to identify configuration updates and system enhancements to increase auto processing.

Check Run/Remittance Advice: HPA can schedule check runs by day and time as frequently as daily. Our team performs quality checks of claims adjudication and the claims payment file prior to initiating the check issuance process. The system can issue live check or electronic fund

transfers depending on the provider's preference. Additionally, the system is able to intercept specific claims scenarios, such as high dollar claims, claims for select providers, special handling requirements, etc., for management approval before funds are released. HPA also maintains check registries and ledgers related to claims payment for financial control, bank reconciliation and accounting activities.

Monitoring and Reporting: HPA manages inventory and ensures timely processing of claims utilizing multiple tools and reports available in within our claim processing platform and other surround solutions we've built. Inventory is monitored daily, multiple times a day, breaking out claims into date range categories so any claims that are trending toward the beginning, middle, and end of the agreed upon service levels can be identified. Daily open claim reports are created which includes a listing of all open claims pending adjudication. These reports are monitored by the Claim Supervisors and Team Leads to ensure all claims are processed in a timely manner and in accordance with turnaround requirements. Below are some sample reports used to monitor the claims processing cycle and related metrics.

Auditing: All auto-processed and manually processed claims are randomly sampled for financial and processing accuracy. Results are shared with all levels of the organization and are reported monthly in an executive dashboard. Prior to releasing funds for payment, additional audits are conducted to ensure correct payees, identify anomalies, and provide a final comprehensive view of the adjudicated claims ready for payment:
• Concurrent Audits are performed pre-claim adjudication based on specific criteria
• Retrospective Audits are performed on a percentage of claims per adjudicator for continuous performance monitoring with continual feedback for training opportunities

The Audit team works closely with the Claims Administrator and Training team to provide timely feedback on audit results. Performance is closely monitored and progressively managed by the Claims team and remedial training is provided based on audit results. Our progressive management approach includes employee performance review, failure to improve after additional training and coaching may result in the termination of the employee or re-assignment to another Lighthouse department more suited to the employee's skills. As needed, the percentage of claim audits is adjusted based on performance results as assessment of assignment and responsibilities.

Fraud, Waste and Abuse: The anti-fraud processes utilized provide analytics, case tracking, data manipulation, and visualization tools that identify patterns and outliers, as well as ad hoc and scheduled analyses. We also use an internal data warehouse to identify patterns that may be indicative of fraud, waste and abuse (FWA). Together, these tools are used to identify potential FWA such as:
• Over-utilization;
• Up-coding;
• High-dollar claims;
• Unusual patterns by subscribers, providers or facilities;
• Unusual dates of service;
• Excessive time units for time-based codes;
• Unusual claims volume by providers or subscribers;
• Unbundling services;
• Incorrect reimbursement to providers, subscribers, facilities and/or pharmacies; and
• Incongruous procedure code, prescription, and diagnostic code combinations.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Our FWA edits are informed by analytics from Optum Insights. These powerful analytics ensure that our automated FWA detection efforts adapt as new patterns of potential FWA emerge.

METRICS TO TRACK TIMELINESS AND ACCURACY OF CLAIMS PAYMENT

Lighthouse has reviewed the federal and State Claims and Provider Payment requirements set forth in 42 CFR 447.45 and 447.46 and Chapter 641, F.S., and is dedicated to processing claims and paying providers in compliance with those requirements.

Standards for Timely Claims Processing --

Below is the summary of timeframes health insurers and Health Maintenance Organizations (HMO) must follow to pay and/or address claims in a timely manner pursuant to s. 627.6131 and 641.3155, Florida Statutes, respectively.

All Electronically Submitted Claims
• Lighthouse will acknowledge receipt of an electronically-filed claim within 24 hours after receipt of the claim using a HIPAA 999 transaction which is returned to a submitting provider on the same day that a claim is submitted.
• Lighthouse will pay or notify the provider or designee if a claim is denied or contested within 20 days after receipt of the claim. Our claims system currently processes 95% of claims within 20 days.
• We will require providers to submit additional information regarding the denied or contested claim within 35 days after receipt of the notification.
• We will pay or deny all claims within 90 days after receipt of the claim. We understand that failure to pay or deny a claim within 120 days after receipt creates an uncontestable obligation to pay the claim.

Paper Claims
• We will acknowledge receipt of a claim within 15 days after receipt of the claim.
• Within 40 days after receipt of the claim, we will pay the claim or notify a provider or designee if a claim is denied or contested.
• We will require providers to submit additional information or documentation within 35 days after receipt of the notification.
• All claims will be paid or denied within 120 days after receipt of the claim. We understand that failure to pay or deny a claim within 140 days after receipt creates an uncontestable obligation to pay the claim.

We also understand that any overdue payment of a claim bears simple interest of 12% per year.

Standards for Accuracy of Claims Payment --

In addition to tracking the speed of our claims processing system, we will employ a comprehensive claims auditing approach to evaluate the performance of our claims payment processes. Each claim selected for audit will be reviewed to ensure compliance with the Agency's and Lighthouse's policies and directives.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

To consistently report our ability to demonstrate excellence, claim accuracy will be measured in the following categories:
• Procedural Accuracy (Total Claims Reviewed minus Claims with Procedural Errors /Total Claims Reviewed)
• Financial Accuracy (Correct Dollars Payable minus Payment Errors /Correct Dollars Payable)

Procedural Accuracy --

Measures compliance with established Lighthouse policies, procedures and processing rules. Procedural Errors are assessed at the claim level and a single error is charged regardless of the number of procedural errors committed (financial or non-financial impacting). This measurement is included in the overall results for the audit period. Any claim found to have a payment or financial error is procedurally inaccurate. Procedural Accuracy is calculated by subtracting the number of claims with procedural errors from the total claims reviewed and dividing the difference by the total claims reviewed.

Procedural non-compliance may include, but is not limited to the following:
• Improper claim routing
• Incomplete or inaccurate claim documentation
• Incorrect or omitted Remark, Reject, Status or Comment Codes
• Failure to investigate per established procedure
• Incorrect provider selection
• Failure to investigate or question irregularities that do not comply with established business rules
• Incorrect or improper handling that negatively impacts turnaround-time or other service level indicators

Financial Accuracy --

Financial Accuracy measures compliance with benefit, plan and provider calculations and is calculated at a claim level. Calculations are made for the individual claim and results are included in the overall results for the audit period. Any claim found to have a payment or financial error is financially inaccurate. To calculate Financial Accuracy, the Total Dollars Paid are subtracted from the Correct Dollars paid to determine a Payment Error Dollar amount. A financial accuracy percentage is calculated by subtracting the Payment Error dollar amount from the Correct Dollars Payable and dividing the difference by the Correct Dollars Payable.

Every category within the Quality Measurement is important. We cannot provide exceptional service or produce reliable reporting if errors are made and procedures are not followed.

DATA-DRIVEN PROCESS IMPROVEMENT

Our claims processing operations are focused on the early identification of potential deficiencies and risks to meeting service levels so that they can be addressed in a timely manner before performance metrics are negatively impacted.
Process for Identifying Deficiencies and Variance from Standards –

Our process for identifying deficiencies and variance from claims processing standards includes:
• Daily inventory reporting consists of claims received, unfinalized and targeted claims reporting.

• These reports are monitored and aggressively managed by Claims Managers and team leads to ensure timely adjudication.
• General claim summary reports are created as needed that indicate all claims received and the adjudication status (paid, denied, and pending). The daily Electronic Data Interface (EDI) files are monitored and receipts are tracked on an Excel log indicating that the claims submitted via the clearinghouse have been loaded into the claim system.

Our audit program includes concurrent and retrospective audits. A random sampling of 100-500 claims from each check run are audited. The Audit team works closely with the Claims Administrator and our Training team to provide timely feedback on audit results. Performance is closely monitored and progressively managed by the Claims team and remedial training is provided based on audit results. If the employee's performance does not improve they may be terminated or reassigned to another health plan function more suited to their skills. As needed, the percentage of claim audits is adjusted based on performance results as assessment of assignment and responsibilities.

Addressing Deficiencies and Variance from Standards –

Performance and service levels are closely monitored on multiple levels. The Claims Lead has access to scheduled, pushed, on-demand and ad- hoc reporting to monitor system performance, inventory, inbound and outbound file transfers, turn-around- time, auto-adjudication rates, etc. Any activity that is outside of our expected parameters is investigated and if needed escalated for remediation and root cause analysis. Claims that remain on the report for more than 10 business days will be escalated to the Operations Director and the VP of Claims. Claims that remain on the report for more than 15 business days will be escalated to the COO and the senior manager of any department with claims on the list.

Examples of root causes include incomplete or incorrect system configuration, missing or invalid provider data, claims that require manual intervention or concurrent audit.

Example of Addressing Deficiencies and Variances --

One of the most significant risk factors that impacts compliance with claims payment timeliness standards is the number of claims that are pended for manual review. We monitor daily, weekly and monthly pend queue trending reports. Variances outside of normal thresholds are tracked and assessed for remediation or additional technical or manual support to process claims timely. High volume queues, where claims cannot be auto-adjudicated are evaluated for partial or full automation via scripting or virtual agent processing. These technologies mirror the steps of an adjudicator and codify them to be repeatable. These technologies eliminate manual effort and related manual errors. The through-put can be increased or decreased depending on pended volume. Quality is monitored and controlled and technology requirements refined to address any variances and automatically reprocess claims. In parallel we provide details of these automations to our Product Development team to prioritize for future system releases as auto-adjudication enhancements. This feedback cycle continuously improves our core system to increase speed and accuracy both long and short term.

A recent example is related to automating the processing of potential duplicate claims. Due to health plan requirements, the claims processing system initially required potential duplicate claims to route to a pend queue for manual review by an adjudicator for correct processing as a denial

for duplicate or confirmation of a corrected claim for additional consideration. Requirements were developed to automatically identify these claims via more granular characteristics and rules were implemented to properly auto-deny true duplicates and automatically route true corrected claims on in the cycle for processing. This automation reduced the manual claims review workload and contributed to an overall improvement in the timeliness of claims payment.

SHARING CLAIMS PAYMENT SYSTEM PERFORMANCE DATA WITH THE AGENCY

Lighthouse will make documentation of our claims payment system performance available to the agency. We will submit an aging claims summary as specified in Section XVI. Reporting requirements and the Managed Care Plan Report Guide. These reports will be submitted in the manner and format as determined by the Agency. We are also able to provide designated staff at the Agency with access to the dashboard reports that Lighthouse uses internally to track and monitor our performance against quality, accuracy, and timeliness standards. The dashboard contains key metrics including claims inventory, open claims, claims awaiting check run and closed claims.

SHARING CLAIMS PAYMENT SYSTEM PERFORMANCE DATA WITH NETWORK PROVIDERS

In addition to providing providers with an itemized accounting of individual claims included in any payment sent, including the enrollee's name, date of service, procedure code, service units, and payment amount, Lighthouse provides real time claims status information through the provider portal. Claims status reporting shows providers information about their submitted and closed claims including claims source (paper vs. electronic), claims volume, billed amounts and paid amounts. Providers can also access information about open claims (claims pending adjudication) and claims awaiting check run.

In addition to provider-specific claims information, we will regularly report claims payment system performance data to our entire network. We will include an update on claims payment performance in quarterly provider newsletters and will highlight aggregate performance on our provider website. We will also share information about the performance of our claims system during the monthly provider trainings held during the first year of the contract. During these sessions, we will discuss common claims errors and how to avoid them and we will provide guidance and answer questions about the claims submission process. Transparency around claims payment not only improves provider satisfaction, it can also result in suggested process improvements from our network providers and their office staff.

OVERSIGHT OF SUBCONTRACTOR CLAIMS PAYMENT

Lighthouse delegates the majority of claims payment to our third-party administrator, Evolent Health who processes claims using the systems and processes described above. We will provide rigorous oversight of the claims payment process through review of reports, real time dashboards and issue identification and corrective actions. Claims payment for certain claim type are delegated to specialized subcontractors as follows:

- Pharmacy Claims- CVS Health
- Behavioral Health- Access Health
- Dental, vision and hearing- Avesis
- Transportation Claims- OneCall Care Management

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Lighthouse conducts appropriate on-going monitoring, auditing and oversight for all activities conducted by its subcontractors in accordance with applicable state and federal laws, regulations, and guidelines. Lighthouse compliance, quality, and Claims department representatives conduct functional area level monitoring of its delegated subcontractors to ensure that they fulfill their compliance and contractual requirements.

For example, Lighthouse's oversight activities of subcontractors include monitoring various claims activities to determine if AHCA's guidelines and/or plan benefits are being applied appropriately. The following reports are used to monitor claims:
• Pended Claims – weekly reports to monitor appropriateness of claims being held
• Denied Claims – weekly report to monitor appropriateness of denial, does adjustment reason code properly reflect enrollee or provider liability
• Claims Awaiting Check Run- weekly report showing claims that have been processed and are scheduled for payment in the next check run.
• All Paid Claims – monthly report to monitor all aspects of correct claim payments including but not limited to timeliness, interest payment if appropriate, benefit configuration and benefit changes
• Adjusted Claims – monthly report to identify trends, benefits that were misconfigured and confirm that adjustment was done correctly
• Focus Audit – a focus audit will be performed to confirm changes to plan benefits has been done correctly

In addition to monitoring these reports, Lighthouse representatives conduct bi-weekly meetings with subcontracted claims teams to assure appropriate processing and timelines. They also meet monthly with the configuration team to ensure that benefit change requests are being updated timely.

Evaluation Criteria:

1. The extent to which the respondent has described key components of its claims processing and payment process in a format suitable for the public, including a description of the processes for claims submitted both on paper and electronically.

2. The extent to which the respondent has included detailed metrics to be employed by the respondent to track timeliness and accuracy of the claims processing and payment process.

3. The extent to which the respondent has included a detailed description of how metrics from the claims processing and payment process will be used throughout its organization to provide for rapid cycle improvement.

4. The extent to which the respondent has included a detailed description of its process to make data and metrics regarding the claims processing and payment process available to the Agency and that the described process provides sufficient opportunity for the Agency to access this data.

5. The extent to which the respondent has included a detailed description of its process to make data and metrics and trend data regarding claims processing and payment process

available to network providers on a real-time basis and that the described process provides sufficient opportunities for network providers to access this data.

6. The extent to which the respondent has included its applicable proposed subcontractors in its response, with each component addressed for each applicable proposed subcontractor.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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E. DELIVERY SYSTEM COORDINATION

SRC# 18 – Utilization Management (Statewide):

The respondent shall describe the following related to its utilization management (UM) approach:

a. A description of the process used to determine whether a service should be prior authorized and that the UM criteria for each service have been evaluated to determine their appropriateness for administering a Medicaid benefit.

b. A description of how the respondent will ensure consistent application of the review criteria for authorization decisions.

c. A description of how the respondent will ensure that services are not arbitrarily or inappropriately denied or reduced in amount, duration or scope.

d. A description of the approach used to determine whether a service will be needed short-term vs. long-term (i.e., maintenance therapy) for an enrollee, specifically highlighting any differences in the respondent's service authorization approach (if any exists) based on the length of time that the service will be needed.

e. To the extent that a service is needed long-term, a description of the strategies that the respondent utilizes to ensure continuity of care and safeguards that are in place to reduce gaps in authorization.

f. A description and example of how the respondent will detect, monitor and evaluate under-utilization, over-utilization and inappropriate utilization as well as processes to identify and address opportunities for improvement.

Response:

Lighthouse Health Plan's subcontractor, Evolent, provides a full range of Utilization Management (UM) services, including prior-authorization, concurrent review, and retrospective review, designed to ensure Enrollees' needs are addressed holistically through application of evidence-based medical necessity, state-specific criteria and a review of Enrollees' assessed needs, resources and living situation. Utilization review (UR) clinicians work closely with the local, multidisciplinary care management team aligned with the Enrollee's primary care provider (PCP), working together with the Enrollee, family/caregivers, and other treating providers, to make sure UR decisions are coordinated and support the Enrollee's established goals and the provider's treatment plan.

Our UM Program --

• Increases access to medically appropriate services;
• Ensures provision of medically necessary physical health and behavioral health services at the right intensity, duration and level of care
• Assesses and ensures Enrollees receive care that conforms to established clinical practice guidelines and evidence-based practices

• Monitors over-utilization, under-utilization, inefficiency, access to and delays in care, and fraud and abuse, implementing corrective actions where necessary;
• Improves Enrollees' health status; and
• Supports the Enrollee/provider relationship and treatment plan.

Evolent's NCQA-certified UM program operates under the oversight of our Medical Director and Medical Director of Behavioral Health guided by the UM Committee (UMC) reporting to the Quality Management Committee (QMC). The Medical Policy and Pharmacy and Therapeutics Committees are responsible for development and review of all medical policies and prescribed drug policies, including UM criteria, which are provided to the UMC and QMC for review and approval.

We delegate UM of behavioral health, vision, hearing, dental, pharmacy and non-emergency transportation services to subcontractors and ensure compliance with all UM requirements through our delegated oversight process described in our response to SRC # 26 and summarized later in this section. Subcontractors provide authorization data for incorporation into the Data Warehouse. As we work with multiple contracted partners to perform UM, we will develop a strategy to collapse overlapping technology into a single sign-on UM authorization portal. Until that strategy is deployed, providers will work with multiple authorization portals/processes. All provider literature, including the provider manual and quick reference guides, will address these processes.

Our UM Coordinator oversees day-to-day operations working with a staff of experienced and highly qualified clinicians operating under the direction of our Medical Directors. Licensed clinicians supervise all prior-authorization and concurrent review decisions. Clinicians have the appropriate education, training, and professional experience in medical or clinical practice, and hold current, unrestricted licenses for their specific field of practice or specialization. All medical necessity denials of healthcare services or authorizations of a service in an amount, duration, or scope less than requested are completed by board certified physicians, dentists and PharmDs, as appropriate to the requested service.

Our integrated UM approach is supported by Identifi, our IT solution that brings local care management teams, providers and UM staff together on a single platform. Identifi includes care management, utilization management and provider-facing applications with available electronic health record (EHR) integration that supports real-time communication, alerts and information sharing across providers, settings and levels of care.

Evolent contracts with McKesson for the InterQual™ decision-support clinical guidelines, and uses internally developed policies and state-specific requirements and guidelines. InterQual™ guidelines embedded in Identifi are automatically updated via McKesson software ensuring UM team access to the most current knowledge base available. We use InterQual™ guidelines when reviewing requests for services such as non-emergency inpatient services, outpatient therapy, home care and DME. Our BH subcontractor uses national and Florida-specific criteria as applicable, including Florida Medicaid Level of Care Criteria (LOCC) for mental illnesses and ASAM criteria for substance use disorders. Our Pharmacy Department ensures compliance with Florida's formulary and uses industry standard, and when specified, Florida-prescribed medical necessity criteria.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Our UM Program policies and procedures comply with state and federal rules and regulations and NCQA standards. We will comply with the Florida Medicaid contract requirements and, for prescribed drugs, the requirements related to the Hernandez vs. Medows settlement agreement, and apply those guidelines that take precedence over internally developed or InterQualTM guidelines as applicable. We will ensure when we develop prior authorization criteria and protocols these are no more restrictive than used by the Agency as indicated in the Florida Statutes, the Florida Administrative Code Rules 59G-1.010 and 59G-4.192, the Medicaid State Plan and criteria posted on the Agency website. We will also ensure our guidelines are approved by the Agency before implementation of the guideline. Our UM program approach will be documented in an annual UM Program Description, UM Program Evaluation, policies and procedures which assess the effectiveness of our interventions.

Quality Improvement --

On annual basis, the Utilization Management Program is evaluated by the UMC and QMC reviewing the program structure, scope, and processes as well as information sources used for medical necessity and benefit coverage determinations to determine if changes are necessary. We include a summary of our UM monitoring results in the annual UM and CM Clinical program evaluations and report our results to the UM and Quality Committees. Subcontractors perform similar, annual Quality Improvement processes as required by our contract with each subcontractor.

DETERMINING WHETHER A SERVICE SHOULD BE PRIOR AUTHORIZED

Our medical necessity review process is designed to ensure that Enrollees receive medically necessary, quality care in the most appropriate and least restrictive setting that is in accordance with all Medicaid benefits. We determine whether a service will require prior authorization (PA) and if a service can be removed from the PA list by reviewing nine (9) key data sources – listed below. PA requirements are modified as the health plan and providers evolve in the provision of services and/or changes occur to the Medicaid benefit. All changes are reviewed and approved by our health plan's UM committee. We notify providers through e-news, fax blast, their Provider Relations Representative, website or during Town Hall meetings 30 days in advance of any modifications to the UM program including PA changes.

Key data sources and rationale for their use include --

• Contractual Obligation – We prior authorize (PA) services when required to do contractually. For example, we PA non-emergency inpatient services.
• Historical Claims Data – We evaluate the need to prior authorize specific services from a review of historical claims data. Procedures or conditions that are typically high cost and that require a high degree of care coordination are candidates for inclusion on the PA list.
• Historical PA Data – We also review historical PA data such as requested inpatient admissions versus approved admissions; readmissions across all settings (all hospitals, for both physical and behavioral health readmissions in 30, 60, 90-day review periods); and program specific review data (including post-acute admits/days per 1,000 by level of care per facility) to inform the PA list. Additionally, we review data from high-intensity services for which less intensive, alternative services are available to determine if PA will promote the use of clinically appropriate alternatives.
• Benefit Determination Review – Any service that might be provided for non-covered reasons, such as cosmetic services, is placed on the PA list.

• Other Health Plan's PA Services – We also review PA lists for health plans in the same service area and, to the maximum extent possible, align our requirements to avoid additional administrative burden for providers or Enrollees.
• Overturn Rates – We consider data from overturns on appeals and Medicaid Fair Hearings outcomes when developing or revising the PA list.
• Denial Rates – A key aspect of our PA criteria review is identifying opportunities to reduce denials and streamline authorizations without a corresponding increase in service use, demonstrating improved network performance. Services may be removed from prior authorization when the determination process results in consistent approval or when a service previously identified as under or over-used returns to an acceptable baseline.
• Prescribed Drugs Review - Evidenced based clinical guidelines will be used when considering the addition of certain prescribed drugs when step therapy is supported by evidenced based clinical guidelines.

Provider Input Review– As part of the UM criteria evaluation process, we include a systematic review of provider input obtained from our annual provider UM process satisfaction survey as well as complaints and appeals that relate to UM. When analysis of this information indicates areas of dissatisfaction, we develop action plans to improve on the specific UM criteria and areas of concern. Actions may include development or revision of UM PA list, criteria, policies and procedures.

For example, our community providers in one Medicaid market raised a concern regarding the required reauthorization for therapy visits for chronically ill medical fragile children who require longer-term therapies. We worked with community providers, therapy technicians and our State partners to create a solution that permitted authorization of maintenance therapy with safeguards to ensure the service was medically necessary and continued to benefit the child. In another Medicaid health plan, we reviewed low cost DME (under $1,000) and found we could remove this DME from PA without subsequent over-utilization, supporting administrative simplification.

APPROPRIATENESS OF UM CRITERIA FOR MEDICAID

Our implementation team, in conjunction with our Compliance Department and clinical teams, check all contract requirements against our medical necessity criteria and UM policies and procedures to ensure the criteria are appropriate and consistent with policy requirements for the State's Medicaid benefits. This includes review of notification requirements as well as adverse determinations and appeals processes. In addition to the extensive initial compliance process in preparation for readiness review, our ongoing review process includes as-needed and annual review of current contract requirements to confirm compliance.

Medical policies and UM criteria are submitted to the Quality Management Committee (QMC) for review and final approval. The QMC is comprised of active practitioner representatives (including physical health, behavioral health, and pediatric providers) from the community who provide review, approval and recommendation for adoption of medical criteria and policies.

ENSURING CONSISTENT APPLICATION OF REVIEW CRITERIA

We ensure consistent application of criteria through an extensive orientation, training and retraining program, Interrater Reliability Reviews (IRRs) and continuing education. An annual consistency review is conducted to demonstrate the Nurse Reviewers' and Medical Director's

aptitude at applying criteria and protocols in a consistent manner. The BH subcontractor and other subcontractors implement IRR specific to their scope of services.

Training --

We implement a formal orientation and training program for all UM staff initiated with the Human Resources department in conjunction with the UM department on all UM policies including those that are new or revised. Our UM review staff receive comprehensive training for 8 to 10 weeks. The training program consists of the following components:

- Utilization management principles
- Care management and specialty program referral process
- Systems training including process workflows
- Policy and procedure training
- Regulatory requirements
- Criteria training and application
- Review requirements
- Specialty program training when applicable

Trainees complete a skills check off list after each training module and must obtain 100 percent accuracy with all skills requirements. We gradually introduce the trainees to the working environment upon completion of the training modules. We assign a preceptor to new staff to assist in the transition from trainee to reviewer and the preceptor monitors the progress of the new employee for a minimum of 30 days. We audit 100 percent of all new UM staff work and provide immediate feedback.

Ongoing education includes educational forums with associated Continuing Education (CE) credits and training sessions (clinical and nonclinical), which are formulated by analyzing the needs of the staff and the relativity of the content of the training. The Trainer designs and plans trainings and approves the educators and their curriculum. The UM Coordinator reviews feedback and evaluations of current trainings and review ideas and qualifications of future trainers for upcoming professional development offerings.

We monitor attendance at each training session and record this in the staff Enrollee's personnel record. If staff are unable to attend the training, they must attend the next available session. The attendee's direct supervisor/manager receives a list of all attendees, is required to review it and take all appropriate actions. The supervisor/manager is then required to ensure that the trainee attends the next training session and/or works with the staff trainer to conduct an ad hoc training session. If the trainee fails to attend the next training session, the supervisor/manager will then take all appropriate corrective action steps up to and inclusive of dismissal. In addition, licensed professionals are also required to maintain CEUs for appropriate active state licensure requirements.

INTER-RATER RELIABILITY (IRR)

Performance monitoring activities help identify opportunities for improvement that can improve the delivery of high quality services, lead to more efficient operations and ensure standardization of core clinical processes among all clinicians.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We use the InterQual™ IRR testing tool to evaluate consistency in authorization determinations where InterQualTM criteria is applied and internally-developed audit tools to evaluate consistency in application of other (non-InterQual) criteria. Clinical leaders monitor for process improvement and effectiveness on an ongoing basis. The Inter-Rater Reliability (IRR) Program is designed to assess consistency in the application of the use of Medical Necessity Guidelines. We evaluate this consistency for all UM health care professionals through:

- Audits to determine appropriate application of guidelines
- Medical Director review of concurrent reviews
- During multi-disciplinary rounds to ensure selection and application of appropriate criteria

Audits and program findings are reported to the UM Committee and then to our Quality Management Committee (QMC) for follow up.

Physician Reviewer IRR --

We conduct Physician Reviewer IRR annually to ensure consistency and objectivity of UM decisions made by physician reviewers. The IRR reviews verify that service request determinations are consistent with our policies and state-specific requirements and guidelines. The Medical Director develops hypothetical Medicaid case studies that reflect the common types of requests that are reviewed by each physician, then discussed during an IRR meeting. Physician reviewers document their review decision and any questions they would like to discuss. At the scheduled meeting, the physicians discuss their decisions and the rationale used to make the determination. They also clarify and interpret evidence-based clinical resources to encourage review consistency in the future.

The IRR Administrator scores the physician reviewers based on the consistency of the decisions made by each physician. The Medical Director monitors the scores and establishes performance improvement plans for reviewers who score below a 90 percent adherence target. An annual summary report is prepared and presented to the UMC and QMC. Additional education or action may be taken to improve consistency in the application of clinical evidence criterion and followed by the UMC until closure, if needed. In 2017, physician reviewer IRR results were 100 percent.

Nurse Reviewer IRR --

We conduct Nurse Reviewer IRR quarterly to ensure consistent understanding and application of evidenced-based clinical resources. the UM Manager carries out IRR reviews under the direction of the Senior Director of Utilization Management. The UM Manager assigns sample cases to the nurse reviewers who must complete the reviews with 90 percent accuracy.

We calculate overall scores based on individual case scenario scores, and the UM Manager establishes corrective education plans for reviewers scoring less than 90 percent. The UM Manager monitors the corrective education plan to ensure the 90 percent standard is met within one quarter or implements a corrective action plan that includes training and retesting until the desired score is reached. Annually, the UM Manager prepares a summary report for the UMC and QMC that summarizes the IRR Program and details the IRR components assessed, number of clinicians evaluated, the range of scores, reasons for trends or failures, and opportunities for improvement. In 2016, 91 percent of nurse reviewers passed IRR review on the first attempt. The nine percent requiring re-training passed on the re-test.

BH Clinician Review --

Our BH subcontractor ensures UM criteria are applied consistently and appropriately across all levels of care and lengths of stay through annual inter-rater reliability (IRR) audits of all staff who complete utilization reviews including clinicians, clinical supervisors, and Medical Directors. The process includes conducting focused monthly supervisory reviews of the clinical staff, reviewing and providing feedback on specific input and process metrics that cover the continuum of the UR and case management clinical process.

The IRR uses approximately 15 to 20 vignettes in which clinicians apply medical necessity criteria to make determinations. The BH subcontractor combines IRR with monthly monitoring of service request calls from providers that includes a review of the documentation received against the audit tool to confirm the request addresses all the elements required to make a determination. If the BH subcontractor encounters frequent errors, they increase the frequency of the monitoring and implement an assessment of the reason for deficiencies and the related corrective action, which may include policy clarification and/or provider training.

Pharmacist Reviewer IRR --

Pharmacy IRR evaluates clinical decision-making consistency by type (prior authorization, step therapy or quantity limit, and initial request or appeal) through a careful selection of sample medication requests received and reviewed by our Clinical Pharmacy Services (CPS) team.

The CPS Quality Improvement Committee coordinates these audits by selecting cases for review confirming sound clinical judgment, adherence to the prior authorization policy, and adherence to the specific medication policy. A minimum of two cases per CPS team Enrollee are selected and reviewed biannually.

A pharmacist Enrollee of the CPS team leads a clinical discussion of the sample medication requests. Sample medication requests are selected based on questions received from the CPS team, identifiable review inconsistencies pulled from the UM prior authorization platform data or from CPS team Enrollee request. The IRR process evaluates individual clinical decision making and overall adherence to the prior authorization process.

NETWORK PROVIDER EDUCATION AND TRAINING

Each provider approved for network participation by Lighthouse receives a welcome letter which includes the Provider Handbook that describes our service authorization policies and guidelines. Field-based Provider Relations Representatives train new providers in person within 30 days of contracting and on an ongoing basis as needed. The Representatives also help providers with operational issues, including our UM and authorization processes.

Training includes a review of available resources, covered services and benefits, provider responsibilities, quality improvement, billing and payment, care management and disease management, appeals and grievances, pharmacy services, service authorizations and compliance.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We revise provider materials to incorporate new or revised policies and procedures, including service authorization procedures and CPGs, for example. These provider updates are distributed through the provider portal.

ENSURING SERVICES ARE NOT ARBITRARILY OR INAPPROPRIATELY DENIED OR REDUCED

We ensure services are not arbitrarily or inappropriately denied or reduced by:
• Adhering to specific NCQA processes
• Following evidenced based criteria
• Proactively contacting the requesting provider to gather additional information needed to decide including through peer-to-peer consultation and discussion with the Lighthouse Medical Director
• Consulting with the local care management team to ensure decisions consider the Enrollee's assessed needs, living situation, and other factors that may impact the need for a service
• Requiring physician review of all service requests that do not appear to meet medical necessity
• Confirming compliance with established criteria through chart audits, telephone monitoring, and IRR reviews for nurses and physicians

The foundation of our UM program is the extensive series of NCQA accredited policies and procedures that guide the decision-making process and daily operations The Utilization Management nurse or BH clinician reviewer is authorized to make decisions providing that he/she is operating within the framework described within these policies and procedures and may approve services that meet objective medical necessity criteria.

During review, the clinician reviewer will contact the requesting provider when additional documentation is needed to support medical necessity. The reviewer ensures the requested service is covered and takes into consideration any special circumstances applicable to the individual request. He or she contacts the local care management team, including for Enrollees enrolled in care management, the Enrollee's assigned care manager, to identify unique considerations and may ask a local nurse care manager or CHW to make a home visit when needed, to gather additional information from the Enrollee and his or her family/caregivers as applicable. The clinical reviewer will also schedule a multidisciplinary case conference to review the request for those Enrollees with complex or intensive service needs who require a high degree of coordination including children transitioning home from a nursing facility or who need ongoing private duty nursing and other intensive services. Providers, external case managers, discharge planners and others involved in an Enrollee's care will be invited to participate (with Enrollee consent). The collected information is evaluated using the established criteria. If the decision is outside the scope of the reviewer's authority, the request is referred to the Medical Director for a determination.

The Lighthouse Medical Director or BH Medical Director are the only health plan representatives with the authority to deny, in part or whole, authorization for services based on medical necessity/appropriateness. The Medical Director or designee reviews all potential medical necessity denials and makes a determination based on currently accepted medical or healthcare practices and state specified medical necessity criteria and considers the special circumstances of each request that may require deviation from the norm. In addition to the physician review process for adverse determinations, we employ nurse clinical letter writers specially trained in writing adverse determinations. Clinical letter writers are responsible for reviewing adverse determination decisions against criteria and policy, escalating questions to the physician reviewer,

and creating letters that meet regulatory and Plain Language requirements. Clinical letter writers act as a second quality check on denials prior to the provider and Enrollee notification, ensuring adverse determinations are appropriate and supported by specific criteria.

Our Pharmacy Department reviews daily claims reports evaluating both paid and rejected claims to ensure claims are not inappropriately denying. All claim discrepancies are further reviewed on an individual basis within the adjudication system and escalated appropriately.

Finally, we ensure appropriate service request determinations through our program of IRR reviews, when needed as described previously in this section.

SHORT TERM VERSUS LONG TERM AUTHORIZATIONS

Our approach to service authorization includes identifying those services that Enrollees need on an ongoing basis that require prior authorization and providing a streamlined and timely method to ensure continued long-term access while making sure the service continues to be effective. For example, our approach for authorization of private duty nursing (PDN) for Enrollees who have conditions that are expected to continue to require intervention by a nurse beyond intermittent nursing will include the following requirements:

• For a first-time authorization of PDN where the Enrollee is expected to require PDN for at least 90 days, we will complete a review of service effectiveness after 60 days and if the service continues to be medically necessary and is expected to be needed on an ongoing basis, will reauthorize the service for six months, or if needed for less than six months, the period requested, using the process described below.
• We will authorize continued PDN without review for up to 60 days for Enrollees receiving PDN at the time of enrollment into our health plan to ensure continuity of care.
• We will automatically extend an authorization for an additional 60 days to confirm medical necessity when necessary.

The review will be conducted by a UR nurse working with the Enrollee's assigned local nurse care manager, and other Enrollees of the local care management team as needed. The review will include:

• The Enrollee's nurse care manager's confirmation that PDN services are meeting the Enrollee's needs and being delivered as prescribed based on a home visit and observation of the nursing services
• The Enrollee's PCP's statement of continued need for the service that includes attestation that the Enrollee's diagnosis or condition necessitating PDN services has not significantly changed since initial authorization and the need for PDN is expected to continue
• Attestation by the nurse provider that he or she will promptly notify the Enrollee's nurse care manager and PCP of any changes in the Enrollee's condition that require a change in authorized PDN hours
• Attestation by the Enrollee's PCP, Enrollee or legally authorized representative, and nurse provider that the number of hours of PDN may be changed during the authorization period by the health plan if the Enrollee's need for skilled nursing care changes significantly.

PDN may then be authorized for up to six months at a time with review required 30 days prior to expiration of the authorized period. We will automatically extend services for an additional 60 days when necessary to complete a determination and ensure no gaps in care.

The Enrollee's nurse care manager will be responsible for obtaining the Enrollee's or legal representative's signed attestation and for helping the Enrollee and/or family obtain the needed attestation from the PCP, or may obtain it on the Enrollee's behalf. The PDN nurse provider will be required to ensure that a new physician plan of care is obtained within 30 calendar days of the authorization expiration date and will become part of the Enrollee's record.

CONTINUITY OF CARE, INCLUDING FOR LONG-TERM SERVICES

Our approach to ensuring continuity of care acknowledges the importance of maintaining established Enrollee/provider relationships during transitions of care and to continue long-term services without interruption, avoiding gaps in care that can lead to costly ER visits or even inpatient admissions.

We have an established process to continue a newly enrolled Enrollee's services for at least 60 days that takes into consideration the new Enrollee's unique needs. When an Enrollee enrolls and is in an active course of treatment at the time of enrollment, we continue these services from both in-network and out-of-network providers without requiring prior authorization until the Enrollee's PCP or behavioral health provider (as applicable to medical or behavioral health services, respectively) reviews the Enrollee's treatment plan. Pregnant women who transition into our health plan may continue to see an out-of-network obstetrician through the course of their pregnancy and through six weeks post-partum. Enrollees who have received a transplant and have an out-of-network provider at the time of enrollment may continue with their current provider for one year post-transplant.

We typically extend out-of-network service authorization for Enrollees receiving other services from an out-of-network provider at the time of enrollment through the course of their treatment to promote the best possible outcome for the Enrollee.

If an Enrollee is in a hospital or receiving services from a provider who terminates their agreement with our health plan, we notify the Enrollee and arrange for continued treatment for the current episode of illness until the medical care or treatment can be fully transferred to a new treating provider who has agreed to assume responsibility for the remainder of the care needs (including the remainder of the hospitalization and follow up care). If we are unable to find an in-network treating provider who agrees to the transfer, we will continue to authorize the services until the episode of illness is over or we locate an alternative in-network provider.

For Enrollees who require services long-term, our priority is making sure these Enrollees continue to receive medically necessary services without gaps in authorization and will authorize these services for up to six months at a time as described previously. For services that are needed to support a chronic condition, longer authorization periods can be issued to prevent administrative burden to the providers. Approval letters also specifically spell out the authorization time period so providers know when to request an extension of service to avoid any gaps in care.

UM reviewers document the long-term services authorization period in Identifi, including the reauthorization review date, which is 30 days before the end date. This documentation triggers an alert that flows into the UM staff work queue and displays the required activity (service review and reauthorization). In addition, the UM reviewer will set a reminder prior to the expiration of the service authorization at specific periods, such as 14 and 7 days prior to expiration, which will

display in the reviewer's work queue as a reminder to ensure the review is complete or confirm auto extension.

Enrollees with special needs may be enrolled in our Enrollees with Special Health Care Needs Care Management program or another care management program including Care Coordination depending on the Enrollee's risk level, diagnoses/conditions, and needs. Our UM approach includes collaboration between the local care management team, the Enrollee's assigned care manager and UM clinicians. Even if an Enrollee has previously declined care management, the local care management team assists the UM clinician with review of service requests for Enrollees with special needs upon request, working with the Enrollee's PCP, treating providers and Enrollee to support a thorough review of the Enrollee's needs and requested service.

We help avoid gaps in prescribed drug use by issuing a defined length of authorization for both initial and reauthorization approvals. Upon approval, we send both the Enrollee and provider written notification of the approval dates. Requests for reauthorization can be submitted for review prior to the termination of the current authorization period to prevent gaps in authorization if the reauthorization criteria are met. In addition, we will provide up to a 72-hour medication supply in accordance with the requirements of s. 409.912(5)(a)1, F.S. to support continuity of care and will continue the medication prescribed to a Enrollee who was previously in a State mental health treatment facility for at least ninety days before discharge unless the prescribing psychiatrist, in consultation and agreement with the facility's prescribing physician, determines that the medications are not medically necessary or are potentially harmful to the Enrollee.

UNDER AND OVER UTILIZATION AND OPPORTUNITIES FOR IMPROVEMENT

Our UM Plan outlines five key components for the management of under and over utilization opportunities as follows:

1. Active Case Reviews
2. Hospital Contracting Strategy
3. Monthly UM Authorization Data Reviews
4. Medical Economic Reviews – Provider Profiling Data Reviews
5. FWA – SIU Data Reviews

Active Case Reviews of Inpatient and Subacute Patient Stays --

Inpatient Reviews: UM clinicians and the Lighthouse Medical Director review inpatient stays that fail to meet InterQual criteria at any time during the stay as well as all stays over 15 days. Additionally, the Lighthouse Medical Director conducts telephonic review rounds three times a week and is available at any time when a nurse clinician believes a review is needed. Because NICU stays are often prevalent among the Medicaid population, we assign a dedicated Medical Director (Pediatrician) to conduct a daily review of NICU stays of concern.

All inpatient reviews are focused on ensuring the Enrollee is receiving the right service in the right setting and identifying whether the Enrollee needs ongoing inpatient care, or instead is ready for transition to a subacute setting or home. This review is coordinated with the local care management team, and Enrollee's PCP to ensure the Enrollee receives the level of care management support needed based on their level of care and any planned transitions. After an initial review, when it's a DRG based contract, we conduct another review on the 4th day, unless an Enrollee's medical condition warrants something else. As DRG outlier days begin often on the

5th day of the stay, we want to ensure the stay continues to be medically necessary and is not delayed due to factors we can resolve through collaboration with the Enrollee's local care management team and treating physician(s), such as providing additional in-home services to support more timely transition home.

Subacute Reviews: Like inpatient reviews, the UM clinicians and Lighthouse Medical Director conduct telephonic rounds on Enrollees in a subacute setting two times per week. Review is focused on ensuring the Enrollee is receiving the right service in the right setting and identifying whether the Enrollee is ready for transition to a subacute setting or home.

Hospital DRG Contracting Methodology --

In accordance with our DRG contracting methodology, after the initial review, the inpatient stay will be reviewed on the 4th day, unless an Enrollee's medical condition warrants something else. As outlier days begin often on the 5th day of the stay, we want to ensure the stay continues to be medically necessary and is not delayed due to factors we can resolve through collaboration with the Enrollee's local care management team and treating physician(s), such as providing additional in-home services to support more timely transition home.

UM Authorization Data Reviews --

Quarterly, our UM clinicians together with the Lighthouse Medical Director and the UM Committee review key indicators and compare against goals outlined in the UM plan. These key indicators are compared to stated goal(s), month over month, month to previous year, quarter over quarter, provider to provider (same specialty) and against external benchmarks when available We review, trend and develop action plans to address targets not met that include additional provider education, additional reviews with hospitals if hospitals repeatedly exceed targets, alteration of services on the preauthorization list and economic credentialing.

Key metrics reviewed monthly include:
• Requested vs authorized admissions
• Admissions/1,000 Enrollee months
• Days/1,000 Enrollee months
• Average length of stay
• Prior-authorization requests/1,000 Enrollee months
• Admissions/ 1,000 Enrollee months
• Readmission Rate within 30 days of discharge
• ER visits/1,000 Enrollee months
• In-network utilization
• Outpatient surgeries/1,000 Enrollee months
• PCP visits within 7 days of discharge
• Maternity Review – C Sections, early elective deliveries and NICU cases
• Services deemed not to be medically necessary
• Specialist

Additionally, we review the following data to evaluate for over and under-utilization:
• Disease State Data - Assessing the incidence and prevalence of disease states and analyzing preventive services and outcomes

• Gaps in Care Data - Gaps in care are addressed by the clinical team, in coordination with other functional areas as appropriate, through Enrollee and provider outreach and investigation and formulation of an Enrollee- and/or provider-specific plan to resolve barriers to care or a provider's lack of adherence to CPGs. When we identify an under-utilization trend across multiple Enrollees and providers we develop a performance improvement plan.
• Enrollee/Provider Complaint Data – We review Enrollee and provider complaints, such as an access issue or ongoing failure by provider to remain compliant with health plan protocols.

From the review of the data, if a pattern of inappropriate utilization trends is detected, the findings will be discussed with the Lighthouse Medical Management staff to create an action plan to improve performance. Based on the nature of those findings, the health plan's Compliance and/or FWA-SIU team will be included in the action plans.

Behavioral Health Services --

Our BH subcontractor analyzes monthly UM and admissions reports to identify Enrollees who are or may become high need and who have had multiple admissions to higher levels of care in the last six months. BH clinicians follow up on the Enrollee's progress in the community and refer Enrollees to the care management staff for those Enrollees needing enhanced outreach and care coordination. Care management staff assess the Enrollee's needs and enroll the Enrollee into the appropriate level of care management.

Prescription drug services --

We will employ a comprehensive approach to detecting, analyzing, and targeting both overutilization and underutilization of pharmaceuticals, with a goal of improving care and reducing costs. Leveraging the Medicaid expertise of our Director of Pharmacy, Pharmacy Analyst, Analytics Department, and PBM subcontractor, we will review pharmacy and medical claims data routinely to identify Enrollees with over/under utilization of services. In 2016, our approach resulted in a 1.8 percent reduction in total spending for other Medicaid managed care plans.

Using the Identifi Analytics and Reporting platform, our pharmacy team will identify drug management opportunities through the following pharmacy analytics activities and processes:
• Monthly generation and review of utilization statistics and trend reports including those specified in the contract
• Monthly generation and review of prior authorization statistics and cost avoidance savings
• Monthly generation and review of concurrent DUR reporting that includes savings estimates based on the cost of those claims that are rejected or not filled after DUR edits are processed and evaluated
• Quarterly generation and review of retrospective DUR data of potentially inappropriate or medically unnecessary prescribing
• Pharmacy risk stratification for pharmacy care management intervention based on identification of care gaps, potential medication non-adherence, polypharmacy, and potential over- and/or under-utilization.

Data generated through our Data Warehouse will be used to generate required reporting to the Agency, the Medicaid P&T Committee and DUR Board. In particular, we will be able to identify opportunities to manage preferred drug utilization, improve performance of the plan's proposed lock in program, and reduce costly over-utilization of controlled substances.

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GENERAL SUBMISSION REQUIREMENTS
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Drug Utilization Review Program --

Our multifaceted Drug Utilization Review (DUR) program ensures that prescriptions are appropriate, medically necessary, and unlikely to result in adverse medical consequences in compliance with the requirements in section 1927(g) of the Act and 42 C.F.R. part 456, subpart K. Through prospective/concurrent and retrospective DUR, our programs provide the control necessary to achieve optimal utilization management and enhanced financial control.

Our Pharmacy Director will participate in the Agency's DUR board meetings, initiate implementations and ensure submission of a detailed description of the Plan's DUR activities to the Agency on an annual basis.

For prospective and concurrent drug utilization review, we utilize CVS's Concurrent Drug Utilization Review (CDUR) program.

Concurrent DUR Program --

The CDUR program takes a comprehensive approach to helping network pharmacists identify and evaluate drug therapy related problems prior to dispensing. The CDUR program is designed to identify patient safety issues as well as possible misuse before a medication is dispensed through real time edits and alerts. CVS's claim system can perform up to 500 concurrent DUR edits on every prescription, in real time, to help ensure the prescription meets both administrative and Enrollee safety criteria. The system is designed to reduce wait time and help eliminate disruption for Enrollees. The CDUR program reviews the following areas:

- Conformity with Florida-specific requirements and health plan design
- Drug-allergy interactions
- Enrollee eligibility
- Drug-gender interactions
- Drug-pregnancy interactions
- Refill and dosage limits
- Dispensing accuracy and consistency
- High and low dose alerts
- Drug-drug interactions, including with behavioral-related drugs
- Therapeutic duplications
- Formulary compliance

These edits serve as job aids while still permitting pharmacists to override select DUR edits if deemed clinically appropriate or in consultation with the prescriber.

Retrospective DUR Program --

Retrospective DUR revolves around review and identification of potentially inappropriate medication utilization. This program acts as a "safety net" for serious drug interactions that may have a negative clinical impact on an Enrollee and were not addressed at the point of sale. It allows for a change in the prescription if such an interaction is detected after the Enrollee obtains the original prescription. Clinical staff review both mail and retail prescriptions within 72 hours after the claim adjudicates for potential safety issues that were not addressed when the drug was dispensed. Then, if needed, they message the physician via mail, telephonic, or direct

consultation with actionable Enrollee-specific communication that identifies the clinical issue and provides suggestions for improving medication therapy. The program will be managed by the Pharmacy Director, Pharmacy Analyst, and the Account Manager.

Components of the Retrospective DUR program will include:

• Identify potentially inappropriate or medically unnecessary prescribing and Enrollee drug utilization patterns (e.g. generic utilization, therapy duplication, over/under utilization, drug safety)
• -Identify those medications for other serious medical conditions (such as hypertension, diabetes, neurological disorders, or cardiac problems), where this is a significant risk to the enrollee posed by potential drug interactions between drugs for these conditions and behavioral-related drugs.
• Educate prescribers and pharmacists on identifying and reducing the frequency and patterns of fraud, abuse, or medically inappropriate or unnecessary care
• Achieve specific pharmacy utilization management and financial goals

Opportunities for Improvement --

On a quarterly basis, DUR reports are reviewed from CVS that combine all retroactive, point-of-sale, and detailed DUR edits from the previous quarter. These sophisticated reports provide an in-depth review of certain drug categories and outline opportunities for interventions, actions taken, and outcomes. We then review quarterly comparison reports to identify where there are opportunities for improvement through either new outreach methods, care management referrals, and targeted prescriber or pharmacy outreach using embedded pharmacists.

Medical Economics Review – Provider Profiling --

Through our Lighthouse analytic and actuarial group, we use the Identifi Analytics and Reporting tool to identify and address trends in both over and under-utilization of services through reporting and data mining, analyzing claim transactions, pharmacy claim data, eligibility files, authorization records and other ancillary records, such as historical claim data, laboratory results or immunization registry data. Our Cost and Use Report, on an inpatient and outpatient basis, profiles contracted providers to benchmarks and to similar specialty providers.

The key components of our Medical Economics Review process include:

• Cost and Utilization Assessment: Identify opportunities through setting and service category review and comparison to benchmarks, isolating the impact of cost versus utilization on overall trends, and drilling down to further explain trends and highlight opportunities for cost savings
• Population Assessment: Evaluate demographic characteristics and changes over time, assess enrollment trends, profiling high cost Enrollee characteristics and trends, measure chronic disease burden
• Provider Network Assessment: Analyze PMPM, utilization and Key Performance Indicator trends by provider practices and areas, drilling down on key focus areas, assessing in- versus out-of-network services
• Care Management Assessment: Summarize care management engagement rates and drill down to unengaged patients to identify root causes

The Medical Economics team uses the reporting in these key categories to determine which insights are actionable, and to recommend prioritization of actions.

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FWA – SIU Data Reviews --

Through our Fraud Waste and Abuse unit and our Special Investigations Unit, we help to identify aberrant trends in utilization. Lighthouse uses Optum Insight's analytic tool to identify provider and Enrollee outliers and allows for comparisons between peers. Enrollee emergency room data is also reviewed such that case management or care coordination can be offered to the Enrollees as needed.

Based on the findings from the analytic review, the FWA team may engage with the medical management team to review medical records. Our SIU unit will conduct investigations as warranted. Findings from this review and/or investigations, will be discussed with the Lighthouse Medical Director to determine next course of action. Once determined, findings and action will be shared with the provider and/or Enrollee. Should a provider want to further discuss a finding or provide additional information, the appeals process will allow them to do. Should an SIU investigation uncover nefarious activities, our health plan will report all findings to State, Federal or OIG investigators, as required by the contract, Section X. Administration and Management, Part F. Fraud and Abuse Prevention.

Additionally, through Optum Insight, we have access to national tracking and trending data from all 50 states. For example, if an FWA trend was identified in Iowa, that trend information could be applied to our Florida claim data and/or applied to the claim processing system configuration build. Application of this trending information in a proactive way helps manage the healthcare dollar. In addition, specific configurations based on Florida regulations or FWA findings can be built to in a proactive manner to prevent identified trends of FWA.

Lighthouse will work in a collaborative fashion with all State and Federal regulators in the identification, detection, prevention of any FWA activities.

Subcontractor Oversight --
Lighthouse follows a rigorous process to identify and select the best subcontractors. An entity under consideration for delegation must be audited by our representatives to validate their capabilities and financial stability. They must be judged to be compliant with our standards and with standards established by the NCQA. Our staff present pre-delegation audit results, indicating approval or denial, to the Delegation Oversight Committee. Upon successful completion of the pre-delegation audit and only with the approval of the Delegation Oversight Committee, the Contract Specialist executes a contract with the subcontractor.
We retain accountability for any delegated functions and services and monitor the performance of subcontractors responsible for UM functions through review of the following:

• A Utilization Management Program Description
• Quarterly UM statistics including number of determinations by type, number of denials by type and reason, and number of denials appealed
• An annual site audit conducted to review UM files (If the subcontractor is NCQA accredited, the required level of oversight is reduced. No annual onsite evaluation is required as long as the subcontractor remains NCQA accredited.)
• The subcontractor's URAC and/or NCQA accreditation award, if accredited

EXHIBIT A-4-a
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Lighthouse's Delegation Oversight Committee (DOC) is directly accountable to the of the Board of Directors through the Quality Management (QM) Committee. Enrollees of the DOC include Lighthouse's Medical Director, pharmacy, and compliance experts.

EXAMPLES OF OPPORTUNITIES FOR IMPROVEMENT

Controlling Growth in the Use of High-Cost Services --

In one of our Medicaid health plans, an analysis of paid claims data showed an increasing trend in in utilization per 1,000 Enrollees for advanced radiology services such as MRIs and PET scans. We implemented a High Dollar Radiology Program prior authorization process to address the increasing trend by:

- Requiring prior authorization of all advanced radiology services
- Educating physicians about the most clinically appropriate and cost-effective diagnostic testing for specific diagnoses
- Identifying and avoiding duplication of diagnostic services
- Providing targeted education to providers identified with over-utilization patterns to avoid a recurrence.

Our goals included reducing unnecessary radiation exposure to our Enrollees and reducing unnecessary expenditures. The first-year post program implementation resulted in a 14 percent reduction in use of advanced radiology procedures because we determined the service was inappropriate or not medically necessary. This equated to approximately $400,000 in savings to the plan each quarter.

Pharmacy Lock-in Program Helps Prevent Abuse and Misuse --

Since 2006, our team has experience using pharmacy lock-in protocols with one of our Medicaid health plans, placing an average of 1,159 Enrollees per year in a Pharmacy Lock-in program. The program has achieved an average pharmacy savings of $3,600 per lock-in Enrollee per year. In addition to lowering pharmacy costs, the program has also decreased general hospital utilization and costs with an average medical savings of $2,473 per enrolled Enrollee.

With the Agency's approval, we can implement a Pharmacy Lock-In program that will identify Enrollees who use an abnormal amount of controlled substances from multiple prescribers and providers. Our algorithm identifies Enrollees for the program based on their pharmacy, prescriber, and prescription patterns. Once identified by the data team, our Pharmacy department reviews the report and contacts the Enrollee and provider upon inclusion into the program. Enrollee can be restricted to one prescriber for controlled substances and one pharmacy. Dedicated coordinators work with Enrollees to educate them on the appropriate use of benefits and help them to connect with care managers to aid in accessing benefits and condition management.

We can customize the Pharmacy Lock-in program to address Florida's utilization patterns. We will submit specific Lock-In program protocols to the AHCA for review and approval.

Controlled Substance Safety Edits Reduce Enrollee Harms --

In 2016, out team recognized an opportunity to further improve the management of controlled substances beyond the standard requirements established by another State Medicaid program.

Through identification of controlled substance utilization patterns that suggested inappropriate use, the pharmacy team designed additional point of sale safety edits to evaluate the medical necessity for controlled substances. These safety edits identified instances of inappropriate combinations of opioids and central nervous system depressants, polypharmacy of controlled substances, use of multiple providers (pharmacies and physicians), duplicate therapy, opioid dosing greater than a 120-morphine equivalent dose, and treatment durations of short acting opioids. After six months of program implementation, the Medicaid plan experienced a 7% reduction in controlled substance costs, a 3.8% reduction in controlled substance utilizers, and a 4.7% reduction in controlled substance use. Overall, the program has improved the safe use of controlled substance through reduction of concomitant opioid-benzodiazepine utilization and shortening duration of short acting opioid therapy. The results of our program have been shared with another State's DUR subcommittee and we are actively working with the State to potentially expand the controlled substance safety edits to all the Medicaid plans supported by our Pharmacy Team.

Increasing Use of Outpatient Behavioral Health Services --

In one of our Medicaid health plans, the way the state Medicaid agency handled outpatient behavioral health services was through CMHC. No other outpatient provider types would receive reimbursement. Only 14 CMHCs existed throughout the state. Enrollees often did not want to utilize CMHCs due to access issues, reputational issues and perceived stigmas. Our health plan together with other health plans in the state, worked to have Medicaid revise provider participation rules to allow for the creation of a Behavioral Health Service Organization (BHSO). BH providers, who were not CMHCs, and who had a care team within their practice could apply for participation in the BHSO. Our plan helped providers understand the BHSO application process and all billing requirements via provider workshop, provider relations visits and website information. Once approved by the state, our plan then contracted with these providers thereby expanding access to care. With this expansion to greater outpatient care settings, more Enrollees could stay at home while participating in the more readily available outpatient treatment options. Our outpatient utilization nearly doubled from 2014 to 2016, while inpatient length of stay was reduced. Child and adolescent average length of inpatient stay declined from 11 days to 6 days from 2013 to 2016, while adult average length of inpatient stay declined from 6 days to 5 days over that same time period.

Evaluation Criteria:

1. The extent to which the respondent describes the process and data sources utilized to determine whether a service should be prior authorized, including reviewing complaints or feedback from providers regarding burdensome or unnecessary prior authorization criteria.

2. The adequacy of the processes used by the respondent to determine whether the utilization management criteria selected are appropriate and consistent with policy requirements for a Medicaid benefit.

3. The adequacy of the respondent's approach to ensure the consistent application of review criteria for authorization decisions (e.g., inter-rater reliability studies, and training for plan staff and network providers).

4. The adequacy of the review processes (data collection and analysis) deployed by the respondent to ensure services are not arbitrarily being denied or reduced.

5. The adequacy of the review processes (data collection and analysis) deployed by the respondent to identify aberrant utilization patterns (under and over utilization).

6. The adequacy of the respondent's approach in differentiating between UM protocols for authorization of services that are needed short-term (e.g., one-time authorization) vs. long-term (ongoing maintenance services/therapies).

7. The adequacy of the respondent's approach at ensuring continuity of care, particularly as it relates to special needs populations.

8. The extent to which the respondent provides a specific example of how its review processes resulted in successful interventions to alter unfavorable utilization patterns in the system.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
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SRC# 19 – Utilization Management – Ease of Use (Statewide):

The respondent shall describe the following related to its utilization management systems:

a. A description of how the respondent will ensure that the UM processes are designed so that service authorization requests are completed efficiently and with minimum administrative burden on network providers and enrollees;

b. A description of software capabilities that facilitate ease in requesting service authorization and support data exchanges between providers, subcontractors and the respondent (to the extent any UM functions are delegated);

c. A description of the respondent's experience meeting timeliness standards for service authorization requests;

d. A description of the approach that the respondent will use to educate enrollees and providers about the process for seeking authorization; and

e. A detailed workflow of how "special service" requests are processed for enrollees under the age of 21 years. Special services are requests that are made to the plan to exceed the limit on a Medicaid covered service or to cover a medically necessary service that is not listed in the Florida Medicaid handbooks/coverage policy or the associated fee schedule.

Response:

Lighthouse Health Plan (Lighthouse) will contract with experienced subcontractors to process service requests efficiently, with minimum administrative burden on network providers and enrollees, and in compliance with specified contract requirements. We will ensure compliance with all service authorization requirements through our delegated oversight process. Evolent Health provides a complete health plan infrastructure to support provider-led health plans such as Lighthouse including an NCQA-accredited utilization management (UM) program that meets all Florida Medicaid requirements. Evolent will process all service requests other than those managed by the subcontractors noted below:

- Access Behavioral Health - Behavioral health services
- Avesis – Dental, vision and hearing services
- One Call –Non-emergency transportation or NEMT
- CVS/Caremark – Prescribed drugs

Evolent will receive authorization data from other subcontractors into its Data Wearhouse where the data will be readily available to authorized users.

The design of the UM process is undertaken by the Lighthouse executive management team, inclusive of the Medical Director and in conjunction with the Utilization Management Committee (UMC) reporting to the Quality Management Committee (QMC). The UMC and QMC includes Lighthouse providers ensuring providers are represented in all decision making.

EFFICIENT AND STREAMLINED SERVICE AUTHORIZATION PROCESS

Lighthouse, with our subcontractor Evolent, will operate UM processes that are efficient, cost effective and aimed at the reduction of administrative burden for the provider and enrollee. We seek processes and technology solutions that promote interoperability and reflect our plan's medical management philosophy. The UM processes focus on physician-led care delivery and are designed to ensure appropriate service use, improve enrollee and provider satisfaction, and hold providers accountable for achieving quality outcomes. The processes take into account the daily needs of physicians and their teams, tailoring the service request submission and review process for convenience within the existing practice workflow reducing administrative burden. Referring physicians and specialists are involved in vetting, designing and ultimately approving the utilization review process.

Our UM Platform Provides Ready Access To Enrollee-Specific Information –

Identifi, Evolent's information technology platform, provides all authorized clinicians, utilization management, care management and provider staff, with the information needed to complete a review of service requests, including enrollee eligibility information, benefit information, authorization information, care management information and claims data.

Providers May Submit Requests in Multiple Ways –

We offer providers multiple ways to request an authorization through, our web-based UM portal, by phone or by fax and our subcontractors will also offer these options. Identifi UM is the web-based prior authorization platform for initial requests that includes a practice facing interface for service authorization requests submission and for submitting pre-service review requests of inpatient medical/surgical services.

Our UM portal is easy-to-use and features intuitive design. We display fields that are mandatory for completion and offer a guide that walks the provider through the submission process, explaining the information needed to complete a review.

We Offer Stream Lined and Auto Authorization for Certain Services and Providers –

Our processes support auto-authorization of specific services when certain criteria are met, streamlining authorization. For example, we can use the provider taxonomy code to auto authorize services commonly needed by specific types of providers for diagnostic purposes, such as a neurologist requesting an MRI. We can also create a "gold card" expedited or auto authorization process for key provider groups who meet specific quality, economic, and enrollee satisfaction benchmarks.

UM Staff Are Available 24 Hours A Day, Seven Days a Week –

Enrollees may need a service that requires prior authorization at any time and so we make UM staff available 24 hours a day, seven days a week to assist providers with their service authorization questions. Help line staff will connect providers to UM staff for prior authorization requests between the hours of 8 a.m. and 7 p.m. Monday through Friday excluding state holidays in the provider's time zone. On-call UM staff provide after-hours coverage, including on weekends and holidays, to help providers with prior authorization requests.

Our behavioral health subcontractor, Access Behavioral Health, provides authorization for behavioral health inpatient and other higher levels of care, psychological and psychiatric testing and electro convulsive therapy and will offer online submission through a UM web portal in 2018. Avesis offers a 24/7 IVR option and web portal for prior authorization request submission and assistance.

Proactive Outreach to Providers promotes Timely Review –

Our process includes proactive outreach to providers to obtain additional information when needed and coordination with the local care management team aligned with the enrollee's PCP to discuss the enrollee's service needs, including alternatives to more restrictive services for enrollees with complex conditions or disabilities. The local care management team may also work with the enrollee, family and PCP or make an in-person visit when needed to support a coordinated CM and UM decision.

In the event a reviewer determines a requested service does not appear to meet medical necessity criteria or he or she is unable to make a determination, the Medical Director performs a review and may call the treating provider to discuss the service request, gather additional information and make a final determination. In this way, we avoid administrative denials due to lack of documentation.

We understand we may not delay service authorization if written documentation is not available in a timely manner and will complete reviews in accordance with the Agency's specified timelines.

Periodic Review of Services Subject to Prior Authorization –

We periodically review the criterion used to determine the services subject to prior authorization and analyze claims, authorization or denial, appeals and grievance, and enrollee and provider survey data to identify opportunities to streamline the process. This review seeks to strike a balance between ease of use, appropriate service receipt and cost. For further description of the processes used to develop our prior authorization list, please refer to our response to SRC #18.

Seamless Integration of Information –

As we work with multiple contracted partners to perform UM, we will develop a strategy to collapse overlapping technology into a single sign-on UM authorization portal. Until that strategy is deployed, providers will work with multiple authorization portals/processes. All provider literature, including the provider manual and quick reference guides, will address these processes.

Using Information from Providers and Subcontractors To Enhance Care Coordination –

Timely access to service authorization data can help care coordinators and case managers more quickly identify changes in an enrollee's acuity or level of care, and initiate outreach, assessment and potential engagement in specific care management programs, such as complex care, transitions of care, or high-risk maternity care. As data from subcontractors is loaded to our data warehouse, it is incorporated into our identification and risk stratification process refining the enrollee's risk score triggering identification of appropriate clinical programs based on this risk score. The enrollee is then referred automatically to the care management staff to determine if the enrollee needs outreach to address a new condition or clinical need, enrollment into a specific

care management or disease management program, or enhanced care coordination. If the enrollee's risk level is rising, this also triggers analysis of what is driving this increase in risk, including gaps in care or a decline in the enrollee's health. Care managers initiate enrollee assessment or reassessment to identify any unmet or changing needs and to help close gaps in care. Care managers may also initiate case conferences with the enrollee, his or her family/caregivers, PCP, other treating providers and additional enrollees of the local care management team (such as the nutritionist, therapist or pharmacist) when necessary for enrollees with complex care needs.

SOFTWARE CAPABILITIES THAT FACILITATE SERVICE AUTHORIZATIONS AND SUPPORT DATA EXCHANGE

Identifi fully supports all medical management activities by providing staff and providers with the capability to perform all functions associated with medical management, including UM authorizations, discharge planning activities and care coordination and case management activities on a single platform reducing redundancies. Clinical staff can monitor authorizations, assign tasks across departments, and expedite reviews through the system as well. Identifi UM is a web-based, rules driven prior authorization platform used by both Lighthouse clinicians and providers. Identifi UM includes the following service authorization features:

- Easy to use authorization creation workflow for any staff at the provider's office.
- "Required fields" that are clearly defined so all medical information is captured at the time of authorization entry
- Built in logic enabling patient lookup, prior authorization policy check, and enrollee eligibility check
- Built in rules and criteria based on UM policies and customization to support auto- authorization, resulting in faster turnaround times for service request decisions
- Real time status of authorization requests

Identifi uses machine learning techniques to improve processes, continuously improving the auto-authorization rules bases on historical authorization data and trends. Our platform also supports integration of service authorization determinations with our claims processing system to support timely claims payments.

Identifi Practice, the provider-facing version of Identifi, is a web-based application offering providers the ability to participate directly in enrollee care management, view enrollee's care plans and UM authorization information, enter a UM authorization and manage gaps in care. Identifi Practice integrates with provider Electronic Health Record systems to promote data exchange, improving care efficiency and the accuracy of our risk stratification models.

BEHAVIORAL HEALTH

Access Behavioral Health will offer providers a web-based UM portal in 2018 for submission of service authorization requests in addition to their existing fax process with telephone support.

Prescribed Drugs --

Providers will be able to submit requests for physician administered drugs as well as outpatient medications through our web-based portal or by fax, phone, email and mail. Web-based submissions will be available via a prior authorization and formulary exception link available on

the Lighthouse website. Providers will also have the ability to submit prior authorizations requests using our end-to-end prior authorization solution which is integrated with the provider's EHR workflow. The ePA solution allows providers to respond to online questions sets based on medical policy and clinical criteria, receive a status on the submitted prior authorization or non-preferred exception request, and submit additional supporting documentation, as necessary.

Dental, Vision and Hearing Services --

Avesis offers an online provider portal for submission of dental, vision or hearing services requests with business hour call center and 24/7 IVR system help available to providers.

Non-Emergency Transportation (NEMT) --

One Call offers two electronic NEMT request options:

• Relay Transportation Web Application–The requestor can electronically submit a transportation request into the web application on their desktop computer.
• Electronic Referrals–The requestor can send an electronic referral via easyreferral® through One Call's website with the necessary referral information where it is retrieved and entered into One Call's system. Our online easyreferral® form guides users through the referral process ensuring fast, accurate referral intake.

Data Exchange --

Authorizations and claims from our contracted partners are loaded into the Identifi warehouse. Claims are visible to the clinical team in Identifi helping support coordination of care. We intend to develop the capability to integrate subcontractor authorization data feeds directly into Identifi Care, Identifi UM and Identifi Practice in the future.

EXPERIENCE MEETING TIMELINESS STANDARDS

Evolent and its partners have experience consistently meeting or exceeding State Medicaid programs' timeliness standards for service authorization requests:

• In a Kentucky plan with over 300,000 Medicaid enrollees, including enrollees with disabilities, timeliness standards have been met every year since 1998.
• In an Illinois plan serving over 140,000 Medicaid enrollees timeliness standards have been met between 99 and 100 percent of the time since program implementation April 2016, for routine requests (within five business days) and urgent requests (within two business days).
• In a Texas plan with over 50,000 Medicaid enrollees, including enrollees with disabilities, 100 percent of prior authorizations and concurrent reviews have been processed within the contractually-required timeframe of three calendar days, and one calendar day, respectively for five years.

EDUCATING ENROLLEES AND PROVIDERS ABOUT THE SERVICE AUTHORIZATION PROCESS

Enrollee Education About the Service Authorization Process: All newly enrolled enrollees will receive an AHCA-approved welcome kit that includes the enrollee ID card and Enrollee Handbook

that provides information about all covered services (including medical necessity definitions, prior authorization requirements, copayments, services limits, emergency guidelines, as examples) for physical health and BH services. The handbook includes a benefit chart and additional sections to explain covered services that are more difficult to understand or apply primarily to special populations.

Examples of specific information includes:
• Emergency services. Information about the definition of an emergency with examples. We make sure that our materials stress that there is no prior authorization required for emergency services, explain that use of out of network providers is covered in emergencies, includes information on how to access emergency services through 911 or the operator, and explains how to reach their PCP and how to use our 24/7 Nurse Line, also information about our Emergent Care programs.
• Post-stabilization services. Included is information that required services following an emergency do not require prior authorization, will be provided after the immediate emergency to ensure the enrollee is stable and may be provided in or out of state/network. We also include information about our Transitions of Care Program.
• EPSDT/Wellness. Targeted outbound calls for enrollees with care gaps and/or missed appointments will be made. EPSDT education also includes information about expanded EPSDT benefits for eligible beneficiaries based on EPSDT screenings. These may include home health, private duty nursing, adolescent counseling and other services.
• Behavioral Health and Substance Use Disorders. Information about all covered BH services pursuant to 42 C.F.R § 438.3 and the Mental Health Parity and Addiction Equity Act (MHPAEA) are included in our Enrollee communications. The Care Manager will discuss the availability of covered services to treat these and other behavioral health diagnoses as part of that education.
• Pharmacy Services. The preferred drug list, use of generic medication, and the process for obtaining prior authorization and delivery are included in this outreach. If enrolled in a care management program, enrollees will receive a medication reconciliation.

When first implementing a plan, the UM team spends extra time on the phone with providers explaining the prior authorization process and making sure they know where to access resource information as well as the prior authorization form. We have also implemented a transition period where we allow providers to learn the PA process for the first 30 days without denying services for late notification.

Enrollee Call Center: Because enrollees may call us with questions about service authorizations, we train our Enrollee Services Representatives on state -specific program requirements including covered services and prior authorization requirements, including how to request services (through the PCP or treating provider). Enrollee Services Representatives will inform enrollees about the services covered through our health plan; other Medicaid-covered services available fee-for-service, such as prescribed pediatric extended care (PPEC) services; and services available through other Medicaid delivery systems, such as certain home and community-based waivers or a prepaid dental plan. We also train Enrollee Services Representatives to escalate questions involving services for children or where the caller is asking clinical questions to their supervisor who works with the correct clinical team members to resolve the caller's issue, often a member of the UM team, in consultation with an enrollee's local care management team. Any on hold time will be used for educational messaging.

Enrollee Open Houses: Our Community Advocacy team will host a new enrollee open house to educate enrollees about our health plan. Topics include how to effectively use covered benefits,

work with your PCP, access NEMT, and use pharmacy benefits. Enrollee manuals will be made available.

Lighthouse Website: We will publish a Lighthouse website that contains all information necessary for an enrollee to navigate the health plan inclusive on how to establish care with your PCP/FQHC and work through the UM authorization processes of our health plan.

PROVIDER EDUCATION

Lighthouse uses a multitude of approaches when educating providers about our medical management processes and those of our subcontractors performing UM.

Provider Manual: Each provider approved for network participation receives a welcome letter which includes the Provider Handbook that describes our service authorization policies and guidelines. The handbook will also be posted on our website in a searchable format. Information on how to access the searchable provider directory will be included in the manual.

Town hall Meetings: Town Hall meetings are large group meeting that focus on all operational aspects of the health plan inclusive of a “tour” of the Lighthouse website, demonstration of the provider authorization portal, Identifi Practice and Identifi Care. Agenda topics vary and includes a high-level review of the Provider Handbook and will include a review of the prior authorization process and services requiring review.

Focused Training: For a period of at least twelve months following contract implementation, we will conduct educational sessions with a special focus on the top five provider types identified by our QI monitoring, claims review, and payment process review as the highest volume providers and providers who need specialized help, reviewing all operational aspects of working with Lighthouse. While the primary emphasis will be placed on appropriate claim processing, we will review all service authorization procedures as well. We want to ensure providers understand the linkage between service authorization and appropriate claim submission procedures, where applicable.

Provider Relations Team: Provider Relations Representatives will meet with providers in a small group, office setting within 30 days of placing a newly contracted provider or provider group on active status and then on an organized schedule. Utilization management-related training covers available resources, covered services and benefits, provider responsibilities, quality improvement, billing and payment, care management and disease management, appeals and grievances, pharmacy services, service authorizations and compliance. A demonstration of the provider portal and those of other subcontractors will also be offered.

Lighthouse Website: The website will contain instructions for PA process, the PA list (inclusive of CPT 4 codes) information on the UM authorization portal, links to our contracted partners websites and general contact information. As the UM process evolves or the PA list changes, we update the website

Fax Blast: For providers who prefer their information in paper format, we will fax blast the UM process or PA list changes.

Hold Time Messaging: On-hold messaging can be created that educates providers about the UM process or any forthcoming changes to the PA list.

Behavioral Health Services --

Our Provider Handbook will include information on how to access behavioral health services, the behavioral health subcontractor's authorization requirements and processes, and the supports available to enrollees and providers to support service authorization, including the subcontractor's call center and e-service.

At any time, treating providers or enrollees may request UM/clinical criteria pertinent to a specific authorization or benefit provision by contacting the Evolent UM team. Additional subcontractors post UM/clinical criteria and a description of their UM process in their provider portal, available free of charge. The Provider Handbook also describes how providers can gain access to clinical criteria and policies and procedures. The Handbook is updated annually and providers are notified of any changes accordingly.

Evolent is in the process of expanding its relationship with McKesson' InterQualTM to purchase a new module called InterQualTM Transparency. This gives providers access to criteria that are critical to their practices in an intuitive, reference-only format via our provider portal. Physicians can simply log into the portal and click the link for InterQualTM Criteria. The criteria subsets that our health plan uses appear in an easy-to-navigate screen display.

EPSDT SPECIAL SERVICE REQUESTS PROCESS

We recognize the critical role that special services covered under EPSDT play in providing any medically necessary health care that falls within the scope of services listed at 42 U.S.C. § 1396d(e) to a child, even if the service is not available under the State's Medicaid plan.
We have a process in place to ensure compliance with this regulation and to ensure that special services under EPSDT are authorized and not erroneously denied as non-covered services.

We operate a user-friendly service authorization submission and determination process. The UM team is trained to review all requested services for medical necessity for enrollees under the age of 21. Like all prior authorization requests, requests for EPSDT special services originate with a provider request submitted online or when necessary, via phone, fax, or mail. Intake staff will route the request to a clinical reviewer, as applicable to the type of service requested, who initiates the review process.

The reviewer confirms the enrollee is under 21 years of age on the date of service and then reviews the submission for completeness. He or she contacts the provider if additional clinical documentation is required for the review determination. The reviewer documents pertinent clinical information in the UM system, including, but not limited to the enrollee's:

- Age
- Diagnosis (primary and secondary)
- Signs and symptoms – subjective and objective
- Medical history, including a history of the presenting problem
- Test results
- Treatment plan related to the request
- Psychological history

• Information on consultations with the treating provider
• Cultural and linguistic barriers
• Psychosocial information

The clinical reviewer:
• Reviews available clinical information (described above) to support the appropriateness and level of service or treatment proposed, including care management (case management, care coordination and disease management) information documented in the UM system
• Reviews coverage criteria and guidelines including nationally recognized criteria sets and state-specified criteria. National criteria sets include InterQualTM Criteria, Florida Medical Necessity Criteria for behavioral health services or ASAM criteria for substance use disorders. State-specified criteria include the criteria contained in a state's Medicaid statutes, rule, policies, managed care contract and other documents specified by the state.
• For inpatient hospitalizations, nursing facility and other post-acute care stays, reviews for appropriateness of stay and goals set for discharge.
• Contacts and collaborates with the local care management team to obtain additional information about the child, including information obtained during care coordination and care management interventions. A member of the team may also visit the child to gather in-person information and contact external case managers or case workers or others involved in the child's care.
• For children with complex care needs, the reviewer may convene a multidisciplinary case conference with the local care management team, the child or adolescent and family, involved providers, external case managers and others as applicable, to identify the needed specialized services that in combination with other available services and supports will meet the child's needs.
• During the review and prior authorization process, if the child is not enrolled in a care management program and could benefit from additional support from a multidisciplinary team, the UM team will refer this child to the care management team for outreach to the parent or guardians for permission

If the reviewer is unable to make a determination to approve the requested service her or she refers the request to the Medical Director. During this review process our physicians look at the standards of care, clinical research, state and federal guidelines and if applicable complete a peer to peer discussion. If the service is approved, the reviewer or Medical Director (depending on who made the determination) faxes the approval to the PCP, requesting provider (if applicable) and mails the approval letter to the parent or guardian.

If an adverse determination is made, regardless of the type of service requested, the enrollee, PCP, ordering/rendering provider and the facility rendering services, if applicable, are notified in writing. In addition, we notify the requesting provider via phone of the denial and provide information about how to request a peer to peer review or initiate an appeal.

Behavioral Health Services –

To obtain prior authorization for any otherwise uncovered mental health services requested for children under 21 years of age, the provider calls the Access Behavioral Health team to request prior authorization. The Access team uses National Medical Necessity Criteria or ASAM criteria for substance use disorders to determine if the enrollee meets criteria for the requested uncovered service. The Access team will also contact the local care management team to obtain additional information about the child to ensure the determination considers the request within the context of all of the child's needs and authorized services. If the uncovered service is experimental, the

Medical Director will review the case to ensure the service is appropriate for enrollee. If the uncovered service is non-experimental, medical necessity criteria will be applied.

CARVED OUT SERVICES

If we receive a request for a service that is carved out, including a request that might constitute "special services" under EPSDT, our clinical team will contact the appropriate entity such as the QIO or a prepaid dental provider, and forward the request, providing relevant enrollee-specific information as authorized by the child/family. We will cooperate with subsequent requests for information and coordinate any authorized, carved out special services with the child's covered services and supports to ensure the child's needs are met.

Evaluation Criteria:

1. The extent to which the respondent proposes the use of interoperable systems that will seamlessly integrate information from providers to the respondent and its subcontractors (to the extent any UM functions are delegated) and the extent to which the respondent describes how that information will be used to enhance care coordination services and to ensure there are no delays in authorization or gaps in care.

2. The extent to which the respondent uses strategies to reduce administrative burdens for the provider (e.g., software capabilities) in requesting authorization and its approach is streamlined with little to no redundancies between and across departments which could contribute to delayed service authorizations.

3. The extent to which the respondent has demonstrated experience with meeting timeliness standards for service authorization requests.

4. The adequacy of the respondent's education and training plan providers on the service authorization processes.

5. The extent to which the respondent ensures transparency in service authorization processes (e.g., makes available all utilization management protocols and criteria in an accessible location for service providers).

6. The extent to which the workflow describing the respondent's process for handling "special service" requests is consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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SRC# 20 – Care Coordination (Statewide):

The respondent shall describe its approach for identifying, assessing, and implementing interventions for enrollees that present with the following:

- Complex medical and/or behavioral health needs;
- High service utilization;
- Intensive health care needs; and
- Consistently accessing services at the highest level of care.

The respondent's approach shall include:

a. A description of the algorithm used to identify and stratify eligible enrollees by severity and risk level;

b. A description of minimum contact frequencies and contact type for each severity and/or risk level;

c. A description of the maximum caseloads for each case manager (ratio requirements) and support staff;

d. A description of evidence-based guidelines utilized in the care coordination approach, including interventions deployed to improve enrollee engagement and improve treatment adherence; and

e. A description of performance metrics used to evaluate the efficacy of the care coordination, including cost-savings, reduction in the use of higher cost services, etc.

Response:

Baptist Health, as the provider sponsored organization for Lighthouse Health Plan (Lighthouse), will leverage Evolent's Care Management model to identify, assess and implement interventions for enrollees with complex medical and/or behavioral health needs; high service utilization; intensive health care needs; and/or who are consistently accessing services at the highest level of care. Baptist Health has implemented several programs that target patients with complex needs or who are high cost to support improved coordination of their inpatient care and discharge, including:

• Our post-acute hospitalist program, staffed by an internist, geriatrician and seven advanced practice nurses covering nine facilities focus on managing patent's length of stay to transition patients home or to the next level of care as expeditiously as clinically appropriate. This program has not only reduced lengths of stays but has steadily increased the proportion of patients discharged directly home, from 23 percent in the second quarter of 2015 when we started this program, to 78 percent in the third quarter of 2017.
• Screening patients before discharge using the LACE index that identifies patients at risk for readmission or death within 30 days of discharge. We deploy inpatient care coordinators to work with patients who score greater 13, scheduling a follow-up visit before discharge and helping to arrange transportation when needed. The care coordinators have access to the outpatient EHR

to support on-demand scheduling. For patients discharged to palliative care, the care coordinators arrange a post-discharge home visit from the post-acute hospitalist program advanced practice nurse to ensure the patient and family/caregiver understand the patient's care and emotional support needs.
• Baptist tracks frequent ED users and intervenes to keep them out of the hospital through their LEAP (Linking, Engaging, Accessing, and Planning) program. Baptist's care coordinators will be able to connect Medicaid-eligible ED users to the local care management team while the enrollee is in the ED, and arrange an in-person visit with a Lighthouse care manager. Navigators work with individuals while at the ED coordinating appointments with specialists, transportation and home health agencies, and work closely with the Escambia Community Clinics (ECC) social workers to address the needs of Medicaid or uninsured patients served at an ECC clinic.

Building on Baptist's local experience and Evolent's model, we will implement a comprehensive approach that spans the entire continuum of care. The Care Management model is based on proven Population Health techniques that integrate physical health and behavioral health services and recognize that a person's total needs, including social support needs, must be met if meaningful gains are to be made in improving a person's health and functional outcomes. Key features that distinguish this model from other managed care models include:

• A proprietary identification and risk stratification tool incorporates multiple social data sets, as well as claims, clinical and electronic health record (EHR) data, supporting identification of enrollees at higher risk because of the combination of health and social factors. This predictive model has a higher reliability rating than other industry-leading models.
• A key feature of this model is identifying enrollees with anticipated high future costs (who have "rising risk") and impactable conditions for care management, in addition to enrollees with chronic conditions or high service use, expenditures or levels of care, allowing us to intervene early and change the enrollee's trajectory.
• Interventions focus on the factors most likely to improve an enrollee's health outcomes and quality of life: enrollee education on self-management, primary care provider (PCP) engagement and support, and coordination of the enrollee's services and supports that address identified health needs and social determinants of health. Our model includes local, multidisciplinary care management teams aligned with specific PCPs and their patients, and embedded in high volume practices, that support the PCP/enrollee relationship and implementation of the PCP's treatment plan.
• This integrated approach brings care management teams, providers and utilization management (UM) staff together working on a single platform, Identifi, which includes care management, utilization management and provider-facing applications with available EHR integration. Identifi supports real-time communication, alerts and information sharing across providers, settings and levels of care.

The care management approach integrates physical health, behavioral health and social interventions, assigning enrollees to a local care manager most qualified to meet their needs. For example, enrollees with primarily medical needs have an assigned nurse care manager, those with primarily behavioral health (BH) needs, a BH care manager and enrollees with a high-risk pregnancy, an obstetrical (OB) nurse care manager. Care managers with pediatric experience work with children and their families and caregivers.

Care managers work as part of the local multidisciplinary team aligned with an enrollee's PCP. This team of nurse and BH care managers, social workers, health educators and community

health workers (CHWs) have access to an extended team of pharmacists, nutritionists (Registered Dieticians) and other clinicians who work together with the enrollee's PCP and specialty providers to meet the enrollees needs holistically. The local care management team provides in-person outreach, in-home service coordination, community resource referrals, and other care coordination activities.

The local care management team will work closely with our network providers, including Patient Centered Medial Homes (PCMHs) such as Escambia Community Clinics (ECC), that is certified as a Level 2 PCMH. ECC has implemented standardized order sets to streamline testing and referrals for patients with certain diseases, such as diabetes, and is conducting daily huddles to identify patients with care gaps, ED use or who have been discharged from the hospital. The combination of Lighthouse's and ECC's chronic condition clinical management will enable us to rapidly engage Lighthouse enrollees in multidisciplinary care that includes highly coordinated physician treatment, care management and disease management. In addition, Lighthouse's local CHWs will work in the community with hard to reach or hard to engage enrollees, coordinating their outreach efforts with vital community providers like ECC.

We propose exploring the use of Congregational Liaisons with the Coalition of Pastors who meet monthly to share ideas on health care and how to support their congregant's healthcare needs. The Congregational Health Network at Methodist Le Bonheur Healthcare in Memphis educates parishioners from the African-American community to serve as volunteer health liaisons helping fellow parishioners discharged from the hospital who need post-discharge support. The Congregational Liaison is teamed with a hospital navigator who completes the transition plan and initial visits post discharge. The volunteer helps follow-up on scheduling appointments and services. In addition to connecting enrollees with Congregational Liaisons post-discharge, we believe the liaisons can serve a valuable role locating and helping us to engage enrollees who may otherwise be reluctant to speak to us.

Because Faith Based Organizations (FBOs) serve a vital role in many communities, we also plan to offer training to interested volunteers on evidence-based programs like the Stanford developed Chronic Disease Self-Management Program (CDMSP) and other health and wellness programs. We would bring certified CDMSP trainers, for example, to the community to provide training, organize classes and oversee implementation.

Through Lighthouse's care management programs, Baptist Hospital will be able to extend the reach and impact of their inpatient and ED support programs through direct connection to the local care management teams. For example, Baptist tracks frequent ED users and provides care coordination through their ED navigation program. Baptist's care coordinators will be able to connect Medicaid-eligible ED users to the local care management team while the enrollee is in the ED, and arrange an in-person visit with a Lighthouse care manager.

CARE MANAGEMENT PROGRAMS

Each care management program is designed to:
• Improve enrollees' care coordination in collaboration with their PCP and other treating providers, including behavioral health providers when applicable
• Improve enrollee's medication adherence and educate enrollees about their medications
• Educate enrollees about their specific conditions, interaction with co-morbidities, "what to watch for" and as applicable, relapse planning

• Collaborate with PCPs to reinforce enrollees' care plans and PCPs' and other treating providers' treatment plans
• Collaborate on developing an enrollee's self-management plan
• Address enrollee and caregiver needs to make sure there is adequate support and resources at home
• Engage other members of the care management team as needed to address enrollee's comorbid or complex conditions, specialty drug needs, dietary needs and in-home support needs
• Link enrollees to local agencies and community-based programs

A primary focus of all clinical programs is enrollee self-management through enrollee education, modeling and teach back. We help enrollees and their caregivers gain critical self-management skills employing evidence-based teaching methods, while considering their readiness to assume responsibility, the complexity of their health and social support needs, and resources. Care managers prioritize focus on those conditions and needs of priority concern to the individual, which may be social supports, such as housing, rather than health care-related.

Program goals and objectives are customized by program but in general include:
• The enrollee demonstrates knowledge of his or her condition(s) and self-management or recovery plan
• The enrollee has maintained or improved their health and functional status
• The enrollee has an established relationship with their healthcare management team and community based support services, and knows how to navigate these services
• The enrollee follows his or her medication regimen, as prescribed
• The enrollee has completed specific health care activities including wellness care as well as activities specific to their conditions (such as lab testing related to the use of certain medications)

We also leverage technology to support communication between the enrollee and local care management team, health education and self-management.

Lighthouse will provide enrollees with access to our comprehensive enrollee-facing Mobile application, Identifi Engage. Identifi Engage is a secure mobile application that encourages convenient communication between enrollees and care teams while limiting interruptions in enrollees' daily lives. Identifi Engage will be used to:
• Locate a Network Provider
• Schedule Appointments with Providers
• Receive timely counsel from members of their care team
• Enable care teams to proactively communicate with Enrollees
• Foster prompt coordination among the extended care team; case managers, nutritionists, pharmacists, etc.
• Support secure communications between care teams and enrollees
• As a supplemental communication channel for Enrollees (especially those who are harder to reach via telephone / mail).

Lighthouse will offer free cell phones with unlimited text messaging including Android smart phones. Through text messaging, enrollees will receive health information and educational messaging, including child development information from birth until a child is three years old, appointment reminders, and recommended exams, screenings and vaccinations. Enrollees will also be able to refill medications through Baptist's Pharmacy benefits Manager, CVS Caremark Text to Refill program.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We recognize that a growing body of research demonstrates the important link between health outcomes and social factors such as income, educational attainment, and access to food and housing. We will therefore deploy the Healthify social and community resource solution designed specifically to address enrollees' social determinants of health. Healthify will provide our care managers and care navigators with access to a powerful database of social and community resources. Care team members will search the Community Resource Network to find new services, filter through the resource and eligibility taxonomies, and ultimately refer patients to the best programs and community services for managing their social and behavioral health needs.

The care management model includes longer term and episodic care management programs and care coordination designed to meet the needs of enrollees with different levels of risk or condition severity. All our care management programs adhere to our population health model that provides enrollees with integrated physical health, behavioral health and social supports using evidence-based practices.

The programs are based on ongoing analysis of specific populations and the interventions that are most effective and efficient in maintaining or improving a populations' health outcomes. Programs vary by target population and program focus and may be defined to meet state-specified requirements when applicable.

Enrollees are identified for enrollment into specific care management programs through the predictive modeling and risk-stratification process and from referrals. We encourage enrollees, family members and caregivers, internal staff, and providers to refer any enrollee for care management who they believe will benefit from our programs. The target population and focus for each of our care management programs are summarized below.

Care Management Hierarchy –

Because enrollees may meet the targeting criteria for more than one care management program, we use an enrollment hierarchy, from the most intensive to less intensive program -
- Complex Care
- Catastrophic Care
- Advanced Illness Care
- High-Need BH Care Management
- Care Management for Members with Special Health Care Needs
- Lower-Need BH Care Management
- Condition Care (DM)
- Care Coordination

Enrollment in longer term care management programs is suspended if an enrollee has an episodic need – for instance, the enrollee needs transitional care or has a high-risk pregnancy. Following completion of an episodic program, we reassess and re-stratify the enrollee to ensure they are re-engaged in the appropriate program.

Care management programs are summarized below.

Longer-Term Care Management Programs –

Complex Care: We enroll enrollees of all ages identified through risk stratification as having "rising risk" into Complex Care. These enrollees are high risk for a future inpatient admission or emergency department (ED) visit that can be avoided with the additional support from a nurse or behavioral health care manager, as applicable. Enrollees stratified at this level can learn and use self-management skills. Children have an assigned nurse or BH care manager with pediatric experience who works closely with the child's family and caregivers.

Catastrophic Care: Catastrophic Care enrolls enrollees of all ages who experience a catastrophic critical event or diagnosis that causes an immediate impact on their ability to function independently. Most enrollees are identified for Catastrophic Care proactively through the UM team during multidisciplinary rounds and are in an inpatient setting at the time of identification. These enrollees benefit from coordination of home care, DME, and specialist services prior to discharge to support transition home and adjustment to their change in functional status. Infants discharged from the NICU with multiple complex needs are included in this program with support provided by a pediatric nurse care manager.

Advanced Illness Care: We enroll enrollees of all ages with a diagnosis consistent with end of life in Advanced Illness Care. Nurses and social workers support enrollees with symptom management, service coordination at the end of life, and advance directives.

High-Need Behavioral Health Care Management: High-Need BH Care Management enrolls adult enrollees who have a serious mental illness or children with a serious emotional disturbance and co-morbid conditions that significantly impair functioning. A BH care manager works with enrollees, or the child and family, to develop a recovery and resiliency plan, provide intensive coordination of all the enrollee's services and social supports, and to ensure the enrollees complex and co-morbid needs are addressed. An RN assesses enrollees for co-morbidities and completes medication reconciliation. Enrollees receiving Targeted Case Management (TCM) from a mental health provider will be co-managed. Our care managers will participate in multi-disciplinary care rounds, providing notifications for admissions alerted through Admit, Discharge, Transfer (ADT) feeds, serving as a liaison between the mental health provider and PCP, and performing medication reconciliation activities.

Care Management for Members with Special Health Care Needs targets enrollees of all ages who require intensive and enhanced care coordination from a clinical team that includes nurse care managers, social workers, care coordinators, dietitians, and pharmacists, to meet enrollees' complex health care needs. This includes coordination of skilled nursing facility services and private duty nursing services. The clinical team has access to therapists (speech, physical therapy and respiratory therapists), BH clinicians, a DME specialist, Community Health Workers and care coordinators designated as waiver or foster care specialists. The clinical team works together to support nursing facility care, and when feasible discharge and transition home or to another community-based setting, arranging in-home and other covered services and coordinating carved out services such as Prescribed Pediatric Extended Care (PPEC).

Lower-Need Behavioral Health Care Management: A BH specialist or social worker helps link enrollees, including children, who have a primary BH condition that does not meet the criteria for a serious mental illness or serious emotional disturbance to a BH provider and coordinates these services with the enrollee's PCP.

Episodic CM Programs –

Maternity Care Program: All pregnant enrollees are enrolled in our Maternity Care Program and stratified into low, moderate or high-risk groups. Women at all levels of risk receive outreach, educational materials and care coordination throughout their pregnancy. Pregnant women stratified as high-risk have an assigned Maternity Care Manager who provides personalized care management interventions working closely with the woman's OB provider and PCP, and coordinating needed services, including specialty care, home health services, and community resources as applicable to her specific needs. Women may also be referred for Maternity Care Management by their OB provider, by self-referral, or from other internal and external sources.

A dedicated team of Maternity Care Managers and support staff work with obstetrical clinicians, Health Start Coalitions, Women, Infant, and Children (WIC) programs, local health departments, home health agencies, and others to identify and meet pregnant enrollees' psychosocial, nutritional and educational needs. We enroll women with identified high-risk conditions – based on the provider's completed assessment or plan outreach –into the high-risk component of our program. We assign to each identified woman a local Maternity Care Manager who promotes access to prenatal services, coordinating all covered and non-covered services and connecting women to community supports.

Our program seeks to reduce the incidence of preterm deliveries, increase compliance with a schedule of appropriate prenatal visits based on gestational age and risk factors, increase compliance with evidence-based maternity care guidelines and decrease the incidence of elective (non-medically indicated) delivery at less than 39 weeks gestation. Our model includes embedded Maternity Care Managers in high-volume or high-risk OB practices that serve primarily Medicaid recipients to further enhance identification and engagement of women with high-risk pregnancies.

Transitions of Care is our program supporting enrollees of all ages admitted to an inpatient facility identified through risk stratification as at-risk of readmission. Identification includes consideration of social determinants of health. Enrollees may also be enrolled upon referral from a nurse or BH care manager and/or the hospital discharge planner when enrollees lack natural supports in the home, there are barriers to linking the enrollee back with his or her PCP, or there are other factors that could increase the risk of ED visits or readmission. The approach to transitions of care employs rigorous population health principles and evidence-based transition models, including Project RED and Coleman's Care Transition InterventionTM practices and adopts elements from the National Quality Forum (NQF), "Safe Practice" or SP-11, an integral part of reducing readmissions and ensuring safe and effective transition from the inpatient setting.

Our approach to transitions of care includes:
• Identifying an enrollee's risk of inpatient readmission using our predictive modeling and risk stratification algorithm to initiate the care management process (this is true regardless of where an enrollee is admitted to hospital from; home or NF as an example). Our proprietary predictive model is multi-factorial including key enrollee conditions and illness burden, medical expense, and key readmission risk criteria (i.e., ED visits, previous inpatient admissions, pharmacy trends, and social determinants of health).
• Assigning enrollees at risk of inpatient readmission and enrollees transitioning from a nursing facility (NF) rehabilitative setting to home, a nurse or BH care manager, as applicable to the enrollee's primary needs, who coordinates the enrollee's transition as part of the local, multidisciplinary care team aligned with the enrollee's PCP and hospital.

• Providing enrollees at low risk of inpatient readmission or who decline care management, care coordination assistance from the embedded care team or Community Health Workers (CHWs).
• Coordinating transitions from inpatient to NF rehabilitation settings through close collaboration between our Utilization Review (UR) clinicians and facility discharge planners, including embedded UR clinicians at high volume hospitals.

Care Coordination --

Enrollees not otherwise identified for a care management program receive care coordination delivered by CHWs working with other members of the local care management team including RNs and social workers when needed. Care coordination is an important component of all care management interventions and includes addressing barriers to care like transportation, adequate housing, and nutrition needs. Care coordination focusses on:

• Connections to school-based, community, and state agency resources
• Health behaviors - interventions encourage enrollees to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use).
• Psychosocial issues – interventions address factors that impact an enrollee's adherence to the healthcare plan, such as social, emotional, or financial barriers.
• Caregiver support – interventions support caregiver's emotional resources, providing external/ community based resources such as caregiver support groups, respite, and development of coping skills.

Examples of specific care coordination activities include:

• For enrollees who are homeless – linking enrollees to housing and other services. Enrollees are identified through staff collaboration with shelters or from the state enrollment file. The care management team social worker assesses the enrollee's needs, particularly substance use and mental health needs, and depending on his or her findings, may refer the enrollee for enrollment in care management and/or to community BH providers. CHWs coordinate access to housing and other essential supports.
• For enrollees with an HIV diagnosis and receiving treatment, or with other complex or strictly regulated medication regimens such as Harvoni for hepatitis C. The CHW supports the enrollee's adherence to the treatment plan and connects the enrollee to the care management team health educator for self-management support and education as needed.
• For enrollees with avoidable ED visits: The CHW educates the enrollee about the appropriate use of the ED and alternatives to the ED, helps the enrollee reconnect with their PCP, helps schedule preventive care and arrange transportation, and may accompany an enrollee to an appointment when needed to help the enrollee complete timely preventive care.
• For children and adolescents in Foster Care/Guardianship identified by the state as an enrollee placed out of home. The care management team social worker completes an assessment and care plan to support the foster parent/guardian in providing care, removing barriers to treatment and ensuring communication between providers.

Condition Care (Disease Management) –

Enrollees with a single, primary chronic condition are enrolled in our DM program, Condition Care. Health coaches educate enrollees about their condition and support self-management, help close care gaps and promote compliance with the provider's treatment plan. We offer Condition Care

for enrollees with a primary single diagnosis of: asthma, cancer, COPD, diabetes, heart failure, hypertension or who have a BH diagnosis of anxiety, depression or substance use.

Enrollees stratified as low-risk receive targeted condition-specific informational materials and health coaches monitor the enrollee's service use to identify care gaps, intervening with the enrollee and his or her provider to close these gaps. In addition, the health coach makes outreach calls to low-risk enrollees when they identify a change in the enrollee's health status, such as an inpatient admission, to determine the need for more intensive intervention and support.

Health coaches work telephonically with enrollees stratified as having moderate risk, their caregivers and family members, PCP and other providers as applicable, delivering evidence-based interventions that:
• Educate enrollees on their targeted conditions, overall health and self-management
• Support the enrollee's behavior change
• Reduce the incidence of complications
• Improve physical functioning
• Improve emotional well-being
• Support the provider/enrollee relationship
• Emphasize and reinforce provider's use of clinical practice guidelines

The health coach:
• Delivers self-management training through personalized enrollee interventions documented in an enrollee Action Plan
• Collaborates with the enrollee's PCP and specialists to reinforce treatment plans
• Provides feedback to enrollees and the enrollee's PCP and other treating providers on specific chronic management issues and successes
• Coordinates referrals to other clinical programs when enrollees experience heightened acuity
• Collaborates with the local, multidisciplinary care management team to coordinate access to community-based resources and to provide in-home health education and support when needed
• Identifies available community evidence-based support programs, like the Stanford Chronic Disease Self-Management Program or CDMSP.

The health coach works with an extended team of nurse care managers, BH specialists, nutritionists, and pharmacists who provide consultation and support specific to Condition Care as needed. In addition, the health coach coordinates the enrollee's self-management and related interventions with the local, geographically-aligned care management team aligned with the enrollee's PCP. The team includes licensed RN and BH care managers, CHWs, dietitians, pharmacists and health educators hired from the local community who collaborate to make sure enrollees are connected to their PCP and care is closely coordinated for maximum effectiveness. When the health coach determines an enrollee would benefit from an in-home assessment or other outreach visit, he or she coordinates outreach from the local CHW, nurse care manager or BH care manager, depending on the enrollee' specific needs. The local care management team may also help identify and coordinate access to community resources that support the enrollee's Condition Care Action Plan.

Coordination among health coaches and the extended Condition Care team, local care management team enrollees, utilization management and other internal staff is supported by our sophisticated technology platform, Identifi, that aggregates all available data, to provide authorized users, including the enrollee's PCP with a comprehensive enrollee profile and real-

time health management platform. The data can also seamlessly integrate into the provider's electronic medical record system.

Enrollees with targeted chronic conditions, including comorbid conditions, stratified as high risk or having "rising risk" are enrolled into the previously described care management programs. All our care management programs include the essential elements of disease management including enrollee education, self-management support and coordination in support of the provider's treatment plan.

IDENTIFYING ENROLLEES FOR CARE MANAGEMENT

We identify enrollees for care management engagement using a variety of methods, including from claims and other data analysis, predictive modeling, and internal and external referrals. Enrollees may be identified based on diagnosis (e.g., have a serious mental illness), service utilization characteristics (e.g., high service utilization, frequent inpatient use), risk (e.g., predicted to be high-cost in the future) or from a combination of these factors.

Our algorithm identifies enrollee/program matches and applies the care management program hierarchy enrolling the enrollee in the most intensive program for which they qualify. Our algorithm is highly sensitive to the challenges Medicaid enrollees face daily and is described in detail in our response to Item b in this section.

In addition, we accept internal and external care management referrals: the local care management team identifies the most appropriate program for each referred enrollee based on information from the referral source (PCP, family member, 24/7 Nurse Line staff, UM staff, hospital discharge planners, pharmacy, and others) and a review of available data. Enrollment is subsequently confirmed during the first outreach call and enrollee assessment. The assigned care manager:

- Obtains the enrollee's verbal agreement for program participation
- Completes a comprehensive enrollee assessment to identify the enrollee's needs and the most appropriate program to meets these needs

If an enrollee declines enrollment, we look for other opportunities to engage the enrollee through less intensive programs such as Condition Care (DM) or Care Coordination, although enrollees may decline participation at any time. Our objective is to meet the enrollee wherever he or she is, establishing an ongoing and supportive relationship, and helping the enrollee address the needs of priority importance to him or her. For those enrollees who decline participation we will work with the PCP to encourage participation, as well as include them in the monitoring process for these enrollees.

ENROLLEE ASSESSMENT

All enrollees enrolled into a care management program and who agree to participation receive a comprehensive assessment of their needs, barriers, and preferences to inform the development of a personalized care plan and for enrollees with a BH diagnosis recovery/resiliency plan.

Assessments are completed telephonically or when needed, in-person, and may include a family member or caregiver when an enrollee authorizes this or when an enrollee is unable to complete

an assessment without assistance. We use a single, comprehensive assessment tool with branching logic that includes evidence-based modules.

The initial assessment includes, but is not limited to, the following:
• Home/living situation
• Clinical history, including medications
• Health status, including medical and behavioral health condition-specific issues
• Current providers
• Activities of daily living and cognitive functions, needs, preferences and barriers
• Mental and social-economic health status needs, preferences and barriers
• Life-planning activities such as living will, advance directives, and power of attorney
• Cultural and linguistic needs, preferences, or limitations
• Visual and hearing needs, preferences or limitations
• Health beliefs and behaviors including smoking, diet and exercise
• Caregiver availability and involvement
• Available benefits, governmental programs and community resources
• Personal safety
• Need for long term services and supports (LTSS)

The assessment is housed in our clinical documentation system that automatically suggests evidence-based assessment modules such as the PHQ2 and 9 and medication adherence assessments, based on the enrollee's responses. The assessment results help the care manager confirm the enrollee's initial stratification level and recommended CM program is appropriate (or identify the alternative CM program assignment based on identified needs) and forms the basis for the development of a personalized care plan.

Enrollees engaged in transitional care management or the high-risk component of maternity care receive a customized assessment that incorporates situation-specific information from UM staff, such as an enrollee's hospital discharge plan, and the enrollee's treating provider, such as a pregnant woman's ACOG assessment.

Interventions –

The assessment results drive development of an automated care plan in Identifi Care that is customized by the care manager to reflect each enrollee's personal needs and goals.
Our programs for high risk populations have been designed for Medicaid enrollees combining Medicaid care management delivery experience with the latest population health evidence-based practices and building on a foundation of fully-integrated care management and care coordination. Our care management approach includes:

• Identifying barriers to meeting goals and complying with the care plan;
• Developing follow-up coaching/care coordination encounter schedule with the enrollee;
• Developing and communicating enrollee self-management plans;
• Continuously monitoring the progress against care plans;
• Identifying gaps between recommended and provided care;
• Proposing and implementing interventions to close care gaps;
• Reevaluating the enrollee's care needs and adjusting care management intensity; and
• Identifying a graduation date and plan, when applicable.

The Identifi Population Health Platform provides a structured, reportable module that tracks problems, goals, interventions, barriers, and enrollee strengths. We train Care Management Team enrollees to use SMART goals (specific, measurable, achievable, and time based or trackable) to ensure a uniform approach to goal setting. This core work between the enrollee and Care Management Team automatically populates the care plan using enrollee-friendly words. For sensitive topics or when privacy is a concern, the Care Management Team can "hide" one, partial, or all information. At a population level, this information is aggregated to proactively identify common themes such as transportation barriers or common focus areas such as weight loss and drive quality improvement activities.

Our care management model not only designates the enrollee's PCP as the physician who will manage and coordinate the enrollee's overall care, but also brings the PCP into the geographically-based local care management team aligned with specific PCP practices. Care managers assigned to specific PCP practices and their patients, or embedded in high-volume practices, coordinate the enrollee's care and facilitate communication between the enrollee, PCP, and other service providers.

Development of the Person-Centered Plan --

The development and implementation of the person-centered integrated care plan includes the enrollee, family, caregivers, formal and informal supports, other service providers, and the enrollee's PCP, as well as others involved in the enrollee's care or selected by the enrollee. Care Managers work with the enrollee, family members, and the enrollee's PCP, to identify care planning participants, the timeline, and the method for information sharing. The Care Manager is responsible for scheduling care planning meetings and teleconferences, gathering relevant information to support development of the care plan, and guiding the enrollee and care planning participants through the person-centered process. Identification of needed services and supports includes those services that help the enrollee achieve his or her desired physical and emotional health outcomes and support the enrollee in the least restrictive setting chosen by the enrollee. Integrated Care management workflows guide care management activities to help ensure enrollee's needs are addressed comprehensively and consistently.

The care plan takes into consideration:
• Enrollee and/or caregiver preferences to prioritize goals;
• Re-evaluation including problem solving and re-setting of goals when progress is not being made;
• Assigning key responsibilities for specific care plan goals to the extended care management team staff most appropriate to support the enrollee;
• Involving caregivers when the enrollee has involved family/significant others;
• The enrollee's covered and carved-out services, network, and community based services.
• Care management interventions that adopt evidence-based models, such as the Chronic Care Model, which focuses on prepared, proactive, productive interactions and a strong self-management support that actively engages enrollees with chronic conditions in their care.
• Telephonic and in-person visits made at the frequency based on the enrollee's assessed needs, agreed upon goals and care management interventions.
• A focus on both the enrollee's comprehensive needs and those of the caregiver, incorporating the enrollee's physical and behavioral health status, trauma history (PTSD, childhood trauma, domestic violence), personal preferences, activation and level of self-efficacy, and current lifestyle risks.

Care managers assisted by CHWs outreach or make in-person visits to enrollees at a frequency based on the enrollee's needs and risk-level, to support the enrollee's compliance with their integrated care plan and provider treatment plans and to monitor progress. Contact frequency is based on the enrollee's needs. For example, an enrollee newly transitioned home from an inpatient setting may require daily check-ins while an activated enrollee with mild depression enrolled in BH Care Management may need a monthly call.

The care manager reviews each identified goal with the enrollee and/or family/caregiver, as applicable and documents progress and any barriers to achievement. The care manager, with the enrollee and with input from the provider, assesses the enrollee's progress and the need for revised interventions, which the care manager documents in the integrated care plan.

The care manager discusses each identified goal with the enrollee and/or family/caregiver, as applicable and documents progress and any barriers to achievement. The care manager with the enrollee and with input from the provider, assesses the enrollee's progress and the need for revised interventions, which the care manager documents in the care plan.

Innovative Strategies for addressing the unique needs of highly resistant or difficult to serve populations --

We know that developing a supportive and ongoing relationship and offering in-person help that includes attention to an enrollee's social determinants of health, can be effective in meeting the unique needs of hard to engage enrollees. Our approaches include:

• In-person visits from Community Health Workers and care managers trained to use motivational interviewing and be present, caring, empathetic, and encouraging
• Accompanying enrollees to appointments and advocating for the enrollee, modeling and reinforcing self-management skills
• Meeting enrollees at the point of care or connecting enrollees to our care managers embedded in select primary care practices and acute inpatient facilities
• Working alongside providers who serve these enrollees, such as at homeless shelters or community centers
• Convening multi-disciplinary case conferences that include the enrollee's primary treating provider and members of the local care management team, to strategize and identify methods to work with highly resistant enrollees and to ensure consistency across the care continuum.

In instances where enrollees with physical health and BH needs repeatedly miss scheduled visits, we convene a case conference with the care team and the enrollee's PCP and BH providers to troubleshoot additional solutions. If a BH provider offers co-located primary care services or vice versa, we help schedule both visits on the same day at the single site to reduce barriers to accessing these services. For example, ECC has six licensed clinical social workers (LCSWs), including pediatric LCSWs, covering nearly all of their primary care clinics. A psychiatric nurse practitioner also provides services at sites every other week. We will work with ECC to connect enrollees repeatedly missing appointments who have physical health and BH needs to appointments at these sites and help coordinate the enrollee's ongoing needs once seen by a PCP and LCSW or the psychiatric nurse practitioner, enrolling or reenrolling enrollees in DM or care management programs, when applicable. Because these enrollees are frequent no-shows, we will also connect the enrollee to a CHW for ongoing assistance and in-person visits when

needed. CHWs can also accompany enrollees to their health care appointments, reducing gaps in care.

We also know it is important to work with enrollees on those issues of priority importance to them, which may not initially be health-related. Addressing an enrollee's need for stable housing, or access to food, may take precedence over their prioritized health goals, which can be addressed as the enrollee becomes more comfortable working with the CHW or care manager.

Coordination with Other Providers --

Coordination with other providers is an essential component of our care management and care coordination activities. The local care management team forms a close working relationship with the enrollee's PCP, other treating providers and local hospital staff. They also coordinate with other agencies and programs involved in the enrollee's care including state and county agencies through sharing of information including care plans (with appropriate enrollee authorization), case conferences, telephone calls, and in-person meetings held at a location convenient to the enrollee and family as applicable. The care manager considers all available services and supports, including natural supports, during development of the enrollee's care plan, inviting with enrollee consent, external case managers, case workers or social workers from other programs to participate in care planning.

Length of CM Program Enrollment --

A primary objective of our care management approach is supporting and helping enrollees develop self-management skills, and for children, helping families develop skills that meet their child's care coordination needs, and support achievement of each child's developmental milestones. We have established graduation goals for each program and an anticipated program length of enrollment. However, CM program enrollment continues as long as needed and enrollees may transition to less intensive programs, such as Care Coordination, as they achieve their self-management goals and when their health is stable. For example, the anticipated length of enrollment in Complex Care is about 120 days. Graduation goals include:

• Enrollee takes an active role in self-managing condition
• Enrollee adheres to prescribed medication regimen
• Enrollee actively works with his/her doctor(s) on treatment plan
• Enrollee understands and has a plan for managing symptoms and knows when to contact physician
• Enrollee has been educated and provided information on Advance Directives
• Enrollee had no avoidable hospitalizations in 60 days
• Enrollee had no avoidable ED visits in 60 days

Enrollees with more complex needs may require ongoing case management and continue to receive support from their local care management team through a combination of CHW, care manager and other clinician interventions.

Enrollees enrolled in episodic care management remain enrolled until they complete the program – through the transition period (for Transitions of Care CM) or through the post-partum period (for Maternity Care). Upon completion, re-stratification helps identify programs that can help meet enrollee's ongoing care management needs.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

ALGORITHM

The Identifi Population Health Intelligence Engine continuously analyzes all available sources of data, including claims and pharmacy data, socioeconomic data, data from the enrollee enrollment file including existing authorizations when available, and results of health risk screenings and health risk assessments, to accurately stratify the entire membership into four risk levels: low-risk, moderate-risk, rising-risk or high-risk.

Using the combined data sets and our proprietary predictive modeling we focus not only on identifying enrollees with specific conditions, service utilization patterns and levels of care, but on accurately predicting enrollees' risk for incurring future costs – enrollees with "rising risk". These enrollees have upward trends in utilization patterns, such as an increasing number of pharmacy prescriptions, increased inpatient admissions or readmissions, and a change in available clinical diagnostic data (HbA1c values for example). They are predicted to have higher costs and health risk in the coming period. We have found applying interventions that support clinical, behavioral, and community strategies can change the trajectory of this rising risk.

Our model includes identification of enrollees with rising behavioral health risk who often have no diagnosis of a serious mental illness or substance use disorder but who have BH-related pharmacy claims from a primary care provider, multiple specialist visits, opioid use, clinical notes indicating a BH condition or enrollee-reported assessments such as PH2/PHQ9.

We evaluate the opioid risk by reviewing claims data for days of opioid prescriptions, number of overlap days, number of pharmacies and prescribers of the opioid scripts and average daily milligram morphine equivalents to assess patient's high behavior health risk and likelihood of incurring future cost. Including this in our model allows us to identify patients at possible risk for over-utilization or dependence on opioid medications and quickly do outreach and engagement.
We continuously re-stratify the membership to proactively identify enrollees for care management engagement, or to determine if the enrollee's profile has changed and they may benefit from a different CM program.

Predictive Modeling --

We have invested significant resources in developing a highly reliable predictive algorithm that is differentiated from industry-standard models. Our algorithm:
• Accurately predicts future events that we can change and identifies enrollees on this trajectory
• Has predictive capabilities superior to other industry-leading approaches
• Applies machine learning algorithms that continuously improve the model's accuracy

Traditional case management programs often identify enrollees for enrollment based on factors like diagnosis, utilization, cost, and/or psychosocial determinants. While this method can be sensitive (meaning it will identify many enrollees), it is not designed to:
1) predict a future event;
2) precisely identify the enrollees at highest risk; or
3) determine who will benefit from the intervention.

Our model uses predictive analytics to forecast the probability of a specific outcome while also determining if we can change it. Our targeted interventions avoid this occurrence or lessen the

impact on the enrollee instead of providing a “one size fits all” intervention. Using this individualized approach, the clinical team is proactive instead of reactive.

Because many traditional case management programs use guidelines or algorithms that purposefully identify enrollees who have high acuity medical conditions and increased utilization, the annual cost of those enrollees is also high. Typically, the enrollee is identified in year one when the cost is high and then in year two, the cost significantly. Importantly, this drop is in the absence of a case management intervention. This phenomenon is known as “regression to the mean”, a statistical term meaning if a variable is extreme on its first measurement, it will tend to be closer to average on its second. In other words, the high cost of the enrollee is most likely decreasing in year two because they were identified after the high cost event occurred.

Our Population Health focused methodology is different and is designed to find enrollees before the event occurs. This group of enrollees may not appear to be as sick today, but we know they will be in subsequent years in the absence of population health interventions.

By intervening before the enrollee’s acuity increases, we avoid negative health outcomes and cost in the second year. On an enrollee level, this results in feeling better, being able to continue to do what is enjoyable, not being in the hospital, or lessening the exacerbation of disease. The foundation for this work is rooted in how the timely and accurate aggregation of data from multiple sources as described above. We match the data at an enrollee level and then use it in our statistical models.

Our statistical models focus on predicting highly specific events, based on the population type. For Medicaid, these events include preterm deliveries, infants born with neonatal abstinence syndrome and behavioral health related ED visits and inpatient admissions. We have also developed a New Enrollee Model to identify and triage new high-risk Medicaid enrollees moving between health plans within 60 days of enrollment using data that is more readily available.

Our predictive models have high predictive accuracy --

One of the most frequently cited measures of predictive performance is the model’s c-statistic. At 0.82, our model’s c-statistic is higher than industry standards and demonstrates strong predictive ability. For example, our model’s c-statistic is higher than that of the:

- Johns Hopkins Adjusted Clinical Groups Model
- Chronic Comorbidity Counts Model
- Minnesota Tiering Model
- Charlson Comorbidity Model

Our models have also been validated and tested with Medicaid enrollees by capturing the Medicaid population specific characteristics and service utilization patterns. Finally, we strengthen our predictive models through access to Electronic Health Record (EHR) data from health systems.

RISK STRATIFICATION DATA SOURCES

We build our predictive models from many data sources. These include medical and pharmacy claims, EHR data, laboratory and other diagnostic data, self-reported data, health assessment

data (including American College of Obstetrical and Gynecological assessment data in the context of enrollees with high risk pregnancies), data supplied by the state Health Information Exchange and socio-economic data.

This data integration allows for comprehensive view of enrollees' health, integrating disparate medical datasets to describe disease severity, enrollee health trajectory, and/or engagement. Because different data sources can generate complementary insights, we leverage them together. An example of this is utilizing medication orders and pharmacy claims fill information from provider EHRs, made possible through our close relationship with providers as a Provider-Sponsored Health Plan.

Due to the importance of psychosocial and socio-economic issues on health outcomes we leverage a variety of assessment data as well as publicly available data sources to determine a population's social determinants of health. The American Community Survey (ACS) from the U.S. Census Bureau tracks over 100 data elements on education, poverty and housing status by neighborhood. Our social data sets extend far beyond those used by other managed care plans and include a wealth of data elements such as ethnicity, language, housing status, income level, healthy food access, household composition, commute distances, transit availability, walkability, job density, caregiver support and more. We incorporate social data at the census block level and at the individual address level when this data exists (such as the use of federal subsidized housing or shelter data) providing more refined risk identification within specific subpopulations.

Our predictive modeling accuracy and sensitivity is greatly enhanced by this data.
We take advantage of the recent developments in the "Internet of Things", leveraging Google technology (like the technology that allows users to locate amenities in Google Maps) to calculate distances to the nearest pharmacy, grocery store, physician's office, and hospital which may identify potential gaps in the community's health care access.

CARE COORDINATION CONTACT FREQUENCY AND CASELOADS

We have established minimum care manager contact frequencies by program that reflect the overall risk stratification and targeting for each program. For example, enrollees enrolled in Transitions of Care are at risk for inpatient readmission and so have more frequent contacts from the care manager than an enrollee enrolled in a program serving enrollees stratified into Condition Care (disease management). In addition, as new data becomes available we re-stratify enrollees – enrollees receive additional contacts when their risk score indicates "rising risk" or indicates they need a more intensive care management program.

The minimum care manager contacts by type are:
• Transitions of Care: Weekly contact by phone with one in-person contact in the inpatient setting and one post discharge
• Complex Care: Bi-weekly contact by phone with a mix of telephonic and in-person contacts, including in-person contact during the enrollee's provider visits
• Specialty CM programs: Contact by phone every two weeks for the first 90 days enrolled in the CM program. After 90 days, the care manager reviews the enrollee's current risk score and adjusts the contact frequency up or down accordingly. Specialty CM programs are: Catastrophic Care, Advanced Illness Care, High-Need BH Care Management, Care Management for Members with Special Health Care Needs, and Lower-Need BH Care Management

• Condition Care (Disease Management): contact by phone every three weeks. When in-person visits are needed, a member of the local care management team makes this visit.
• Care Coordination: Contact frequency and type varies by enrollee need. Enrollees will be stratified into three levels of care coordination (low, moderate and higher need care coordination) and contacts will be by phone monthly, every six weeks and quarterly, respectively. Contacts may also be in-person as directed by the local care management team and include accompanying enrollees to medical appointments or visiting enrollees with gaps in care who do not complete recommended care following phone outreach.
• Maternity Care: High risk women's frequency of contact varies by diagnosis and risk level. The method of contact is telephonic for women at all risk levels and includes in-person contact for high risk women. Pregnant women with hypertension or who are teenagers receive at least one contact per trimester. Pregnant women with diabetes receive one contact in the first trimester, two in the second trimester and monthly contacts thereafter. Women with a history of pre-term labor receive one contact the first trimester and two contacts in the second and third trimesters. Women with risks such as homelessness or domestic violence receive contacts every two weeks. Low and moderate risk women receive an outreach call during their pregnancy to check-in and identify any unmet needs. All women who have a C-section or are at risk for an inpatient readmission receive 2 to 3 contacts in the six weeks post-partum.

While care managers must meet at least the minimum contact frequency, actual contacts may be more frequent and are established by the care manager following an assessment of the enrollee's needs. In addition, enrollees may receive additional contacts, including in-person outreach and engagement from community health workers, under the direction of the care manager. Contact frequency and type may also vary over time as the enrollee's needs change. An enrollee newly transitioned home from an inpatient setting may require daily phone check-ins while an enrollee with mild depression enrolled in BH Care Management who is actively participating in care management may need a monthly call.

Caseloads –

The following caseloads are point in time caseloads:
• Case manager caseloads for nurse and BH care managers are 1:115 for adults except for Maternity Care.
• Maternity Care Manager caseloads for high-risk women are 1:70 and for low-risk women, 1:200.
• Caseloads for community health workers for enrollees of all ages and enrolled in any care management program are 1:50.
• Caseloads for nurse and BH care managers working with children, other than children with special health care needs in a nursing facility or receiving private duty nursing, are 1:115 for nurses and 1:50 for BH care managers.
• Caseloads for nurse care managers working with children under the age of 21 receiving services in skilled nursing facilities will be 1:15 and for children under the age of 21 receiving private duty nursing services at home or in another community settings will be 1:40.

Care Management Evidence-Based Guidelines --

All our care management programs are designed using evidence-based guidelines and combine standardized CM practices with specialized support to ensure enrollee's needs are fully met. Care managers implement our evidence-based chronic and complex care model, which includes:
• Wagner's Chronic Care Model focused on prepared, proactive, productive interactions

• Lorig's Self-Management Support Model that actively engages recipients in their care
• Project RED for care transitions
• Coleman's Care Transitions Model
• Stanford Chronic Disease Self-Management Program (CDMSP)
• Trauma Informed Care (TIC)
• Integrated Care Management (ICM)

Our care management system offers a pre-loaded, clinical program workflow that focuses care managers on the highest risk enrollees and the most effective interventions. Evidence-based clinical content drives the creation of structured and understandable person-centered care plans, and the application supports cross-functional collaboration with the entire care management team. We have a team of dedicated staff that focus exclusively on building clinical programs and clinical content (assessments and problems, goals and interventions) incorporating the latest evidence-base.

Performance Metrics and Outcomes --

We evaluate the effectiveness of our CM programs through a structured Quality Improvement process gathering and analyzing an array of clinical and claims data including inpatient and outpatient service use, readmission rates and ED visit rates, average lengths of stay, and specified HEDIS CAHPs and Agency-defined measures.

Examples of goals include:
• Decreased admissions/readmissions
• Decreased LOS in facilities
• Increased PCP and specialist visits
• Improved medication adherence
• Improved enrollee satisfaction

BH Metrics:
• Improved standardized screenings-PHQ 9/GAD 7
• Decreased TME for population identified with BH needs

Each program has defined quality measures focused on program-specific goals. For example, goals for Complex Care include a reduction in ED visits, reduction in inpatient ACSC admissions, an increase in medication compliance/adherence, and a reduction in total per member per month spending for the targeted population.

Some examples of data used to assess performance on established goals include:
• Care coordination performance metrics (claims driven data)
• Bed days/1,000
• Admissions/1,000
• 30-day readmission rates
• ED visits/1,000
• PCP visits/1,000
• Specialist visits/1,000
• All cause unplanned 30-day readmission rates

EXAMPLE OUTCOMES

The Maternity Care Program implemented in Kentucky, where Evolent supports a Medicaid managed care plan, has reduced the percentage of deliveries that are low or very low birth weight deliveries and decreasing preterm deliveries.

• Low birth weight (LBW) deliveries decreased from 7.0% in 2012 to 6.90% in 2016. The LBW rate in 2016 surpassed the Healthy People 2020 goal of 7.8%.
• Very Low Birth Weight (VLBW) deliveries have decreased nearly 67% from 1.5% in 2012 to 0.5% in 2016. The VLBW rate in 2016 was well below the Healthy People 2020 goal of 1.4%.
• Preterm deliveries (less than 37 weeks) have decreased by 33% since 2012 (from 11.2% to 7.5%). The 2016 rate of 7.5% exceeded the Healthy People 2020 goal of 11.4%.
• The C-section rate declined from 34.2 % in 2015 to 32.3% to date in 2017.

A study of two provider-led Medicare Advantage health plans showed reductions in cost, ACSC inpatient admissions and ED visits, for both plans. The reduction was greater for cost and ACSC inpatient admissions for the previously unmanaged plan, but significant for the plan that changed from their previous model to our model.

Group A – Managed under a previous CM model, after implementation of our model
• 24% decrease in PMPM
• 38% decrease in ACSC inpatient admissions
• 51% decrease in ED visits

Group B – Previously unmanaged population
• 48% decrease in PMPM
• 66% decrease in ACSC inpatient admissions
• 51% decrease in ED visits

A study of Medicare Advantage patients identified for Condition Care between January 1, 2015 and December 31, 2015 comparing those who enrolled with those who did not, demonstrated the effectiveness of Condition Care interventions. Patients were matched on demographic characteristics, 12-month historical utilization and disease severity using a propensity score methodology. Multivariable regression was used to examine the association between engagement in Condition Care and outcomes, when appropriate. Preliminary findings demonstrate:

• Patients enrolled in Condition Care had significant increases in PCP and specialist visits
• Among patients who had a PCP or specialist care gap, patients enrolled in Condition Care had a higher gap closure rate of 81 percent compared to 53 percent for those not enrolled
• Patients enrolled in Condition Care were significantly less likely to be subsequently identified for Complex Care through either stratification or referral – 15 percent compared to 28 percent

Evaluation Criteria:

1. The extent to which the respondent's algorithm and risk stratification approach is well-defined and incorporates data elements other than diagnosis.

2. The extent to which the respondent describes data sources that are incorporated into the risk stratification process that is used for new enrollees.

3. The extent to which the respondent's approach includes the use of predictive modeling.

4. The extent to which the frequency and intensity of the care coordination services (i.e., maximum caseload and minimum contact requirements) are aligned with the respondent's risk stratification process and proportional to the clinical and psychosocial needs of the target population.

5. The extent to which the respondent's approach includes innovative strategies for addressing the unique needs of highly resistant or difficult to serve populations.

6. The adequacy of the respondent's description of evidence-based interventions in achieving improved outcomes and enhancing enrollee engagement.

7. The efficacy of the respondent's approach in achieving cost savings, cost avoidance, emergency department diversion, increased utilization of ambulatory care settings, etc.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 21 – Coordination of Benefits (Statewide):

The respondent shall describe the strategies utilized in care coordination with other plans and insurers (e.g., Medicare) to provide necessary services for its enrollees when the third party payer is the primary insurer. The respondent shall include information on its approach in the following circumstances:

a. Florida Medicaid does not cover the service, but it is available through the third party payer;

b. Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid;

c. The third party carrier benefit limit is exhausted and the service is now a Medicaid expense. In this scenario, the respondent shall identify any differences in its approach if the enrollee is dually eligible for Medicare and Medicaid; and

d. The service is not covered by the third party but is available through Florida Medicaid.

Response:

Lighthouse Health Plan is committed to help address the full range of healthcare needs experienced by our Enrollees. This includes the services and supports that we provide directly, services provided by community-based organizations and other state programs, and healthcare services that are paid for by another insurer as the Enrollee's primary healthcare coverage. Our care coordination and claims payment processes are designed to minimize burdens on providers and enrollees and avoid disruptions in care that can occur when there is confusion about the entity who is responsible for providing coverage.

We will employ a proven coordination of benefits strategy utilizing a proactive solicitation of other coverage to ensure Florida Medicaid is the payer of last resort without disruption to our enrollees' care. Our process is highly collaborative and will involve regular interaction with the AHCA's Third Party Liability staff, and other plans and insurers, as needed.

Lighthouse has selected HMS to provide support to our Coordination of Benefits efforts. HMS pioneered COB for Medicaid MCOs in 1985 – and it's been their core competency ever since. HMS'IT infrastructure and data mining algorithms were custom-built for Medicaid COB and payers. They include a balanced approach to cost avoidance and recovery. As the preeminent COB contractor, HMS's data is the best in the industry, with usage agreements already in place. HMS continually receives refreshed coverage information from more than 1,000 plans, including major medical, dental, prescription drug, and vision payers. The information is consistently verified for accuracy.

Enrollee records will be updated to reflect COB when we receive confirmation of TPL including receipt of primary payer documentation. If a claim is received with COB information that has not already been captured by our system, the following workflow will be followed to ensure proper research and documentation, and to ensure prompt adjudication of claims.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. Claims with COB information or primary payer information present on the x12 837 file for enrollees with no active COB segment for the date of services will be routed to eligibility and enrollment staff.
2. The Eligibility team will update the enrollee's COB segment within 5 business days of receipt.
3. Following completion, the enrollee's file will be updated accordingly.

We communicate claim denials based on the presence of a third-party resource to the provider with a reason code indicating the availability of the third-party resource. The Identifi Health Plan Administration (HPA) claims processing system captures these claims for cost-avoidance and TPL savings reporting to AHCA.

COORDINATION OF BENEFITS WHEN A THIRD-PARTY PAYER COVERS THE SERVICE

The following processes are used to coordinate care, and to coordinate payment when a service is covered wholly, or in part by a third-party payer. This includes the following scenarios:
1. Florida Medicaid does not cover the service, but it is available through a third-party payer
2. Both Florida Medicaid and the third-party payer cover the service, but Lighthouse is only liable for the coinsurance/copayment expenses (including but not limited to situations where Medicare is the primary payer).

Coordinating Care –

Coordination with other providers is an essential component of our care management and care coordination activities. In addition to working closely with and facilitating referrals among an enrollee's PCP, specialists, and local hospital staff, our care management team coordinates with other payers that provide services as the primary payer. For example, we coordinate with Medicare special needs plans through sharing of information including care plans (with appropriate enrollee authorization), case conferences, telephone calls, and in-person meetings held at a location convenient to the enrollee and family. Close collaboration with other entities that have a financial obligation for services to our Enrollees is an essential component of our model.

To the extent that other payers are not actively involved in providing Care Management to the Enrollee, our care teams will seek to understand the benefits available to the Enrollee from the other payer so that we can help the Enrollee effectively navigate their health care coverage across healthcare payers. The Care Team has access to third party coverage information in the enrollee record that is maintained on the Identifi Platform. The care team can coordinate with the enrollee's provider to ensure that services are billed appropriately to the correct payer.

Coordinating Payment –

We adjudicate claims that involve third party coverage using rules that ensure the enrollee's Medicaid benefit is the payor of last resort. The Identifi HPA claims processing system receives and stores other insurance coverage information received from AHCA. Claims edits ensure that claims for services rendered to enrollees with identified third party resources are processed through our coordination of benefits (COB) process.

In cases where a service is not covered by FL Medicaid but is available from a third-party payer, if a claim is submitted to Lighthouse it will be denied as a non-covered service, e.g. remark code on provider EOP will identify service as denied. If the Enrollee has COB indicated on their enrollee

record, our denial notice to providers, e.g. remark code on provider EOP, can include a message alerting the provider that other coverage may be available. Providers can then work with their patients to submit a claim to the third-party payer.

Claims for covered services eligible for COB must be submitted with the following information:
• Complete and accurate claim data (including enrollee eligibility, provider, claim data; and
• The primary payer's EOBs for all services rendered including the date the primary payer finalized payment. If multiple primary payers exist, the above information must be submitted for each payer.

Our processes are driven by the need for the claim to include primary party COB information. We do not process claims that have not been submitted to the primary payer first. For services covered by a third party and Florida Medicaid, it would be processed first by the third-party payer, and we would use the EOB to determine coinsurance/copayment expenses for which Florida Medicaid is liable.

Lighthouse's health plan administration subcontractor, Evolent Health, participates as a trading partner with CMS via the Coordination of Benefits Agreement (COBA) to coordinate claim payment when Medicare is the primary payer (Medicare crossover claims) to alleviate provider from having to submit claims to both payers. Dually eligible enrollees' claims are submitted to CMS for primary claim payment, and CMS will then submit claims to Evolent Health for potential cross over coordination of benefits. This applies to dually eligible enrollees who receive services when Florida Medicaid is partially or wholly liable for payment. We intend to leverage this COBA agreement to facilitate the automatic processing of crossover claims in place of participation in the SMMC Auto Crossover Pass Through Project.

COORDINATION OF BENEFITS WHEN THE THIRD-PARTY PAYER DOES NOT COVER THE SERVICE

The following processes are used when services are not covered by the third-party payer and are covered by Lighthouse. This includes the following scenarios:
1. The third-party carrier benefit limit is exhausted and the service is now a Medicaid expense (including but not limited to situations where Medicare is the primary payer)
2. The service is not covered by the third party but is available through Florida Medicaid.

Coordinating Care –

Lighthouse coordinates care for all services for which it is wholly or partially financially responsible. Care coordination is an important component of all care management interventions and includes addressing barriers to care like transportation, adequate housing, and nutrition needs. Care coordination focusses on:
• Connections- Identifying and providing to the enrollee connections to school-based, community, nutrition programs and state agency resources
• Health behaviors - Interventions that encourage enrollees to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use).
• Psychosocial issues – Interventions that address factors that impact an enrollee's adherence to the healthcare plan, such as social, emotional, or financial barriers.

• Caregiver support – Interventions that support caregiver's emotional resources, providing external/ community based resources such as caregiver support groups, respite, and development of coping skills.

Examples of specific care coordination activities include:
• For enrollees who are homeless – linking enrollees to housing and other services. Enrollees are identified through staff collaboration with shelters or from the state enrollment file. The care management team social worker assesses the enrollee's needs, particularly substance use and mental health needs, and depending on his or her findings, may refer the enrollee for enrollment in care management and/or to community BH providers. Community Health Workers (CHWs) coordinate access to housing and other essential supports.
• For enrollees with an HIV diagnosis and receiving treatment, or with other complex or strictly regulated medication regimens such as Harvoni for hepatitis C. The CHW supports the enrollee's adherence to the treatment plan and connects the enrollee to the care management team health educator for self-management support and education as needed.
• For enrollees with avoidable ER visits: The CHW educates the enrollee about the appropriate use of the ER and alternatives to the ER, helps the enrollee reconnect with their PCP, helps schedule preventive care and arrange transportation, and may accompany an enrollee to an appointment when needed to help the enrollee complete timely preventive care.
• For children and adolescents in Foster Care/Guardianship identified by the state as an enrollee placed out of home. The care management team social worker completes an assessment and care plan to support the foster parent/guardian in providing care, removing barriers to treatment and ensuring communication between providers.

Care coordination supports are available to any enrollee with significant health challenges regardless of whether Lighthouse is the primary payer.

Coordinating Payment --

As described above, Lighthouse relies on information from the third-party payer's EOB and COB segment from the x12 834 file if available, to determine our payment liability. The following are scenarios where Lighthouse would pay for services rendered to Enrollees with third-party coverage:
• If the third-party payer's benefit limit is exhausted, Lighthouse will pay the amount allowable for the service if the service was a covered Medicaid benefit/service and enrollee was eligibility with plan at the date of service;
• If the service is not covered by the third party and the EOB indicates a denial, we would pay the amount allowable for the service if the service was a covered Medicaid benefit/service and enrollee was eligible with the plan at the date of service

COMMUNICATION STRATEGIES TO REDUCE ENROLLEE CONFUSION

We alleviate confusion and effectively communicate our policies regarding Coordination of Benefits to enrollees in the following ways:

Our enrollee handbook and Enrollee Services staff will inform enrollees about the services covered through our health plan; and coverage provisions when:
• Florida Medicaid does not cover the service, but it is available through the third party payer.

• Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
• The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.
• The service is not covered by the third party but is available through Florida Medicaid.

Lighthouse recognizes the difficulty in explaining alternate insurance coverages and their implication to authorizations and claims payments to all enrollees. As such, we will ensure that all enrollee material will be written in the 4th grade level and written with clarity utilizing infographics or pictures as possible. These descriptions will also be made available on Lighthouse's website. We will also create an Enrollee-focus group to review materials prior to their submission to the Agency for approval. This focus groups will review materials that are specific to understanding COB and how Enrollees can use their benefits from multiple insurers.

Call center materials will include contact information, with phone numbers and websites, that call center reps and clinicians can share as appropriate when enrollees call in with related questions. We will update these materials regularly so that Enrollee Services staff have current information at all times.

Additionally, Lighthouse's local care management team, including community health workers, nurse and behavioral health care managers will educate enrollees about the differences in Lighthouse and third-party benefits during outreach, assessment and care planning process.

IDENTIFYING NON-COVERED SERVICES FOR INDIVIDUAL ENROLLEES

Through our care coordination processes, our care teams will work with Enrollees to help them understand their healthcare coverage, including coverage available from third party insurers. Our care coordination services include a focus on health literacy and we offer help to Enrollees who may have trouble understanding notices and documentation from their health insurers. Enrollees of the care team can communicate coverage to the Enrollee's treating providers so that providers appropriately bill the Enrollee's primary insurance first.

As described above, our claims payment process relies on receiving an Explanation of Benefits (EOB) from the primary insurer to identify non-covered services by the primary insurer for individual Enrollees. EOBs serve as an official notice from the primary insurer that a service is not covered, or that the Enrollee has exhausted a benefit limit. Using the EOB to identify non-covered service is the most reliable and accurate approach to preserve FL Medicaid as the payer of last resort.

STREAMLINING ONGOING AUTHORIZATION AND PAYMENT OF SERVICES NOT COVERED BY THE PRIMARY INSURANCE

Lighthouse understands that traditional COB approaches can be burdensome on Enrollees and Providers especially as it relates to ongoing services that are not covered by the primary insurance. We will balance our obligation as stewards of Florida Medicaid dollars with our goal for administrative streamlining by establishing an exception process for ongoing services for enrollees who would be put at risk of service disruption if repeated denials from the primary insurer are required for ongoing service authorization and payment. This exception process will be documented in a policy and procedure that will be submitted to the Agency for review and approval. The exception process involves collaboration across the Utilization Management, Care

Management and Claims Operations departments. The exception process will include the following conditions:
1. The requested service must be medically necessary an ongoing in nature. This determination will be made by the Utilization Management department.
2. Documentation from the primary insurer in the form of an EOB must include: (a) Initial determination that the service is not covered, or that a benefit limit has been exhausted. (b) For services that exceed a benefit limit imposed by the primary insurer, the EOB must clearly state what the limit is, and what time parameters apply to the limit. (i.e. when the limit would reset as for services that are limited to a certain level annually). (c) Additional coverage documentation as needed to verify that the service will not be covered by the primary insurance for at least 180 days.
3. Claims Operations will review notes from the UM department and the documentation from the primary insurer and will place a "Enrollee Hold" on claims from the rendering provider for services provided to the Enrollee. This will route the claims for manual adjudication.
4. Claims processing staff will process the claim bypassing COB edits in accordance with the exception.
5. The COB exception will expire after 180 days at which time, if the service is ongoing, the provider would need to submit an updated denial from the primary insurer in order for the claim to pay.

SPECIAL PROCESSES FOR DUALLY ELIGIBLE ENROLLEES

As mentioned above, Lighthouse considers coordinating care for all of our Enrollees as essential to the value we provide to the Florida Medicaid program. As such, all enrollees have access to care coordination even if they are dually eligible and Medicare is the primary insurer. Specific to dually eligible enrollees, our care coordination program assists enrollees in accessing the services they need from providers who will accept their Medicare Coverage. In terms of primary care, if a dually eligible Enrollee has an established relationship with a PCP through their Medicare coverage we will coordinate care with that provider regardless of whether they are in our network. These enrollees can also be exempt from PCP assignment by Lighthouse in accordance with Agency policy.

In terms of coordinating payment, Lighthouse's health plan administration subcontractor, Evolent Health, currently participates as a trading partner with CMS via the Coordination of Benefits Agreement (COBA) to coordinate claim payment when Medicare is primary (Medicare crossover claims) to alleviate provider from having to submit claims to both payers. Dually eligible enrollees' claims are submitted to CMS for primary claim payment, and CMS will then submit claims to Evolent Health for potential cross over coordination of benefits. We intend to leverage this COBA agreement to facilitate the automatic processing of crossover claims in place of participation in the SMMC Auto Crossover Pass Through Project.

SUBROGATION SERVICES

Because Lighthouse believes in a holistic approach to appropriate cost containment, we offer a brief description of our subrogation services. While not a cost avoidance approach like, COB, identification and collection of subrogation dollars, assists with the management of MLR. Given their depth of experience with subrogation management, Lighthouse will delegate this function to HMS.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We will utilize HMS's purpose-built subrogation case management system, Maestro. Maestro provides:
• Secure, reliable, and web-based access around the clock
• Real-time updates
• Document imaging
• Prompt-driven workflow

Our subrogation process follows the identification and recovery steps outlined below:

Identification --
1. Data mining on paid claims: paid claims data is analyzed using proprietary algorithms to identify potentially recoverable claims.
2. Enrollee Questionnaire: Once the data is mined, enrollees are identified to receive a questionnaire in order to obtain more information. The enrollee questionnaire template will be submitted to the Agency for review and approval prior to use.
3. Enrollee Outreach: After all other avenues have been exhausted, HMS will call the enrollee. HMS recognizes the sensitive nature of these calls and treats every enrollee with respect and understanding.

Recovery --
1. Notice to Third Parties: HMS will send an initial letter to the third party on behalf of Lighthouse. This letter will follow a template that will be submitted to the Agency for review and approval and will include a notice that the Agency may have a separate line for services not covered by Lighthouse.
2. Negotiation: Lighthouse will notify the Division of any claim prior to initiating negotiations. HMS will negotiate with third parties on behalf of Lighthouse. At no point during the negotiation process will HMS state or imply that it is working on behalf of the Agency.
3. Payment Recovery: Once a settlement is reached, HMS will collect the recovery and will return a payment file to Lighthouse's Identifi Health Plan Administration system.
4. Reporting: Status of negotiation and recovery will be reported to the Agency per the requirements of the SMMC contract.

Evaluation Criteria:

1. The adequacy of the respondent's approach when:

- **(a)** Florida Medicaid does not cover the service, but it is available through the third party payer.
- **(b)** Florida Medicaid and the third party payer cover the service, but Medicaid is only liable for the coinsurance/copayment expenses.
- **(c)** The third party carrier benefit limit is exhausted and the service is now a Medicaid expense.
- **(d)** The service is not covered by the third party but is available through Florida Medicaid.

2. The extent to which the respondent's approach includes:

(a) Documentation of effective communication strategies to reduce confusion for the enrollee (e.g., strategies used in enrollee materials).

(b) Processes used to identify non-covered services by the primary insurer for individual enrollees.

(c) Processes used to streamline ongoing authorization and payment of services once the initial determination has been made that a service is not covered by the primary insurer or the benefit from the third party insurer has been exhausted.

3. The extent to which respondent's description specifically addresses special processes in place to improve care coordination, including provider communications, and service provision for dual eligibles when Medicare is the primary insurer.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 22 – Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (Statewide):

The respondent shall describe its approach to education and monitoring of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements, including:

a. A description of outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements and to improve compliance with the periodicity schedule and treatment recommendations that are identified as a result of a screening.

b. A training plan that includes descriptions of strategies that will be used to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan (case management, utilization management, provider relations, etc.) as well as subcontractors.

c. A description of the monitoring approach that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the plan and with subcontractors.

d. A plan for ensuring greater transparency among external stakeholders (e.g., advocacy groups) in the respondent's approach towards coverage of the EPSDT benefit.

Response:

Lighthouse Health Plan (Lighthouse) is committed to ensuring children receive all components of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT), and families, their children and providers are fully informed of EPSDT requirements. Evolent, with its partners, has been successfully overseeing and promoting completion of timely preventive care and treatment for Medicaid-eligible children for over 20 years. Their approach has demonstrated competency in all aspects of the EPSDT program, including outreach and education, coordination of timely EPSDT screenings, and oversight of diagnostic services and referrals for EPSDT-identified services.

In calendar years 2015 and 2016, Medicaid health plans supported by Evolent exceeded national and regional means on numerous child wellness measures:

Childhood Immunization Status (Combo 3):
• In Kentucky and Maryland, exceeded the national and regional means in CY 2015 and CY 2016
• In Illinois, exceeded the regional mean in CY 2016.

Well-Child Visits in the First 15 Months (6 or more):
• In Kentucky, exceeded the national mean and regional mean in CY 2015.
• In Maryland, exceeded the national and regional mean in CY 2015 and CY 2016.

Immunizations for Adolescents (Combo 1):
• In Kentucky and Maryland, exceeded the national and regional means in CY 2015 and CY 2016.
• In Illinois, exceeded the national mean and regional mean in CY 2016.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life:

• In Kentucky, exceeded the national mean in CY 2015. We exceeded the regional mean in CY 2015 and CY 2016.
• In Maryland, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015.
• In Illinois, exceeded the national mean and regional mean in CY 2016.

Adolescent Well Care Visits:
• In Maryland, exceeded the national and regional mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Illinois, exceeded the national mean and regional mean in CY 2016.

ENROLLEE/FAMILY OUTREACH AND COMMUNICATION STRATEGIES

We will educate and increase child and family compliance with EPSDT (Florida's "Child Health Check-Up") screenings and treatment through child/family outreach and engagement using a multifaceted approach that includes child and family education, enrollee incentives, reminder mailings, automated calls, text messaging and two-way smart phone communication, live outreach calls and, when needed, in-person visits to families of children who are overdue for recommended health screenings, immunizations, and annual visits.

New Enrollee Welcome Packets and Welcome Calls --

We send new enrollees a Welcome Packet that includes a Welcome Letter, Enrollee Handbook, and Enrollee ID Card with the enrollee's selected or assigned PCP's contact information. The Enrollee Handbook will include an array of preventive care information, including the EPSDT/Child Health Check-Up periodicity schedule and services, who to call for help accessing services, how to access our audio health library, and more. Enrollee Service Representatives make outbound calls to all enrollees or families of minor children, to welcome the enrollee to the plan. During this call we review covered benefits, confirm the enrollee's selected or assigned PCP, and reinforce the value of completing scheduled preventive care, as well as the follow-up treatment recommended by the enrollee's PCP and/or specialist. We use the welcome call as an opportunity to help the enrollee or family make the initial PCP appointment and arrange transportation.

Telephonic Outreach to Children and Their Families --

Through multi-lingual telephonic outreach programs, both automated and live, we provide focused reminders to children and their families about preventive health benefits and screenings, including information about disease progression and incentives for obtaining the screenings. We identify needed outreach at the household level so that each contact with a family covers all their enrolled children.

• An auto-dialer system delivers EPSDT-related messages to each household with enrollees under the age of 21. The automated message reinforces the availability of preventive care, the recommended schedule for EPSDT screenings and immunizations, as well as the importance of follow-up when referred for a service identified as the result of an EPSDT screening.
• Families who answer the automated call or who indicate during a live call they need help coordinating their child's care or accessing an appointment will be assisted by an enrollee Services Representative with appointment scheduling, transportation scheduling through the transportation vendor, referral to community resources and, at the family's request, identifying

and selecting a new PCP. Families who need additional help or who have clinical questions will be referred to their local care management team for follow-up and assistance, which may include home visits from a member of the local care management team community health worker (CHW).

Tracking Completion of Scheduled Appointments and Gaps in Care --

We track completion of scheduled appointments to ensure children receive the full range of timely EPSDT screenings and treatment as specified in the ACIP Recommended Immunization Schedule, the AAP Bright Futures guidelines, and the Agency's Child Health Check-Up Periodicity Schedule, and identify children and their families for outreach who are more than two months behind based on claims reports. Specially trained care coordinators contact families with a child who has gaps in care for services related to preventive health screenings and chronic care, review the child's needed screening or care, and help schedule the appointments and eliminate any barriers to keeping the appointment, such as arranging transportation. Care coordinators also make outbound appointment reminder calls.

Text Messaging and Mobile Applications --

We will use an electronic texting service, CareMessage, to deliver personalized, interactive health information via text messaging. The programs include reminders for recommended exams, screenings, and vaccinations, as well as developmental milestones. We can also inform families about services and benefits and send administrative alerts (e.g., re- enrollment reminders) via text message. Independent evaluations of these services have demonstrated improved outcomes on several HEDIS and EPSDT quality measures such as immunization compliance and appointment attendance.

Enrollees and families will also have access to our secure mobile application, Identifi Engage. Identifi Engage supports convenient communication between enrollees or their families and local care management teams and can be used to:
• Locate a network provider
• Schedule appointments with providers
• Receive and send messages to and from the local care management team on a range of enrollee or family needs including closing gaps in care

Care Management and EPSDT --

For enrollees engaged in care management programs, case managers and community health workers (CHWs) consistently educate and remind families to complete schedule preventive care and how to earn incentives related to EPSDT screenings. Maternity care program care coordinators and OB nurses educate pregnant women and new mothers on the recommended schedule for newborn visits and screenings and follow-up during the woman's post-partum calls. They make an in-person visit or accompany the woman and newborn to an appointment when needed to support completion of newborn (and the mother's post-partum) check-ups.

Certain members of our local care management teams will be embedded in or provide periodic on-site services at high-volume PCP offices, including OB/GYN offices. Care managers and care coordinators will work alongside office staff providing point-of-care assistance to ensure enrollees receive appropriate preventive care during any office visit, including EPSDT screenings. They will also make outbound reminder and follow-up calls from the office, as well as coordinate and

schedule visits, as needed. Enrollees with gaps in care who consistently miss scheduled preventive care appointments, despite reminders, letters, and outreach calls, will receive a home visit from a member of the local care management team.

Supporting Provider Outreach --

We will work closely with our network providers, including Patient Centered Medical Homes (PCMHs) such as Escambia Community Clinics (ECC) certified as a Level 2 PCMH, to support their EPSDT outreach and engagement initiatives. ECC employs a nurse care manager and care coordinator who focus on reaching, scheduling and documenting completion of ECC's Medicaid patients' wellness visits. As a leading Medicaid provider in the Pensacola Area, ECC is interested in establishing a wellness clinic to provide increased access to wellness care. Lighthouse will collaborate with ECC through our local care management team and automated outreach options (such as text messaging) to coordinate outreach to enrollees. Care team members will be embedded or visit high volume primary care clinics such as ECC's, to further enhance coordination. Our local CHWs will be available to make in-person visits to families who are hard to reach referred to us directly by ECC and coordinate scheduling with the ECC care coordinator, assisting with follow-up and referrals to specialists and/or clinical programs including Lighthouse care management, for children with more complex or specialized health care needs. We will also work with providers like ECC, to implement increased scheduling of clinic days, where blocks of clinic hours are set aside for wellness checks and immunizations, providing local staff to assist with scheduling and coordinating outreach through notices and calls to children's families.

Partnering with Local Programs to Promote and Increase Preventive Care Completion --

We will explore coordinated outreach efforts with local health departments or programs whose staff make home visits to families with Medicaid-covered children. Using this collaborative approach in Kentucky, local health department staff conducted over 589 home visits to families with EPSDT gaps in 2016 and 450 families scheduled an appointment after this home visit.

We will also build on our existing relationships with schools and community health organizations participating in on-site medical and mental health screenings and other services that promote the health and educational success of children and adolescents within our local communities.

Enrollee Incentives –

We will offer an enrollee incentive program that rewards families and their children for completing wellness care, closing gaps in care or participating in specified health education and wellness programs. Enrollees may earn $25 per qualifying activity up to a maximum of $50 a year distributed on a reloadable card. Qualifying activities directly related to EPSDT include:
• Completion of well child visits (must attend all well child visits per AAP for age)
• Care gap closure (must have all necessary care gaps closed based on age, gender, race)
• Completion of a dental visit and completed treatment plan
• Successful participation in a medically directed weight loss program

Treatment --

If a child's PCP makes a referral to a specialist because of an EPSDT screening, we will conduct additional outreach calls to the child's family to ensure the appointment has been made, as well

as to eliminate barriers to attending that appointment and make reminder calls prior to the appointment. We implemented this process following provider feedback in a Kentucky Medicaid plan that caregivers were not scheduling or attending specialist appointments after referral from their PCP.

PROVIDER ENGAGEMENT TO PROMOTE EPSDT COMPLIANCE

Provider engagement is essential to closing care gaps, including overdue EPSDT screenings. We work with providers to ensure they have the information and tools needed to meet EPSDT screening and treatment requirements, including delivering initial and annual EPSDT provider training, providing care gap reports, and offering provider incentives that include those promoting completion of specific annual child and adolescent screenings or immunizations.

Provider Education --

We educate providers on all requirements including state and federal EPSDT requirements at the time of enrollment with the plan, and make trainings available through multiple modalities including face-to-face, via webinar, using self-paced web-based modules with post-test questions, and include an attestation of completion for remote training. We include EPSDT requirements in the Provider Handbook and will post updates on the provider website. Retraining is required annually and includes a review of each provider's performance for the previous year. Additional provider training details are included in the section b of this SRC.

Provider Incentives --

We will also offer provider incentives that include or are related to improvements in EPSDT compliance. The PCP Scorecard Incentives is a pay for performance program based on a scorecard comprised of a subset of quality metrics from our "Measures that Matter" list. Incentive payments will be calculated based on the PCP's performance on the identified measures at or above the 75th percentile benchmark. Included measures relevant to EPST include:
• Adolescent Well-Care Visits
• Immunization Status – Combo 2

Measures that will help improve completion of EPSDT visits include:
• Expanded office hours outside the hours of 8am-5pm.
• Pre-Visit Planning

Actionable Information --

The Identifi Practice application delivers PCP patient rosters identifying children and adolescents who are missing screenings and specifying which screenings are overdue. Identifi Practice includes a days-calculator designed to help PCPs determine the age interval screen a child is due to receive, an interactive population dashboard, longitudinal patient profiles and a care gaps closure workflow. This platform also uses the practice's EHR to optimize workflows to support outreach to children and their families requiring care gap closure.

Outreach and Compliance --

Our quality team refers physicians who have large numbers of children with care gaps to specially trained care coordinators who provide targeted assistance to help close these gaps. Physician leaders deliver provider education on EPSDT requirements when care gaps persist. We also audit PCPs and include verification of compliance with EPSDT requirements as part of the review. If a newly enrolled provider meets the required review thresholds, we place them on a three-year cycle. If the threshold is not met, we educate providers on the elements they did not pass and re-audit them in six months. Ongoing review and analysis of enrollee gaps in care alert us to providers who may need earlier intervention to ensure compliance.

EPSDT TRAINING PLAN

We will train all clinical staff including our Population Health Management (care management and quality staff), utilization management staff, as well as outreach staff, enrollee services representatives, provider relations representatives and any other staff with enrollee or provider facing responsibilities on both federal and state EPSDT requirements and updates. We will require subcontractors to provide the same scope of training for all clinical staff as well as other enrollee and provider facing staff.

Population Health Management and Utilization Management Training –

Employees joining our Population Health Management (care management and quality management) and Utilization Management teams will attend a proven training program aimed at ensuring proficiency in the Identifi medical management system followed by four to six weeks of job shadowing with a seasoned team member who has the same role and responsibilities.
During our Foundations of Care Management training that provides foundational knowledge and understanding of the components of a best practice, patient-centric care management model, we will include training about federal and State EPSDT requirements. Essential areas of focus will include:

- What is EPSDT?
- Florida's EPSDT program – Child Health Check-Up
- Who can provide screenings?
- Who is eligible for screenings?
- The Child Health Check-Up Periodicity Schedule
- Review of the required components of the screening
- Review of health education/anticipatory guidance requirements
- Treatment services, medical necessity and EPSDT
- Follow-up care
- UM process for special services covered under EPSDT
- Assisting families, children and providers with EPSDT (preventive care, wellness exams and access to treatment services)
- Making every PCP visit count
- Billing and reimbursement
- Child Health Check-up forms and tools
- Provider gaps in care reporting and clinical team oversight/responsibilities
- Lighthouse enrollee and provider outreach overview

All staff will receive ongoing training in new policies and procedures, system updates, new initiatives, Medicaid program changes, changes to state and federal laws and regulations, and other updates. An auditor will record and perform ongoing monitoring of calls to assess

compliance with contract standards and other regulatory requirements. We will use the results to provide both individual feedback and refresher trainings for a larger group.

Enrollee Services Training --

New employees will attend a two- to three-week classroom- style training program conducted by a dedicated Enrollee Services Trainer. Following the training, new employees will spend up to an additional 90 days answering calls under the close supervision of seasoned staff. The curriculum covers all topics needed to help enrollees with an emphasis on one-call resolution. In addition to training on our computer and telephone systems, and customer services skills, including use of approved call scripts and proper call documentation, we will include EPSDT requirements training. Critical issues for enrollee services staff will include making sure enrollees have access to a PCP of their choice, helping enrollees schedule visits to access preventive care and treatment, and making sure any request for services for a child is forwarded to the clinical team even if the service is not a covered service except through EPSDT. Call scripts will include the correct prompts to ensure appropriate routing of these calls and will include reminders to escalate calls that cannot be resolved to a supervisor for speedy resolution while the enrollee is on the line.

We will continue to train our Enrollee Services staff with on-the-job experiences and at least quarterly training updates to ensure compliance with changing requirements and continuous quality improvement. An auditor will perform ongoing monitoring of calls for all Enrollee Services call center staff to ensure quality and consistency. We will share recorded calls and audit results with employees and with supervisors who will provide verbal feedback to employees as well as additional guidance and support via “side by sides.” Issues identified by auditors will be communicated to the trainer, who will develop and conduct routine refresher training on an individual, small group, or department-wide basis, as necessary.

Provider Services Call Center Training --
We will provide comprehensive training to our Provider Services Call Center staff, recognizing that they play an integral role in servicing our provider partners. New employees will participate in a two-week training program, followed by job shadowing a more experienced employee. Similar to the training for enrollee services staff, provider services staff the curriculum covers all topics needed to help providers with an emphasis on one-call resolution. In addition to training on our computer and telephone systems, and customer services skills, including use of approved call scripts and proper call documentation, we will include EPSDT requirements training. Critical issues include how to respond to provider’s calls concerning billing for essential elements of the Child Health Check-Up, referring calls about service requests for children directly to the clinical team even when a service would typically not be covered, understanding provider care gap reports, and coordinating access to resources, often the local care management team, for help closing these gaps.
An auditor will record and perform ongoing monitoring of calls to assess compliance with contract standards and other regulatory requirements. We will use the results to provide both individual feedback and refresher trainings for a larger group.

Provider Network Representatives Training –

Our training program for Provider Network Representatives includes two weeks of in-house training conducted by an experienced trainer, followed by two weeks of training “in the field” where the new employee accompanies an experienced team member to learn how to resolve provider

issues. Provider Network Representatives will also participate in formal orientations with other Lighthouse departments to fully understand each department's function, and observe Provider Claims Representatives, Enrollee Services Representatives, and Provider Enrollment staff. The training agenda is extensive. Focus areas that include education about EPSDT requirements include:

- Managed care and an overview of the Florida SMMC program and goals
- The Identifi Health Administration Platform (such as claims and inquiry documentation and tracking); Intranet site; provider network reports; web-based applications
- Training providers on our policies and procedures for administering enrollee benefits
- Meeting and effectively communicating with assigned provider practices to present performance data as well as best practices
- Keeping current on and communicating updated regulations and policies about benefit administration
- Working across departments to develop, promote, and execute strategies for providers to improve health care for enrollees
- Championing collaborative provider partnerships to implement health plan initiatives and best practices

Our Provider Network Representatives will receive ongoing training in new policies and procedures, system updates, new initiatives, Medicaid program changes, changes to state and federal laws and regulations, and other updates.

Claims Management Training --

Claims Management employees supporting the Florida health plan will attend five weeks of extensive, job-specific training. The training program will employ an approach that focuses on hands on experience reinforced with feedback, coaching, and formal training. Claims Management staff will train in a computer lab and learn to use the telephone and computer systems, how to process all types of claims and claims appeals, including EPSDT-related claims, and how to leverage our Online Help resource to assist providers and enrollees with inquiry resolution that includes EPSDT.

New employees will be required to achieve a 90 percent accuracy rate on 30 online assessments designed to measure proficiency of training material. Employees with assessments not meeting the 90 percent threshold will receive additional training on the areas of concern. The entire claims team will meet monthly to further enhance open communication and provide ongoing training and mentoring.

Provider Training --

Our provider training approach uses a mix of in-person, media, including print, audio and video trainings, and online resources to provide a comprehensive approach to understanding EPSDT requirements and processes. This makes provider training readily accessible in locations and at the time and frequency needed by the provider.

Training modules and documents are available in print, on the provider-portal and shared in web-based training curriculums. Resources include:

- EPSDT Provider Manual
- EPSDT Provider Orientation Packet

• EPSDT Provider Tool Kit
• EPSDT Quick Reference Guide
• Educational content includes claims submission and payment processes, enrollment and credentialing, Florida's definition of medical necessity, Child Health Check-Up Requirements, and adult protective services requirements.

Facilitated Training Sessions will be provided in multiple venues.

• Educational initiatives will begin 90 days prior to the first enrollee enrollment date.
• We will invite all providers to attend classroom training sessions scheduled at convenient locations throughout their area. Classroom sessions will continue through program launch.
• We will offer the same curriculum through multiple delivery modalities including classroom training, online, office and video training, to allow as many providers as possible to participate.
• For providers who are unable to attend a formal training session, we will review the critical elements of the curriculum with them during a regular visit by a provider network representative. Provider network representatives offer in-person education and assistance to PCPs to support their essential role, as the child's Medical Home, in ensuring delivery of Child Health Check-Up services.
• In addition to in-person provider network visits, providers can access any of our comprehensive training modules on the web portal or by contacting their provider relations representative for follow-up or repeat training as needed.
• The provider manual in its entirety will be available on the provider portal.
• We will accommodate the training times and days of the week requested by our providers, including evenings and weekends, as needed through the implementation period.
• We will provide targeted education for providers performing below required thresholds.
• Quality Improvement staff provide onsite education visits, phone contact, and written notices to support EPSDT compliance. Onsite visits include in depth discussion of all EPSDT/Child Health Check-Up elements and review of the American Academy of Pediatrics Recommendations for Preventive Care, the encounter form use and the required medical record documentation.

Awareness Campaigns --

Our outreach channels such as eNews and Provider Newsletters will focus on pertinent Child Health Check-Up issues and topics. Newsletters will be posted to the provider portal and a notification faxed to each provider announcing the issue. We will facilitate EPSDT awareness and training at State-wide provider forums and lunch and learn venues.

EPSDT MONITORING

Identifi, the web-based information technology solution supports all Lighthouse departments, providers and subcontractors with monitoring of compliance with EPSDT requirements. Identifi designs a preventive care schedule for each enrollee based on their age and diagnoses and the periodicity schedule and provides an organized membership list that includes this schedule, supporting proactive outreach activities to encourage compliance and follow-up when we identify care gaps. Identifi also tracks outreach productivity and reports on all outreach efforts.

We use the following data sources to review compliance with the EPSDT requirements:
• Paid claims data
• Subcontractors' encounter data

• Prior authorization data
• Enrollee-specific data from file reviews
• Care gap reports
• HEDIS interim reports
• CMS 416 reporting
• EPSDT audits,

We can also perform an audit of provider billing for an EPSDT visit to determine if all elements are documented. We can then reduce payment for non-compliance until the threshold is met.

ENSURING EPSDT TRANSPARENCY

We are committed to transparency with our external shareholders and will share:

• A summary of our EPSDT "special services", including the physical health and BH services review process, in the Enrollee and Provider Handbook
• Our EPSDT "special services" prior authorization policy and procedure for review by our quality committees that include enrollee and provider representation and with external stakeholders who may be directly involved in the enrollee's care plan because they provide other services and supports, such as HCBS waiver services
• Our EPSDT screening rates and participation rates with our quality committees that include enrollee and provider representation

EPSDT information will be shared with providers in provider newsletters, on the Lighthouse website provider landing page, via the provider portal and in self-service reports available in Identifi.

EPSDT information will be shared with enrollees/families through newsletters, on the Lighthouse website enrollee landing page, and through additional enrollee mailings including reminder postcards and enrollee incentive mailings.

We will also include our screening rates and information about EPSDT special services in an annual Lighthouse report to the community, which will be shared with providers and community leaders to enhance greater transparency.

Following release of a community report, pediatricians in a Medicaid plan in Kentucky reported families and children frequently miss scheduled appointments and then become unable to reach. The plan identified two age bands with significantly lower rates of completed EPSDT visits: children six to nine years of age and adolescents. The plan implemented a well child visit enrollee incentive program for completion of EPSDT visits for these two age groups and expanded the focus more recently to children and adolescents seven to 20 years old.

Evaluation Criteria:

1. The adequacy of the respondent's approach related to outreach and communication strategies that will be used to enhance enrollee education on EPSDT requirements.

2. The adequacy of the enrollee engagement approach and strategies that will be deployed to improve compliance with the periodicity schedule and treatment recommendations, including identification of the data sources that will be used to monitor compliance.

3. The adequacy of the respondent's training and education approach to facilitate a firm understanding of federal and State EPSDT requirements throughout all operations of the plan/subcontractors. The respondent must illustrate a commitment to ongoing training and retraining of staff/subcontractors utilizing an array of mediums to earn all points for this component.

4. The adequacy of the respondent's monitoring approach, including all data sources that will be used to ensure compliance with EPSDT requirements throughout all relevant departments within the respondent and with subcontractors.

5. The extent to which the respondent's overall outreach approach identifies opportunities to improve upon the level of transparency for external stakeholders.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 23 – Behavioral Health/Primary Care Integration (Statewide):

The respondent shall describe its proposed approach in promoting integrated behavioral health and primary care models, including:

a. Identification of integrated models in various practice settings that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness.

b. Identification of opportunities for improvement across the respondent's system of care (e.g., care management, provider network, utilization management, enrollee services) with the goal of advancing to more integrated care models.

c. Description of strategies the respondent will deploy to overcome the barriers/gaps identified to increase its capacity for providing integrated care models, including use of alternative payment models/financing strategies.

Response:

Lighthouse Health Plan (Lighthouse), as a provider sponsored health plan, is focused on strengthening the enrollee and primary care provider (PCP) relationship and promoting behavioral health (BH) and primary care integration as an essential component critical to improving health outcomes, particularly for enrollees with complex health needs. Research suggests that 70 percent of primary-care visits stem from psychosocial factors. We also know that chronic health conditions, such as diabetes, substance abuse, asthma, obesity and cardiovascular disease, require behavioral health interventions for best outcomes (New England Journal of Medicine, 2010). Quality of life and, not surprisingly, the cost of caring for someone who has both a chronic illness and depression can be twice the cost of caring for a patient with chronic illness.

Most health systems - hospitals, primary care practices, BH providers and ancillary providers – are engaged in multiple efforts to improve integration, increase primary care access, improve coordination of care, and redirect patients from high-cost settings or intensive services when clinically appropriate. Most health plans add an additional layer of clinical programs designed to achieve the same objectives. This often leads to provider and enrollee confusion and duplication of effort, with limited success.

Our approach focuses on bringing providers together as an integrated delivery system and using population health management strategies to actively engage enrollees and their families in their plans of care. Lighthouse will deploy strategies that promote integrated behavioral health and primary care models and practices, providing an array of supports to help providers progress toward a fully integrated delivery model.

IDENTIFICATION OF INTEGRATED MODELS WITH DOCUMENTED IMPROVED OUTCOMES

There are limited studies that specifically address documented, improved outcomes when using integrated models for Medicaid enrollees. (MACPAC March 2016.) Two approaches with demonstrated cost savings and improvements in key quality indicators are the Patient Centered Medical Home and Health Homes.

Patient Centered Medical Homes --

The most recent evaluation of Patient Centered Medical Home studies shows the greatest cost savings from the combination of:
• Team-based interventions, including case management;
• Having a usual source of care; and
• Having a larger pool of higher risk patients with comorbid conditions.

The longer the PCMH operates, the greater the cost savings. Patient satisfaction is also high. Clinical and quality outcomes are mixed with some studies showing increased quality and reduced emergency department (ED) use, or increased outpatient service use. (July 10, 2017 PCPCC Press Release).

Co-Location Models --

SAMHSA's Primary and Behavioral Health Care Integration (PBHCI) program awards grants to co-locate primary and specialty care services in community-based mental and behavioral health settings (health homes). Results from grantees shows statistically significant improvement in the overall health of adults with SMI served in these settings at six months and again at 12 months post implementation. (SAMHSA. Integration of Primary Care and Behavioral Health. Mental Health America Regional Meeting, Feb. 19, 2016.) The Collaborative Care model, an integrated care model developed at the University of Washington designed to improve outcomes for individuals with common mental health conditions, demonstrates that Collaborative Care is more effective than usual care. (AIMS Center. University of Washington. Website.)

OPPORTUNITIES FOR IMPROVEMENT

Early Identification of Behavioral Health Diagnoses --

PCPs often see enrollees who have low-level BH needs or who have the first indicators of a BH condition, including depression, ADHD or a first episode of psychosis. These enrollees would benefit from early identification of BH conditions and referral to the local care management team for additional assessment and management. We believe there are opportunities to increase early identification and get enrollees into care management and coordinated treatment before they experience a decline in health or crisis.

Need for Improved Communication –

Care managers, UM staff and providers use different systems to document their care and communicate across the team. Different provider groups often use different EHRs. Communication often relies on phone calls and faxes, may be delayed or may not occur at all. Providers may work in silos, missing opportunities to intervene with their patients at the most opportune time.

Need for Increased Provider Collaboration Across the Care Continuum --
An opportunity for improvement is the need for PCP provider education and updates on the BH network, standardized screenings and treatment modalities and enhanced methods for working with enrollees with BH and substance use disorder diagnoses.

STRATEGIES TO INCREASE CAPACITY FOR INTEGRATED CARE MODELS

Integrated Delivery Arrangements (IDA) --

We believe that communities of providers can work together in a shared, risk-based arrangement that incentivizes improved access to care and reduced ER and inpatient use using a care continuum approach. Our integrated delivery arrangements (IDAs) model includes, by Years 4 and 5 – but sooner if providers are ready for the complexities - a sub-capitation option with bonus opportunities. IDAs may be led by a primary care practice, a specialist or a hospital according to the targeted member population. The sub-capitation would be based on a percentage of the total cost of care, and calculated based on prior claims experience by actuaries. The Value Bonus (performance scorecard) is paid above and beyond the capitation and is tied to quality outcomes and savings generated. Participating providers must achieve specific quality outcomes to qualify for payments (quality gate).

An example of a specialist-led IDA would be a psychiatrist leading an IDA that serves a group of attributed enrollees with schizophrenia. The quality gate/performance scorecard would be a mix of primary care and BH related “measures that matter” and the two providers would share in the savings. Examples of achieved savings include those resulting from avoiding a psychiatric hospitalization or avoiding hospitalization for a chronic physical condition, such as diabetes or COPD because the enrollee’s health is managed more effectively through the collaborative efforts of the PCP and specialist.

Co-Locating BH Clinicians in Primary Care Practices --

We will partner with our BH providers to increase co-location of BH clinicians in high-volume primary care sites. BH care managers will help PCPs develop expertise on providing integrated care by supporting the practice in incorporating standard BH/SUD screens into the workflows, closing the loop on positive screens and BH referrals, providing education related to more common BH medications to the practice’s clinical team, and strengthening the relationship between primary care and the BH providers within the local network. Through this collaboration we will encourage providers share what they have learned with other PCPs and BH providers in small group meetings and individual case conferences. Where co-location is not an option, we will collaborate with mobile psychiatry services and tele-psychiatry providers to help FQHCs and PCPs in rural areas treat patients with underlying BH conditions.

Providing PCPs with Screening Tools, Training and Referral Workflows --

We will provide PCPs with evidence-based, clinical guidelines and validated screening tools for prevalent conditions, such as depression, substance use disorders and ADHD and a step-by - step guide for connecting enrollees who have an identified BH need to the local care management team and appropriate BH providers. We will encourage and train PCPs on the use of Screening, Brief Interventions, Referral and Treatment (SBIRT) to identify substance use problems in the primary care setting, and provide referral processes that include support from the aligned local care management team.

We will also provide copy-ready member education materials on specific conditions, and a list of BH providers in the network that specialize in the treatment of each of these conditions

Encouraging Providers to Achieve PCMH Recognition --

Our network development efforts to date in Region 1 have already resulted in contracts with 12 primary care sites that are certified PCMHs which include 179 primary care providers delivering services through the integrated, coordinated PCMH model of care. Lighthouse will offer tools and supports to network providers who are operating as PCMHs as well as to those practices that are transforming their clinical processes to align with PCMH approaches.

• Our aligned care management team community health workers and care managers locate and engage members, connect members to covered services and community resources, identify enrollees for care management and DM programs, and schedule routine appointments. They also provide information on how to decrease no-show rates.
• Using Identifi Practice, providers can see their patients with active conditions, and their patients' diagnoses and risk stratification score, in a single view. To make sure members receive proactive care and interventions before they experience an adverse health event, we review the PCP's patients' risk stratification with the PCP quarterly. Identifi Practice can be used to guide providers' patient assessments and documentation. Office staff can use Identifi Practice to stratify their patients for early outreach and scheduling and estimate appointment length, helping to ensure patients receive timely preventive care and chronic condition treatment and increasing efficiency. Identifi Practice also gives providers, including in remote locations, real time access to population health measures and other valuable data and analytics. It supports providers' quality improvement efforts, tracking each provider's progress toward defined targets and quality goals and incentive status.

Education –

We will work with BH integration experts to develop education programs for both PCPs and BH providers to strengthen coordination and communication among these providers. We will host annual BH trainings for our PCPs and offer quarterly webinars, which will be recorded and made available to PCPs on our website. Trainings will focus on promotion of physical and BH care integration and coordination of care. Since roughly two-thirds of all behavioral health medications are prescribed by PCPs, we will also target behavioral health coordination in our pharmacy trainings, as well. Information effective collaboration with also be shared with PCPs and BH providers through the Provider Portal.

Evaluation Criteria:

1. The extent with which the respondent thoroughly describes its current approach to and readiness for promoting/incentivizing, and removing barriers to, integrating behavioral health and primary care throughout its system of care.

2. The extent to which the respondent provides examples of more effective integrated models within its provider network that have documented improved patient outcomes, patient satisfaction, and cost-effectiveness. The respondent must also describe the data sources.

3. The extent to which the respondent identified opportunities for improvement in delivering an improved integrated care model and subsequent steps the respondent will implement across its systems to increase capacity for providing integrated care.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 24 – Transportation (Statewide):

The respondent shall describe its experience and approach for coverage of non-emergency transportation services by providing the following:

a. A description of the software capabilities utilized to facilitate ease in scheduling and tracking of enrollee pickup adherence;

b. Strategies for determining the most appropriate mode of transportation; and

c. Providing data on the following performance metrics for calendar year 2016:

- **(1)** Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
- **(2)** Percentage of missed trip requests (failed to pick up the enrollee);
- **(3)** Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
- **(4)** Percentage of urgent care requests fulfilled within three (3) hours of the request; and
- **(5)** Number of transportation related complaints and grievances per 1,000 enrollees.

d. A description of how the respondent uses the performance metric data above to identify areas in need of improvement and implements successful strategies that improve the provision of service.

Response:

Lighthouse Health Plan recognizes the challenges associated with administering a Medicaid transportation benefit, and the frustration that is caused to Enrollees and Providers when problems arise with scheduled transportation to medical services. As a result, we have selected One Call Care Management (One Call) to administer the transportation benefit using their unique and innovative blend of a traditional transportation broker model and “on demand” transportation that leverages ridesharing platforms including Uber and Lyft. One Call has been providing Non-Emergent Medical Transportation for 20 years with programs nationally and in Florida.

As a Florida-based, industry leader in transportation, One Call understands healthcare transportation is an essential part of an enrollee’s treatment plan and takes precise care in the handling of enrollees. With their current nationwide network, One Call can provide service in any area including Region 1. One Call transportation experts arrange the service, secure the provider, and coordinate all aspects of the referral making the ride request easy for our enrollees. They deliver superior tools, support, and metrics that will help Lighthouse provide efficient, comprehensive management of transportation services for all types of enrollees including TANF and medically complex/fragile children.

We understand each enrollee’s transportation needs may be different and as a result, we will offer two transportation services models for our Enrollees to select from. One Call’s traditional transportation model includes providing non-emergency medical transport through sedan, wheelchair-accessible, stretcher-accessible, basic life support (BLS), and advanced life support (ALS) contracted, network providers. One Call will also manage an authorized and appropriate

public transportation and gas mileage reimbursement benefit. Through One Call, we will also offer an on-demand transportation model which includes non-emergency, ambulatory services through One Call's transportation network companies including Lyft and Uber. On demand transportation services include active trip monitoring where One Call team enrollees can monitor live trips and mitigate issues such as driver cancellations by quickly re-scheduling the trip with another available driver. This active monitoring means enrollees receive the treatment they need quickly.

SOFTWARE CAPABILITIES TO FACILITATE EASY SCHEDULING AND TRACKING OF TRIPS

One Call has developed formal procedures as a guide for One Call employees when processing referrals utilizing a proprietary system. These processes have been designed, evaluated, and improved over the years to optimize turnaround times and reduce administrative burden for clients. To accomplish this, they use Relay Transportation, their own proprietary scheduling system. One Call makes investments into its proprietary system(s) regularly, so that they are continually improving service levels and enhancing the health plan and enrollee experience.

The scheduling process begins when an enrollee, case manager or care coordinator determines that transportation services are needed for an enrollee. The referral is sent to, or called into One Call for scheduling with an approved network provider.

One Call has developed proven procedures for processing referrals and scheduling enrollees that provide a seamless experience for our enrollees. One Call's team of care coordinators are trained to handle requests for services expeditiously and professionally.

One Call offers several methods for sending transportation referrals and prides itself on being flexible. Referrals at One Call can be initiated through any of the following methods:
• Phone–The requestor calls into the One Call toll free dedicated number and provides the necessary referral information for entry into One Call's system.
• Fax–The requestor faxes the necessary referral information to the One Call where it is retrieved and entered into One Call's system.
• Email–The requestor emails the necessary referral information to One Call and then retrieved and entered into One Call's system by a care coordinator. Pre-developed PDF referral forms can be supplied to supplement this method.
• Relay Transportation Web Application–The requestor can electronically submit a transportation request into the web application on their desktop computer.
• Electronic Referrals–The requestor can send an electronic referral via easyreferral® through One Call's website with the necessary referral information where it is retrieved and entered into One Call's system. The online easyreferral® form guides users through the referral process ensuring fast, accurate referral intake. This tool offers less manual rekeying, as it can carry forward primary data points to other areas of the form, and preference storage, as it can recall your personal information and preferences. To avoid follow up calls, it provides instant alerts for missing information and can upload supporting documentation. The easyreferral® tool can be accessed via the website and provides anytime, anywhere access with no username or password hassle.

Through years of experience in referral management, One Call knows that payers and programs need flexibility when it comes to not only how referrals are placed, but also with who can make the referral. One Call will accept referral requests from various individuals, including Lighthouse staff, enrollees, and/or case managers.

One Call's proprietary technology includes automatic provider selection based on the provider's ability to provide the required service, provider quality rating, and proximity to the assignment location. The provider quality rating is determined based on the provider's reliability, quality of service (reflected by the number of service issues or complaints received), and overall compliance with One Call's system and best practices. The provider rating is updated based on real-time information that is instantaneously refreshed within the scheduling system. This real-time information includes information captured from customer feedback, the quality assurance calls made to enrollees the business day after each appointment, and the data available to the internal operational team based on the success/failure of appointments and any quality issues raised by any party.

Referral Entry --

When a referral request comes in, the care coordinator will first search One Call's system to determine if the request for the same referral already exists. If no existing referral is located in the system, the care coordinator will create a new referral.

One Call processes with accuracy, to prevent delays in scheduling. One Call's solution for processing referrals with the correct information is a sophisticated scheduling platform designed with checks and balances. In order for a referral request to be processed and scheduled into the system, automated edit checks are performed on the referral to validate that the minimum required information necessary has been entered. The minimum information required includes the enrollee's name, address, and phone number. This also includes checking eligibility and plan verification.

If any additional information is needed to complete the referral, an error message will be displayed on the user screen listing those items that must be completed before the referral processing can be completed. If information is missing, a care coordinator will make several attempts to obtain the missing information. The care coordinator will update the file with the correct information. Once accuracy of the referral input is verified and any discrepancies resolved, the referral is routed via workflow within the system to an interactive voice response (IVR) queue which is an automated system that will make the first attempt to contact the enrollee within one hour.

Typically, when a referral is received by One Call for enrollee transportation services, the type of service is already indicated based on enrollee level of need. However, One Call has a team of transportation experts who are well versed in enrollee care and will offer recommendations of the appropriate level of service required. If at any point, the One Call team determines this may be potentially an advance/complex care enrollee, they will flag in the One Call system, which will alert One Call's specialized complex care team to review the request to ensure appropriateness of selected transportation.

Referral Service Reminders and Delivery/Service Completion Confirmation --

One Call utilizes interactive voice recognition (IVR) to aid confirmation of scheduled transportation on the business day before the service. The system makes two attempts to contact the enrollee in order to confirm scheduled transportation. If contact fails, a report is generated to notify their staff. At that point, a live agent can attempt to contact and confirm with the enrollee, who has not

yet been contacted. Detailed reporting is provided upon request, as it helps to demonstrate noncompliance by the enrollee.

Providers selected to provide a service must accept the assignment as initial confirmation. One Call proactively follows up with the provider at 24 hours prior to the pick up or appointment time to confirm the provider is scheduled to perform the upcoming service.

On Demand Transportation –

Relay Transportation is a proprietary web-based desktop application. Users can effortlessly schedule on-demand or future transportation by submitting a request including minimal required information (e.g., enrollee's name, phone number, pick up address, and destination address). The Relay Transportation tool also allows for entry of special instructions or unique handling requirements at the time of scheduling to ensure appropriate accommodations can/will be provided (e.g., "Gate code is 1234#" or "Pick up at Door 34"). Relay Transportation is available as a mobile app for Apple and Android devices and can be used by enrollees or authorized Lighthouse or facility staff to request ambulatory transportation services. Users also have visibility into scheduled rides, active rides in progress, and completed trip logs.

Relay Transportation–Dashboard

Lighthouse Relay Transportation Dashboard users also have visibility into active, in-progress rides as well as those scheduled for a time in the future.

Relay Transportation users can easily access completed appointment details including time-stamped activities and invoicing details.

One Call's comprehensive Relay Transportation solution helps reduce costs for non-emergent ambulatory transportation services through savings via transparent pricing and administrative savings. Use of the Relay Transportation solution for scheduled trips allows an enrollee's treatment to remain on track.

Additional Benefits of the On-Demand Transportation Services Model --
• Open Application Programming Interface (API)–Relay Transportation has a flexible infrastructure that enables One Call to add additional strategic partners through an open API. API integration is not required in order to utilize the Relay Transportation desktop platform or the mobile app. However, the API is open should Lighthouse wish to connect this solution to desktop or mobile applications.
• SMS/Text Messaging–Once a ride has been scheduled through Relay Transportation, One Call initiates a series of text messages keeping the enrollee informed of their transportation arrangements. These text messages are designed to offer enrollees greater peace of mind by providing them with details about their upcoming ride, their driver, the vehicle and ride tracking. These text messages also enable enrollees to request a return ride with the press of a button on their phone and allow them to provide instant feedback by rating their ride experience and driver.
• Active Trip Monitoring and Issue Prevention–One Call has a team dedicated to monitoring Relay Transportation rides in real time. Through this active monitoring, their team is alerted to potential issues and takes action to proactively address transportation issues. This real-time visibility allows One Call to immediately notify Lighthouse if an enrollee is a "no show" for transportation or if a

late arrival is anticipated. This reduces the administrative burden of Lighthouse staff following up and making multiple outbound calls.
• Mitigate Fraud, Waste, and Abuse–When using Relay Transportation, the driver and enrollee can only contact each other through masked phone numbers—only valid for the duration of each specific trip. Phone numbers are masked so that enrollees and drivers cannot arrange for transportation outside of One Call and without specific authorization. Entry of multiple stops outside designated pick up and drop off addresses or unauthorized locations are prohibited through the Relay Transportation platform.

DETERMINING THE APPROPRIATE MODE OF TRANSPORTATION

Lighthouse will provide modes of transportation that are appropriate to meet the needs of our individual enrollees. This includes a range of options from mileage reimbursement and public transportation to ambulance transport for enrollees requiring advanced life support while in transit. These levels of transportation are described below.

Ambulatory (Sedan) --
• Provides an option for non-emergent ambulatory transportation.
• Simplifies on-demand transportation by integrating with well-known and familiar ridesharing companies (e.g., Lyft and Uber).
• Provides real-time visibility for peace of mind and improved client and enrollee experience.
• Allows One Call to proactively impact the continuum of care through real-time monitoring, management of active alerts and proactive notifications of no-shows, late arrivals and cancellations.
• Enhances enrollee satisfaction through instant driver ratings.

Wheelchair-accessible --
• Transportation in a wheelchair-accessible van, which allows the enrollee to remain in the wheelchair while in transit.
• Wheelchair van service includes options for assisting the enrollee in and out of the vehicle for each leg of the trip.

Stretcher-accessible --
• Transportation in a van or vehicle that is equipped with tie-downs for a gurney, but does not include emergency medical technician (EMT) or paramedic care.

Basic Life Support (BLS) --
• BLS includes one EMT and two attendants in the vehicle with the enrollee.
• BLS enrollees may be transported with needs such as oxygen, heart monitoring, or a medication pump.
• BLS EMT does not administer any medication, but does provide basic care during the transport, such as suction, regulating oxygen, etc.

Advanced Life Support (ALS) --
• ALS, which includes two EMTs and at least one paramedic in the vehicle with the enrollee.
• ALS enrollees may be transported with conditions/needs such as IV, tracheotomy (less than two weeks prior), ventilator, medication, heart monitor, etc.
• ALS paramedics are able to provide advanced critical care such as IV solutions, administering medication, and defibrillation.

In extreme situations, our vendor, One Call, can also provide the following additional transportation services:
• Air Ambulance
• Travel Coordination

One Call has a team of transportation experts well versed in enrollee care and they will utilize various strategies to ensure the appreciate mode of transportation is selected based on level of need. One Call will take the following into account when determining lowest cost and most appropriate mode to meet the level of need of each enrollee:
• Is the enrollee eligible to receive benefits?
• What is the enrollee pickup and drop off address?
• Is the enrollee ambulatory?
• Are there any special services required?
• Does the level of service require a driver medically certified?
• Does the enrollee have other means of transportation?
• Would the enrollee prefer to utilize the gas/mileage reimbursement option?
• Is there an opportunity to utilize public transportation by the enrollee?
• Protocols (ADA, Plan, State, Federal) (Example: Verification of medical transportation ability form)

If at any point, the One Call team determines this may be potentially an advance/complex care enrollee, they will flag in the One Call system, which will alert One Call's specialized complex care team to review the request to ensure appropriateness of selected transportation and receive authorization from Lighthouse as required.

Overall, Lighthouse strategy is designed to be:
• Effective-get the enrollee where they need to go when they need to be there.
• Efficient-use public dollars economically.
• Accessible-Ease of use for enrollee.

IDENTIFYING OTHER MEANS OF TRANSPORTATION

As mentioned above, One Call will inquire during the intake process with the enrollee and/or requestor to determine if the enrollee should have another means of transportation that could be utilized in lieu of providing transportation and if there is another means, discuss with the enrollee the option of utilizing gas/mileage reimbursement for driving themselves or for having another authorized family member/friend etc. drive them to their appointment.

One Call's Relay Transportation App also offers mileage tracking and can allow for submittal of reimbursement if permissible. This is a quick and easy way for both the enrollee and the State to ensure accurate mileage reimbursement.

PERFORMANCE STATISTICS

One Call's performance metrics for 2016:
• Percentage of trips where the enrollee arrived to their scheduled appointment on time: 98.02%
• Percentage of missed trip requests: 0.9%
• Percentage of hospital discharge requests fulfilled within 3 hours of the request: 95.52%

• Percentage of urgent care requests fulfilled within three (3) hours of the request: This metric is currently not being tracked; we will collect this data for enrollees going forward. We do track fulfillment of urgent transportation requests (scheduling within 1 business day). One Call currently fulfills 99.1% of such requests.
• Number of transportation related complaints and grievances per 1000 enrollees: 8.9

USING PERFORMANCE METRICS TO DRIVE IMPROVEMENT

One Call is a customer-focused organization and providing superior service is a key component to ensuring they meet their customer's needs. One Call has a dedicated process excellence team that deploys process improvement models and methodologies, such as Lean Six-Sigma, to empower the business to significantly improve productivity and profitability. They utilize, implement, and train enterprise resources on best practices that drive process and operational excellence using performance metrics as a key tool.

In addition, One Call has a dedicated quality assurance team of over 19 associates focused on monitoring compliance ensuring ongoing consistency and quality. This high-touch service model enables One Call to be a leader in both customer service and cost effectiveness. Inbound calls to care coordinators can be observed live by supervisors and/or the quality assurance team to ensure call standards are being met. Results are discussed with the individual care coordinator during their regular meetings with their supervisors to address any concerns.

One Call has a dedicated training department whose mission is to provide training and employee development programs that enhance the performance of employees. The dedicated training department conducts regular staff education presentations and refresher training for all care coordinators. The courses available to employees vary and are dependent upon the employee's role within the organization. Courses can be either web-based or leader-led. Leader-led training courses provide the participants the opportunity for hands-on experience and the ability to ask questions.

Through the process excellence team, quality assurance team and the training department, One Call provides superior quality assurance across the enterprise from network, clinical, service, and all the way through billing. Examples of One Call's efforts to maintain high quality are described below.

Provider Quality Grading and Selection --

Selection of a network provider to deliver a product or service is based on a combination of quality rating, geographic proximity, and contractual compliance. One Call utilizes a proprietary, algorithm that reflects a provider's position in the network. The system integrates elements of quality, geography, cost, and contract compliance. This ranking determines how often the provider receives a referral from One Call. This application, unique to One Call, allows best-in-class provider selection for every referral.

Provider Compliance --

Provider contracts include service level agreements (SLA) that safeguard the high standards set by One Call and Lighthouse. One Call's comprehensive approach to network management has resulted in strong provider partnerships and high-quality programs. In addition, One Call's

provider contracts require providers to notify them timely of any demographic and/or service changes. One Call is committed to providing a weekly provider directory to Lighthouse to ensure we have the most current information at all times.

Network Quality Scorecards --

One Call utilizes network quality metrics that align with the Triple Aim framework for optimizing health system performance. Triple Aim is comprised of:
• Improving enrollee experience
• Improving population health, and
• Reducing per capita costs

Achieving Triple Aim is a complex endeavor, requiring healthcare organizations to understand their past and current performance, then implement interventions to improve that performance. This entire process requires a strong data foundation and the tools to continuously measure performance. It also requires the ability to combine clinical, financial, administrative, and enrollee satisfaction data.

Performance and quality data is gathered on a regular basis (e.g., when an enrollee is discharged from One Call services) and scoring metrics are reviewed every 30 days to assess trends or identify the need for a call to action.

Grievances --

If a grievance occurs, One Call's grievance specialist in the provider relations department reviews the grievance for variances from, or violations of, applicable Medicaid care standards and the One Call SLA. The grievance specialists log the grievance in One Call's database. Then, the grievance specialist contacts the provider and any other appropriate department(s) within One Call to research the issue. Based on the findings, the grievance specialist partners with the provider to develop a satisfactory resolution for all parties, including developing a corrective action plan (CAP) for the provider as necessary. All final outcomes are updated in One Call's database and the results of these grievance reports can affect the provider's quality rating and position in the provider network.

Removal of Providers from One Call's Network --

Providers may be removed from the network due to significant grievances, service issues, low quality rating, or breach of contract. One Call actively manages the network to ensure providers comply with quality guidelines and reporting standards, which helps to ensure quality care and favorable outcomes. While they rarely remove providers from their network, it can happen due to several reasons such as provider offices may close or become acquired, the provider may terminate its agreement with One Call, or One Call may terminate its agreement with the provider. In all cases, there is formal documentation between One Call and the provider who will be removed. At the time of removal, One Call will determine if there are enrollees scheduled for future dates of service and make arrangements for them to be re-scheduled with other network providers, if need be. One Call will also set up a process to collect any outstanding medical reports that the provider may have for enrollees.

One Call's provider relations department handles provider grievances. When a grievance is received, the sender receives an acknowledgement. The grievance is logged and the provider is contacted (via phone or email). Based on the issue and the resolution received from the provider, the coordinator responds back to the submitter who initiated the complaint and after all issues are reviewed/resolved by the provider to the satisfaction of the initiator of the grievance; the issue is filed consistent with One Call's retention policy.

The Provider Quality and Credentialing Committee reviews all recommendations for provider terminations monthly. If the matter is of a grievous nature, One Call may decide to terminate the provider's contract. When this occurs, the provider receives a termination letter stating the reason for the termination and instructions regarding their right to appeal. The provider relations department sends an internal email to notify One Call departments of the provider termination. Providers who receive multiple complaints of a less serious nature over a short period of time are also reviewed and considered for removal from the network if they are unable to provide or implement an action plan to resolve the recurring issues in a timely manner.

Provider Quality and Credentialing Committee --

One Call's Provider Quality and Credentialing Committee (Committee) ensures enterprise provider network quality, across all of One Call. The Committee meets monthly to evaluate provider compliance with One Call policy, assess providers with sub-par performance, and act on recommendations identified through One Call operating departments. This Committee reviews and approves the providers being added to or removed from the One Call network or whose quality rating is being lowered.

Providers may be removed from One Call's network due to significant grievances, service issues, low quality rating, or breach of contract.

Provider Account Management Team --

One Call has invested in a provider account management team specifically to handle business development, problem resolution, and overall communication between their largest providers and One Call. This team is organized regionally, and allows the provider to experience regular face-to-face contact with a dedicated account manager in the field for optimum relationship building. This account management team also develops new programs for providers who receive new requests directly to care for an enrollee in the communities they service, and wish for One Call to facilitate the authorization through the insurer. The account management team also works with larger providers and manufacturers to understand the newest products and technologies that improve the ability to deliver care to an enrollee, and offer those proactively.

Provider Education --

One Call's provider and training solutions program is a proprietary education program that includes product specific training manuals, educational webinars, job aids, and newsletters for new and existing network providers. The program drives increased compliance with One Call policies and procedures, reduction in grievances, improved turn-around time for invoicing and payments, increased provider retention, improved One Call/provider relationship and reduction in rework by all parties.

Provider Satisfaction Surveys --

One Call administers provider satisfaction surveys to gauge provider satisfaction with One Call service, offerings, and performance. Survey results are vetted and areas that are identified as needing improvement are engaged to take action to research and take corrective measures as warranted.

Enrollee Satisfaction Surveys --

One Call will administer a Lighthouse-approved enrollee satisfaction survey to gauge enrollee satisfaction with One Call and network provider service, offerings, and performance. Survey results are vetted and areas that are identified as needing improvement are engaged to take action to research and take corrective measures as warranted.

In addition to these customer satisfaction surveys, as mentioned above, One Call asks every passenger after every on-demand ride to rate their driver on a scale of one to five, with one being the worse and five being the best. The most recent rating results were a 4.9.

If an issue is identified during the survey process or a driver is rated a three or below, One Call will not map the passenger with that driver moving forward. If a specific driver receives too many low ratings, they will no longer be available for any of One Call's ride requests moving forward.

Proactively seeing feedback from enrollees allows One Call to mitigate any concerns and prevent formal grievances from occurring.

One Call has a multifaceted approach to utilization of information from provider complaints, monitoring and recommendations from our Quality Improvement Committee not only during the recredentialing process but for day to day selection of a provider. One Call offers the highest quality network by applying stringent credentialing, recredentialing, education and scoring requirements across the network of providers. As a result, One Call can schedule the best-performing, most appropriate provider for the enrollee.

One Call's network quality program consists of the following key components:

Auditing --

One Call performs ongoing provider oversight through grievance and provider remediation, as well as repeat offender programs. These auditing programs begin with identifying non-compliant providers and/or those providers not performing according to contractual obligations. They continue with grievance processing, provider probation, and potential provider termination from the network.

One Call assesses sub-par provider performance by reviewing the following areas, at a minimum.
- Grievance risk level, measured against a severity scale of 1–4; with 1 being the most severe
- Requested provider services not delivered
- Provider rejected the referral, after accepting it
- Non-submission of required documentation (e.g. invoices)
- Services not completed in a timely manner
- Investigation (e.g. law enforcement is engaged)

Repeat Offender Program --

One Call utilizes a repeat offender program for providers who are not complying with their contract terms and conditions. Any provider receiving multiple grievances within a rolling 90 days is considered a repeat offender and is referred to the provider retention and support team for action. This team reviews each grievance and identifies ways to assist providers through a remediation continuum, which includes:
• Educating the provider
• Clarifying expectations and responsibilities
• Identifying One Call protocol education opportunities, and/or
• Providing additional training

If the grievance issue is not resolved through the remediation continuum, the issue is escalated within the provider's organization, as well as One Call. The final resolution attempt is remediation, which can include a 90-day corrective action plan, probation, suspension of referrals and/or termination from the program. One Call has found that the remediation continuum successfully resolves compliance concerns.

Evaluation Criteria:

1. The adequacy of the respondent's software capabilities to facilitate ease in scheduling transportation and tracking of enrollee pickup adherence;

2. The extent to which the respondent describes strategies for determining the appropriate mode of transportation equipped to meet the enrollee's individual needs.

3. The extent to which the respondent's approach includes an assessment of whether the enrollee has any other means of transportation, including a description of the process that will be utilized to make this assessment.

4. The adequacy of the respondent's performance related to:

- **(a)** Percentage of trips where the enrollee arrived to their scheduled appointment on-time;
- **(b)** Percentage of missed trip requests;
- **(c)** Percentage of hospital discharge requests fulfilled within three (3) hours of the request;
- **(d)** Percentage of urgent care requests fulfilled within three (3) hours of the request; and
- **(e)** Number of transportation related complaints and grievances per 1,000 enrollees.

5. The extent to which the respondent uses performance metric data to identify areas in need of improvement and implements successful strategies to improve the provision of services.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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SRC# 25 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Deshea is 25 years old. She was auto-assigned to your plan and enrolled effective January 1, 2019. Deshea's enrollment information did not include a telephone number and listed a local area homeless shelter as her last place of residence. She left the shelter on December 27, 2018, and the shelter does not know her current whereabouts.*

The respondent shall describe the process it will use to attempt to contact Deshea by March 29, 2019.

Response:

Lighthouse Health Plan understands that being enrolled in a plan is merely the first step towards helping Enrollees fulfill their healthcare needs. In this case, Deshea is struggling with homelessness and it is likely that housing issues may be contributing to healthcare challenges. Our new Enrollee enrollment processes are designed to make sure that all our Enrollees understand and can access the services and supports available to them. For Deshea, these supports are more critical, and connecting her to service requires enhanced efforts.

IDENTIFYING DESHEA AS A NEW ENROLLEE

The first step in engaging Deshea is identifying her as a newly enrolled Enrollee and quickly determining her service needs. Lighthouse will identify new Enrollees like Deshea using a holistic and Enrollee-centric approach as described below.

Lighthouse's core system, the Identifi Health Plan Administration (HPA) platform, is equipped to process HIPAA EDI transaction sets including daily, weekly or monthly enrollment data in a HIPAA 834 file format. This system and the associated process has been effectively exchanging Enrollee information with Medicaid programs for 13 years.

Files are retrieved via EDI and are auto-validated prior to being loaded into the Identifi HPA core system. This auto-validation process includes rules that confirm EDI structural integrity, and any files which are not structurally sound are rejected from the load process. Rejected files are sent back to the Agency's fiscal agent so that a corrected file can be sent if necessary. Files are loaded with a "preliminary" status in the Identifi HPA platform and record additions, terminations and changes are identified. The preliminary load also identifies rejects and warnings for record updates where there are discrepancies between what is in the load file and what is in our database. The rejects and warnings are reviewed by Lighthouse Eligibility and Enrollment Specialists and either resolved or returned to the Division on an error report. Enrollment Specialists review all 834 transactions prior to the files being loaded into production. The Agency has visibility into the load status of every transaction received in enrollment files via delivery to a shared SFTP site upon finalizing the load in our core system.

Upon loading eligibility and enrollment files into the system, new Enrollees like Deshea will have their record flagged as requiring action. The following actions will be triggered when new enrollee records are loaded into Identifi:

• Mailing of Enrollee information packets including provider directory information, Enrollee handbook and Enrollee ID cards
• Primary Care Provider (PCP) selection and assignment
• Outreach to complete a Welcome Call including a Health Risk Screening. Given that Deshea's record does not include a telephone number, additional efforts will be made to contact her as described later in this response.

Eligibility and enrollment files will also be loaded into Identifi Network, our web-based provider services portal, to facilitate Enrollee eligibility verification and new Enrollee appointment scheduling by providers. The data will also be loaded into the Identifi HPA claims processing system to support claims payment, and it is provided to our subcontractors as needed to facilitate delegated services.

IDENTIFYING DESHEA'S NEEDS

Determining Enrollees with special health care needs or circumstances is of utmost importance. We leverage external data sources, Enrollee health risk assessments and powerful healthcare analytics tools to identify any special health care needs or circumstances within 90 days in accordance with the model contract.

The first source of information on Deshea's potential special health care needs or circumstances is the enrollment file received from the Agency. We will first review the x12 834 file, Detailed health coverage information located in the field: "Loop 2300 HD – Health Coverage and Segment" to determine if a special circumstance exists. Additionally, in this case, since the address provided is a known homeless shelter, Deshea's record will be flagged with a "homeless indicator". Not only will this trigger specialized outreach efforts, but even once Deshea is engaged and connected to stable long-term housing, the presence of historical housing challenges is considered as a factor by our risk stratification algorithms qualifying Deshea for more intensive ongoing care management supports depending on her other health related conditions.

Next, prior claims history, if available, along with external demographic information that indicate other social determinates of health are run through the identification and stratification algorithms contained within the Identifi Analytics module. These processes are run on a continuous basis so that as soon as additional information is available which would stratify Deshea into one of our care management programs, she will be identified and enrolled in the appropriate support program (e.g. Disease Management, Care Coordination, Maternity Care etc.). This includes identification and stratification based on health risk assessment information collected once our outreach staff has contacted Deshea.

MAKING CONTACT WITH DESHEA

To fully assess Deshea's needs and connect her to the Lighthouse services that can help her, we must first locate Deshea, update demographic information in our system and facilitate having her information updated with the Agency.

In this case we received an address for Deshea which is a homeless shelter. Lighthouse outreach staff maintain relationships with community organizations that serve the homeless, including shelters including organizations such as the EscaRosa Coalition on the Homeless. Since the

shelter address was provided by Deshea when she applied for Medicaid Benefits, our staff would reach out to the shelter to contact her. It is during this outreach that we would learn from the shelter staff that she has left and that her location is unknown. Shelter staff have a designated point of contact at Lighthouse and would be asked to encourage Deshea to call in to our Enrollee Services center if she returns to the Shelter.

Because of not being able to deliver a new Enrollee welcome kit and Enrollee ID card (homeless shelter address only), and since Deshea's enrollment record did not include a telephone number, our health plan follows multiple strategies to obtain demographic information so outreach can occur as outline below. Enrollees of our enrollment department and outreach department would be assigned to outreach to provider. When updated demographic information is received, the enrollment specialist would update the system.

1. Sponsoring Hospital Registration Systems - As a PSN, Lighthouse has a unique ability to collaborate with our sponsoring health system to locate Enrollees. The enrollment specialist will work with the Baptist Health System liaison to check the Baptist Health System registration system to determine if Deshea has sought care at any Baptist Health facility. Through this process we may identify alternative addresses or phone numbers to use in our attempts to contact Deshea.
2. Data Files - Additionally, we will use X12 834 enrollment file or claims history to identify a PCP of record. If the x12 834 enrollment file, or claims history indicates a PCP of record, our enrollment specialists will outreach to those providers to request updated contact information for Deshea. Simultaneously, Outreach Coordinators who also have access to the Identifi health plan administration module will be able to search current claims history and outreach to provider office as well.
3. Community Engagement - Finally, if none of the efforts above are successful, we will engage community partners who can help connect individuals they serve to Lighthouse. We will deploy a secure, read-only access of our eligibility system to key community partners. These community partners will be asked/trained to check the Lighthouse Enrollee eligibility verification system at the time a possible Enrollee seeks services from the community partner. If eligibility is confirmed, through secure messaging between the community partner and Lighthouse, our eligibility department will be notified of the community partner's registration, complete with all updated/revised demographic information.

If revised demographic data is identified through any of the strategies described above, Lighthouse will update the file in its system and appropriate outreach will occur. Additionally, new demographic information will be given to AHCA/enrollment broker in an acceptable x12 834 file, if permissible.

Keeping in contact with Enrollees is an important component of ensuring the health of the Enrollee population. Keeping Enrollee information up to date is vital to complete this task. Lighthouse will continue to utilize an exhaustive process for obtaining and updating Enrollee information. Key components of outreach are described below:

1. New Enrollee Welcome Kit – New Enrollee materials will be sent to Enrollees within the timeframe outlined in contract. All materials will be pre-approved by AHCA. In additional to the standard material included in the kit will be a reminder to Enrollee to call the enrollment broker any time Enrollee's demographic information changes.
2. Enrollee Portal – Enrolled Enrollees will be invited to register for a secure Enrollee portal. The Enrollee portal will allow Enrollees to access information on the plan, providers in the network and claim status. Portal will also remind Enrollees to contact the enrollment broker whenever the Enrollee updates their demographic information. Portal will also allow for secure messaging

between Enrollee and Lighthouse. Should updated information be provided by Enrollee to plan in this format, if permissible, we will submit updates Enrollee information to AHCA.
3. New Enrollee Welcome Calls - As part of the new Enrollee outreach protocol, a customer service rep will confirm demographic information and will update system. Should updated information be provided by Enrollee to plan in this format, if permissible, we will submit updates Enrollee information to AHCA.
4. New Enrollee "Open House" - Lighthouse will host New Enrollee "Open Houses" at Baptist Health System's various locations. The purpose of the open house will be to orient the new Enrollee to their healthcare system, review all AHCA offered benefits, instruct the Enrollee on the appropriate use of his/her PCP, re-confirm all demographic information and offer support for medical, behavioral and psycho-social needs.
5. Enrollee Contact & Interoperability between Customer Service and Medical Management Departments - Lighthouse can "flag" an Enrollee in its system that shows the Customer Service Rep or the Medical Management Rep, that Lighthouse's outreach coordinators want to contact the Enrollee. Should an Enrollee whose record has been flagged contact either the Call Center or the Care Management team, the representative can then warm transfer that call to the outreach coordinator or clinician for appropriate handling. Prior to the transfer, the representative will confirm all current demographic information and system will be up dated. Revised demographic data will be provided back to enrollment broker if permissible. Once transferred to a clinician, if an Enrollee is identified as having a special care need or circumstance and may be eligible for a disease management program the Enrollee will asked if he or she wishes to enroll in the disease management program. If the Enrollee does join a disease management program the case management team will also, as part of the normal outreach protocol, confirm Enrollee demographic and personal information.

ENGAGING COMMUNITY PROVIDERS

As described above, Community Partners and Network providers play a critical role in the overall strategy to identify Enrollees like Deshea. To identify Enrollees, network providers and community partners will be engaged from the very onset of receiving Deshea's enrollment from AHCA. As outlined earlier, these community partner's engagement efforts can be divided into an initial and ongoing engagement efforts as part of the overall identification process. The initial approach encompasses reaching out to community partners to review enrollment information. Secure data files with Enrollee information will be provided to partners for which Enrollee information indicates an address with a community partner. The ongoing engagement approach consists of providing community partners secure, read-only access to Lighthouse's eligibility and registration system. This will allow for real-time and immediate updates to Enrollee data. As part of the ongoing engagement efforts with community partners we will continue to embed case managers with key community partners. Embedded case managers will work together with community partners to identify Enrollees as well as to help in assisting and training community partners on utilizing our registration system.

In addition, network providers will be engaged in efforts to identify Enrollees. As noted earlier, PCP of record information will be immediately evaluated upon receipt of enrollment information via x12 834 files from AHCA. We will reach out to the provider to confirm and update information on each Enrollee. Providers will also be engaged as active participants in the process of identifying Enrollees. Baptist Health System provider locations will be used to host a wide range of events from educational events on chronic conditions to back-to-school immunizations. Enrollees will be notified of these community events using materials that have gone through the

standard internal and AHCA approval process. Enrollees that attend will be asked to provide updated information which will then be recorded and updated.

DESHEA'S STORY
In the case of Deshea, the homeless shelter listed as her address reported that she was no longer staying there. Deshea's enrollee file was flagged with a homeless indicator which put her in a queue for outreach. The Outreach coordinator contacted our liaison at Baptist Health System and it was determined that Deshea had not sought care in any of Baptist's facilities. The next week, Deshea called into our Enrollee Services line. Deshea had sought supportive services at Favor House of Northwest Florida, a program for women who are the victims of domestic abuse. Deshea was staying with a boyfriend but left due to domestic abuse. She first went to the homeless shelter where she applied for Medicaid programs but left the shelter after a brief time to stay with a friend. At her friend's urging she sought help at Favor House. Since Lighthouse Health Plan had established a relationship with Favor House, they knew to check Deshea's eligibility and determined that she was an enrollee with Lighthouse. The counselor at Favor House urged her to call in to engage in healthcare services. Deshea was linked to a PCP and completed a health risk assessment. Through the initial contact it was determined that Deshea was pregnant and she was enrolled in our Maternity Care Program. The Maternity care coordinator collaborated with the staff at Favor House to ensure that she received all prenatal services while transitional housing was arranged. Deshea was eventually connected to permanent subsidized housing and gave birth to a healthy baby girl.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

(a) Identification of strategies for identifying new enrollees; and

(b) Description of the sources of data/information that will be utilized to identify enrollees with special health care needs or circumstances.

2. The extent to which the respondent describes its process for contacting enrollees, including the data sources.

3. A description of how network providers and community partners will be engaged in the identification process.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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F. OVERSIGHT AND ACCOUNTABILITY

SRC# 26 – Subcontractor Oversight (Statewide):

The respondent shall list any proposed subcontractors to which it will delegate the management of: provision of covered services, utilization management, provider networks or paying providers. The respondent shall describe how it will oversee and monitor the performance of subcontractors in general, as well as any specific oversight planned for certain subcontractors, including any corresponding service level agreements. The respondent shall include in its response the schedule and type of monitoring and how findings are reported, remediated, and used for process improvements.

Response:

Subcontractors are an integral resource in Lighthouse Health Plan's (Lighthouse) approach to provide value to enrollees, providers and the state. At all times, Lighthouse will be accountable for meeting the requirements of Florida's Agency for Health Care Administration contract and the overall performance of our subcontractors. Our subcontractor oversight program meets all NCQA health plan accreditation requirements for delegated oversight, as well as the requirements of the contract. See attached list of proposed subcontractors.

EXECUTIVE OVERSIGHT OF SUBCONTRACTORS

Lighthouse's Delegation Oversight Committee (DOC) is directly accountable to the Board of Directors through the Quality Improvement (QI) Committee. Enrollees of the DOC include lighthouse's Medical Director, compliance experts, and Florida providers.

Lighthouse follows a rigorous process to identify and select the best subcontractors. An entity under consideration for delegation must be audited by Lighthouse representatives to validate their capabilities and financial stability. They must be judged to be compliant with the standards of Lighthouse and in accordance with standards established by the NCQA. Lighthouse staff will present pre-delegation audit results, indicating approval or denial, to the Delegation Oversight Committee. Upon successful completion of the pre-delegation audit and only with the approval of the Delegation Oversight Committee, Lighthouse's Contract Specialist will execute a contract with the subcontractor. All delegation agreements will be in compliance with applicable regulatory and accreditation requirements and will include Medicare, state Medicaid and/or NCQA required terms as appropriate. Any necessary filings will be performed by the Legal or Compliance Departments.

The Delegation Oversight committee meets monthly and oversees the ongoing monitoring of delegates and reviews the results of audits. The Delegation Oversight Committee reviews and approves pre-delegation and annual assessments, with input from the business area owner that performed the assessments. The Committee oversees Governance Structure tracking and remediation of delegates under corrective action and remediation confirmation as part of closing out of CAPs. The Chair of the Delegation Oversight Committee reports on the status of open delegate CAPs at the Quality Improvement Committee meeting, each quarter.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Lighthouse delegation oversight activities include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following:
• Baseline Risk Assessment and updates to the Risk Assessment.
• Development of an annual Monitoring and Audit Work Plan that is updated as additional areas of risk are identified.
• This Audit Work Plan includes an annual delegation review and compliance review of delegates.
• Routine ongoing monitoring of compliance operational risk areas.
• Focused audits based on results of the Risk Assessment.

Pre-Delegation Assessment –

The initial evaluation consists of review audit and written review of the provider's understanding of relevant standards and the delegated tasks, and staffing capabilities.
• QI Program Description, Work Plan and Annual Evaluation
• UM Program Description, Work Plan and Annual Evaluation
• UM decision-making criteria
• Appeal and Denial Policies/Procedures
• Credentialing and Re-credentialing Policies/Procedures
• Enrollee Complaint and Grievance Policies/Procedures
• Provider Access and Availability statistics
• Operational Standards
• Training Requirements
• HIPPAA/HITECH Privacy and Security Safeguards
• Protecting Confidentiality of Electronic (PHI (ePHI)
• Protecting the Confidentiality of Paper PHI
• Best Practices
• Network Management (NET).

A final audit report after the conclusion of the audit fieldwork, is shared with the business owners of the functional areas, affected business partners, the Compliance and Regulatory Affairs Committee, Lighthouse's Senior Leadership, Board of Directors, and with the downstream entity that was audited, if applicable. Any corrective actions or follow-up will be led by the business owner with oversight by the Compliance Department.

LEVERAGING SERVICE LEVEL AGREEMENTS TO OVERSEE SUBCONTRACTORS

Lighthouse requires that subcontractors submit reports that support operational oversight and monitoring of service level agreements. Our Compliance and Quality departments along with representatives from Lighthouse's functional areas will monitor these reports to identify trends that confirm appropriate utilization of health services. The focus of these reports includes, but are not limited to, quality improvement, utilization management, enrollee rights, and network management.

Quality Improvement –

To monitor quality improvement, subcontractors must submit a Quality Improvement Program Description, a Quality Improvement Plan listing annual goals and/or objectives, a Quality Improvement Program evaluation, and the results of an enrollee and provider satisfaction survey,

if applicable on an annual basis. Subcontractors are also required to submit Quality Improvement Committee minutes on a quarterly basis.

Utilization Management –

Where applicable, subcontractors submit a Utilization Management Program Description and Case Management Program Description. Utilization Management statistics, including number of determinations by type, number of denials by type and reason, and number of denials appealed are submitted quarterly. Case Management statistics include engagement rates and completion of assessments. An annual site audit is conducted to review UM and CM files. If the subcontractor is NCQA accredited, the required level of oversight is reduced. No annual onsite evaluation is required as long as the subcontractor remains NCQA accredited. If accredited, a copy of the subcontractor's URAC and/or NCQA accreditation award is submitted.

Enrollee Rights –

To monitor subcontractor compliance with enrollee rights and responsibilities, quarterly submissions of the following items is required:
• Enrollee complaint data by number, type and action taken and turnaround times
• Enrollee appeal data by number, type and disposition and turnaround times
• Telephone statistics including average speed of answer, call abandonment rate, calls taken, and average hold time
• Required submissions also include enrollee communications, such as enrollee newsletters, brochures, etc.

Network Management –

An annual site audit is conducted to review credential and re-credential files. If the subcontractor is NCQA certified, the required level of oversight is reduced and no annual onsite evaluation is required as long as the subcontractor remains NCQA certified. However, there will be annual submission of a roster of practitioners and providers credentialed and recredentialed, and a network summary report of geographic availability. Subcontractors will submit and analysis of credentialing and recredentialing data and the Credentialing Committee meeting minutes.

Copies of contracts with practitioners that include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations are submitted, along with an annual assessment of access and availability of practitioners.

Information Security and Privacy --

Lighthouse monitors the adequacy of subcontractor information security and privacy protocols by reviewing the following annually:
• Policies related to privacy and information security
• Proof of staff training
• Proof of level II background investigations
• Statement on Standards for Attestation Engagements 16 (SSAE 16) report

Subcontractors who are hosting data or systems are also will also have the following items audited annually:
• Proof of backups
• Contingency test reports
• Terminations and destructions certificates

Other Oversight –

Other enrollee connection components that are monitored and reported on are website and pharmacy benefit updates, website and telephone functionality and training modules, and accuracy of online and telephonically accessible information. Subcontractors will annually submit policy and standard operating procedure, screenshots of website functionality and documentation of formulary changes. Telephonic training modules used by Enrollee Services are also submitted annually. Website functionality and telephone modules will include:
• Exception process
• Mail-order prescription refill
• Location of in-network pharmacy
• Conducting a proximity search by zip code
• Determine potential drug-drug interactions
• Determine a drug's common side effects and significant risks
• Availability of generic substitutes

The quality improvement process on the accuracy of website and telephone information will include:
• Annual submission of policy and standard operating procedure
• Quarterly submission of audit results. Audit will include:
• Estimation of financial responsibility for pharmaceuticals
• Exception process
• Mail-order prescription refill
• Location of in-network pharmacy
• Conduct a proximity search by zip code
• Determine potential drug-drug interactions
• Determine a drug's common side effects and significant risks
• Availability of generic substitutes

Subcontractors must also submit an attestation of compliance with all CMS general compliance and fraud, waste and abuse training requirements and report fraud activity describing any activities that are related to the review or investigation of potential or proven fraudulent actions by enrollees, providers, or subcontractors. Complete documentation of the subcontractor's Compliance Program is submitted, including policies, procedures and trainings, as well as attestation of ongoing monthly checks of federal and state exclusion databases, including, but not limited to, the Office of Inspector General's List of Excluded Individuals and Entities (LEIE), System for Award Management (SAM), Medicare Exclusion Database (MED), Office of Foreign Asset Control (OFAC) and National Practitioner Data Bank (NPDP), as applicable.

FINANCIAL OVERSIGHT OF SUBCONTRACTORS

Lighthouse requires subcontractors to undergo a financial vetting process prior to signing agreements with the plan. Subcontractors are required to submit their most recent fiscal year

audit, prepared using Statutory Accounting Principles (SAP) by a reputable accounting firm for analysis and approval by the Lighthouse Delegation Oversight Committee. Annually subcontractors must resubmit their most recent fiscal year audits for review by the Lighthouse Delegation Oversight Committee.

If a subcontractor is taking capitation or risk for services the subcontractor is required to escrow a percentage of premium, mutually agreed to by Lighthouse and the subcontractor that equates to the risk based capital (RBC) for the services provided by the subcontractor. For example, a subcontracted vendor who Lighthouse contracted with for behavioral health in a sub-capitation agreement would hold a much larger amount in escrow than a vendor who was sub-capitated for dental.

On an annual basis Lighthouse audits the escrow account and, depending on membership and services the subcontractor and Lighthouse may change the amount of the escrow account. The financial review will be part of the yearly Delegation Audit and will be performed no less than annually.

ONGOING MONITORING

Lighthouse conducts appropriate on-going monitoring, auditing and oversight for all activities conducted by its subcontractors in accordance with applicable state and federal laws, regulations, and guidelines. Lighthouse compliance, quality, and functional area representatives conduct functional area level monitoring of its delegated subcontractors to ensure that they fulfill their compliance and contractual requirements.

For example, Lighthouse's oversight activities of subcontractors include monitoring various claims activities to determine if AHCA's guidelines and/or plan benefits are being applied appropriately. The following reports are used to monitor claims:
• Pended Claims – weekly reports to monitor appropriateness of claims being held
• Denied Claims – weekly report to monitor appropriateness of denial, does adjustment reason code properly reflect enrollee or provider liability
• All Paid Claims – monthly report to monitor all aspects of correct claim payments including but not limited to timeliness, interest payment if appropriate, benefit configuration and benefit changes
• Adjusted Claims – monthly report to identify trends, benefits that were misconfigured and confirm that adjustment was done correctly
• Focus Audit – a focus audit will be performed to confirm changes to plan benefits has been done correctly

In addition to monitoring these reports, Lighthouse representatives conduct bi-weekly meetings with subcontracted claims teams to assure appropriate processing and timelines. They also meet monthly with the configuration team to ensure that benefit change requests are being updated timely.

ANNUAL DELEGATION AUDITS

Lighthouse subjects each subcontractor to formal review at least once a year consistent with NCQA standards. We utilize standardized audit tools to conduct annual delegation audits. During this evaluation, the subcontractor must make available for purpose of an audit its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems

relating to its Medicaid enrollees. Lighthouse verifies that the subcontractor is in compliance with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. Lighthouse's auditors prepare an audit report that details the audit findings and whether deficiencies or opportunities for improvement were identified. These findings are included in the Annual Quality Management Program Evaluation.

The report is reviewed at the next scheduled Delegation Oversight Committee meeting. DOC either recommends that Lighthouse continue to contract with the delegate, continue to contract with the delegate so long as it agrees to a Corrective Action Plan (CAP) to resolve any deficiencies identified during the annual audit, or terminate the contract. The Secretary of the DOC communicates the committee's decision to Lighthouse's Board of Directors. Any decision to terminate a subcontractor would be submitted to the Agency for review not less than thirty calendar days of Lighthouse's desire to terminate a subcontract.

ADDRESSING SUBCONTRACTOR PERFORMANCE ISSUES

If a Lighthouse representative identifies a performance issue during a monitoring activity, the issue is reported to Lighthouse's compliance department. The report should include severity, root cause analysis and beneficiary impact, if any. The Compliance Department will present the report to the Delegation Oversight Committee who may take any of the following actions based on the severity of the performance issue, these actions may also be used as a path of escalation:

• Notification of deficiency/Letters of concern: We will notify the subcontractor of a potential deficiency or risk for contract variance and give them the opportunity to improve their performance through the implementation of a process improvement plan (PIP). Our Vendor Management department tracks the issues and monitors activities to determine whether the issue is resolved or if further actions is needed.

• Formal Corrective Action Plan (CAP): We will issue a formal CAP in cases where we have identified major deficiencies and any failure to comply with contractual requirements. The CAP must describe the remediation actions to be taken, a timeline for correcting the deficiency or contract variance, and the metrics that will be used to determine if the corrective action is successful.

• Probationary Status: We may place subcontractors who fail to improve their performance on probationary status, subjecting them to additional oversight, including more frequent oversight meetings (daily or weekly) to monitor corrective action.

• Penalties/Liquidated Damages: We may assess penalties or liquidated damages against the subcontractor for failure to correct deficiencies and contract variances. These penalties are assessed separate and apart from any penalties assessed against Lighthouse by the Agency for contract performance concerns.

• Contract Termination: If a subcontractor fails to correct performance over a period of time, or if the nature of the deficiency or contract variance is severe, Lighthouse may terminate the subcontractor's agreement and perform the functions ourselves or delegate to another entity with Agency's approval.

Lighthouse's compliance department supports the Delegation Oversight Committee by overseeing the creation of thresholds/timing for Corrective Action Plans (CAP), communication of CAPs, monitoring of CAPs, closure method of CAPs, and testing of remediation. No CAP is closed without approval from the Delegation Oversight Committee.

Evaluation Criteria:

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

1. The extent to which the respondent provides a list of subcontractors it proposes to use under the SMMC Program for the delegation of work as described above.

2. The adequacy of the respondent's oversight structure, including the extent of executive level staff participation.

3. The extent to which the respondent uses and monitors for service level agreements consistent with the SMMC Program Scope of Services.

4. The adequacy of the respondent's approach to monitoring the quality of work performed by subcontractors, including the frequency and type of monitoring.

5. The adequacy of the respondent's processes for addressing performance issues, including the triggers for increased monitoring activities, interventions and Contract compliance action.

6. The extent to which the respondent provides monitoring activities it will use to ensure the financial stability of the subcontractor, including the required financial reporting frequency for subcontractors.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 27 – Subcontractor Oversight (Statewide):

The respondent shall submit a sample contingency plan it would enact in the event a subcontractor to which the plan has delegated authority to manage utilization and pay providers on behalf of the plan, files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Response:

Lighthouse Health Plan, in partnership with its subcontractors, strives to deliver the highest standard of managed care to enrollees, providers and the state. Subcontractors are put through a rigorous process to ensure they are capable of achieving that standard. However, should a subcontractor file for bankruptcy or become otherwise financially insolvent, Lighthouse maintains ultimate responsibility for adhering to and fully complying with Florida's Agency for Health Care Administration contract. We fully assume all obligations of any subcontractor that is unable to fulfill its commitments. We will execute a seamless transition that disrupts neither enrollees receiving services nor providers getting paid in a timely and accurate manner.

PROMPTING THE CONTINGENCY PLAN

Lighthouse requires subcontractors to undergo a financial vetting process prior to signing agreements with the plan and annually thereafter. Lighthouse shall require a vendor to submit their most recent fiscal year audit prepared using Generally Accepted Accounting Principles (GAAP) by a reputable accounting firm for analysis. The Lighthouse Finance Department and Delegation Oversight Committee (DOC) must sign off on that audit. DOC representatives will validate potential subcontractors' capabilities and financial stability, and whether they are in compliance with Lighthouse standards.

Further, if a subcontracted vendor is taking capitation or risk for services, the vendor will be required to escrow a percentage of premium, mutually agreed to by Lighthouse and the vendor that equates to the risk based capital (RBC) for the services provided by the vendor. For example, a subcontracted vendor who Lighthouse contracted with for behavioral health in a sub-capitation agreement would hold a much larger amount in escrow over a vendor who was sub-capitated for dental. The subcontracted vendor and Lighthouse shall agree during implementation of the subcontractor, that Lighthouse's access to this account is unencumbered and we shall have access to it when, in our sole discretion, it is needed to pay providers after a catastrophic event.

For all subcontractors, an annual GAAP audit must be presented every fiscal year. Lighthouse will review the audit for indicators of increased risk of subcontractor insolvency. Signals from the annual audit that would trigger consideration of implementation of the contingency plan would include, but not be limited to: a severely depleted reserve, a very large financial settlement that impacted the reserves, the loss of a significant piece of business or the closure of locations or divisions.

IMPLEMENTATION AND COMMUNICATIONS

Should a catastrophic event impact a subcontractor, Lighthouse will form a SWAT team with members from Legal, Compliance, DOC, vendor management, enrollee services, and provider

services. The catastrophic event is not limited to bankruptcy; it would be any event where a subcontractor is unable to perform services as required by the terms of the Agreement with Lighthouse.

The vendor management department will work with the legal and compliance departments to determine if another subcontracted vendor is the best option for Lighthouse, or if this is a service the health plan should provide internally. This team, including the Director of Vendor and Ancillary Contracting and the Program Manager, will thoroughly vet another subcontracted vendor, if desired, ensure the delegation oversight process is followed for the new vendor, and determine how soon they can stand up a new subcontracted vendor.

The SWAT team would use encounter, claim, and any additional reporting available to identify enrollees impacted by the catastrophic event. Affected enrollees would be matched with their Care Managers, if assigned, and to a temporary Care Manager if they are not currently enrolled in a care management program. The Care Manager would call each enrollee telephonically to assess individual enrollee needs and address them accordingly, working in conjunction with the provider services team and utilization department to ensure authorizations for out of network care were granted during the triage period. Additionally, a letter would be mailed to all affected enrollees with a number to call and frequently asked questions.

The SWAT team would use encounter, claim, subcontractor provider network reports, and any additional reporting available to identify providers impacted by the catastrophic event. The provider relations team, along with any necessary temporary staff, will contact each provider to ensure they are aware of the catastrophic event and the actions Lighthouse is taking to ensure enrollees receive adequate care in a timely manner. Lighthouse will work with the original subcontracted vendor to ensure all providers are paid out of the escrow account.

In addition to all newsletters and individual communication, Lighthouse commits to communicating with the community at large through the media, as needed, to ensure all enrollees and providers are informed and aware of what Lighthouse is doing to ensure enrollees are not affected by the catastrophic event.

MAINTAINING TIMLEY PAYMENTS

As subcontracted vendors will be required to put mutually agreed upon escrow dollars aside, Lighthouse is reasonably able to ensure providers will receive payment for services rendered during the transition period, until a replacement subcontracted vendor can be onboarded or a direct network agreement can be signed with Lighthouse.

Once a subcontractor is unable to administer the program for which they have been contracted, the vendor management staff, along with the DOC, and the compliance team, will take over control of the program and will oversee payment to network providers, ensuring prompt payment is made from the funds held in Lighthouse's escrow. The SWAT team will meet with the subcontractor and the list of impacted providers to review any outstanding claims. The SWAT team will ensure claims previously filed and those not yet filed are paid out of the escrow account. The subcontractor will have to turn over control of the account to the Lighthouse Chief Compliance Officer who will ensure the monies are distributed accurately among providers.

MONITORING FOR FRAUD, WASTE AND ABUSE

Once a subcontractor of Lighthouse is unable to provide services due to breach of agreement, bankruptcy or lack of financial resources the specific oversight and operations of that subcontractor's functions will be moved from the vendor management team to the compliance team and DOC. Lighthouse will work with the Network Contracting team to identify contingency providers, where necessary, and ensure network adequacy standards are maintained. All new contingency providers approached for services will be subject to the same Fraud Waste and Abuse (FWA), disbarment verification, and credentialing requirements as the remainder of the providers or subcontractors in the plan who are not in bankruptcy.

The Lighthouse FWA policy and procedures will be applied to all providers, vendors or staff that were previously under the insolvent subcontractor. Lighthouse assumes all oversight function to ensure that any potential or suspected FWA is promptly identified, reported, investigated, and resolved. This policy applies to employees, enrollee of the Board of Directors, consultants, subcontractors, and any other parties with a business relationship with Lighthouse. Lighthouse is committed to the responsible stewardship of our resources, and maintaining a comprehensive plan for detecting, preventing, and correcting fraud, waste, and abuse.

To that end, Lighthouse encourages any individual who is aware of or suspects acts of fraud, waste or abuse of resources in any departmental area, by any provider or with any entity that Lighthouse contracts with to report such acts to the Lighthouse Compliance Department. Lighthouse does not tolerate fraudulent or other dishonest behavior and will take appropriate investigative and corrective action upon receiving such reports.

Evaluation Criteria:

1. The extent to which the respondent has outlined the data sources it would use to trigger the respondent to put the contingency plan into play in advance of the subcontractor filing for bankruptcy or otherwise becoming unable to continue operations due to lack of financial resources.

2. The extent to which the respondent outlines a communications strategy in the contingency plan.

3. The extent to which the contingency plan includes strategies for ensuring providers get paid for situations where there were open authorizations.

4. The extent to which the contingency plan includes strategies to prevent provider fraud and abuse in situations where a subcontractor files for bankruptcy or otherwise becomes unable to continue operations due to lack of financial resources.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 28 – System Modification Protocol (Statewide):

The respondent shall describe, in detail the following change control IT processes:

a. How the respondent will initiate and coordinate internal modifications for any of its core systems (including, but not limited to, encounter submission, EDI/Clearinghouse, and financial reporting) or any potential subcontractor's core systems,

b. How the respondent will accommodate Agency-directed IT modifications; and

c. How the respondent will identify, track, communicate, and resolve IT production issues that affect internal or external stakeholders.

For each of the descriptions, the respondent shall also include the expected timeframes for making modifications, the prioritization process employed, the communication processes used for planned or unplanned changes, as well as status updates provided to employees, Agency staff, and providers. The descriptions shall also address testing procedures, production control procedures, and any applicable claims/encounter reprocessing for historical or retroactive system changes.

Response:

Lighthouse Health Plan works with its health plan administrative subcontractor, Evolent Health, to continuously improve our IT systems in support of our mission to improve Enrollees' health. The enhancements that IT system changes enable can only be realized if system modifications are implemented carefully according to a comprehensive change control process. Our approach to system modification is described below.

PROCESSES TO SUPPORT INTERNAL MODIFICATION OF CORE SYSTEMS AND SUBCONTRACTOR SYSTEMS

Within ten (10) days of the AHCA contract execution date, an Identifi Account Lead will be designated to work with AHCA on the management of all modification requests for all related systems including those that are used to support care management, utilization management, encounter submissions, EDI/Clearinghouse transactions, enrollment, claims processing, and reporting. Additionally, the process encompasses all requests related to any core system utilized by any potential subcontractor.

Lighthouse's Enterprise Management Information System, the Identifi Platform, represents an end-to-end enterprise level, integrated MMIS and population management platform that includes functionalities and process flows that support meeting the requirements of the Florida Medicaid program. While our system has the needed capabilities and functionality to operate a successful Provider Services Network, we do anticipate minor configuration and modifications that are standard to any implementation to support specific Agency requirements including:

• Operational Reporting layouts to conform to the requirements in Section XVI. of the Florida Medicaid model contract.
• Reporting data extraction methods and coding

- Stratification and Rules Configuration specific to the target population
- Fee Schedule Configuration
- Provider Configuration
- Benefit Plan Configuration
- Utilization Management requirements

These system configurations are included in our standard implementation process and will be included in our overall implementation workplan. These configurations will be fully tested and implemented prior to the go-live date. Our MMIS system is a configurable cloud-based SaaS platform that accesses web-based content and can accommodate the Agency's prescribed reporting formats and frequencies without the need for core system modification or customization to the Identifi applications. Any configurations to the Identifi application, rules, workflows, and data are managed by our IT staff, with direct input from Lighthouse business owners as part of the implementation process and activities. The configurations listed above will follow the implementation and change control process described below.

Identifi Implementation and Enhancement --

Identifi is a highly configurable, cloud-based SaaS platform. A standard Identifi implementation requires no software development due to the configurability of the system. Any configurations to the Identifi platform, rules, workflows, and data are managed by Evolent Health with direct input from Lighthouse as part of the implementation process and activities. Evolent has found that most requirements can be supported through configuration and do not require application customization or additional software development. Configurability supports a faster and more agile implementation and provides Lighthouse with the ability to adjust to meet the requirements of the Florida Medicaid program and to optimize the performance of our systems to better support our work to improve the health of our enrollees. The modifications that are outlined above to support specific Agency requirements are accomplished via system configurations.

During the course of the engagement, as configurations and or possible customization requirements emerge (if applicable), Lighthouse will define any new scope, including business, platform and user-driven requirements to meet the Florida Medicaid's unique environment and needs.

If needed enhancements are identified during implementation, they will be handled by our Identifi Account Lead. Identifi enhancements and change requests goes through a documented approval, testing, and validation process. All proposed enhancements are reviewed by an internal cross functional team on a weekly basis. This Cross-Functional Review Board (XRB) reviews and approves scope and timeline commitments for new client opportunities, implementations, expansions, and other significant client commitments that require cross-functional implementation resources. This cross functional team will analyze the high-level impact of the change request and communicate a plan for including the change in a scheduled system update.

The Identifi Platform is continually updated and enhanced. These updates are tested rigorously and validated prior to release to ensure that compliance with Florida Medicaid program requirements is not jeopardized. The Identifi Platform maintains separate environments as each update and enhancement release matures closer to production. Development, Quality Assurance (QA), User Acceptance Testing (UAT), and production environments are utilized ensure each change is validated prior to promotion to production and release into the client instance.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Change Control Process --

Required systems changes are handled by our Identifi Support team or via the Identifi Account Lead. Clients may submit enhancement and change requests at any time through our Identifi Support team or via the Identifi Account Lead. The Identifi Account Lead will review the requested change with the appropriate Lighthouse business owners to verify business requirements.

Upon receipt of any such modification request via electronic mail or telephonically, the Identifi Account Lead will document all associated requirements with AHCA prior to presenting to the XRB team. The Identifi Account Lead creates a new entry within our centralized intake form for change management documentation. Each request will receive a unique identifier (e.g., XRB-###, where ### is a sequential number) that can be noted for later retrieval purposes and to track the change request throughout the entire change management process from request to production.

Enhancement and change requests are then reviewed by the Cross-Functional Review Board (XRB) to analyze the high-level impact of the request relative to other contractual commitments, our product roadmap and resource availability to deliver on the request. The Cross-Functional Review Board sets schedule commitments based on capacity and cross-client priorities, escalating to an outside Executive Operations team as needed. The XRB team provides leadership visibility and oversight for macro-level client communications. The XRB team also facilitates the evaluation of all change requests for resources, scheduling, and pricing with impacted teams including those associated with Medicaid, PBM, RAF, Analytics, Clinical, Payor Partnerships, PSHUP / UM Governance, TPA services, and Provider/Network. If detailed analysis is required for a complex request, a cross-functional team of subject matter experts, called the Solutioning and Scoping Team, convenes to provide a detailed response to the request in terms of options, proposed high-level timelines and potential costs. This team also works with the Product Leadership Team which reviews approved priority requests for scoping and sizing and schedule on the product roadmap. This team also sets the overall Identifi roadmap priorities based on internal and client feedback. After the requests are reviewed by the appropriate parties and consensus is reached, XRB will then communicate the response back to the Identifi Account Lead with the proposed recommendation and next steps. The Identifi Account Lead will then facilitate a collaborative discussion with Lighthouse business owners which includes systems subject matter experts if needed, to arrive on a decision on whether to proceed with the proposed change.

A formal change request response document will be presented to AHCA for their review and approval between five (5) and fifteen (15) days from the date of intake.

Pending the enhancement or change request approval, the Identifi Account Lead will relay the decision on whether to proceed with the proposed change to the XRB team. The XRB team documents the approval and subsequently triages the change and or enhancement through the Identifi Platform Management team according to where the development efforts fall within the Identifi Platform: either Identifi Health Plan Administration system or the Identifi Population Health Management system.

Changes that fall within the realm of the Identifi Health Plan Administration (HPA) system include changes to eligibility and enrollment; benefits management for covered services; enrollee and provider services; coordination of benefits; and clearinghouse interface and claims management. Changes that fall within the realm of the Identifi Population Health Management system include

provider and network management; care management workflows; reporting; analytics and business intelligence; utilization management; enrollee and provider portals; and performance management.

All changes include the following procedural steps as further outlined in the “Internal Testing” section below.
1. Application Code Management
2. Application Quality Assurance
3. Application UAT
4. Application Security Vulnerability Assessment
5. Application Production Deployment

PROCESS SUPPORTING AGENCY-DIRECTED MODIFICATIONS

We use a system modification protocol that is designed to provide AHCA with a single point of engagement for the intake, management, and resolution of all Agency modification requests. Agency directed modifications and enhancements to any existing TPA systems as a part of the Identifi Health Plan Administration system are managed and completed within ninety (90) days. All other system modifications would be scoped and planned with the Agency to be delivered within ninety (90) days or a mutually agreed upon timetable in accordance with the scope and required Level of Effort (LOE). Our software development cycle and platform update process is explained in more detail below.

Identifi platform software development cycle –

Platform updates follow the standard Agile-Scrum Software Development Lifecycle (SDLC) for change management processes. Agile-Scrum executes projects according to a methodology that emphasizes empirical process control. Delivery is iterative and incremental to minimize risk and introduce feedback loops early and often in the SDLC. Agile-Scrum is built upon the three pillars of Transparency, Inspection, and Adaptation. Agile-Scrum defines a methodology, known as Scrum rituals, for executing projects in iterative fashion.

Each software release will contain several iterations, known as sprints, to complete all deliverables identified for the release. Once all sprints have been completed, the software is released to the User Acceptance Test (UAT) environment for end user testing and certification. Once a release is certified in UAT, it is version-stamped and prepped for deployment to Production. Major Production releases occur at least once per quarter for changes within the Identifi Population Health Management systems and every eight (8) weeks for changes within the Identifi Health Plan Administration systems.

The Identifi Platform has been developed in accordance with industry-standard secure coding guidelines as published by Open Web Application Security Project (OWASP). Throughout the System Development Life Cycle (SDLC), Evolent Health developers run application code through a static code analysis engine to discover any vulnerabilities which may have been introduced into the code base for immediate remediation.

Frequency of Identifi platform updates --

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The Identifi Platform is offered as a SaaS solution, and our subcontractor Evolent provides all required hosting, support, monitoring, and upgrades.

Evolent makes constant updates and product enhancements and these are provided at no cost to Lighthouse or the Agency. Application-specific maintenance functions are done during our maintenance windows. Identifi users are notified via an email communication in advance of these patches and fix deployments.

Major releases of the Identifi Population Health Management system go out on a quarterly basis (every 90 days), on the last Sunday of a predetermined month while releases within the Identifi Health Plan Administration system go out every eight (8) weeks on Fridays (after business hours). Minor updates to the Identifi Platform are also released every second and last Friday of the month in accordance with the Release Management Cycle. Most production releases are completed within a 4-6 hour time frame, and happen during our already-established maintenance windows outside of business hours to minimize disruption. Identifi Health Plan Administration releases are promoted to production during well-communicated, non-peak processing times (2 a.m. to 6 a.m. Central Time). Identifi Population Health Management system production releases are promoted to production during a 1:00 a.m. to 6 a.m. Eastern Time block after business hours to minimize impacts to users.

HANDLING PRODUCTION IT SYSTEM ISSUES

Evolent Health has convenient self-service portals to give Lighthouse and our Identifi users the ability to communicate easily and directly about any application issues. These service portals are available for users to have a secure and quick way create work items, or “cases,” to report system errors, ask questions, request batch jobs, or create enhancement requests as they span employee technical support, health plan administration, and population health management.

In order to relay issues to support staff, Lighthouse users would log into our Evolent Support Center. Existing Evolent employees (including the Identifi Support team and the Identifi Account Lead if necessary) log into Evolent Service Desk which takes the employee to two (2) centralized intake options allowing users to align their issues with either health plan services support or population health support. Health Plan Solution issues traditionally fall within the areas of: claims system, provider and enrollee portals, enrollment and eligibility and encounters, and system configuration (benefits, contracts, etc.). Population Health Management support issues traditionally fall within the areas of: Identifi Care, Identifi Practice, Identifi Analytics and Reporting, Utilization Management, risk adjustment, and Network Management.

Examples of issues that can be reported to the Identifi Support team, via the aforementioned portals, include the following:

- Infrastructure or System Performance Issues: outages and enhancement requests
- Files (837, 834, etc.) Fail: file load issues for DMS eligibility file or loading claims
- Provider or Enrollee Issues: TPL, Provider contract rate changes, new enrollee is not in the system, enrollee dismissal from panel by a provider, systemic PCP issues, significant provider refunds/outstanding balances
- Configuration Needs: DRG updates, authorization guideline changes, rate changes, code configuration/reconfiguration, fee schedule updates
- Claims Issues: large scale claims reprocessing or investigation

• Encounter Issues: submission failures
• Access Issues: existing access troubleshooting and resolution, requesting new access to the Identifi Platform, user provisioning
• General: requesting a task, asking a question

Our self-service portals allow for robust communication mechanisms which establishes documentation, centralizes communication, and supports visibility of issues and needs. This in turn allows for efficient assignment to an appropriate team enrollees, with prioritization through a triage function to align with established SLAs.

Identifi support SLA information --

There is an established set of SLAs for the Identifi Platform (comprised of the Identifi Health Plan Administration system and the Identifi Population Health Management system) regarding issue response, tiering, hours, and resolution times.

The Identifi Support team is responsible for handling problems and inquiries received from users of the Identifi Platform. Identifi Support will analyze the issue and respond to the user with a solution, or escalate to other enrollees of the Information Technology team or existing partners who can provide resolution.

All requests for support are entered into a ticketing system (JIRA) via the Evolent Support Center and Service Desk, where all issues affecting Lighthouse and Identifi users are stored. Within JIRA, there are several different pathways for escalation to various internal partners. The Identifi Support team ensures follow-up on all escalations and ensures that issues are being resolved in a timely manner, and according to the agreed-upon SLAs as outlined below.
As part of our communication standards, for systems issues other than those that cause service disruption, we will respond in writing within (twenty-four) 24 hours to (7) days of receipt, and within three (3) business days and no more than (20) days, with a Root Cause Analysis document, which contains requirements and specifications for the necessary correction including technical detail and next steps.

When Lighthouse notifies Evolent about a concern related to core business functions (Identifi HPA), their IT team immediately assigns a priority level in accordance with the below severity levels and issues an identification number to track resolution.

• Severity 1 – Critical Business Impact. The Client is unable to access the Payer Platform. Severity 1 Issues can only apply to the production environment. Evolent starts work on resolving a Severity 1 Issue within one (1) business hour of receiving the reproduced issue, and keeps our staff engaged until a Resolution is achieved. Evolent will provide a resolution to Severity 1 Issues within one (1) business day. If Evolent determines that the time to provide a Resolution will fall outside of this timeline, we will notify the Client immediately to reach a mutually acceptable delivery time. The Client will accept partially-tested Resolutions for Severity 1 Issues.
• Severity 2 – High Business Impact. The impact of the reported Issue is such that a part of the Payer Platform necessary to conduct business is causing a serious reduction in Client's ability to use the platform. Evolent will begin work on resolving a Severity 2 Issue within four (4) business hours of receiving the reproduced issue, and will keep our staff engaged until the issue is resolved. Following receipt of a reproducible case, Evolent will provide a Resolution to Severity 2 Issues within five (5) to ten (10) business days. If Evolent determines that the time to provide a Resolution

time will fall outside of this timeline, we will notify the Client immediately to reach a mutually acceptable delivery time. The Client will accept partially-tested Resolutions for Severity 2 Issues.
• Severity 3 – Medium Business Impact. Important features of the Payer Platform are not working properly and there are no acceptable, alternative solutions. While other areas of the Payer Platform are not impacted, the reported Issue has created a significant, negative impact on Client's productivity or service level to individuals maintained in the eligibility file, as represented by a unique system identification number. Evolent will begin work on resolving the Issue within (2) business days of receiving a reproducible case. Upon receipt of a reproducible case, Evolent will provide a Resolution for Severity 3 Issues within five to fifteen to twenty (15-20) business days. If Evolent determines that the time to provide a Resolution will fall outside of this timeline, we will notify the Client immediately to reach a mutually acceptable delivery time. The Client will accept partially-tested Resolutions for Severity 3 Issues.
• Severity 4 – Low Business Impact. Features of the Payer Platform are unavailable, but a Resolution is available or non-essential features of the platform are unavailable with no Resolution. The time for determination of an Issue is generally affected by Customer's ability to deliver a reproducible case to Evolent. Following receipt of a reproducible case, Evolent will provide a Resolution for Severity 4 Issues in standard releases of the Customer Product Package.
• Severity 5 – Minimal Business Impact. The defect does not affect functionality, productivity, or data and does not require a workaround. The defect may be only cosmetic in nature. Examples: Layout or format discrepancies, spelling, grammatical, or punctuation errors. Following receipt of a reproducible case, Evolent may, or may not elect to provide a Resolution. If a Resolution is provided, it will be included at Evolent's discretion in a standard release of the Customer Product Package.

The Core Identifi HPA Platform Availability (Average Uptime %) has stayed over 99.99% for the period from Apr – Aug 2017. The Portal Availability (Average Uptime %) has stayed over 99.97% for the same time period.

When Lighthouse notifies Evolent about a concern with the population health applications, our IT team immediately assigns a priority level in accordance with the below severity levels and issues an identification number to track resolution.

• "Severity 1" means Client request for Evolent IT help desk support where all Client user groups experience substantial loss of service including critical application functionality, including an Identifi application outage, severe application performance degradation, the inability to launch essential/critical functionality, or non-operational ADT service. Acknowledgement of these issues is immediate with status updates communicated hourly. Resolution responses are communicated to the client within 6 hours of receiving the issue notice. Due to the severity of the issue, resolution is performed within 24 hours.
• "Severity 2" means Client request for Evolent IT help desk support where operations that significantly impact long-term productivity are restricted, and a temporary workaround solution is identified, including non-operational major functionality, minor data issues, or users' inability to access major functionality. Acknowledgement of these issues is immediate with status updates communicated as needed. Resolution responses are communicated to the client within 48 hours of receiving the issue notice. Resolution of the issue is performed within 4 weeks.
• "Severity 3" means Client request for Evolent IT help desk support where operations of some components are impaired, although the user can continue to use the application, including cosmetic issues, including data mismatches, errors in non-critical functionality, formatting or spelling. Acknowledgement of these issues is immediate with status updates communicated as

needed. Resolution responses are communicated to the client within 72 hours of receiving the issue notice. Resolution of the issue is performed within a future release of the Identifi platform according to our established quarterly release cycle.
• "Weekend Support" means from 8 a.m. ET to 6 p.m. ET on Saturday except national holidays.

Typical technical support hours are: Monday through Friday, 8 a.m. to 9 p.m. Eastern, and Saturday, 8 a.m. to 6 p.m. Eastern. Our Identifi Support services are available via toll-free phone support (1-888-959-4031) as well as via email communication (support@evolenthealth.com).

Outside of regular support hours, we provide 24/7 coverage for high severity issues with an On-Call team. Any issue that results in the system being unavailable is treated as a high severity issue and is worked continuously until the issue is resolved. Maximum response time for the highest severity issues (e.g. system not available) is one hour, both during and outside normal working hours. Lower severity issues allow for more time to response and resolve.

The Identifi Population Health Management system maintains a 99% uptime/reliability during agreed upon business hours.

COMMUNICATIONS PROCESS FOR SYSTEMS ISSUES AND UPDATES

Effective communications are critical to the change management process and when responding to IT systems issues. In addition to the communication referenced throughout the process descriptions above, additional communications protocols are summarized below.

Planned & unplanned downtime communications --

Identifi Platform users are notified via an email communication from the Identifi Support team in advance of patches and fix deployments and change enhancements.

Planned downtime includes Identifi Platform updates, including quarterly major releases and hot fixes and is typically done during our maintenance window. Unplanned downtime could be the result of an internet outage or other disruptive event.

In the case of planned downtime, the Identifi Support team sends an e-mail communication to all Identifi Platform users about one (1) week prior to the downtime (or in the case of a hot fix, as soon as we know that we need to take the system down for maintenance), another e-mail communication before the system goes down, and follows up with an e-mail communication to users when the system is again available.

With regard to unplanned downtime, Identifi Support will communicate with all Identifi Platform users as soon as possible. We will provide updates on expected return to service, and a final e-mail communication when the system is back up, as well as some explanation of the root cause of the outage.

Issues/updates are identified during the change control process --

Identifi Platform users will have access to a system that is free of recurring errors or failures on the backend. We proactively monitor the platform for errors and resolve any issues as part of the SDLC development cycle within the change management process. Each software release will

contain several iterations, known as sprints, to complete all deliverables identified for the release. The Identifi Platform has been developed in accordance with industry-standard secure coding guidelines as published by Open Web Application Security Project (OWASP). Throughout the System Development Life Cycle (SDLC), Evolent Health developers run application code through a static code analysis engine to discover any vulnerabilities which may have been introduced into the code base for immediate remediation.

In the event any issues are discovered during the change management process, they are assessed within the aforementioned Agile-Scrum team for business impact. The Scrum team's Product Owner will communicate the issue to impacted business units and negotiate a solution based upon business needs and objectives, as well as any technical constraints which may exist. These issues are communicated directly to Identifi Account Lead to report to the agency for transparency. If gaps are identified in requirements during the change control process, the product owner will communicate with the Identifi Account Lead and the business owner representatives for the agency to ask for clarification and gap resolution.

Identifi platform scalability --

Identifi is architected in a manner that allows the solution to scale both horizontally and vertically across the infrastructure to handle ever-increasing system demands. ELK stack log aggregation and monitoring technology is used to monitor the system for availability, performance, and load. Identifi servers are Azure Hyper-V virtual machines that allow Evolent Health to scale the infrastructure very rapidly if system load were ever to exceed current peak system capacity. There is no upper limit on number of users, number of lives, or platform capacity.

Evolent utilizes a number of automated processes to monitor for application performance. Zabbix is used to manage server alerts when CPU, RAM, or available disk utilization falls outside of pre-defined parameters. SQL Server monitoring is utilized to send alerts for any database blocking, locking, or long running SQL statements that are detected by the system. A number of homegrown availability tests are continuously executed via automated scripts to test for application availability and response times. Any responses outside of threshold will trigger alerts to the Identifi Support team for remediation.

Outside of communications relating to issues discovered during the development and change management cycle, the Evolent Health Platform Solutions team conducts mid-quarter check-ins with the partner/market teams to provide an overview of the next quarterly release product enhancements. In addition, the team will meet with the partners/market teams around 2 weeks prior to the release to provide a detailed overview of the upcoming changes.

INTERNAL TESTING PROCESS

Major releases of the Identifi Population Health Management system go out on a quarterly basis, on the last Sunday of a predetermined month while releases within the Identifi Health Plan Administration system go our every eight (8) weeks on Fridays (after business hours). Minor updates to the Identifi Population Health Management system are also released every second and last Friday of the month in accordance with the Release Management Cycle. Most production releases are completed within a 4-6 hour time frame, and happen during our already-established maintenance windows outside of business hours to minimize disruption.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evolent's change control process is a formal process used to ensure that changes to the product or system are introduced in a controlled and coordinated manner. It reduces the possibility that unnecessary changes will be introduced to a system without forethought, introducing faults into the system or undoing changes made by other users of the software. The goal of the change control process is to minimize disruption to our products, reduction in back-out activities, and cost-effective utilization of resources involved in implementing change.

Identifi Health Plan Administration Development & Testing --

Evolent Health has branches for all current versions of our Identifi Health Plan Administration software within our Team Foundation Server (TFS). TFS is a Microsoft product that provides source code management (either with Team Foundation Version Control or Git), reporting, requirements management, project management (for both agile software development and waterfall teams), automated builds, and testing and release management capabilities. It covers the entire application lifecycle, and enables DevOps capabilities. Our Production Support team regularly applies fixes to all versions where a bug exists, including the current "in-progress" new enhancement branch. Our development team utilizes an Agile Scrum SDLC. We release service packs every eight (8) weeks that include new system enhancements and bug fixes. The eight (8) week release consists of four (4) sprints each two (2) weeks long. Each Scrum team consists of analysts, coders and QA testers. Each new enhancement is tested and validated by QA and the product owner at the end of each sprint. The forth sprint in each release is identified as a 'hardening' sprint where no new code is introduced but full regression testing, manual and automated, is performed on the system.

After successful acceptance testing, a release is promoted to production during well-communicated, non-peak processing times (2 a.m. to 6 a.m. Central time).

All product patches and releases are handled by a central group for repeatable process. Each release is numbered as Rel. N.XX.YY where N.XX is the denotation of a master release and .YY is the version number. Lighthouse has a dedicated UAT environment. Each release is placed into the UAT environment at a time mutually agreed to by Lighthouse and Evolent. Changes are typically provided with thirty (30) days of acceptance testing in the UAT environment. Test times can vary based on the complexity of a particular release and the potential impact of the feature changes to Lighthouse.

Comprehensive test beds have been created that can be modified to suit Lighthouse's requirements. Business owners and internal stakeholders define the content of the test cases that will be executed and will help define the expected result of each test case if necessary. Reusable test beds will be comprised of applicable EDI Files and data loads that execute specific test cases for that client. The files from the reusable test bed can used for all future testing efforts which will bring a consistent testing approach to each client.

Job scheduler function in the core payor system is leveraged to load the files from reusable test beds and run additional jobs to execute other required test cases (e.g. invoicing).

Test Cases that cannot be executed through a scheduled job will be executed with a manual test case. There are some instances where the software functionality must be tested through the user interface; these test cases will also be executed during the manual test case execution. For example, the best and most realistic way to test the Enrollee Profile functionality is through the

user interface; however, the enrollee used for this test could be loaded through an 834 Eligibility Load.

Negative test cases are also handled. A negative test case can be defined as ensuring the software gracefully handles unexpected input and data variables. For example, the system should not allow a user to save a “letter” in a date field. Some examples of eligibility and claims regression testing are shown below:

Non-Automation Eligibility Regression Testing:
• Load/Processing
• ID Card Generation
• Invoicing (if applicable)
• Effectuation (if applicable)

Non-Automation Claims Regression Testing:
• Top 50 Providers
• Top 50 Procedure Codes by frequency
• Top 50 Procedure Codes by Dollars
• Top 20 Diagnosis Codes (by frequency)
• Top 20 Revenue codes (by frequency)
• Top 20 Revenue Codes (by dollars)

Identifi Population Health Management System Development & Testing --

The Identifi Population Health application configuration is managed through environment specific configurations and a controlled change management process for deploying the code to production. All deployments to the production environment are managed through an Enterprise Release Management process. Thorough post-production deployment validations are performed to check for application and data consistency.

Each release contains a pre-determined scope that is identified via feature tagging in Identifi’s source code management system (including the XRB numbers showcasing approved change requests). Once the code has been completed, the build process is engineered such that only the specified features tagged as being in scope for a specific release are built in the application binaries for production release. This prevents code, which has not been through the certification processes, from being included in any production deployment. Our Release Management team builds a feature checklist and sequence of events for each release to ensure that the change management process is followed. Only a very limited team of system administrators have rights to perform the actual deployment to production.

Changes are approved by Lighthouse business owners based upon their testing in User Acceptance Testing (UAT). Both Quality Assurance (QA) Analysts and business owners validate and approve production deployments prior to turning the new version over to end users. All source code is maintained and versioned in a code repository. Once a version has been approved in a QA environment, the code is moved to a UAT environment. Business users test in UAT and once testing is complete and any issues are addressed, business sign-off is received. Once the version is deployed to production, business and IT users validate the changes in production. Once validation is complete, the system is made available for external users. Identifi users are notified in advance of any changes to the User Interface and subsequently, training is provided for the

any changes in the process/business workflow. This training may be provided in various forms depending on the scope of the update including job aids and webinars. We use the GitHub code versioning tool to track and maintain all code versions. The TeamCity application is used to build and deploy application code, based upon the business-approved version targeted for the production release. The code version is displayed on the user interface to ensure visibility of the deployed code version.

Identifi maintains separate environments as a release matures closer to production. We use development, QA, UAT, and production environments to ensure each change is validated prior to promotion. A combination of manual and automated regression testing is used to ensure the quality of each release. Our testing team maintains a library of over 1500 test cases in Microsoft's Test Manager that are used to validate candidate releases. We use Microsoft's Team Foundation Server to track the execution and status of all targeted test cases for each production release. Release notes and a "List of Known Issues" is published with each release.

Each new release of the Identifi application is also assessed by the Web Application Security team to evaluate any impact to the risk profile of the application so that new risks can be mitigated.

For production checkout, a checklist is utilized to ensure that the all required functionality has been executed prior to QA sign-off. After successful testing and a production checkout executed, the enhancement and or change release is promoted to production during a 1:00 a.m. to 6 a.m. block after business hours to minimize impacts to users.

Emergency ("off-cycle") changes --

There is an established process by which emergency changes can be requested. Emergency (or "off-cycle") changes still go through the same process as routine changes (documentation of requirements, testing and sign off, etc.). The only difference between a change that is made through the normal change management process and the emergency change management process is that items that are requested as emergency changes are evaluated to ensure that they meet emergency change requirements (e.g. there is an impact on patient care or revenue) and there is a strong case to be made for why the change should be made outside of the regular deployment cycle.

Procedural code back-out process –

In the event that a change does not test successfully after production implementation and a fall-forward remediation is not feasible, the release management back-out procedure will be implemented. The back-out procedure consists of the following:

1. Restoring the database backup that was captured as the first step of the deployment.
2. Redeploying the previous production version of the code from TeamCity.
3. QA certification of the previous production version, indicating a successful back-out.
4. Site is made available for use on the previous version.

End user testing capabilities --

The testing process starts with design of the Lighthouse-specific workflows. The workflows reflect the spectrum of client-specific configuration and considerations. From this, a master test plan is formulated. The master test plan includes the testing scope and scenarios, testing team, and

timeline. The testing scope and scenarios outline the Identifi application features, functionality, and client-specific configuration to be tested. Based on the scope and scenarios, a series of step-by-step scripts are written to conduct the testing. Testing, using these scripts, is then performed by Evolent IT quality assurance testers, the Evolent implementation team, and a selection of Lighthouse end users.

Testing sessions are led by the Evolent implementation team and Lighthouse end-user testers are assigned test scripts to complete during the session. During testing, if issues are identified, they are logged in a formalized issue tracker by the Evolent implementation team, and are evaluated for triage to the appropriate area for resolution. If it is a technical issue, the Evolent Support team is notified. If it is a configuration issue, the implementation team will address it. Testing and results are communicated throughout the testing process through test plan design meetings, in-person testing sessions, test issue logs, and master plan documentation. At the end of the testing session, a report-out on status is provided to everyone involved with testing.

Security testing --

Evolent Health utilizes GuidePoint Security, LLC as its web application security vendor. GuidePoint performs manual penetrations tests annually and automated static code analysis quarterly to ensure Identifi is free from common vulnerabilities. The GuidePoint program tracks vulnerabilities and their mitigations across software releases to present a holistic view, over time, of the resilience of the application against various attack vectors as defined by OWASP (Open Web Application Security Project). Evolent's Identifi application currently holds a perfect score of 100 in manual penetration tests across all modules.

Evolent adheres to OWASP guidance for classification and remediation patterns to manage common web application vulnerabilities.

Each new release of the Identifi Platform application is assessed by the Web Application Security team to evaluate any impact to the risk profile of the application so that new risks can be mitigated. Evolent scans for vulnerabilities on all systems and performs remediation within 30 days. Application vulnerabilities discovered through our web application security program are remediated based upon severity and priority according to the CWE classification system. All Identifi application components are currently VL5, the highest level of certification offered by GuidePoint.

The vulnerability static scan definitions are constantly being updated by GuidePoint Security as new threats are discovered.

Identifi's last GuidePoint penetration and vulnerability test was conducted June 2017. There are no known high, medium, or low level findings in the latest completed web application security assessment. Identifi's current score from GuidePoint Security, LLC is 100/100.

Examples of changes in the past:
Identifi is built to support various levels of customization through configuration and its rules engine. The Identifi Team will partner with Lighthouse to understand their workflow and clinical model to tailor the clinical programs that become available via Identifi. There are also various stratification models and rules thresholds that can be customized to meet Lighthouse requests. Workflow can also be customized by providing customized clinical content for care plan and

assessments. The Identifi Team also supports customization for the various reports that are available through Identifi Reporting.

Evolent has partnered with other clients to build new features to meet a business need and once launched those features are available to all our clients. Some examples of these client requests are:

1. Identifi Community – This application was built as one of Evolent's partners has a need to have a single forum for communication with all of their network physicians. This application provides a secure way to post articles, documents and events to this group of users. It also supports functionality for forums, blogs and the ability to moderate discussions.
2. Quality/Complaints Module – This module was built as an add-on to our care management and utilization management application. One of Evolent's clients was an alpha partner in defining the business need and they built a module that is now widely used across all of their clients.
3. ER Claims Authorization – We recently collaborated with one of our clients to support auto intake for their Emergency Room authorizations, thus increasing operational efficiency for their team to tackle a large volume of Emergency Room authorizations.

We will work with Evolent to implement similar changes as needs arise.

INTEGRATION TESTING

Both systems within the Identifi Platform (Health Plan Administration system and the Population Health Management system) utilize multiple environments during the development cycle. The Identifi Platform maintains separate environments as a release matures closer to production. We use development, QA, UAT, and production environments to ensure each change is validated prior to promotion. Separation of environments allows any issues or problems to be isolated and remediated before they are promoted to the next environment in the development queue, potentially jeopardizing existing code and applications. In the event any issues are discovered during the change management process, they are assessed within the aforementioned SDLC Agile-Scrum team for business impact. The Scrum team's Product Owner will communicate the issue to impacted business units and negotiate a solution based upon business needs and objectives, as well as any technical constraints which may exist. Once resolution is obtained, the code is revaluated in its respective environment and, once confirmed to be issue-free, is promoted to the next environment to near production. Evolent Health adheres to strict environmental exit criteria. All code must be fully validated and must pass all exit criteria before it is promoted to the next environment in the queue.

Evolent development teams use a combination of manual and automated regression testing to ensure the quality of each release. Regression testing is the process by which we test any changes and or enhancements or updates to the Identifi Platform to ensure that system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems as well as ensuring that older programming still works with the new changes. Our testing team maintains a library of over 1500 test cases in Microsoft's Test Manager that are used to validate candidate releases. Of the 1500 test cases, roughly 600 are dedicated solely to regression testing and they are executed both manually and automatically. Our regression testing ensures that system changes do not impact system components which have not been changed for a release.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

CLAIMS RE-PROCESSING FOR RETROACTIVE SYSTEM CHANGES

The core platform contains the ability to perform mass adjustments on claims automatically based upon retroactive enrollment change. Claims that are routed to workflow queues can be mass adjusted through the application on a scheduled basis, one time basis, or on-demand as users see fit. If processing workflow queues manually, the mass adjustment options include the ability to select claims based on user-entered criteria and to automatically resubmit those claims through the adjudication process. The criteria that can be accessed includes:

- Group.
- Enrollee.
- Provider.
- Claim number.
- Benefit plan.
- Remark code.
- Received date range.
- Service date range.
- Claim form type.
- Workflow queue.
- Specific user.

Finally, there is an option for mass adjustments which allows the end user, based on security, to upload a spreadsheet of claims to be reprocessed. Claims that required a recalculation can be identified using the various reporting tools and a list of claims can then be imported into the application for processing.

Evaluation Criteria:

1. The adequacy of the respondent’s IT processes addressing internal modifications for its core systems and subcontractor’s systems.

2. The extent to which the respondent’s IT processes documented for implementing Agency-directed modifications is less than ninety (90) days.

3. The adequacy of the respondent’s processes documented for handling production IT system issues.

4. The adequacy of the respondent's communication process used when system issues/updates are identified and resolved by the respondent and/or its subcontractors throughout the change control process.

5. The adequacy of the respondent's approach to system internal testing to ensure the respondent's and/or subcontractors' system changes/updates are accurate.

6. The adequacy of the respondent's approach to integration testing to ensure the respondent's and/or subcontractors' system changes/updates do not adversely affect other systems, including systems operated by Florida Medicaid and subcontractors' systems.

7. The adequacy of the respondent's approach to applicable claims reprocessing for retroactive system changes, including processing performed by its subcontractor(s).

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 29 – Encounter Data Submission (Statewide):

a. The respondent shall submit a flow chart and narrative description of its encounter data submission process including, but not limited to, how accuracy, timeliness and completeness are ensured.

b. Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.

c. The respondent shall demonstrate quality control procedures to ensure documentation and coding of encounters are consistent throughout all records and data sources (ASR, FMMIS, special submissions) and across providers and provider types. The description should include tracking, trending, reporting, process improvement, and monitoring of encounter submissions, encounter revisions, and methodology to eliminate duplicate data.

d. The respondent shall include any feedback mechanisms to improve encounter accuracy, timeliness and completeness.

e. The respondent shall include documentation of the most recent three (3) years of encounter data submission compliance ratings, corrective actions, if indicated, and timeframe for completing corrective actions for Florida Medicaid.

f. The respondent shall submit documentation describing the tools and methodologies used to determine compliance with encounter data submission requirements.

Response:

Lighthouse Health Plan understands the importance of accurate and timely encounter data submission to the Florida Medicaid program, including capitation rate development, program oversight and meeting reporting requirements. Our encounter data submission process is overseen by the Lighthouse Chief Information Officer who will also serve as a Florida-based point of contact of any issues related to encounter submission. We will use proven approaches for collecting, validating, and submitting complete and accurate encounter data in a timely manner, consistent with federal regulatory requirements in C.F.R. § 438.818 and the requirements of the Florida Medicaid model contract. The Lighthouse Team brings encounters submission experience and procedures that have been successfully deployed in other Medicaid markets, accurately reporting encounter data to state Medicaid programs for over 14 years.

At the core of our encounters process is the Edifecs Encounter Management platform. Edifecs Encounter Management delivers a consolidated platform that ensures the accuracy, completeness and timeliness of encounter data submissions across all managed care programs and lines of business. Health plans are able to manage all aspects of RAPS/EDPS submission and reconciliation, state-specific Medicaid encounters, dual eligibles and the Marketplace (via the Edge Server) without the IT cost and complexity of operating multiple systems. Integrated exception management workflows enable the rapid correction and re-submission of rejected

encounters. A flexible architecture ensures that the platform can scale to meet evolving health plan needs.

ENSURING ACCURATE, TIMELY AND COMPLETE ENCOUNTER DATA

Lighthouse's encounter management and reporting system and process is comprised of four key components including Intake/Pre-processing, Encounter Creation, Submission and Response and Reconciliation. These four components are shown in Attachment SRC 29-1 Encounter Management Flowcharts and are described below.

Intake/Preprocessing –

• Adjudicated medical (Institutional, Professional) claims are extracted from our core claims system (HPA) and loaded into the Edifecs Encounter Management (EM) platform in a proprietary CSV file format. During the intake process data is validated and subsequently converted into a common data format within the EM platform and is subsequently made ready for encounter creation.

Encounter Creation –

• To ensure accuracy, during the encounter creation process the Encounter Management (EM) system validates each encounter record against state specific configured rules and edits based on state encounter reporting requirements, state companion guides, as well as other data integrity validation, including HIPAA and other syntactical and structural data validation checks. Encounter accuracy and validation checks include, but are not limited to:
• Business edit validation
• Compliance validation
• Provider validation
• State specific Business edits
• Validation exception (dup check, NPI, etc.)
• Voids/Replace for denials or accepted encounters
• Encounters passing all business and compliance edits are generated and made ready for state submission based on pre-determined submission frequency. Records that do not pass all edits are systematically identified as "exceptions" and are logged for review and remediation, as applicable, prior to submission.

Encounter Submission –

• The Edifecs platform will generate outbound encounter extract files in accordance with FL encounter file submission specifications eliminating the need for manual manipulation of the files prior to submission. Additionally, the encounters platform queues and tracks the claims that have been extracted for submission and reconciles the acceptance, failure, or warning status upon receipt of state response files.
• Edifecs supports flexible submissions scheduling allowing for both pre-scheduled and on-demand encounter transmissions and utilizes tracking and reporting functionality to allow for the ability to quickly work and resubmit any rejections received from the state at any time.

Response and Reconciliation –

• Upon transmission of encounter files, response files are received from the State and are subsequently uploaded to the EM system and are systematically reconciled against submitted encounters. The system will update the disposition of each submitted record with an appropriate status (Accepted/Rejected/Warning) based on received State response file.
• Lighthouse also utilizes subcontracted service providers for the delivery of vision, dental, non-emergent transportation, pharmacy and behavioral health services. Each subcontracted vendor adjudicates claims via their respective internal systems employing numerous edits and validations to ensure that the required claim data elements are present and correct prior to payment. The resulting claim encounters are transmitted, electronically, to Lighthouse in the prescribed FL FMMIS file format.
• Subcontracted vendor files are received by Lighthouse on a pre-determined submission schedule. These state ready files are then transmitted to FL FFMIS and loaded to the Encounters Management platform for visibility and tracking.
• Lighthouse works closely with our subcontractors on issues related to encounter submission, and our subcontractor oversight process includes specific steps to ensure timely and accurate submission of encounter data. Lighthouse has established encounter reporting processes with all subcontractors included in this proposal who will be handling provider payment. The Encounter team and Data Operations team maintain a subcontractor contact list for any issues that occur during encounter submission (host connection issues, file non-receipt, file validation failure, etc.). Inbound data is proactively monitored against expected delivery dates and frequencies. We log any deviations from expected receipt schedules and promptly investigated for root cause and remediation. We monitor data quality and integrity at receipt of data and throughout processing. We monitor key volume and metric trends on an ongoing basis, measuring against historical trend and upper/lower control limits to monitor for consistency and completeness in inbound data. We use these monitoring procedures and alerts to ensure that timely and accurate encounter data submissions are received from subcontractors. Encounters Analysts meet weekly with each subcontractor to discuss encounter data and provide error resolution prior to submission of data to the Agency.

Validating Encounter Data –

Our encounters staff validates encounter files prior to submission. Encounters are validated against X12 and HIPAA standards using WEDI SNIP level 4 verification, as well as any state specific rules based on the Agency's prescribed formats for encounter submission through custom rules added to the verification process. We will leverage a Florida specific knowledge pack developed by Edifecs as part of our rules-based verification process.

Additionally, Lighthouse will support the Agency's validation efforts which may involve comparing chart reviews of a sample of enrollees with our reported Enrollee Encounter data. We will support this process by making medical records and claims data available, and validating any files used in this process upon request.

When modifications to the Encounter collection, validation or submission process are necessary, (e.g. in response to regulatory changes, or Florida Medicaid requirements) Lighthouse will follow an established process to make the necessary changes.

Submitting Encounter Data in a Timely Manner --

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

We will submit Enrollee Encounter data files to the Agency's Agent electronically using HIPAA-compliant standards for information exchange. Our encounter submission process is currently reporting encounter data using ASC X12N 837I, 837P, 837D and NCPDP file formats. Enrollee Encounter data files are generated within two business days of the end of each payment cycle, and we will submit Enrollee Encounter data files to the Agency on a weekly basis within two business days of the end of the last payment cycle during a calendar week. The encounters submission process includes encounter tracking to monitor the 'lifecycle' of an encounter - from the initial extraction of the claim, status of validation of the data, to initial submission to the state agency, and the response from the state agency. If the encounter returns with a rejection, the encounter is monitored for aging, and its resubmission. Daily reports are sent to appropriate workgroups to ensure timely submissions, and corrective actions in situations where timely submission is at risk.

Monitoring for Completeness and Managing Non-Submission --

Lighthouse will develop and submit an annual Data Completeness Plan to the Agency for review and approval. The plan will describe how claims and encounters are submitted accurately and timely by providers and subcontractors. Through the plan, we will demonstrate resolution and re-submission of denied encounters. The plan also outlines our evaluation of provider and subcontractor compliance as well as demonstrating our process for acting on issues uncovered by our monitoring activities. We are confident that our Enrollee Encounter submission process will exceed the contractual requirement that the submissions include at least 98% of all Enrollee Encounter Data in a valid format and that at least 95% of the records in our submission will pass the Agency's compliance edits. Our approach includes a process for assessing the completeness of our Enrollee Encounter files and addressing provider or subcontractor non-submission.

Managing Provider Non-Submission --

Timely and accurate encounter submission is required as a term of any provider agreement that includes payment arrangements necessitating the submission of encounter data beyond normal claims submission. Lighthouse monitors capitated provider submissions to detect non-submission or incomplete submission based on historic service patterns. Additionally, capitated providers will undergo medical record audits annually to ensure that they have been submitting complete and accurate encounter information. If non-submission or incomplete submission is suspected, our Encounters department will reach out to the provider to address the concern. Consistent issues with non-submission or incomplete submission will result in the provider being required to implement corrective action. If a provider is unable to address issues of non-submission or incomplete submission, their provider agreement will be amended to end the capitated arrangement. Providers may also be reviewed for possible fraud, waste and abuse and may be referred to the credentialing committee. In extreme cases, the provider may be terminated from the network.

Managing Subcontractor Non-Submission --

Lighthouse works closely with our subcontractors on issues related to encounter submission, and our subcontractor oversight process includes specific steps to ensure timely and accurate submission of encounter data. Lighthouse has established encounter reporting processes with all subcontractors included in this proposal who will be handling provider payment. The Encounter team and Data Operations team maintain a subcontractor contact list for any issues that occur

during encounter submission (host connection issues, file non-receipt, file validation failure, etc.). Inbound data is proactively monitored against expected delivery dates and frequencies. We log any deviations from expected receipt schedules and promptly investigated for root cause and remediation. We monitor data quality and integrity at receipt of data and throughout processing. We monitor key volume and metric trends on an ongoing basis, measuring against historical trend and upper/lower control limits to monitor for consistency and completeness in inbound data. We use these monitoring procedures and alerts to ensure that timely and accurate encounter data submissions are received from subcontractors. Encounters Analysts meet weekly with each subcontractor to discuss encounter data and provide error resolution prior to submission of data to the Agency.

CHECKING FOR KEY FIELDS AND KEY FIELD COMBINATIONS

Our Encounters team understands that encounters are only useful if they contain all required information to identify the services that were rendered to our Enrollees. Our pre-submission validation steps check to make sure that key fields are populated at that key field combinations are logical. These key fields include but are not limited to Recipient Medicaid ID, Provider Medicaid ID, Claim Type, Place of Service, Revenue Code, Diagnosis Code(s), Amount Paid, and Procedure codes. Our pre-submission validation edits are designed to identify when these key fields are in conflict so that incorrect encounter information can be quickly reviewed and corrected.

Completeness of encounter submissions requires that key fields are populated accurately for every encounter submission. The respondent must describe quality control processes that will ensure key fields including, but not limited to, recipient Medicaid ID, provider Medicaid ID, claim type, place of service, revenue code, diagnosis codes, amount paid, and procedure code are accurately populated when encounters are submitted.

We will use the Edifecs Florida-specific Knowledge Pack which is a single integrated set of rules for FL encounter management to ensure complete, accurate, and timely submissions and reconciliation. The Knowledge Pack maintains configuration and validation logic based on state business rules, companion guides and other related technical documents and specifications. The Edifecs Encounter Management platform validates each encounter record on key fields including but not limited to; Claim Type, Provider Type, Type of Bill, Enrollee Medicaid ID, NPI, Taxonomy, Place of Service, Revenue Code, Diagnosis Codes, Amount Paid, Procedure Codes, and the state provider file to ensure all required data elements are present and populated accordingly. Records which do not pass all validation edits will drop to an “exception” status for review and remediation prior release.

Our encounter submission process will also be strengthened by our team’s experience submitting encounters through the Florida’s fiscal agent (DXC) in other state Medicaid programs (Kentucky) where DXC also serves as the fiscal agent. This experience will help ensure smooth testing of initial encounters submissions and will facilitate faster, and more efficient resolution of any encounter submission issues that may arise.

QUALITY CONTROL AND PRE-SUBMISSION VALIDATION PROCEDURES

Our quality control process extends beyond validation of the encounter data we submit to the Agency. We apply rigorous QA approaches to the encounter submission process and the rules engine that supports it.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The Edifecs Florida-specific Knowledge Pack is a single integrated set of rules for encounter management that ensures complete, accurate, and timely submissions and reconciliation. The knowledge pack includes:

- Existing pre-built rules to validate finalized claims and supplemental transactions to generate encounters per companion guidelines
- Duplicate logic
- Void / Adjustments processing (e.g. Adjustments: Required to send Void then original)
- Generate compliant outbound submission file
- Load 999/277CA,U
- Load Custom response files (ex. CMS: MA-002, CA: EVR, Indiana: Submission Summary Report)
- Performance Reports

The Edifecs team is continuously managing the rules engine and monitoring for updates by the State. Lighthouse will ensure that Edifecs receives any updates within a timely manner so they can be incorporated within the system. We will do this through monitoring the publication of companion guides and updates to companion guides to determine when changes to the rules are required. Examples of such changes include changes to the inbound acknowledgement process, outbound encounter transmission, and the addition, deletion, or modification of validation edits. We test all updates with Edifecs in a UAT environment prior to moving any change to production.

ENSURING CONSISTENT CODING ACROSS PROVIDERS AND PROVIDER TYPES

Accurate and consistent coding is essential to accurate encounter generation and submission. Consistent coding begins with the provider claims submission process. Our network providers receive billing guides, training, and assistance from provider service representatives that supports accurate claims submission and consistent coding of claims. Additionally, our claims payment system is configured to pay claims only if they are complete and include accurate coding. During the claims adjudication process we apply National Correct Coding Initiative (NCCI) edits as a check for accurate coding. Our goal is that every adjudicated claim record includes complete and accurate coding for encounter reporting purposes.

ENSURING ENCOUNTER CONSISTENCY ACROSS DATA SOURCES

Data for our encounter file submissions comes from our core claims processing system and from our subcontractors who have delegated responsibility for claims payment (Pharmacy, Dental, Vision). Encounters generated from these data sources are loaded into the Edifecs encounters platform where they are validated prior to submission. Validation includes consistency checks that ensure that regardless of the data source, the encounters submitted to the Agency are uniform in their format, and are aligned to Florida-specific specifications.

Prior to go-live, our subcontractors must pass an encounter submission testing process with Edifecs. In order to pass this testing phase, the subcontractor must successfully submit two consecutive encounter files without anomalies and with at least a 95% acceptance rate.
After go-live, the Edifecs systems monitors for consistency and produces reports identifying any variances so that they can be addressed prior to submission. If issues are identified with encounters submitted by our subcontractors, the Encounters Team will work with the subcontractor following the processes described in our response to SRC #30.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

TRACKING, TRENDING AND MONITORING ENCOUNTER SUBMISSIONS AND REVISIONS

We monitor our encounters submission process on an ongoing basis by reviewing performance reporting that tracks and trends our submissions and revisions and provide actionable information for process improvement. Built in encounter management tools and reports allow the encounters team to review and analyze errors for remediation, as well as, to monitor and manage compliance with encounter data submission requirements. The Encounter Management platform user interface provides the ability to view how different transactions are processed in batch or in real-time by displaying summaries of different reports in a single view through management dashboards and reports. Key reports include, but not limited to:

• Transmission Summary: provides metrics of inbound and outbound transactions or files transmitted in and out of Encounter Management (EM) with a count of files by file type, status, transaction type and so on. This provides insight into the file/transaction activity happening within a specific time period.

• Claim Summary: provides metrics about the number of claims in each activity state and disposition. Provides view of the latest status (Activity State/Disposition) of each claim by different dimensions like LOB (Line of Business), Receiver (for encounters) and Claim Type.

• Encounter Summary: provides metrics about the number of encounters in each activity state and disposition. Provides view of the latest status (Activity State/Disposition) of each encounter by different dimensions like LOB (Line of Business), Receiver (for encounters) and Claim Type.

• Encounter Exception Summary: provides correction information by date. Provides ability to analyze information on exceptions that are open and view exceptions-related activity summary (like closed and open exceptions) for the Lines of Business.

• Outbound Reconciliation Report: provides information on the outbound trading encounters submitted to the State grouped by Line of Business (LOB), Destination/Receivers and Status/Disposition. Provides ability to view and reconcile the Outbound encounters and files that submitted for the Line of Business, and drill down into details.

• Monthly Encounter Summary – Outstanding Rejects: monthly report that summarizes Reject Codes for outbound encounters that have not yet been resolved

HISTORICAL COMPLIANCE RATINGS

While Lighthouse is a new entity on Florida and we have not submitted encounters to AHCA in the past, our encounters team and the processes they will leverage have been successfully submitting encounters for several years in support of a Medicaid Managed Care Plan in Kentucky. Our encounters team has achieved acceptance rates that consistently exceed the contract standard of 95% while also realizing continued improvements as a result of ongoing process improvements. Acceptance rates for the past three years in that program were as follows:
• 2015: 96.9%
• 2016: 98.9%
• 2017 (Q1 and Q2): 99%

Our subcontractors also have a strong track record of timely and accurate encounters submission. For example, CVS Health achieved an encounter accuracy rate for Medicaid clients above 99.0% in 2015. In 2014, the encounter accuracy rate for Medicaid clients was above 99.0%.
In 2015, the CVS Health encounter data acceptance/rejection rate across all of our Medicaid clients was 98.1%. In 2014, the encounter data acceptance/rejection rate across all of our Medicaid clients was 98.0%.

TAKING ACTION TO ADDRESS NON-COMPLIANCE

Our encounters monitoring strategy is designed to identify potential issues before they cause submissions to be non-compliant. A root cause analysis is conducted and remediation is quickly executed to address any identified issues.

Examples of addressing issues with encounter submission from the health plan in Kentucky that is currently using our encounters management approach are described below.

1. The Manager of Encounters identified that a subcontractor's encounters files had failed to be accepted. This failure was identified to be the result of a recent system migration which caused their files to be incompatible with the Medicaid's Operating System and unable to be opened. A corrective action plan (CAP) was issued to the subcontractor by the DOC requiring:
• Written explanation of ongoing quality review processes to detect potential errors prior to submission of the file and
• Documentation of change in process or policy to comply and mitigate future file errors submitted to the plan for review. The subcontractor made system modifications to ensure that future files were submitted in a manner that was compatible with the Department for Medicaid's encounter operating system. The subcontractor also acknowledged their responsibility to notify the plan of any system enhancements related to data submission. The subcontractor resumed submitting files in a manner that were successfully processed by the Department for Medicaid. The outcome of the CAP was accepted by the DOC.

2. In March of 2015 it was determined that the health plan or one of its subcontractors had submitted a file that failed in the Department's File Transfer System. The file was password protected and could not be opened. A process change was put in place to eliminate password protection of encounter files (Files are transmitted over a secure FTP connection) to prevent this problem from occurring in the future.

TOOLS FOR DETERMINING COMPLIANCE

We monitor our encounters submission process on a daily, weekly and monthly basis by reviewing performance reporting that tracks and trends our submissions, rejects, exceptions and corrections and develop actionable plans and information for process improvement as necessary State rejected encounters and those identified as part of our pre-submission validation process are identified as part of our encounter reconciliation and performance reporting. Built in encounter management reports allow the Encounters Team to review and analyze errors for remediation.

Depending on the nature of the error, remediation may involve varying resolution paths.
1. Encounter Team - Our encounter management system provides for robust error correction capabilities. Straightforward data errors can be corrected within the system itself by Encounters Team through user friendly interface screens.

2. Operational Areas - Other errors may require involvement of other operational areas such as Claim, Provider, Enrollee or IT. In these situations, the encounters team triages the error(s) and engages the relevant operational area through an internal Issue Ticketing process. Upon receipt of the issue ticket root cause analysis is performed and remediation steps are determined. Depending on the finding this could include adjustment/reprocessing/recoupment of a claim, a claims system coding or edit modification or provider file data update/refresh. Resolution may also include the need for re-training or procedural documentation updates should the error be related to human process error.

PROCESS FOR CONVERTING PAPER CLAIMS TO ENCOUNTER DATA

Special attention is paid to gathering encounter data from claims that are submitted on paper. We employ a rigorous process for converting paper claims, first to an electronic 837 file, and then to encounters using the same process that it used for electronic claims. Lighthouse has selected Smart Data Solutions (SDS) as our vendor to manage intake of paper claims.

SDS provides full mailroom capabilities including scanning and paper to electronic (P2E) claim translation/formatting. This includes translating paper claims, whether they are mailed paper claims or faxed claims, to electronic 837Ansi transactions as well as document processing for attachment to claims for aid in adjudication.

• SDS uses a combination of OCR and manual data verification to ensure that the maximum amount of data is pulled from each document.
• SDS automatically audits claims as an inline process screening each claim against a number of quality control checks.
• Quality control checks include but are not limited to.
• Format Validation
• Completeness of claim
• CPT Validation
• Diagnosis Code validation
• Postal verification
• Claim balancing

IDENTIFYING SYSTEMS OR PROCESSING ISSUES THAT COULD RESULT IN SUBMISSION OF INVALID DATA

In addition to our pre-submission validation edits, we review and assess any threshold errors that are included in the return file from the Agency's fiscal agent. Enhancements to our system and processes are identified, tested and implemented. This may include modifications to the process of collecting encounters from subcontractors, making changes to the Florida-specific knowledge pack, or making other changes to the submission process.

ENSURING THAT ALL ENCOUNTERS HAVE BEEN SUBMITTED

Subcontractor and provider encounter files are validated in depth during implementation process. The process for capitated providers to submit information sufficient to report encounters is reviewed during the provider orientation process. In production, the encounter submission process performs a basic x12 WEDI SNIP level 4 verification to assess submitted information completeness before file submission to the Division.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The Lighthouse Edifecs Encounter Data Management platform tracks all encounters submitted from all sources. This enables Lighthouse to ensure an appropriate response is received for each file submission. We also routinely compare our encounter submissions to paid claims file to identify whether there are paid claims for which an encounter should have been submitted. Our monitoring of this metric for other Medicaid managed care programs shows consistently low percent of claims paid to encounters submitted.

Evaluation Criteria:

1. The adequacy of the respondent's process to ensure accurate, timely, and complete encounter data.

2. Demonstrated knowledge of the combination of key fields needed to identify services.

3. Adequacy of procedures, including quality control procedures, to identify key fields and ensure they are accurately populated during encounter data submission.

4. Adequacy of procedures to ensure encounters are coded consistently across providers and provider types.

5. Adequacy of procedures to ensure encounters (volume, categorization, dollar amounts, dates) are consistent across data sources, including applicable subcontractors.

6. The completeness of the respondent's flowcharts describing its encounter data submission process.

7. The adequacy of the respondent's mechanisms for tracking, trending, monitoring encounter submissions and revisions, including the type and frequency of activities, and methodology to eliminate duplicate data.

8. The adequacy of the respondent's encounter data submission historical compliance ratings.

9. The adequacy of the respondent's ability to implement timely corrective actions to compliance ratings, if indicated.

10. The adequacy of the tools and methodologies used to determine compliance.

11. The adequacy of the respondent's process for converting paper claims to electronic encounter data.

12. The adequacy of the respondent's approach to identifying and correcting specific processing/systems issues that could result in invalid data being submitted to the State.

13. The adequacy of the tool to ensure that all encounters are submitted.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

Score: This section is worth a maximum of 65 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 30 – Encounter Submission for Sub-Capitated, Subcontracted, Non-Par and Atypical (Statewide):

The respondent shall describe how it will work with providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to ensure the accuracy, timeliness and completeness of encounter data.

Response:

Lighthouse Health Plan takes full accountability for accurate and complete encounters submission for all services rendered to our Enrollees. This includes encounters that originate with sub-capitated providers, atypical providers, non-participating providers and our sub-contractors. We understand the importance of collecting sufficient data to support encounters from all providers so that an accurate accounting of the services to enrollees is offered to AHCA. Our encounters process is supported by a provider and vendor engagement strategy that emphasizes the importance of encounter data in the administration of a Medicaid program.

All claims received from providers and processed through Identifi HPA claim system and/or processed claim data files received from our subcontractors, are processed through Lighthouse's encounters platform, Edifecs. Edifecs Encounter Management delivers a consolidated platform that ensures the accuracy, completeness and timeliness of encounter data submissions across all managed care programs and lines of business. Edifecs supports management of all aspects of RAPS/EDPS submission and reconciliation, state-specific Medicaid encounters, dual eligibles and the Marketplace (via the Edge Server) without the IT cost and complexity of operating multiple systems. Integrated exception management workflows within Edifecs enable the rapid correction and re-submission of rejected encounters, while its flexible architecture ensures that the platform can scale to meet evolving needs.

PROVIDERS KNOWN TO FMMIS

The first step to ensuring that encounters originating with providers of all types is to validate that the provider is appropriately enrolled with the Agency. In accordance with the requirements of Section VIII(C)(2) of the SMMC model contract, as part of our provider enrollment and credentialing process we verify that providers have a current provider agreement with the agency, and that non-participating providers have a Medicaid provider identification number in the FMMIS prior to processing any claims for payment.

To ensure the accuracy of provider data being managed, we employ robust data accuracy checks and audits throughout the claims payment, provider enrollment, and credentialing processes including cross referencing FMMIS identification numbers against the ACHA Master Provider File utilizing NPI and other demographics. Lighthouse provider data is also audited on an ongoing random basis through a combination of proprietary algorithmic calculations that identify potential errors. These findings are then investigated and updated in the Identifi Network to effectively impact all downstream directories.

Our ongoing provider data management processes enable us to meet all provider related reporting requirements outlined in Sec. XVI of the model contract, Section 111 of the Medicare,

Medicaid, and SCHIP Extension Act of 2007 (MMSEA) as well as the well as the Affordable Care Act and Florida Medicaid State Plan.

PROVIDER EDUCATION

Once the providers reside within the Identifi HPA system, the next step to ensuring quality encounter submittals is provider education. Lighthouse uses many forums when educating providers about the importance of claim submittal and its role in Lighthouse's submittal of encounter data to AHCA. This provider education is offered to contracted, subcapitated, atypical and subcontracted providers though methods of education may vary by provider. This education is also offered to non-contracted providers via our website.

While the forums for this provider education will vary, overall education on this topic includes the following:
• Process - The review of the encounter data process in general and the importance of the process to the enrollee, provider, the health plan and the AHCA. The process review will include the discussion of liquidated damages and their impact to all constituencies.
• Contract – A brief review of a provider's contractual obligations for claim submittal
• Data Population - The necessity of populating all key fields on a UB 04 or HCFA 1500 form, inclusive of the "Billed" field so that the health plan can properly process a claim with each claim submittal. The role the health plan plays in helping providers understand the importance of correct coding, the fact that the health plan follows NCCI/correct coding initiatives and the implications when correct coding is not followed.
• Data Consistency - The importance of the consistency of data submitted on each claim form so that the health plan can properly process a claim with each claim submittal;
• Timely Claim Submittals - The importance of timely claim submittals such that the health plan can submit its outbound encounter data to AHCA in a timely fashion;
• Questions? - The reminder of whom to contact at the health plan with questions on any type of claim submittal.
• Other –Lighthouse provides education and support for paper submitters both in the initial orientation and with any subsequent issues which are brought to the attention of the provider relations specialist. Detailed instructions about submitting paper claims that include all information required for the collection of encounter data are included in our provider billing guides. The billing guides will be submitted to the agency for review and approval and will be available to providers on the Lighthouse website. Provider Services representatives will also review billing guides, including instructions for submitting paper claims during regular visits to those providers.

This education will be revised as Lighthouse receives revisions from AHCA on encounter data submittals and/or industry changes that impacts encounter data submittals.
Our educational forums or educational materials include the following:
• Provider manual
• Town hall meetings: these meetings focus on all operational aspects of the health plan.
• Focused training: for a period of at least twelve months following contract implementation, we will conduct educational sessions with a special focus on the top five provider types identified by our qi monitoring, claims review, and payment process review as the highest volume providers and providers who need specialized help, reviewing all operational aspects of working with our health plan.

• Provider relations team: provider relations representatives will meet with providers in a small group, office setting within 30 days of placing a newly contracted provider or provider group on active status and then on an organized schedule.
• Lighthouse website: the website will contain instructions on correct claim submittal and the role that encounter data plays in the administration of a Medicaid health plan. Special emphasis will be placed on alerting non -contracted providers to this portion of the website.
• Hold time messaging: on-hold messaging can be created that educates providers about the claim submittal process and the role of encounter data.

ENSURING COMPLETE SUBMITTALS

The Edifecs Encounters Platform provides robust capabilities to submit outbound encounters and regulatory financial fillings to meet all state requirements. These encounters include those generated from claims that were processed by Lighthouse as well as claims processed by third-parties. Our contractual agreements with our subcontractors include terms and conditions to ensure compliance with Lighthouse and state contractual encounter performance requirements. The entire encounter submission is orchestrated and managed by a set of components that track all aspects of the encounter data submitted. These components are also responsible for reconciling the state responses and coordinating resubmissions. A full suite of reports provide transparency to claims submission lifecycle and claims compliance.

The Edifecs Encounter Management platform validates each encounter record on key fields including but not limited to; Claim Type, Provider Type, Type of Bill, Enrollee Medicaid ID, NPI, Taxonomy, Place of Service, Revenue Code, Diagnosis Codes, Amount Paid, Procedure Codes, and the state provider file to ensure all required data elements are present and populated accordingly. Records which do not pass all validation edits will drop to an “exception” status for review and remediation prior release.

The first step for submitting complete and accurate encounter data is to effectively collect all the required components of an encounter. Our process starts with source input files that identify required data elements to be included in claims extraction processes. This claims extraction process includes all finalized claims whether paid or denied, as well as zero dollar claims. Encounter collection also includes data exchange with subcontractors and capitated providers. The Encounter Management System supports bi-directional ANSI-compliant health information exchange including HIPAA compliant X12 standard file formats. This framework supports data exchange with providers and subcontractors who submit encounters for reporting to the Agency.

Submissions from providers and subcontractors are collected according to the processes described below.
1. Encounter Data is transmitted to Lighthouse from subcontractors over a secure FTP connection.
2. Data is loaded into Edifecs so that it is visible alongside other encounter data.
3. Subcontractor encounters are transmitted from Edifecs to the state.

The Lighthouse encounters team will manage the subcontractor encounter collection and submission process as described above.

Each of our subcontractors have claims processing systems with edits for verifying claims data to ensure that all required information is provided in the proper format, that all codes are valid,

enrollees and providers eligible for the program and the specific benefit, program limitations and restrictions are not exceeded, and that the claims are not duplicates. Once claims are completely adjudicated in their systems, the resulting encounters are transmitted electronically to Lighthouse per the agreed upon schedule consistent with the Agency's submission requirements.

Lighthouse will perform periodic reviews of our subcontractors' encounter processes as part of our data completeness monitoring plan. Some of areas that may be evaluated during these reviews include:
• Claims processing edits – Are the edits sufficient to ensure the accuracy and completeness of the claims data?
• Error correction process – Are there controls to prevent overriding of critical edits?
• Encounter process – What steps are taken to ensure that an encounter is submitted for each paid service and any required denied services?
• Internal controls – What internal controls are in place to ensure that all encounters are sent to Anthem? What controls are in place to prevent duplicate submissions?
• Encounter correction process – What is the process for tracking and correcting any rejected encounters?

Lighthouse will also look at any outstanding encounter issues and review the actions that have been taken to resolve the issues. Our subcontractors are currently processing Medicaid claims and submitting encounters to Lighthouse on a regular basis.

ENSURING ACCURACY

Correctly coded claims from providers contribute to the accuracy of encounter data submittals. Therefore, we educate our providers, including out of network providers and atypical providers, on claims coding issues. Instructions on submitting claims correctly is covered during provider orientation. If a provider experiences a high level of claims denials, the encounters team will collaborate with Provider Services to schedule a site visit. Detailed information on correctly coding claims is also included in our billing manuals. The billing manuals include the following instructions related to coding of claims.

Lighthouse requires claims to be submitted using codes from the current version of ICD-10 CM, CPT4, and HCPCS Level II for the date the service was rendered. These requirements may be amended to comply with federal and state regulations as necessary. Claims will be rejected or denied if billed with:
• Missing, invalid, or deleted codes
• Codes inappropriate for the age or gender of the enrollee
• An ICD-10 CM code missing the 4th or 5th digit

Code Auditing and Editing --

Lighthouse uses code-auditing software to assist in improving accuracy and efficiency in claims processing, payment and reporting, as well as meeting HIPAA compliance regulations. The software will detect, correct, and document coding errors on provider claims prior to payment by analyzing CPT, HCPCS, modifier, and place of service codes against rules that have been established by the American Medical Association (AMA), Center for Medicare and Medicaid Services (CMS), public-domain specialty society guidance, clinical consultants, who research, document, and provide edit recommendations based on the most common clinical scenario and

the State of Florida. Claims billed in a manner that does not adhere to these standard coding conventions will be denied. The code editing software contains a comprehensive set of rules, addressing coding inaccuracies such as unbundling, fragmentation, upcoding, duplication, invalid codes, and mutually exclusive procedures.

WORKING WITH PROVIDERS TO REVISE/CORRECT/RESUBMIT CLAIM DATA

Encounters Analysts collaborate with Provider Services Representatives to resolve claims encounter submission issues with providers. If encounters are missing information or key field combinations, the Provider Services Representative will reach out telephonically to resolve the issue. Specifically, for capitated providers, each provider will be required to identify an enrollee of their office staff to serve as the single point of contact for encounters-related issues. If needed, a site visit will be scheduled to offer the provider office staff with additional training. Staff coordinates with the Encounters Department to ensure the provider's files are correct and have been submitted in accordance with Florida Medicaid guidelines.

ENSURING TIMELINESS OF PROVIDER ENCOUNTER SUBMISSION

Contracted Provider and Subcapitated Provider inclusive of Atypical Provider –

A contracted provider is required to submit a complete claim to Lighthouse within 180 days from date of service. Failure of provider to submit a claim within the submittal standard will cause the claim to be denied for lack of timely filing. Encounter data will reflect a denied claim in this situation in accordance with Florida encounter reporting requirements/companion guide. Should a persistent pattern of behavior occur, the Provider Relations team will meet with the provider to discuss the importance of timely claim submittals. Ongoing failures to submit timely, may result in a provider corrective action plan up to and inclusive of provider termination.

Non-Contracted Provider inclusive of Atypical Provider –

A non-contracted provider is required to submit a complete claim to Lighthouse within 180 days from data of service. Failure of provider to submit a claim with the submittal standard will cause the claim to be denied for lack of timely filing. Encounter data will reflect a denied claim in this situation in accordance with Florida encounter reporting requirements/companion guide.

MANAGING COMPLIANCE

Managing Provider Non-Submission --

Timely and accurate encounter submission is required as a term of any provider agreement that includes payment arrangements necessitating the submission of encounter data beyond normal claims submission. Lighthouse monitors provider submissions to detect non-submission or incomplete submission based on historic service patterns. If non-submission or incomplete submission is suspected, our Encounters department will reach out to the provider to address the concern. Consistent issues with non-submission or incomplete submission will result in the provider being required to implement corrective action. If a provider is unable to address issues of non-submission or incomplete submission, their provider agreement will be amended to end the capitated arrangement. Providers may also be reviewed for possible fraud, waste and abuse

and may be referred to the credentialing committee. In extreme cases, the provider may be terminated from the network.

Managing Subcontractor Non-Submission --

Lighthouse works closely with our subcontractors on issues related to encounter submission, and our subcontractor oversight process includes specific steps to ensure timely and accurate submission of encounter data. Lighthouse has established encounter reporting processes with all subcontractors included in this proposal who will be handling provider payment. Inbound data is proactively monitored against expected delivery dates and frequencies. We log any deviations from expected receipt schedules and promptly investigate for root cause and remediation. We monitor file quality and integrity at receipt of data and throughout processing. If file fails while loading to EDIFECS, we send it back to sub-contractor and then cycle begins again. We monitor key volume and metric trends on an ongoing basis, measuring against historical trend and upper/lower control limits to monitor for consistency and completeness in inbound data. We use these monitoring procedures and alerts to ensure that timely and accurate encounter data submissions are received from subcontractors

If a subcontractor or capitated provider fails to submit complete and accurate encounter data in a timely manner, an escalating set of actions to resolve the issue is initiated beginning with the issuance of a corrective action plan through termination if warranted.

• Formal Corrective Action Plan (CAP) - We will issue a formal CAP in cases where we have identified major deficiencies and any failure to comply with contractual requirements, including issues related to encounter submission. The CAP must describe the remediation actions to be taken, a timeline for correcting the deficiency/contract variance and the metrics that will be used to determine if the corrective action is successful.
• Probationary status (subject to enhanced oversight)- We will place subcontractors/ capitated providers who fail to submit complete and accurate encounters in a timely manner on probationary status, subjecting them to additional oversight that includes more frequent oversight meetings (daily or weekly) to monitor corrective actions.
• Penalties/Liquidated Damages- We may assess penalties or liquidated damages against the subcontractor/ capitated provider for failure to correct deficiencies in the encounter submission process. These penalties are assessed separate and apart from any penalties assessed against Lighthouse by the Agency for contract performance concerns, which are passed through to subcontractors.
• Contract termination- If a subcontractor or capitated provider fails to correct performance over a period of time, or if the nature of the deficiency or contract variance is severe, Lighthouse may terminate the subcontractor’s agreement and perform the functions ourselves or delegate to another entity with the Agency's approval.

MANAGING PHARMACY ENCOUNTERS

Our PBM, CVS Health, processes Medicaid encounters in 33 Medicaid markets and will have a dedicated team responsible for submitting weekly initial encounter files and resubmitted files when encounters reject. The CVS encounter system has the functionality to receive response files from the state via the health plan in their specified format, that identify rejected encounters and the corresponding rejection codes. CVS provides a reporting package that allows Lighthouse to monitor the delegated encounter function. CVS has a dedicated Medicaid Regulatory team that

constantly monitors changes in state regulation to ensure they are submitting files in the most current version as required by state or federal regulation. Lighthouse uses the National Council for Prescription Drug Programs (NCPDP) encounter format as required by the Agency. Pharmacy claims reflect the amount paid to the pharmacy not including fees paid to the PBM.

CVS Health maintains a propriety encounter processing system (EMS) that interfaces with its claim adjudication engine to extract all adjudicated claims on a nightly basis. EMS has the flexibility to create outbound NCPDP encounter files in both standards D.0, PAH, and proprietary encounter formats for the original paid claims and all subsequent adjustments to that claim. Upon receipt of response files, EMS will load both state-specific and standard layouts (835, 277, D.0), reconcile the responses to the original submission, and track the outcome of the encounter submission. All rejected encounters can be corrected through the EMS system and generate all corrections on the following cycle file or by a separate file as defined by the state's requirements.

Evaluation Criteria:

1. The adequacy of the respondent's approach to ensure that all network providers, including subcapitated providers, are known to the Florida Medicaid Management Information System (FMMIS) for the purposes of encounter data submission.

2. The adequacy of the respondent's approach to educating all providers about the importance of key field combinations in accurately identifying the service/s provided, the importance of populating all key fields, and the importance of consistency in coding across all records, providers, and provider types on encounter data submissions.

3. The adequacy of the respondent's approach to ensuring that all providers, including subcapitated providers and subcontractors, provide an amount or cost of the Medicaid service provided (including pharmacy paid amount). For pharmacy claims, this includes the adequacy of the respondent's approach to ensuring the amount or cost of the Medicaid service provided must be the amount that was actually paid to the pharmacy excluding any PBM or other administrative costs.

4. The adequacy of the respondent's approach to educating and supporting providers who submit paper claims.

5. The adequacy of the respondent's approach to encouraging providers, particularly subcapitated providers, subcontractors, atypical providers, and non-participating providers to submit accurate, timely, and complete encounter data, including the type and frequency of activities and any incentives/penalties.

6. The adequacy of the respondent's description of how it will connect with providers to revise encounter submissions in a timely manner.

7. The adequacy of the respondent's approach to work with providers to comply with correct coding.

8. The adequacy of the respondent's approach to ensure that all encounters are included in submissions.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

SRC# 31 – Fraud and Abuse/Compliance Office (Statewide):

The respondent shall describe its compliance program including the compliance officer's level of authority and reporting relationships. The respondent shall describe its experience in identifying subcontractor fraud and internal fraud and abuse in managed care programs. The respondent shall include a résumé or curriculum vitae for the compliance officer. The respondent shall also include an organizational chart that specifies which staff are involved in compliance, along with staff levels of authority.

Response:

Lighthouse Health Plan employees will observe all applicable state and federal laws and regulations. We have developed a Compliance Plan that incorporates these standards to be followed by the Board of Directors, employees, subcontractors, and other individuals and/or business partners. The overall Compliance Program includes the Compliance Plan, approved by the Board of Directors, Standards of Conduct and compliance policies and procedures.

Lighthouse's Compliance Program is a tool to promote regulatory compliance and ethical conduct and prevent, detect and resolve non-compliant and illegal conduct, including fraud, waste, or abuse of government programs, whether committed by employees or by those outside of Lighthouse. The Compliance Plan builds on the foundation established by the Compliance Program, including measures related to mandatory compliance training; Fraud, Waste, and Abuse training; HIPAA Privacy Program training; and Fraud, Waste, and Abuse detection, prevention, and correction, including a hotline for anonymous reporting. The Compliance Program is intended to prevent, detect, investigate, and correct non-compliant operational practices and improper and/or unethical conduct.

The Lighthouse Compliance Plan includes:

1) Written policies, procedures and standards of conduct articulating commitment to comply with all applicable federal and state laws and regulations;
2) A Compliance Officer responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Board of Directors;
3) A Compliance Committee accountable to senior management to oversee the compliance program and its compliance with the requirements under the contract;
4) Effective training and education for the Compliance Officer, senior management and employees for the federal and state standards and requirements under the contract;
5) Effective lines of communication between the Compliance Officer and other Lighthouse employees;
6) Enforcement of standards through well-publicized statutory and contractual requirements and related disciplinary guidelines;
7) Establishment and implementation of procedures and a system for internal monitoring and auditing of compliance risks, prompt response to compliance issues, investigation of potential compliance problems as identified during self-evaluation and audits, development of corrective

actions to resolve and reduce the potential for recurrence, and ongoing compliance with the requirements under the contract.
8) The Compliance Plan is intended to meet all federal and state guidelines related to fraud, waste, and abuse, ethical business conduct, and privacy issues related to HIPAA. The Compliance Plan is reviewed annually and associated compliance policies and procedures are reviewed and revised at least annually or more frequently if there are changes in regulatory requirements or business needs.

Lighthouse Health Plan will comply with all applicable federal and State civil rights laws, regulations, rules and policies, including but not limited to Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Titles II and III of the ADA of 1990, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and the Age Discrimination Act of 1975. A Non-discrimination Compliance Plan will be in place.

Policies and procedures are reviewed at least annually by operational and compliance areas and on an as needed basis based on federal or state statutory or regulatory changes. Policies and procedures are formally approved at a cross-functional policy review committee. The Compliance Officer ensures that all employees and subcontractors are informed of applicable policy requirements, and that this training and education is documented and retained in accordance with applicable record retention standards.

The Standards of Conduct state the expectation that all employees will adhere to federal, state and local laws, regulations and standards when conducting business. All employees must attest at the time of hire and annually that they have read and understand the Standards of Conduct and agree to abide by them, as well as related policies and procedures. Subcontractors will adopt and abide by the Standards of Conduct or implement their own Standards of Conduct that incorporate similar requirements.

The HIPAA Privacy Program sets standards for employees in safeguarding confidential and protected health information (“PHI”). Lighthouse recognizes the importance of privacy and confidentiality for Enrollees. All employees are required to understand and comply with HIPAA, as well as other federal and state laws applicable to the protection of confidential health information.

LIGHTHOUSE COMPLIANCE STRUCTURE

An organizational chart that specifying which staff are involved in compliance, along with staff levels of authority is attached as Attachment SRC 31-1 Compliance Org. Chart.

Subcontractor, Evolent Health will have a full-time Director of Compliance dedicated to the Florida Medicaid program. Lighthouse will hire a Compliance Officer who will be a designated full-time employee with knowledge, training and experience in health care or risk management. This employee will promote, implement and oversee the compliance program and serve as the individual liaison to the state regulatory body. The Compliance Officer reports directly to the Board of Directors and has unrestricted access to the Lighthouse governing body for compliance, fraud and abuse and overpayment reporting. The Compliance Officer provides regular updates to the Compliance Committee and governing body summarizing overall compliance activity, including issues identified, investigated and resolved, and any changes recommended to improve compliance.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

The Compliance Officer will design, implement, and oversee a fraud and abuse program designed to ensure program integrity through fraud and abuse prevention and detection, which identifies and addresses emerging trends of fraud, abuse, and waste pursuant to this Contract and state and federal law. The Compliance Officer has sufficient staff and resources to enable the Compliance Officer to perform fraud and abuse investigations, and develop and implement corrective actions plans.

The Compliance Officer is responsible for the following:
1. Overseeing and monitoring implementation of the Compliance Plan. The Compliance Officer routinely reports compliance activities to the Compliance Committee summarizing efforts to ensure adherence to the Compliance Plan;
2. Maintaining compliance policies and procedures and ensuring regular review;
3. Creating and coordinating educational training programs to ensure the governing body, employees, and subcontractors are knowledgeable about the Compliance Program, Code of Conduct, compliance policies and procedures, and all applicable statutory and regulatory requirements;
4. Developing and implementing methods and programs that encourage reporting issues of noncompliance and potential FWA without fear of retaliation;
5. Maintaining a tracker of reported compliance violations showing reporting to resolution;
6. Managing hotline inquiries;
7. Conducting investigations of compliance violations;
8. Ensuring timely completion of risk assessments, audit work plans, and related activities;
9. Directing corrective action plans resulting from compliance reviews, risk assessments, etc., and coordinating any necessary policy or procedure changes, repayments, etc.;
10. Ensuring when compliance violations occur that consistent disciplinary standards are being met;
11. Ensuring that subcontractors that furnish services to Lighthouse are informed of the Standards of Conduct;
12. Coordinating with the appropriate departments to ensure that the National Practitioner Data Bank and OIG and GSA sanction listings have been checked for any providers contracted with Lighthouse, and that the OIG and GSA sanction listings have been checked for all employees, members of the Board of Directors, and subcontractors, prior to hiring and monthly thereafter;
13. Recommending and monitoring the development of internal systems and controls to implement standards and policies and procedures as a part of its daily operations;
14. Developing a system to receive, evaluate and respond to complaints and issues; and
15. Monitoring internal audits and audits from external parties to identify issues and deficient areas and implementing and approving corrective and preventive action.

Lighthouse has a Compliance Committee which the Compliance Officer chairs. The Compliance Committee meets at least quarterly and performs the following functions:
1. Review and provide recommendations regarding current compliance issues;
2. Review and monitor the effectiveness of the Compliance Program;
3. Analyze the regulatory environment and the legal requirements with which Lighthouse must comply, and specific risk areas; and
4. Advise on appropriate strategy/ approach to promote compliance and detect potential violations

The Board of Directors --

The Board of Directors is ultimately accountable for compliance within Lighthouse. The Board receives compliance training on the structure and operation of the Compliance Program to enable them to be engaged, ask questions and exercise independent judgment over the compliance issues with which they are presented. The Board is knowledgeable about compliance risks and strategies, understands the measurements of outcome, and can gauge the effectiveness of the Compliance Program.

The CEO and executive leadership ensure that the Compliance Officer is integrated into the organization and has the resources necessary to operate an effective Compliance Program. The CEO receives regular reports from the Compliance Officer regarding areas of risk facing Lighthouse, strategies being implemented to address them, and the results of those strategies.
To ensure an effective compliance program Senior Management is engaged and committed to the successful implementation and operation of the program. Senior leaders recognize the importance of having a robust and effective compliance plan as being critical for success and actively engage in ongoing communications and activities related to the program. In addition to a Compliance Officer, Lighthouse will staff the Compliance Department as needed to promote and run the day to day operations of the compliance program to ensure compliance with applicable compliance.

Compliance Director --

The Compliance Director is a key member of the compliance team and is highly involved with the compliance oversight program based on state and federal requirements and best practices. This position works closely with operational, clinical, and legal teams to ensure that Lighthouse is fulfilling its contractual obligations. This position works closely with business areas to understand vendor/subcontractor-specific operational risks, and designs and conducts reviews in response to risks identified. This individual serves as a compliance resource regarding Florida Medicaid requirements and monitors proposed and newly enacted legislation, regulations, sub-regulatory guidance, and instructions impacting the Florida Medicaid program and will work with business owners to determine impact and oversee implementation of the changes. The Curriculum Vitae of our interim compliance officer, Elizabeth Callahan, is attached as Attachment SRC 35-2 Compliance Officer CV. Upon contract award, Lighthouse Health Plan will hire a full-time Compliance Officer that is fully dedicated to the health plan’s compliance processes.

Special Investigation Unit --

Our experienced Special Investigation Unit (SIU) team is staffed with a team of highly qualified individuals, including investigators and specialists dedicated to preventing Fraud, Waste and Abuse. This mix of nearly 20 years of national experience and leadership with committed program resources ensures an optimal balance of efficiency, best practices, and focused effort. In addition to the internal staff, the SIU brings a complete solution to monitor, detect and protect the Florida Medicaid program from Fraud, Waste and Abuse (FWA) by using industry leading tools from Optum Insight. The SIU, with the assistance of Optum analytics, was able to identify over $1.3 million dollars from fraudulent activity from only 2 data mining queries. In addition, the Optum Insight tools are used by more than 80 health plans nationwide and Medicaid agencies and have been successful in recovering millions of fraudulent and abusive overpayments including:
• Nearly $150 Million recovered for Washington State Medicaid since 2000
• $129 Million savings over a four-year period with Iowa Medicaid
• Over $50 Million in recoveries for Kentucky Medicaid

As a partner with Optum Insight, our SIU has access and the ability to utilize data mining, algorithms, and other leads that are found in all of Optum's markets. The ability to leverage data mining that is used nationally gives the SIU the ability to identify, detect and prevent FWA for Florida Medicaid in a timely and effective manner.

EFFECTIVE LINES OF COMMUNICATION

The Compliance Officer has a system in place to receive, record, and respond to compliance questions and reports of potential or actual non-compliance from employees, Enrollees of the Board of Directors, and subcontractors. Such lines of communication are accessible to all and allow compliance issues to be reported including a method for anonymous and confidential good faith reporting of potential compliance issues as they are identified. The Compliance Officer maintains open lines of communication with the CEO and Board of Directors regarding activities of the Compliance Department. Compliance Department staff are available for questions or consultation from all employees via phone, email, and instant messenger services.

Mechanisms to reach the Compliance Department are communicated upon hire, through ongoing newsletters, annually as part of required Compliance trainings, as well as available on the internal Compliance webpage. The Compliance Department maintains open lines of communication with operational areas and in turn, its subcontractors. Educational and awareness communications are distributed to employees and subcontractors periodically throughout the year as well as new regulatory guidance and areas of concern or non-compliance. The Compliance Officer is responsible for tracking, communicating, and consulting with functional areas on the impact of new laws, regulations, sub-regulatory guidance, and standards. Business owners/responsible parties are identified for each change. The Compliance Officer works with the functional areas and subcontractors to develop action plans, update policies and procedures, and if needed develop new processes to meet the new guidelines.

All employees and subcontractors have access to multiple methods of reporting compliance and FWA related concerns. Issues may be raised to the Compliance Department through several channels including email, phone hotline or online hotline. The Compliance Hotline is available twenty-four (24) hours a day, seven (7) days a week and is maintained by an outside vendor. Callers may choose to remain anonymous. All calls are investigated and remain confidential.

The Compliance Department utilizes various mechanisms to communicate the availability of the Compliance Hotline. These mechanisms include the Standards of Conduct, the Compliance Plan, new hire and annual required trainings, the company's internal website, and various educational activities. In addition, this information is included in email signatures of all Compliance Department staff.

For an effective Compliance Program, employees, subcontractors, and the Board are educated regarding the process for reporting non-compliant activities, including actual or potential violations of law, regulation, policy, or procedure. In addition, employees, subcontractors and Board members will not be retaliated against if they report such activities. Lighthouse strives to promote a culture of non-intimidation and non-retaliation, including but not limited to reporting potential issues, investigating issues, conducting self-evaluations, audits and remedial actions, and reporting to appropriate officials. Neither retaliation nor intimidation is tolerated by any employee

or level of management within Lighthouse. This policy is outlined in the Standards of Conduct, which is distributed to every employee.

Employees are instructed that the Compliance Officer is available to receive any anonymous issues on a confidential basis. Employees can also report anonymously as noted above.
Employees should contact the Compliance Officer or their immediate manager when non-compliant activity is suspected. This report should be made immediately upon identifying the issue. In the event the employee contacts their immediate manager; the manager will report the alleged non-compliant activity to the Compliance Officer for further investigation. If the employee feels at any time as though their immediate manager is not adequately addressing the concern, the employee is instructed to contact the Compliance Officer directly and immediately, via phone or e-mail.

Calls or issues reported through the website and compliance hotlines are received, logged, and investigated by the Compliance Officer. Documentation will include how the complaint was handled, by whom and when, the specifics of the issue, findings, and actions taken. No disciplinary action will be taken against individuals making truthful reports. Every effort will be made to keep reports confidential, but there may be instances where the identity of the individual making the report must be revealed. Failure to report known violations, failure to detect violations due to negligence or reckless conduct, and making false reports shall be grounds for disciplinary action, up to and including termination. Subcontractors are instructed on how to report compliance issues and fraud through various communication channels.

PROCESS FOR PROMPTLY RESPONDING TO COMPLIANCE ISSUES

Lighthouse may identify the incident of non-compliance through a variety of sources, such as self-reporting channels, internal audits, external audits, operational and Compliance Committee meetings, and or hotline calls. Whenever Lighthouse identifies an incident of misconduct, non-compliance or fraud, waste, or abuse, we take prompt action to investigate the matter, to determine the root cause, and to outline effective corrective action. The Compliance Officer gathers all relevant documentation and findings, and conducts interviews with individuals as necessary. Corrective action plans (CAPs) are required as needed and represent a commitment from the functional area to correct the identified issue in a timely manner. Corrective actions may include revising processes, updating policies or procedures, retraining staff, reviewing systems edits, repayment of overpayments, and eliminating the root cause of the non-compliance. The Compliance Officer monitors the CAP and requires that the functional area report the completion of all interim action steps. Once a corrective action plan is complete, the Compliance Officer validates the corrective action plan by monitoring individual action items over a period of time to demonstrate sustained compliance was achieved and that the corrective action plan was effective.

Monitoring and auditing are critical elements of the Compliance Program. Compliance-related elements are used to develop metrics for evaluating performance against regulatory standards and contractual obligations. Monitoring and auditing allows Lighthouse to identify areas of non-compliance that require corrective action both internally and with its subcontractors.

The Compliance Officer expects that operational areas conduct routine monitoring of their processes. The Compliance Department works in collaboration with the applicable operational subject matter experts to establish monitoring metrics based upon functions and related

requirements. Operational subject matter experts are charged with monitoring applicable subcontractors.

Issues identified through routine monitoring must be reported to the Compliance Officer for further investigation and follow up. This monitoring allows the operational areas to track and analyze metrics and trends to better manage issues of non-compliance at the lowest level of detection. The Compliance Officer works in collaboration with the applicable operational subject matter experts to establish subcontractor monitoring metrics based upon requirements and established internal standards.

DELEGATION (SUBCONTRACTOR) OVERSIGHT

Lighthouse Health Plan monitors and audits its subcontractors to ensure they follow all applicable laws and regulations, and to ensure they monitor and audit the compliance of any downstream entities with which they contract. In conducting monitoring and audits, federal and state regulatory guidance, published best practices and internal policies and procedures are used as measurements of compliance.

Oversight activities include an ongoing evaluation of subcontractors related operational activities to detect and correct potential violations at the lowest level of non-compliance using the following:
1) Risk assessment
2) Monitoring and audit work plan updated as additional areas of risk are identified
3) Routine ongoing monitoring of compliance operational risk areas
4) Focused audits based on results of the risk assessment

Subcontractors are required to submit a Corrective Action Plan when deficiencies are identified through oversight compliance audits, ongoing monitoring or self-reporting. We take appropriate action against any contracted organization that does not comply with a corrective action plan or does not meet its regulatory obligations, up to and including termination of the agreement. All employees and subcontractors are expected to cooperate with all investigations relating to non-compliant activity.

Lighthouse has a delegation oversight committee in place comprised of members from all operational areas and leadership. The committee meets monthly and performs the following functions: vendor analysis (to determine if a new vendor meets the definition of subcontractor), pre-delegation assessment (to ensure the potential subcontractor can comply with all applicable federal laws, regulations, accreditation standards and contract requirements and has the capacity to perform the required functions), and review of ongoing monitoring/oversight reports and any corrective action plans.

Evaluation Criteria:

1. The extent to which the respondent's compliance program complies with all State and federal requirements.

2. The extent to which the respondent has identified a qualified individual with sufficient authority and adequate corporate governance reporting relationships to effectively implement and maintain the compliance program.

3. The extent to which there are sufficient staff to implement the compliance program.

4. The extent to which the respondent's compliance program has experience identifying subcontractor fraud and internal fraud and abuse in managed care programs.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 32 – Fraud and Abuse Special Investigations Unit (SIU) (Statewide):

The respondent shall describe its Special Investigations Unit (SIU) program and its controls for prevention and detection of potential or suspected fraud and abuse and overpayment, including the use of biometric or other technology to ensure that services are provided to the correct enrollee, including verification of home-based visits and services, to ensure those services are being appropriately provided and that services billed were received by the correct enrollee.

Response:

Lighthouse Health Plan ("Lighthouse") brings a complete solution to monitor, detect and protect the Florida Medicaid program from Fraud, Waste and Abuse (FWA). The Lighthouse Team's FWA program uses industry leading tools from Optum Insight. These tools are used by more than 80 health plans and Medicaid agencies and have been successful in recovering millions of fraudulent and abusive overpayments including:

- Nearly $150 Million recovered for Washington State Medicaid since 2000
- $129 Million savings over a four-year period with Iowa Medicaid
- Over $50 Million in recoveries for Kentucky Medicaid

Our experienced Special Investigation Unit (SIU) team is led by our Senior Director of the SIU who has thirteen years of experience in Medicaid health plan compliance, including coordination and oversight of fraud detection and prevention activities across multiple lines of business. She has a J.D. from Seton Hall University School of Law, and a M.B.A. and Healthcare Corporate Compliance Graduate Certificate from George Washington University. The SIU will develop and submit for approval a FWA compliance plan and policies and procedures to comply with all Florida Medicaid contract and state program requirements surrounding FWA including the provisions of Section X of the Florida Medicaid model contract. We will collaborate and comply with the performance measures that monitor our compliance with the program integrity requirements, as established by the Agency for Health Care Administration (AHCA).

FWA DETECTION METHODS

Lighthouse Health Plan's FWA solution includes two key components: pre-pay (proactive) and post-pay (reactive) methodologies. Our pre-pay solution uses nationally recognized policies and complex claims editing methodologies to avoid and detect inappropriate billing patterns. Our post-pay solution uses sophisticated analytics and reporting to identify and detect a comprehensive list of potential misconduct.

- Proactive FWA Detection Methods and Dollar Amount Thresholds. We proactively identify and detect fraud, waste and abuse through a variety of methods including claims editing, data analytics, provider flags, predictive analytics and medical record reviews. There is no dollar amount threshold placed on these proactive reviews.
- Claims Editing. Claims are processed against the current National Correct Coding Initiative (NCCI) edits, consistent with current industry and national standards, and clinical edits adopted by other nationally-recognized professional societies.
- Data Analytics. Using our FWA reference library, we can detect and deploy the most effective means to avoid and mitigate FWA for the Florida Medicaid program. We will refine and customize

our data analytics approach based on Florida Medicaid policy to maximize identification and detection of FWA.

• Provider Flags. Based on a comprehensive review when a consistent issue and/or pattern is identified, a provider "flag" is applied to allow for a pre-pay review of claims from flagged providers. Currently, there are 33,000 provider flags.

• Predictive Analytics. By analyzing patterns and trends, and detecting billing spikes and payment aberrancies, specifically associated with the Florida Medicaid program policies, we will identify new areas for research and analytic development for further FWA investigation.

• Medical Record Reviews. Through analytics targeting overpayments and by substantiating the overpayments through the review of medical records, we will identify and detect potential FWA for further investigation and recovery of funds.

• Monitoring of Enrollee Card Sharing. Through comprehensive claims analysis, review of hotline calls and provider referrals, enrollee cards are monitored for indications of sharing. All credible allegations of card sharing, as defined in the contract, are reported to regulatory bodies as required. Eligibility cases are sent to the State for a determination and next steps. Suspected enrollee FWA will be addressed to the Office of Program Integrity (OPI).

• Hotline Complaints/Referrals. Calls taken and referrals from our hotline conveying potential FWA will be reported for additional follow-up and thorough investigation.

• FWA Call Hotline. These calls will be recorded and available to AHCA at its discretion.

• Internal and External Referrals. We analyze and act on referrals from other CCOs, other State program integrity contractors and State or Federal agencies as appropriate. Additionally, enrollees or other internal or external entities/sources reporting potential FWA are directed to the SIU for further analysis, validation and potential case initiation.

PATIENT IDENTITY VERIFICATION

In addition to the data-driven approach to identify enrollee card sharing referenced above, there is a be a uniform process to verify patient identification to prevent potential fraud and abuse. This process will include using a patient's full name and date of birth to verify their identity. In addition, to update patient demographics in the medical record, a government issued form of identification must be presented to validate name and date of birth. For verification purposes, registration will always match the identification presented and the identification must be one of the following: Valid Driver's License, Passport, Certificate of Naturalization, Valid government photo ID (e.g. Federal, State, Tricare) or Valid Military ID.

A patient's identity will be verified at each point of care including hand-off, transfer, administration of medication or blood products, collection of blood or other samples for testing, and all other testing and treatment. Where registration generated ID bands are issued, the patient must verbally state their full name and date of birth and the provider must compare the stated information to the patient's identification band (ID band). If the patient is unable to provide this information, the provider should ask for a proxy. If no proxy is available, ask a healthcare provider who has previously identified the patient will assist in the verification process.

For patient care in areas not using registration generated ID bands, the patient will must verbally state their full name and date of birth and compare the stated information to the requisition (i.e. medication order, test order, specimen collection label, etc.) to verify the identity of the patient. Any mismatch of information in this process will result in a hard stop until the mismatch can be resolved. Steps to resolve should be taken immediately to ensure patient safety. Once the mismatch is resolved, the patient identification process should be repeated in full.

Lighthouse Health Plan will continue to evaluate the effectiveness and feasibility of other biometric technology solutions to prevent healthcare FWA.

FWA INVESTIGATION METHODS

Our retrospective approach to identifying and detecting FWA includes a multitude of methods such as, claims review - provider and enrollee focused, enrollee card sharing security, hotline complaints/referrals and internal/external referrals.

Claims Review --

We conduct a monthly retrospective review of provider billing and prescribing and enrollee utilization to determine the presence of indicators of FWA and patterns that could potentially lead to FWA.

For provider focused claims review, Lighthouse reviews previous billing and payment history, reports of questionable billing practices related to the same provider, and education outreach conducted by the Provider Network Management department related to the allegation. We will also look at laboratory procedures and referrals, program policy and procedure violations, and prospective and retrospective claims for patterns and suspect activity. If applicable, prescribing habits will be reviewed. We will compare providers within specialties to identify outliers.

To examine enrollee focused utilization, Lighthouse will review encounter/claims data for the number of prescribers, categories of medications, duplicated services, excessive or contraindicated services or treatments, and any evidence of possible card sharing. We will review the enrollee's prescription history and pharmacy claims data in relation to the number and type of office visits and any evidence of possible drug seeking. Claims data will be reviewed prospectively and retrospectively for indications of fraud, waste or abuse, including claims for emergency room (ER) utilization.

SIU Investigations --

If we identify potential fraud, waste or abuse activity, the SIU requests medical records relevant to the case being investigated and as necessary conducts a broader investigation which includes an expanded time frame and comprehensive review of the provider's claims history. The results of the investigation are reported to the appropriate regulatory agencies and, when required, recoveries will be initiated as identified based on the final review and decision of each case. If a provider is identified during a post payment review and the result is a significant violation, the provider may be put on a pre-pay review. The provider may also receive a corrective action plan requiring a follow-up audit, 6-12 months after the first audit is completed. A network provider may be terminated if they are suspected of committing fraud, waste or abuse. We will suspend payments to any provider who is the subject of a credible allegation of fraud according to the State. If we identify an enrollee suspected of committing fraud, waste or abuse, the enrollee is reported to the Medicaid Fraud Control Unit/OAG for investigation.

ELECTRONIC VERIFICATION VISITS

Lighthouse has identified various organizations providing services for electronic verification visits (EVV) including Sandata, Vesta EVV and MEDsys Software Solutions. As Lighthouse evaluates

the various EVV programs, the following services will be used to prevent suspected fraud and abuse:
• Telephone Visit Verification where providers log in and log out, record tasks performed as well as track time and location of services provided
• Real-time GPS technology, verifying caregiver location and visits via GPS enabled devices are tracked for accurate reimbursement for services performed
• No-show alert where Lighthouse will be notified of late or missed visits allowing Lighthouse to redeploy staff to ensure patient care
• Mileage tracking to ensure proper reimbursement to provider
• Plan of Care Entry which will allow real time viewing of health status and needs of enrollees
• Speaker Verification for Employees and Clients where voice recognition can be used by either the caregiver or the client to ensure the right caregiver is serving the correct patient

These technologies protect the patient, the caregiver, and AHCA by ensuring these services are being appropriately provided, appropriately billed, and received by the correct Lighthouse enrollee.

Evaluation Criteria:

1. The extent to which the respondent uses various types of controls and automated approaches as part of a comprehensive approach to prevent and detect potential or suspected fraud and abuse and overpayment.

2. The extent to which the respondent uses biometric or other technology at the point of service delivery to prevent and detect potential or suspected fraud and abuse and overpayment.

3. The extent to which the respondent conducts clinical reviews and SIU investigations to detect potential or suspected fraud and abuse and overpayment.

4. The extent to which the respondent uses innovative technology for the purposes of verifying home-based visits and services.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

SRC# 33 – Disaster Recovery Requirements (Statewide):

The respondent shall demonstrate its capability and approach to meet the requirements described in **Attachment B**, Scope of Services, **Section X.D.4.h.**

Response:

Lighthouse Health Plan ("Lighthouse") has developed and will submit to the Agency a Disaster Recovery Plan that supports compliance with the requirements in Attachment B, Section X.D.4.h of this ITN. Our approach to disaster recovery minimizes systems downtime and prevents disruption of essential services. The plan is invoked following established policies and procedures, and its execution is supported with robust communications protocols. Through disaster preparedness, and effective disaster recovery, Lighthouse ensures the continuity of critical business functions and delivery of needed healthcare services to our Enrollees.

PROPOSED APPROACH TO DISASTER RECOVERY

Lighthouse Health Plan maintains a comprehensive emergency response and continuity of operations plan which enables the core functions of our health plan to support essential services to Enrollees in the event of a pandemic, natural disaster, and system failure. The Lighthouse Chief Operating Officer (COO) will work in conjunction with the Chief Technology Officer (CTO) to oversee the maintenance and implementation of the emergency response and continuity of operations plan. The plan is tested, reviewed and updated on an annual basis, and employees receive regular training on the plan and the procedures for enacting the plan in the event of an emergency. In addition to key components of the plan further summarized below, the Lighthouse Business Continuity/Disaster Recovery Plan (BC/DRP) will include sections related to:

- The Plan's Scope and Objectives
- Key Disaster Recovery/Business Continuity Definitions
- Description of the Emergency Preparedness Team and their role in managing emergency response
- Communications Plan and Key Staff
- Emergency Response Notification Procedures
- Estimated Recovery Time
- Disaster Declaration Procedures
- Core Business Systems and Applications Contingencies
- Data Backup and Recovery
- Data Center Business Continuity and Disaster Recovery
- Auditing and Testing
- Staff Training
- Disaster Planning for Multiple Scenarios

The BC/DRP will be managed by Lighthouse Health Plan's Emergency Preparedness Team (EPT). The EPT is a multi-disciplinary unit chaired by the Lighthouse COO that proactively identifies risks to the company's business operations and staff security; and formulates, implements, and communicates effective strategies to mitigate the impact of those risks. This includes risks to personnel safety, business continuity and security of Protected Health Information (PHI) and other confidential information as defined by HIPAA and other Federal and

State laws. Through the EPT, the company adopts a holistic Anticipate, Respond, and Recover approach to business and safety risk mitigation and response.

The EPT, along with Senior Management, provides leadership and oversight across the whole Crisis Management Lifecycle including the initial onset of site or business-disabling disaster through clean-up and full recovery of business processes.

If Lighthouse data or information is lost or breached, we will comply with all ARRA/HITECH and applicable state legal requirements concerning investigation, reporting and providing required notifications of breaches of protected health information. Security incidents are reviewed by Senior Management, Legal, and Lighthouse's Information Security team to determine the scope and impact of any breach.

Following the discovery of a Breach of Unsecured PHI, we will notify the Agency of such Breach in accordance with 45 C.F.R. § 164.410 without unreasonable delay, in accordance with the terms of the Business Associate Agreement, and in no case, later than sixty (60) days after discovery of the loss, incident, or Breach. The notice will include the identification of each individual whose Unsecured Protected Health Information has been, or is reasonably believed to have been, accessed, acquired, used or disclosed. As required, we will cooperate with the Agency to notify individuals of a Security Breach or unauthorized use or disclosure caused by Lighthouse or any of our subcontractors.

Employee Training—

Lighthouse Health Plan will use an internal Intranet site to promote business continuity and ensure all staff is aware of changes to our disaster response protocols. Training modules that include disaster scenarios are utilized for awareness activities. This training is required for all new hire employees and must be completed annually to reinforce the importance of Business Continuity/Disaster Recovery activities as outlined below.

BC/DRP training occurs in tandem with data security training to assure company-wide awareness of the business recovery function. Security/Disaster Recovery awareness is essential to the successful implementation of any Business Continuity Planning program. Our staff are trained on the contents of the plan, including the tiering of disasters, the prioritization of recovery for business functions, and the procedures the EPT takes in enacting our emergency plan. Staff will be trained on the research and communications chains involved in disaster recovery functions. Key roles and stakeholder responsibilities are also reviewed during this training. Contact information for key personnel is also shared. Emergency meeting location preparedness is reviewed and drills are performed quarterly to ensure staff and workforce can evacuate the building in the event of a disaster. Staff are instructed to meet at designated safety zones outside and away from the building until such time that the EPT and or local emergency services officials deem it safe to return to the workplace.

A record of all security awareness training as well as BC/DR training is maintained as documentation evidencing an employee's understanding of the Lighthouse Security Policies and the emergency response and continuity of operations plan. The policy acknowledgment forms must be updated after each periodic security awareness and or BC/DR training session attended by an employee. These forms are permanently retained in the employee's personnel file.

LIMITING SERVICE INTERRUPTIONS IN THE EVENT OF A DISASTER

The BC/DRP is designed to support continuity of operations and prompt resolution of issues to limit service interruptions to less than 24 hours. We categorize business functions for purposes of pandemic preparedness, natural disasters, and system failure recovery:
• Essential; and
• General and administrative.

Business functions critical to the provision of services to Enrollees and providers are deemed essential. The disruption of these functions can have an immediate and potentially harmful impact on our Lighthouse Enrollees. These also include functions critical to assisting our providers in caring for our Enrollees. Essential functions include eligibility processing, Enrollee and provider call center operations, IT (data warehouse), claims processing, population health management support to Enrollees and providers, and subcontractor operations for pharmacy, dental, vision, and our 24-hour nurse line.

General and administrative functions are also critical to the Lighthouse Health Plan operation but do not have an immediate and potentially harmful impact on Lighthouse Enrollees and include Utilization Management, Quality Management, Provider Network, Subrogation and TPL, Internal Operations, Financial Reporting, and FWA. These functions play a significant role in supporting the Lighthouse operation and complying with Agency requirements as well as federal and state laws and regulations and as such, are an integral component of our contingency plan. Essential and general and administrative functions are further classified into one of four (4) levels according to the criticality of each function to the continued provision of services to our Enrollees and providers. This classification prioritizes and helps to guide our efforts in responding to natural disasters as emergencies (e.g., temporary weather-related stoppages).

Classification tiers as well as their maximum tolerable downtime are as follows:
• LEVEL 1 – Critical. Maximum tolerable downtime can be no more than 24 hours.
• LEVEL 2 – Urgent. Maximum tolerable downtime can be up to, but no more than, 72 hours.
• LEVEL 3 – Necessary. Maximum tolerable downtime can be between 3-7 days.
• LEVEL 4 – Non-Essential. Maximum tolerable downtime can be no more than 14 days.

Examples of scenarios and the actions taken to prevent service interruption are provided below:

The central computer installation and resident software are destroyed or damaged --

Evolent Health performs a nightly snapshot as a backup of systems. In the event of a disaster, Microsoft Azure virtual machines can be restored from last restore point to include all configuration settings and resident software.

System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of transactions that are active in a live system at the time of the outage --

In the event there is a system interruption due to failure from network, operating hardware, software, or operational errors, Evolent Health will be repair and/or replace the affected area of the platform. Any compromised transactions will be rolled back to maintain integrity of the transactions.

System interruption or failure resulting from network, operating hardware, software, or operational errors that compromise the integrity of data maintained in a live or archival system--

In the event there is a system interruption due to failure from network, operating hardware, software, or operational errors, Evolent Health will be repair and/or replace the affected area of the platform. The impacted data from such errors will be restored from last good full backup and restore transaction logs up to point of failure.

System interruption or failure resulting from network, operating hardware, software, or operational errors that do not compromise the integrity of transactions or data maintained in a live or archival system, but do prevent access to the system, i.e., cause unscheduled system unavailability --

In the event there is a system interruption due to failure from network, operating hardware, software, or operational errors, Evolent Health will be repair and/or replace the affected area of the platform. If the criticality of the failure is classified as urgent, the system may be rebuilt and reattached to storage to maintain SLAs.

Malicious acts, including malware or manipulation --

Evolent Health will take malware infected or manipulated systems offline to determine extent of the compromise. If malware/manipulation is determined, the infected system will be rebuilt using last restore point.

ENSURING THAT RECORDS BACKUP STANDARDS AND THE DISASTER RECOVERY PLAN ARE MAINTAINED THROUGOUT THE CONTRACT PERIOD

Lighthouse's health plan administration subcontractor, Evolent Health has already developed, currently maintains, and has in place a comprehensive BC/DR plan which includes our BC/DRP scope and objectives, definitions, descriptions of the Emergency Preparedness Team and their role in managing emergency response, communications plans and emergency response notification procedures, disaster declaration procedures, core system and application contingencies for the Identifi Health Plan Administration system and the Identifi Population Health Management system, data backup, recovery and data center business continuity, auditing and testing procedures, and staff training.

We will maintain a BC/DRP and our existing records and backup standards remain in place for the durations of the entire contract period. The BC/DRP is reviewed and tested annually. Certification proof that the prior year's BC/DR plan is still in place and is unchanged and unaltered will be provided to the Agency before May 1st of each contract year. In the event that the BC/DRP is updated and or changed, Lighthouse will communicate changes to the Agency and provide supporting documentation and certification when obtained and applicable.

RESTORING DAY TO DAY OPERATIONS

Our core business systems are housed on the Identifi Platform, a cloud-based SaaS platform which only accesses secure web-based content and is hosted on Azure, a high availability cloud environment provided by Microsoft. Azure allows us to implement geo-redundant storage for production databases and have pre-defined failover app servers ready to spin up in an alternate

data center for our Disaster Recovery objectives. With several critical/essential business functions residing in the cloud, including the claims processing, eligibility and enrollment functionality, population health management system, and data warehouse, Lighthouse anticipates minimal impact to the platform in the event of a disaster. Cloud technology allows us to ensure that proper customer service capabilities are present for Enrollees and providers in the event of a disaster.

Our business continuity and disaster recovery emergency response plan also includes contingency plans for restoring day-to-day operations for performing both essential and general and administrative business functions even if key staff is incapacitated or our facilities are inaccessible. Disaster response is led by the Disaster Recovery Team and Incident Management Team which are described below along with a summary of our contingency plans.

Key employees incapacitated:

Every Lighthouse functional area identifies a “second in command” employee who, in the event the key employee is not available, will lead the disaster response effort. The Disaster Recovery Team (DRT) conducts initial assessment of an emergency or business interruption, mitigates damages if possible, and reports findings to the Incident Management Team if approval of response strategies is needed. All actions taken or planned are prioritized based on the level assigned as noted in Evaluation Criteria 2. The Incident Management Team (IMT) reviews findings from the Disaster Recovery Team and provides further direction to key employees based upon the type of emergency or business interruption experienced.

Lighthouse’s Disaster Recovery Team (DRT) consists of the Operations Director, CIO, Senior Director of Clinical Operations, Systems Administrator, the Utilization Management Director, the Claims Administrator, and Human Resources. This team is responsible for performing damage assessments in the event a disaster impacts operational locations of Lighthouse. They gather data relative to the estimated length of the emergency and manage the early phases of the incident. The DRT team coordinates with building management and the authorities and further informs the Incident Management Team (IMT) on directions moving forward.

Lighthouse’s Incident Management Team (DRT) consists of the Operations Director, CIO, Senior Director of Clinical Operations, Systems Administrator, the Utilization Management Director, Pharmacy Director, Enrollee Services Manager, Provider Services Manager, Director of Finance, Compliance Officer, and Human Resources. The IMT is responsible for approving the activation of the emergency preparedness plan, declaration of an emergency, business interruption or disaster. The team also is responsible for approving expenditures as required and monitoring all activities with functional areas and recovery management teams. The team provide management direction and counsel as required and in the event of a catastrophic disaster, manage all personnel matters involving employee fatalities and injuries and their notifications to employees’ families and dependents. This may include professional counseling and financial support for employees. The IMT is also responsible for ensuring that Lighthouse can respond to Enrollees’ inquiries and be able to respond to provider inquiries for Enrollee eligibility and claims status. The IMT also manages expectations of claims payments and provides notification and communication with key subcontractors throughout the disaster recovery process.

Primary workplace is unavailable:

Lighthouse Health Plan will remain open for business except in the most weather conditions or catastrophic events. The Lighthouse Executive Team makes decisions regarding the conditions affecting the closure of the health plan. All departments or divisions must be able to respond to the impact of the situation and are expected to continue to operate and provide service to Enrollees and providers. The level of service provided during the emergency/closure is determined based upon employee safety, functions performed, and Agency requirements. The designated EPT Lead - the Operations Director or designee monitors local media and conditions using several forums, including but not limited to: National Weather Service for local forecast and weather advisories; local broadcasts; local school district delayed opening or closings; Department of Transportation; Regional mass transit; and city, state and/or local municipalities. In the event the primary workplace is unavailable, the DRT meets at one of three (3) designated locations near the primary workplace. The IMT explores available options to ensure continuity of service including but not limited to performing essential functions remotely or manually and/or leveraging corporate Lighthouse resources.

During the occurrence of a prolonged disruption, a major responsibility of management for each department is the continuity of all lines of business. Each manager divides their efforts between the continuation of business for undisturbed areas and the recovery of business for affected areas. Accordingly, a number of functions/departments have been pre-designated to perform the support role to the Incident Management Team by serving as the focal point for such corporate wide activities as the:

- Accumulation and consolidation of damage and impact assessment information
- Dissemination of executive decisions and instructions
- Business recovery activities and operational decisions
- Business recovery acquisitions (e.g., alternate facility acquisition etc.)
- Site restoration activities (e.g., special facility or document restoration vendors, etc.)

Telephony services for continued customer service --

Another key component that ensures day-to-day operations are restored to support Enrollees and providers in the event of a disaster is our call center redundancy capabilities. The Lighthouse enrollee and provider call centers utilize ShoreTel based IVR technology. In the event of a disaster, the call centers can be switched over to sister sites and overflow call centers to ensure customer service to our Enrollees and our providers is not impacted. These telephony systems can be transferred to alternative locations within a few minutes (averaging 2-3 minutes of turnover) before they are operational when a disaster is declared and the decision is made to move over these services. During the 2017 hurricane season, one of our overflow call centers located in Corpus Christi, Texas, was in the direct path of Hurricane Harvey. A disaster was declared and the call center was transferred to an alternative location with no impact to call services for existing users. The web-based call center technology allowed for support staff to utilize the SaaS Identifi platform to successfully ensure customer service was maintained. Because Identifi is a web based platform that contains the eligibility, customer service, medical management, claims modules, and population health management applications in a cloud infrastructure, regardless of where the calls are routed, Lighthouse employees have access to all necessary information to service an Enrollee or provider call.

Communication plan to staff and suppliers when normal systems are unavailable --

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Timely and effective communication to staff, suppliers, subcontractors and the Agency is an essential component of our continuity of operations plan – all are apprised when normal systems are unavailable and how business will be conducted until systems resume. Our priority is to ensure Enrollee and provider-facing functions receive priority notification to expedite the actions these employees must take to ensure service to Enrollees and providers is without disruption. As appropriate, the DRT conducts initial assessment of an emergency or business interruption, mitigates damages if possible, and reports findings to the Incident Management Team for action if appropriate.

The Operations Director, in conjunction with the Incident Management Team develops and executes a communication plan. The scope of the plan reflects the impact of the outage, i.e., if it is confined to a few areas or is widespread. For example, if the impact of the unavailable system is wide-spread, company-wide messaging is disseminated via numerous channels, including text, e-mail, online Meeting Place and the Lighthouse intranet. In all cases, communication to employees, suppliers, subcontractors, and the Agency includes instructions on how to conduct business with Lighthouse until the system is restored. All parties are notified when systems resume.

In the event of a disaster, the Compliance Officer will contact the Agency's Executive Director or designee via e-mail or telephone.

Enrollee and Provider-Facing Staff (which includes Enrollee services, care management, provider services, provider network, utilization management, pharmacy and other staff) will be communicated to directly from the management team of the affected area via an e-mail communication describing the issue and how work will be completed in the interim. Depending on the impact and complexity of the disaster, the manager and/or supervisor will meet with the team to answer any questions and ensure staff understanding of work instructions Work instructions mirror those outlined in the Emergency Preparedness Plan Departmental Business Function Guide. As appropriate, Enrollee and provider communication systems (e.g., Enrollee and provider portals, call center greetings) are updated with instructions to Enrollees and providers to ensure additional transparency. Communication is sent via text and internal Lighthouse communication channels including e-mail, intranet, and meetings.

The facilities team maintains a complete list of all suppliers. In the event an unavailable system impacts a supplier, the supplier is contacted via telephone or e-mail. Our list serves as a resource to identify preferred suppliers who can quickly deploy to help solve outages. In the event that Subcontractors (which include pharmacy, vision, dental, and the 24-hour nurse line) need to be reached in an emergency or disaster, Subcontractor Operations Managers communicate with their key contacts via e-mail or telephone.

Plans to ensure continuity of services to providers and Enrollees --

The Lighthouse DRT and IMT will lead all efforts to ensure continuity of services to providers and Enrollees. The teams' efforts are prioritized based on the type of function (essential or general and administrative) and the criticality level (1, 2, 3, or 4). Each functional area also maintains an Emergency Preparedness Plan Departmental Business Function Guide. In addition to documenting the length of time until a disruption interrupts work and describing the necessary systems and equipment utilized for the specific business function, the guide details the department's options for maintaining functionality and the minimum number of staff required to

maintain functionality. Options include but are not limited to performing essential functions remotely or manually and/or leveraging other Lighthouse resources. The guide serves as an important tool for executing the plan communicated by the IMT.

MAINTAINING DATABASE BACKUPS

The purpose of the BC/DRP is to assist Lighthouse Health Plan in managing and restoring operations in the event of a disaster.

All computer and network resources considered critical to Lighthouse operations have recovery capabilities to minimize the impact of any disruption or unavailability. Contingency plans provide for the resumption of data processing services necessary to ensure an acceptable level of Lighthouse operations.

The Data Center employs fully redundant systems to ensure failover capability both within the Data Center and over to the Disaster Recovery site in the event the Lighthouse IT systems are down, breached, corrupted or otherwise subject to a disaster-related event. A data backup plan is in place to ensure that exact copies of Electronic Protected Health Information (EPHI) are retrievable. In the event of an outage that is expected to last over 24 hours, we will begin to implement our disaster recovery plan. If that occurs, our process will be to stand up a new environment in a non-affected US region and attach the new environment to Geo-Redundant Encrypted storage.

Lighthouse Health Plan has a data backup plan is in place in order to ensure that exact copies of EPHI are retrievable in the event our systems are down, breached, corrupted or otherwise subject to a disaster event.
• System snapshots are backed up and stored in an encrypted geo-redundant storage container.
• Database logs and backups are also stored in an encrypted geo-redundant storage container.
• Customer files transmitted via EDI are copied on separate encrypted storage which is located in a different region.

We use automated tools such as Desired State Configuration to deploy our application to an unaffected region in the event of a disaster. Once deployed, we attach the Identifi application to the geo-redundant storage, test, and subsequently release our application for public consumption. The Identifi Platform is hosted on Azure, a high availability cloud environment provided by Microsoft. Azure allows Evolent to implement geo-redundant storage for production databases and have pre-defined failover app servers ready to spin up in an alternate data center for our Disaster Recovery Phase I objectives. This “warm site” will allow Evolent to utilize predefined scripts to rapidly provision the Azure infrastructure and restore data which would reduce the current RTO/RPO. For our Disaster Recovery Phase II, we plan to have global traffic manager route traffic between two (2) live production sites, one for the east and one for the west.

FINALIZING, AMENDING AND SHARING THE DISASTER RECOVERY PLAN WITH THE AGENCY

The Lighthouse Health Plan’s Information Technology and Legal teams will deliver a final Business Continuity / Disaster Recovery Plan to AHCA 30 days prior to contract effective date. The test-validated recovery plan will reflect all agreed upon change modifications requested by the AHCA. Changes to the BC/DRP will be provided to the Agency within 10 days of the change

being made. All agreed upon modifications and updates will be addressed in subsequent testing and documentation that will be completed within a mutually agreed-upon time frame and included in the final disaster recovery plan submitted to the agency. Similarly, future requested updates and modifications to the recovery plan would be incorporated at no cost to the Agency.

In addition to submitting Lighthouse's recovery plans and test results annually to the agency, all aspects of the final recovery plan and any subsequent agreed upon revisions will be available to the Agency at all times via the most recent hard copy documentation of the plan provided to the Agency and via secure SharePoint extranet site. Additionally, the Agency may request a copy of the current disaster recovery plan through the Lighthouse disaster hotline.

ANNUAL TESTING OF THE DISASTER RECOVERY PLAN

Lighthouse Health Plan will perform Business Continuity/Disaster Recovery (BC/DR) Plan testing on an annual schedule or when significant changes have been made to the current plan. Lighthouse will utilize various testing methods to ensure the BC/DR Plan is functional and addresses critical processes and procedures, including:
• Tabletop Test - Members of the recovery team meet in a conference room setting to discuss their responsibilities and how they would react to emergency scenarios by stepping through the plan.
• Walkthrough Test - the recovery teams perform their recovery functions by walking through the content of plan, without initiating recovery procedures.
• Structured Walkthrough Test - a structured walkthrough test of a recovery plan involves representatives from each of the functional areas coming together to review the plan to determine if the plan pertaining to their area is accurate and complete and can be implemented when required.
• Full Interruption Test - is an exercise which all recovery procedures and strategy are tested. It replicates a disaster by halting production.
• Cutover Test - prepares and ensures that the recovery systems can support the critical business ions.

BC/DR testing will ensure that all staff have a good understanding of their responsibilities, trains the EPT team, and evaluates their capability to effectively implement its plan. The Lighthouse BC/DR testing strategy will include increasing the level of complexity after each testing cycle to ensure any deficiencies are identified. A documented BC/DR Testing plan will be established to facilitate the test plan, test execution, test review, and corrective action to its plans.

Evaluation Criteria:

1. The adequacy of the respondent's proposed approach and capability to develop and maintain a disaster recovery plan for restoring the application of software and current master files and for hardware backup in the event the production systems are disabled or destroyed.

2. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan limits service interruption to a period of twenty-four (24) hours and ensures compliance with all requirements under the resulting Contract.

3. The adequacy of the respondent's proposed approach and capability to ensure the records backup standards and a comprehensive disaster recovery plan are developed and maintained by the respondent for the entire period of the resulting Contract and submitted for review annually by the anniversary date of the resulting Contract.

4. The adequacy of the respondent's proposed approach and capability to ensure it maintains a disaster recovery plan for restoring day-to-day operations including alternative locations for the vendor to conduct the requirements of the resulting Contract.

5. The adequacy of the respondent's proposed approach and capability to ensure it maintains database backups in a manner that eliminates disruption of service or loss of data due to system or program failures or destruction.

6. The adequacy of the respondent's proposed approach and capability to ensure the disaster recovery plan is finalized no later than thirty (30) calendar days prior to the resulting Contract effective date.

7. The adequacy of the respondent's proposed approach and capability to ensure it amends or updates its disaster recovery plan in accordance with the best interests of the Agency and at no additional cost to the Agency.

8. The adequacy of the respondent's proposed approach and capability to ensure it makes all aspects of the disaster recovery plan available to the Agency at all times.

9. The adequacy of the respondent's proposed approach and capability to ensure it conducts an annual Disaster Recovery Plan test and submits the results for review to the Agency.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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G. STATUTORY REQUIREMENTS

SRC# 34 – Statutory Community Partnerships (Regional):

The respondent shall describe the extent to which its organization has established community partnerships with local providers or agencies that create opportunities for reinvestment in community-based services that play a critical role in improving the health and quality of life for enrollees, including:

a. Participation by senior executive leadership staff on local health and human service boards, councils, and commissions.

b. Partnerships with local community organizations focused on addressing the following social determinants of health:

(1) Access to Food;
(2) Employment;
(3) Housing Stability;
(4) Education; and
(5) Exposure to Crime/Violence.

c. Participation in both grass-roots and grass-tops provider initiatives.

Response:

As a provider service network, Lighthouse Health Plan has a philosophy, framework, and strong foundation of local engagement and community partnerships to improve health and quality of life. To ensure that we meet the medical and related, broader needs of our enrollees, we will enter into agreements with local social service agencies, community-based and/or faith-based programs and other available supports. These agreements will include protocols for data sharing and data protection, implementing health promotion and disease prevention initiatives, coordinating service delivery with the enrollee's Health Home, and tracking enrollee outcomes and measuring success. We will also partner with agencies such as county social service organizations and local advocacy groups such as NAMI, Area Agencies on Aging, and many more noted below. Enrollees will receive the level of assistance they need to access these programs including help arranging transportation.

To identify enrollees to refer to community resources, we use our proprietary risk-stratification tool to continuously assess and reassess an enrollee's need for additional support, and monitor specific events such as inpatient admissions, avoidable readmissions and ER visits, and gaps in care to make sure we have engaged enrollees in the appropriate level of care coordination and care management. We reinvest into the community by hiring Care Navigators from the community who use their local knowledge working with community- and faith-based organizations and to help locate hard to reach enrollees. CHWs live and work in the community and connect identified enrollees to community-based organizations and culturally relevant health promotion or disease prevention programs. We will also implement community partnerships to conduct outreach to enrollees who are non-English speakers/readers. Our outreach for enrollees with hearing impairments will use American Sign Language interpreters.

But our community involvement goes beyond directly serving our enrollees, to a range of activities and formal and informal partnerships to strengthen the broader care systems and improve the health of our entire community. Through free screenings and medical care, health promotion and education, community assessments, philanthropy and fundraising, staffing, board membership and leadership, and other mechanisms described in the following pages, our founding organization Baptist Health Care is involved in building, expanding, and supporting local hospitals, providers, and other resources, and improving the overall health of our communities. Lighthouse Health Plan will build on these initiatives.

FREE MEDICAL CARE AND SCREENINGS

Baptist Health Care (Baptist) provides free care and screenings throughout the community:
• Health and Hope Clinic offers free medical and dental services to more than 39,000 uninsured and underinsured residents of Escambia and Santa Rosa counties. Primary, specialty and dental care are provided by volunteer physicians and mid-level health care providers.
• Baptist's Remote Area Medical (RAM) clinics provide free dental, vision and medical care to isolated, impoverished or underserved communities. In less than 12 hours, a group of volunteers converts an open area into a mobile medical center.
• Through the Baptist Heart & Vascular Institute and the Baptist's Andrews Institute of Orthopedics & Sports Medicine, Baptist performs echocardiograms free of charge for all incoming sophomore student athletes in the four-county area. Each fall, the Andrews Institute offers free injury clinics on Saturdays to provide student athletes injury evaluations at no charge. Baptist and the Andrews Institute perform annual sports physicals for all high school athletes in a four-county area.
• Baptist provides free heart assessments and education annually during February, heart month, and conducts free wellness seminars monthly, at four locations throughout the community.
• Skin Patrol, a free Skin Cancer Screening in July 2016 screened 141 people (a 15.6% increase over prior screening event); 6 individuals needing additional follow up were given information on a local dermatologist and received certified letters encouraging them to obtain follow up care. In 2017, 124 people were screened, the majority from the local area. Five individuals were recommended for biopsies.
• A free Head and Neck Screening in April 2016 screened 73 people (a 143% increase from the 2012 screening); 17 people were sent for further follow up. In 2017, the total participants rose to 80 (58 appointments and 22 walk-ins); 21 participants were referred for follow up care.
• Lung Screenings were provided to 78 individuals from January to June 2016; 25 were found to be category 3 or 4, and were followed up by the oncology nurse navigator who ensures the patient will have appropriate diagnostics and referrals if needed. To date in 2017, 277 screenings have been conducted, alongside on-site education about Baptist's lung cancer screening program and tobacco cessation program. Four participants from the screening attended the My Healthy Blue smoking cessation class.
• Baptist Women's Imaging conducts free mammograms for indigent women; 68 free mammograms have been provided so far in 2017.
• Baptist and Gulf Breeze hospitals host "Look Good Feel Better" sessions for individuals with cancer, and programs for cancer survivors
• Baptist conducts support groups including Weight-Loss Surgery, Patient and Family Cancer, Prostate Cancer, and a Grief Support Group
• Prenatal and baby program support groups and classes include two free programs (Baptist Mommy and Me, and Baptist Birth Experience), and other classes may be complimentary in case of financial hardship.

FUNDRAISING AND PHILANTROPY

• Baptist Health Care makes an annual contribution to Escambia County Clinic (ECC), a member of the Florida Association of Community Health Centers. Baptist's $550,000 contribution in 2016 enabled ECC to provide 105,984 outpatient visits and more than 1,693 charity patients with prescription medications through pharmaceutical company drug programs. This represents more than 3,598 prescriptions with a value of more than $3,636,740.
• The Women's Board of Baptist Health Care Foundation in 2016 raised nearly $120,000 to support FamiliesFirst Network's Totes for Tots program, a program supporting children in foster care.
• Baptist provides community sponsorship dollars to not-for-profit organizations including the Bear, Levin, Studer YMCA; American Cancer Society; American Heart Association; Gulf Coast Kids House; Favor House; and the United Way of Escambia County.

GRASSROOTS AND GRASS-TOPS PROVIDER INITIATIVES

Our founding organizations and our subcontractors have supported and participated in grassroots and grass-tops provider initiatives to provide advocacy and incorporate positive change in our communities. In addition to supporting Escambia County Clinic and FamiliesFirst Network's Totes for Tots program for foster kids described above, Baptist responded to needs in the community by creating the following:

• Part of Baptist Health Care, Lakeview Center's Victim Services/Sexual Violence program: Through this certified Sexual Violence program for Escambia and Santa Rosa counties, trauma recovery counselors help victims of crime recover from emotional trauma. Victims and their families receive immediate, supportive, non-judgmental intervention and incident-specific counseling in a caring climate. The services are free and available whether or not the crime has been reported. Core services include: 24-hour helpline; information and referral; crisis intervention; advocacy; accompaniment; community awareness; system coordination; support groups/personal growth groups; and therapy.
• Faith-based Congregational Health Network (CHN) program: Partnering with more than 10 churches and ministries, Baptist network Navigators work closely with Congregational Liaisons to educate and help congressional members navigate the health system, and to organize and facilitate support groups for individuals with chronic conditions and health challenges. The navigators and liaisons promote healthy choices, provide health screenings and preventive medicine, create programs tailored to specific needs of the community, serve as advocates during hospital visits, and provide aftercare support following an illness or medical treatment. Twelve additional congregations expressed interest in participating.

SENIOR LEADERSHP PARTICIPATION IN LOCAL ACTIVITIES

Our founding health system's senior executives participate in multiple local health and human service boards, commissions, chapters of national organizations, and philanthropic and volunteer activities. Following are Baptist Health Care officers' positions and roles in these activities, illustrating their personal as well as professional commitment to our community. Lighthouse leadership will be drawn from individuals with similar relationships and involvement in local institutions.

• Mark Faulkner, Chief Executive Officer – Member of Achieve Escambia Leadership Council; First Place Partners board member; Florida Hospital Association board member, immediate past chair; Pace High School Quarterback Club president; Olive Baptist Church deacon; Great Pensacola Chamber of Commerce Foundation board member
• Allison Hill, SVP and CEO of Lakeview Division - Ronald McDonald House past president and current board member; Impact 100 member; UWF Executive Mentoring program participant: Leadership Florida Cornerstone class member
• Scott Raynes, EVP and President of Baptist Hospital – Member of American Cancer Society Making Strides Board; American Heart Association Heart Walk and Heart Ball Board; City of Gulf Breeze Community/City Advisory Council; UWF College of Health Science Advisory Board; Coach for youth ball team
• Brian Matson, Chief Strategy Officer - United Way board member; Escambia County Community Clinic; Partnership for a Healthier Community
• Dr. Dan Sontheimer, SVP and Chief Clinical Transformation Officer, Health and Hope Clinic volunteer physician
• Liz Callahan, SVP and General Counsel – Member of Board of Trustees of Episcopal Day School
• Mike Gleason, Chief Financial Officer - Member of Boards of UF and Shands System, Surgical Care Affiliates, Inc., First Coast Advantage, and Duval County School System
• David Joyner, SVP of Andrews Institute for Orthopedics and Sports Medicine – Member of NFL Players Association Players Trust Board, a charitable division of the NFL Players Association that offers assistance to former players throughout the country in financial hardship and educational grants to support research to make the game safer for all participants (youth, high school, college, etc.)
• Xan Smith, CFO, Lakeview Center -Covenant Care Board Treasurer
• Wanda Kaye Hambrick, VP Quality and Patient Safety, Covenant Care board member
• William Roberts, VP, Finance and Controller – Member of United Way of Escambia County board
• Cynde Gamache, Chief Nursing Officer -University of South Alabama College of Nursing, Advisory Board member, Pensacola State College Department of Nursing and Emergency Medical Services Advisory Committee member, Fortis Institute Nursing Advisory Board member, UWF School of Nursing Leadership Advisory Council member, UWF College of Health, Health Advisory Council member, Search Committee member – UWF Dean
• Mike Hutchins, Administrator, Jay Hospital- Northwest Florida Rural Health Network board member and Vice President; First Priority of the Emerald Coast board member; Church Finance Committee and Personnel Committee member
• Shawn Salamida, VP, Child Protective Services at Lakeview Center - Operations Support Team for Achieve Escambia; Board Chair for the Florida Coalition for Children
• John Porter, VP of Corporate Facilities and Support Services - Chairman of Escambia Community Clinics Board; board member for Waterfront Rescue Mission; Chairman of First Priority of the Emerald Coast, Inc.
• Steve Sarros, CIO - Covenant Care board member

PARTNERSHIPS THAT ADDRESS SOCIAL DETERMINANTS OF HEALTH

Lighthouse Health Plan understands the importance of non-medical influences on individual and population health, such as nutrition, education, employment, housing, and crime. Myriad barriers to health require community-wide action, such as improving access to healthy food, exercise and safe housing. We will build on the multitude of partnerships our founding organizations have

forged with local agencies and programs that address the following social determinants of health, including but not limited to the following:

Access to Food --

• Baptist, Gulf Breeze and Jay hospitals work with community partners to complete a comprehensive analysis exploring the health status of residents in Escambia and Santa Rosa counties through the Community Health Needs Assessment (CHNA). The Live Well Partnership for a Healthy Community facilitates the process to uncover the health issues that have the greatest impact on our community's wellbeing. Healthy weight, which is closely tied to access to healthy foods, is one issue identified through the assessment, along with tobacco use and access to care.

Employment –

• Lakeview Center's Project SEARCH is a one-year high school transition program designed to help people with disabilities prepare for the world of work. PS interns are placed at Baptist Hospital, Gulf Breeze Hospital, and The University of West Florida. During the year, they receive work readiness skills training; participate in career exploration activities; complete three 10-week on-the-job training opportunities; and ultimately are placed into competitive employment in the community. Project SEARCH interns must be 18 to 21 years old, enrolled as a student with the Escambia or Santa Rosa county school system, and have interest in obtaining community-based employment.
• Lakeview Center's Global Connections to Employment (GCE) program helps prepare individuals with disabilities for the workforce, then works with local employers to match them to jobs (see vignette at the end of this document). GCE provides jobs to about 450 local community members with disabilities at 25 sites in the three-county area. In the state of Florida, it employs about 874 Floridians, 619 of whom are persons with a disability.

Housing Stability –

• Baptist Health Care has provided financial support and volunteers for Habitat for Humanity for the construction of homes. Baptist is in the process of sponsoring two Habitat homes in Century, Florida. As part of the sponsorship Baptist provides 50% of the appraised value of the homes (approximately $85k-$95k).

Education –

• Baptist partners with the C.A. Weis Elementary School. Contributions to Baptist Health Care Foundation by team member provide Christmas gifts for every child (about 520 children).
• Student nurses from area schools complete their clinical requirements at Baptist hospitals and mental health care facility (West Florida Community Care Center). Through this partnership with Pensacola Christian School, Pensacola State College, University of West Florida and Jefferson Davis Junior College, these nursing students complete hands-on training— alongside Baptist Health Care's experienced nurses—required to earn their degrees.
• Baptist Health Care leaders participate in Achieve Escambia, an approach to helping the next generation find success from cradle to career. Community partners work together to raise educational and workforce outcomes by aligning data, resources, and passion.
• Pensacola Christian College's The Graf Clinic, a walk-in clinic for students, is operated by Baptist Health Care of Pensacola.

• Baptist sponsors Students of the Year who were recently honored by the Escambia County Council of PTAs and PTSAs. Every Escambia County School District school and many special centers selected a student for this honor. Students are selected for a variety of reasons from overcoming life's obstacles, to community service, to assisting classmates.
• Baptist collaborates with the Northwest Florida Rural Health Network to improve overall health status of the community through health promotion and education. The group hosts free screenings and health education events.

Exposure to Crime and Violence –

• The Lakeview Center Forensic Program works closely with law enforcement agencies, the courts and the corrections system to divert people with mental illness from unnecessary incarceration to effective treatment and case management. Partnering with other community agencies, the program directs its clients to the resources they need to rebuild their lives. Ultimately these efforts will help to improve public safety, reduce recidivism, minimize wasteful spending, reverse the criminalization of mental illness, help people with mental illnesses to work toward recovery within the community, and improve the overall well-being of the entire community
• Lakeview Center's Victim Services/Sexual Violence program is the certified Sexual Violence program for Escambia and Santa Rosa counties. As noted above, trauma recovery counselors help victims of crime and families recover from emotional trauma through immediate, supportive, non-judgmental intervention and incident-specific counseling in a caring climate. The services are free and available whether or not the crime has been reported. Core services include 24-hour helpline, information and referral, crisis intervention, advocacy, accompaniment, community awareness, system coordination, support groups/personal growth groups and therapy.
• As a leading local health provider, Baptist partners with emergency services to train EMTs
• Baptist has trained over 850 local law enforcement officers with crisis intervention skills

TECHNOLOGIES TO ASSESS AND GUIDE EFFORTS TO ADDRESS SOCIAL DETERMINANTS OF HEALTH

To guide Lighthouse efforts to address social determinants of health, we will rely on both enrollee input and data-driven analytics. We will create a Public Programs Advisory Committee whose members are representative of Lighthouse enrollees. The committee will meet at least quarterly and provide feedback to our leadership on issues of cultural competence and meeting the varied needs of enrollees. We will also collect and analyze supplemental data to evaluate whether enrollees' basic needs are being met. Through our use of our technology platform called Identifi, we bring a proprietary model that assesses, stratifies, coordinates and supports the delivery of integrated care to more than two million individuals. Identifi models are differentiated from industry-standard models by four key aspects: a) focus on predicting "impactable" events b) meaningful integration of multiple internal and external data sources including health risk assessment responses, c) use of machine learning algorithms, and d) superior predictive accuracy.

Our sophisticated Population Health analytics strategy incorporates community information into our risk stratification and predictive models. Because of the importance of psychosocial and socio-economic issues on health outcomes we leverage a variety of assessment data as well as publicly available data sources to understand a population's social determinants of health. The American Community Survey (ACS) from the U.S. Census Bureau tracks over 100 data elements on education, poverty and housing status by neighborhood. We use the location affordability index,

walkability index, food access and supermarket availability from U.S. Department of Transportation, as well as the Environmental Protection Agency's Smart Location Database to supplement social economic and environmental information. The U.S. Department of Agriculture tracks food deserts, which are also applied to our risk scoring determination.

These variables, juxtaposed with an enrollee's health conditions, provide a more holistic picture of an enrollee that is much more informative in predicting who needs the highest level of intervention. We take advantage of the recent developments in the "Internet of Things", leveraging Google technology, (like the technology that allows users to locate amenities in Google Maps), to calculate distances to the nearest pharmacy, grocery store, physician's office, and hospital which may identify potential gaps in the community's health care access. This information is also shared with our provider network in the online portal, Identifi Practice.

To support our enrollees in addressing Florida-Specific Social Determinants of Health, our Population Health application, Identifi Care, integrates with Healthify a tool to manage the network of community benefit resources in Florida. Healthify will be used by multiple stakeholders supporting the care of our patients including care managers, care coordinators, community health workers, behavioral health support, and community engagement liaisons. Healthify supports social needs assessments, resource lookup, referral workflow, reporting and analysis. These resources are located throughout the region, and our ability to identify and refer enrollees to these supports will help us improve the health of our Florida enrollees.

COORDINATION WITH LOCAL, STATE, AND FEDERAL PROGRAMS

In addition to the partnerships delineated above, we will establish relationships with state, local, and federal programs so that our Care Managers can coordinate with the following types of services:

- Perinatal High Risk Management/Infant Services System
- Individuals with Disabilities Education Act (IDEA) services
- The Supplemental Food Program for Women, Infants and Children (WIC)
- Head Start programs
- School health services
- The Title V Maternal and Child Health Program
- State agencies such as DMH and DCPS
- Housing agencies
- Homeless shelters
- Local Departments of Health, relating to vaccine campaigns, outreach for gaps in care/well child screenings and car seat programs
- School-based clinics; we will provide additional support for these programs, including ready access to the care management component of our Population Health platform to support the school based clinics' ability to address care gaps
- Chronic condition resources such as the Rural Health Center diabetes programs and Diabetes Telehealth Network, to enhance access to specialist care for enrollees with diabetes in the Delta
- Health system programs such as public health screenings at city and county schools, Boys and Girls Clubs, and senior adult community centers
- Other community and public health groups to address health literacy issues.

ADDITIONAL STRATEGIES TO REINVEST IN COMMUNITY RESOURCES AND IMPROVE HEALTH

Lighthouse Health Plan will engage in the following additional strategies to promote health among enrollees and the broader community:

Targeted Health Education --

Our approach to developing and implementing health education programs to enhance enrollee self-care is comprehensive and includes collaboration and coordination with health systems that is unique to a provider-sponsored organizational structure and includes:

• Developing evidence-based and culturally relevant self-care programs and materials that target prevalent health conditions in each region. For example, in Kentucky, when Somali refugees in various stages of pregnancy were settled, our health plan partner worked closely with local charities and translated our comprehensive maternity, delivery, and postpartum guide into Somali. These mothers-to-be were educated in face-to-face group sessions, which helped alleviate the women's fears and gave them an avenue to discuss their cultural beliefs and practices with a nurse and their OB provider.

• Offering live health education sessions to teach self-care at convenient, familiar community locations, including at our hospitals and at local community centers

• Supporting community organizations' self-care programs through collaborative program development and hospital health promotion staff. These programs are provided by qualified health education specialists and subject matter experts and are participant friendly.

• Using information from enrollee and community health needs assessments to identify relevant community issues and enrollees' health promotion and education needs, and implement initiatives that are culturally appropriate and relevant to each of the target population groups of enrollees served. We use community- based needs assessments and other relevant information available from State and local governmental agencies and community groups to target specific groups and activities. We have special programs targeted at pregnant women, tobacco cessation, specific conditions and programs for our enrollees with complex health needs.

• Delivering self-care education through SMS/mobile messaging and telephone calls, in-person education, including remote education and web-based initiatives. Our enrollee website will be easy to navigate and understand, with easy access to our local partners and our health promotion and education materials. We will also include an event and social ticker on our enrollee website that is continuously updated with local health fair and other community-based health events located in convenient locations such as Walmart, local schools, and the local YMCA.

• Using nationally recognized, as well as our own Florida-specific health education materials to promote enrollee self-care and increase enrollees' understanding of the importance of timely preventive care and management of chronic health care conditions.

Health Fairs and Events --

Our unique local relationships help us easily provide educational materials and opportunities for personalized assistance at health fairs, community workshops, and during special events. These events also will include opportunities for enrollees to stop by and see a nurse or other clinician for help with basic health education needs and referral into case management and disease management programs as appropriate. Our comprehensive list portfolio of local partnerships will be maintained in a calendar of planned health promotion activities that include the topic, targeted population, mode of delivery, and schedule. Events are coordinated with national observances of health and wellness, such as breast cancer awareness events in October, and are in convenient locations such as shopping centers, local schools, and the local Boys and Girls Clubs.

Provider Education and Supports –

As we work with our local partners, we will educate our network providers about enrollees' cultural preferences, health disparities and social determinants of health to improve enrollee engagement in treatment and, ultimately, health and quality of life outcomes. We will also share the information we develop to address enrollees' health disparities through Identifi Practice, a web-based, Provider-facing version of our Population Health Management platform. Because every contact is an opportunity to establish trust among enrollees, their families/ caregivers, providers, and community agencies, our community-based model includes provider supports that encourage personal responsibility and behavior change among enrollees, improved healthcare outcomes, and lower costs.

Evaluation Criteria:

1. The extent to which the respondent provides details on how their local community partnerships, activities and initiatives support the local system of care.

2. The extent to which the respondent has senior executive leadership staff who will be assigned to the resulting Contract who also participate on local health and human service related boards, councils, and commissions.

3. The extent to which the respondent has partnerships with local agencies that focus on addressing social determinants of health.

4. The extent to which the respondent jointly develops and incorporates change from grassroots and grass-tops provider initiatives.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 35 – Organization Commitment to Quality (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall describe its organizational commitment to quality improvement, including active involvement by the respondent's medical and administrative leadership, and document its achievements with two (2) examples of completed quality improvement projects, including description of interim measurement and rapid cycle improvement processes, and a summary of results.

Response:

Lighthouse Health Plan's commitment to continuous quality improvement is instilled through all levels of our organization, starting at the top. Our senior leadership and Board of Directors set overall goals and direction, and are ultimately responsible for the quality of care delivered to every Enrollee. The Board will appoint a Quality Management Committee (QMC), chaired by the Medical Director that provides oversight and management of the clinical care and services provided by all functional areas and subcontractors. Our commitment is operationalized through our comprehensive, robust quality improvement program that aligns with the Florida Medicaid Comprehensive Quality Strategy (CQS) and is supported by a data-driven Quality Management department and a wide array of analytic experts, tools and processes. We supplement our ongoing quality monitoring and improvement activities with targeted performance improvement projects and initiatives, using a Plan, Do, Study, Act (PDSA) approach. We build quality improvement into our culture through careful staff selection and training, and by communicating our quality-driven mission through multiple avenues. We ensure all employees, participating providers, and subcontractors understand their role in quality improvement activities and responsibility toward achieving goals through performance dashboards, quality-based reviews, and provider incentives (including the Agency's MMA Physician Incentive Program). Our population health care management programs, including disease management, teach Enrollees how to manage their conditions and take responsibility for their health. We describe these elements of our Quality Improvement culture and provide QI project examples below.

PLAN LEADERSHIP AND BOARD OF DIRECTORS

The Lighthouse Board of Directors (Board) will provide strategic direction and has ultimate authority and responsibility for the quality of care delivered. The Board reviews and approves the QI program description, confirming that it is aligned with the Plan's overall goals and with Florida's Comprehensive Quality Strategy (CQS) priorities and Contract Provisions It ensures that QI is embedded in all functional areas of the Plan and its subcontractors' activities. The Board reviews and approves the annual Quality Improvement Evaluation report that includes:

- Quality management and improvement activities
- Tracking of trends and issues
- HEDIS results
- Analysis of demonstrated improvements in Enrollees' outcomes, Enrollee and provider satisfaction, quality of clinical care, customer services, and overall effectiveness of the QM program.

The Board meets quarterly to review and assess the QI program's activities, and to ensure that the Plan achieves its mission: to serve vulnerable populations through a holistic, integrated population health model delivered by a provider-sponsored and community-based health plan to ensure Enrollees receive timely access to quality care in a setting most appropriate for their needs.

MEDICAL DIRECTOR OVERSIGHT AND CEO INVOLVEMENT IN QUALITY MANAGEMENT

The Lighthouse CEO reports directly to the Board. The CEO and other executives, directors, and managers will communicate and exemplify a commitment to quality improvement on a daily basis. This is achieved through cross-functional meetings and distribution of written QI bulletins informing staff about quality initiatives and progress toward goals; management training activities; and public recognition and rewards, described further below.

Quality Management Committee and Medical Director:

The Board of Directors appoints the Quality Management Committee (QMC), which will be chaired by the Lighthouse Medical Director. Under the Medical Director's hands-on leadership, the QMC will provide direction, oversight, and management of the clinical care and quality of care provided to Enrollees. The QMC will be composed of at least seven participating providers and will include the Medical Director, Vice Presidents of Clinical Operations, Pharmacy and Medical Affairs and Directors of Quality Improvement, Compliance and Utilization Management, appointed on an annual basis, along with representatives from non-clinical areas. The QMC will meet at least quarterly and review, evaluate, and make recommendations across the full range of quality improvement activities and key guiding documents, in accordance with Florida Medicaid contract Section IX. Quality and other related sections and the Agency's Comprehensive Quality Strategy.

INCORPORATING QUALITY IMPROVEMENT ACROSS THE ORGANIZATION

The QMC's responsibility and influence are woven into the fabric of the entire organization; its written charter includes accountably to:

- Direct and oversee subcommittees responsible for the provision of clinical care, services and credentialing
- Approve the annual QM, UM, CM, DM, and Pharmacy program descriptions, all medical policies, work plans and annual evaluations that include quarterly updates on progress toward goals
- Evaluate, offer feedback, and approve all proposed clinical practice guidelines and preventive health guidelines, under- and over-utilization findings, UM criteria, clinical/medical and service audits and findings, HEDIS® results, EPSDT audit results (that assess EPSDT screening rates and immunizations), QI studies, Enrollee and provider satisfaction results, new technology, and administrative policies (such as confidentiality) that have an impact on Enrollees' care
- Evaluate and approve health management programs
- Recommend provider education and interventions, health education programs, and other initiatives
- Analyze and review individual and aggregate referred Enrollee grievances, appeals, sentinel events and other quality of care and patient safety concerns, and provider audit data, and design plans of correction
- Oversee, approve, monitor, evaluate and close all quality of care plans of correction

• Oversee remediation and provide input into corrective action plans, and other interventions to improve care delivery and quality of services of individual providers and the provider network as a whole.

The QI program is directed by a trilogy of "living" documents that meet the Agency's contract provisions and provide blueprints for our QI activities. Documents include:
• QI program description – includes standards and mechanisms to monitor, assess, and report quality and accessibility of clinical and non-clinical services, disparities, Enrollee and provider satisfaction and more. Our quality strategy describes our transition of care process, relating to Enrollees transitioning in and out of Lighthouse Health Plan and providers entering and leaving the network. Our QI program description will identify staff specifically trained to handle the Medicaid business and delineates how staffing is organized to interact and resolve problems, define measures and expectations, and demonstrate the process for decision making (i.e., project selection, interventions) and reevaluation.
• Annual QI Work Plan – describes goals, timetables, individual accountability per task, and status of QI initiatives
• Annual Evaluation – describes studies, methodologies, results, improvement actions, overall impact.

The Medical Director develops the QI Work Plan, integrates the work plan into all departments, prepares the annual QM evaluation, and is accountable for meeting QM program objectives. The Medical Director will also be responsible for ensuring the integration of Florida's Comprehensive Quality Strategy (CQS) and Quality-related Contract provisions into our plan's QM program. We will comply with the CQS and support this strategy in the following ways:
• Incorporate priority areas of: improved health outcomes; simplified and streamlined services delivery to promote efficient, timely, appropriate use of health services; support person and family-centered care; greater transparency and accountability to promote cost effectiveness and efficient administration; and improved care coordination via performance monitoring and communication. (We will monitor the Agencies priorities as they evolve and make appropriate adjustments.)
• Incorporate CQS performance measures and goals in our QM program and Work Plans, and submit our QM description, Work Plans, and Evaluations to Agency for review, feedback, and revisions
• Collaborate with the Agency and the state's EQRO to implement targeted Performance Improvement Projects (PIPs). At least one will relate to improving birth outcomes and well-child visits, acknowledging that over 60 percent of births in Florida and more than two million children are covered by Medicaid
• Cooperate fully with external evaluations by the Agency or EQRO
• Coordinate with local Healthy Start Coalitions, engage in targeted outreach to promote preventive dental care for children, and participate in promotion of awareness and utilization of long-acting reversible contraceptives (LARCs), the most effective reversible method of contraception
• Implement the Healthy Behaviors program offering an incentive to Enrollees who participate in a medically-approved smoking cessation program, a medically-directed weight loss program, and/or a medically-approved alcohol or substance abuse recovery program.
• Work with the Agency to develop the MMA Physician Incentive Program (MPIP) to provide quality-based incentive payments for physicians to reward value over volume of care, beginning with pediatricians and OB/GYNs. We will use PCMH recognition (by NCQA, AAAHC or the Joint Commission) as an indicator of meeting required quality standards, and we will work with the Agency to monitor and assess the impact of this innovative program.

QMC Subcommittees:

The QMC is supported by the Quality Management Director who oversees the Quality Improvement Department and by medical directors and the following committees and subcommittees representing the key operational areas throughout the Plan.

Quality Management Committee Subcommittees:

- Utilization Management Committee
- Credentialing Committee
- Pharmacy Advisory Committee
- Medical Policy Advisory Committee
- Behavioral Health Advisory Committee
- Enrollee Advisory Committee
- Primary Care Advisory Committee that includes Child and Adolescent Health and Women's Health workgroups
- Delegation Oversight Committee

These committees ensure that the QI philosophy and culture are fully integrated into all aspects of the plan. Full rosters of the Florida providers and other stakeholders who will serve on these committees will be available to the Agency upon request.

Quality Improvement Department and QM Director:

The Director of Quality Management (QM Director), a licensed health care practitioner, will oversee and guide the QM department's day-to-day operations and activities and report to the Medical Director and QMC. QM responsibilities include:
- Monitor, review, and analyze all performance data and trends, including clinical reviews and audits, and facilitation of HEDIS measurement, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and National Committee of Quality Assurance (NCQA) accreditation activities
- Implement and support performance improvement projects for service and clinical goals
- Develop operational reports, ensure all Agency and regulatory requirements are met, and serve as a resource to the QMC and all functional areas for quality measurement and improvement.

The QM Director consults with physicians and the Lighthouse Medical Director as needed, and will supervise a staff of registered nurses (RNs), behavioral health clinicians, non-clinical support staff, and a business analyst. Clinical reviewers include physicians, registered nurses (RNs), and licensed clinical social workers. The QM Director is responsible for ensuring clinical reviewers have current and relevant licensure and/or certification, receive comprehensive training relevant to their position, and participate in ongoing and ad hoc trainings designed to help make sure the QI staff meet federal and state-specific QM program requirements.

PROCESSES AND STRATEGIES TO RECOGNIZE AND SOLVE PROBLEMS BEFORE THEY OCCUR

Data is the foundation for all performance improvement and quality management activities. Utilizing tools such as Identifi (described further below), Microstrategy, SAS, SQL, and our

Enterprise Data Warehouse, supported by myriad informatics and technology teams. We will systematically collect data to monitor, measure, evaluate, and continuously improve nearly all aspects of care and services for our Enrollees. Our trend analyses and benchmarking identify issues for immediate study and action before they exacerbate into major problems. We also use data to design, implement and evaluate the effectiveness of our QM program.

Identifi offers benchmarking across multiple health systems, performance metrics, patient engagement and physician engagement. It is based on a Clinical Rules Engine consisting of more than 1,400 rules, with several thousand Enrollee characteristic categories that cover measures from Medicaid as well as other federal programs. Our NCQA-certified UM solution uses medical policy decision support and education to help transform provider behavior and reduce inappropriate utilization. Clinical guidelines are reviewed on an annual basis, or as frequently as needed, to flag any updates that may impact measures.

The platform facilitates customized reporting capabilities to meet Florida's regulatory, operational, performance and other related reporting requirements.

STAFF TRAINING, REVIEWS, AND INCENTIVES

We drive quality improvement activities into the culture by communicating and ensuring all Lighthouse employees and subcontractors understand how they impact the quality improvement activities or goals. This is achieved through the Health Plan Index (HPI), which is comprised of three sets of quality measures, for health, services, and people. The HPI is the driver of a cascading performance dashboard which clearly identifies the daily impact on the quality improvement activities.

Lighthouse will also conduct quarterly leadership learning series to share collective expertise and promote cross team knowledge sharing. It serves to broaden knowledge, which allows for potential opportunities for improvement. Through regularly scheduled staff meeting and retreats we discuss opportunities for improvement and develop and document potential strategies. These are reviewed at the management level for potential impact and implementation.

THE QI AND PIP PROCESS

Lighthouse follows a consistent, proven approach to our quality improvement activities. All QI activities reflect our Enrollee population in terms of age groups, disease categories, special risk status and cultural and linguistic needs. We use ongoing monitoring and data analytics, and the priorities established by our QMC as delineated in our QM Work Plan and consistent with the Florida CQS to identify gaps and improvement opportunities. Our data collection to evaluate our performance and the effectiveness of our QI program includes the following categories and data sources:

• Assessment of provider/practitioner access and availability – through provider site visit, access and availability reports, Enrollee grievances regarding access, Enrollee utilization reports, practitioner satisfaction survey, delegation oversight, pre-contractual evaluations, annual oversight visits and evaluations, quarterly report review and evaluation, national accreditation monitoring, credentialing and re-credentialing, sanction and license monitoring
• Assessment of patient safety – through adverse or critical incidents, sentinel events and Enrollee grievances related to quality of care, annual Enrollee safety plan, harmful medication monitoring,

accessibility to high quality healthcare providers, provider adherence to documentation standards, medical directors' assistance with clinical decision-making
• Medical management programs and activities – through population health programs (including care management and disease management programs), phone and mail outreach activities, adoption/promotion of preventive health guidelines, utilization management services, care management services, HEDIS, adoption/promotion of CPGs
• Ongoing assessment of population changes – through special needs and preferences, cultural, linguistic, ethnic and racial needs and preferences, Cultural and Linguistic Services Program, assessment of QI Program and Work Plan/Executive Summary
• Assessment of provider/practitioner satisfaction – through annual practitioner satisfaction survey, provider/practitioner grievance reports, accuracy and timeliness of claims processing reports, average speed of answer and abandonment reports for provider services areas, provider/practitioner appeal trends
• Assessment of continuity/coordination of care – through data from Care Management, Disease Management, medical record review, investigation of Enrollee grievances, oversight of internal policy implementation regarding practitioner terminations
• Assessment of Enrollee satisfaction – through annual satisfaction survey, Enrollee grievance and appeal reports, average speed of answer and abandonment reports for Enrollee services areas
• Annual assessment completed by the EQRO – through state measures, annual EQRO audit
• Annual QI Evaluation – through annual update to the QI Program Description as a result of the QI Evaluation, assessment of service initiatives, process analysis of internal departments.

Through the continuous Plan, Do, Study, Act (PDSA) cycle, we define the problem by examining current performance, collecting relevant data, and assessing the root cause; develop and implement interventions and define metrics to measure their effectiveness; confirm results through pre-post comparisons; and document and evaluate results. The PDSA approach supports our ability to incorporate successful strategies into daily processes and workflows, and continue the cycle of improved performance by monitoring and identifying additional improvement opportunities and activities.

Our Performance Improvement Project (PIP) process exemplifies this approach. For 11 years, our quality team has collaborated with State Medicaid agencies, EQROs, CMS, and other managed care organizations to complete over 14 PIPs – with at least six PIPs underway in any given year. In Florida, we will submit at least four PIPs annually for preapproval by the Agency, meet all CMS requirements regarding PIPs, and include PIP activities and updates in our quality program description, QI Work Plan, and PIP report submissions.

APPROACH TO DESIGNING PIPS: We will utilize a cross-functional team of Lighthouse clinical and non-clinical leaders to identify opportunities for improvements and review topics that have been identified as target focus areas from data analysis and from the QI department, the Agency or CMS. Our QI team will collect and examine demographic and epidemiologic data, prevalence, utilization trends, prior focused studies, EQRO reports, audits, grievances, and survey data. The QI team will also compare our data to national standards and benchmarks, and consider healthcare disparities to focus interventions on target populations and subpopulations.

Clinical focus areas for PIPs include primary, secondary, and/or tertiary prevention of acute and chronic conditions, care of acute and chronic conditions, high volume services, high risk services, and continuity and coordination of care. Non-clinical focus areas for PIPs include availability,

accessibility, and competency of services, appeals, and grievances. Once a topic is selected, the QI manager selects a multidisciplinary team of clinical and non-clinical Enrollees with a physician as executive sponsor for each PIP. This team will support the PIP until it is completed. The QI staff builds out our PIP template with the baseline data we have collected for the PIP up to this point and shares it with the appropriate provider QI committees (such as the Primary Care Advisory Committee, Behavioral Health Committee, and Quality Management Committee), medical directors, and the Lighthouse Medical Director for additional feedback and recommendations, before submitting it as a proposal to the Agency for approval. During the design phase, we conduct a "barrier analysis" that includes examining quantitative and qualitative data, discussions with providers, and QI committee brainstorming sessions. In addition to identifying barriers, the analysis identifies the target population for each intervention, and goals and objectives.

Through a collaborative process including the PIP multidisciplinary team, we develop interventions that we expect will address the barriers identified, and design a data collection plan that includes performance metrics such as HEDIS and other standardized measures, health plan baseline data, and Enrollee and provider surveys. This phase also includes designing an evaluation of the PIP interventions whereby we select appropriate process and outcome measures, a sampling methodology, frequency of measurement, and methods for data extraction and verification.

A project outline with goals, interventions, timeline, plans for sustaining improvement, tracking and process measures, and a rationale based on a demonstration of need and expectation that we will achieve measurable benefits to Enrollees and stakeholders is developed is shared with several groups including the multidisciplinary planning group, network providers who would be impacted in the quality committees, and Enrollees. We seek feedback to confirm that the PIP: is appropriate based on the presented facts and data; has the potential to achieve significant improvement; is likely to demonstrate sustained results; has identified potential barriers to success; and contains suggestions for collaborative opportunities and potential interventions. We will submit our PIP Project proposal to the Agency for review, feedback, revisions, and approval before implementation.

IMPLEMENTING AND EVALUATING PIPS: For each PIP intervention, our multidisciplinary team identifies the responsible clinical or non-clinical individuals or groups for implementing the intervention, identifies and secures any budgeting needed, and identifies and engages potential health plan collaborators, including Enrollees, providers and community agencies).

The initial step is to determine baseline measurement, using the proposed metrics, and initiate a six-sigma methodology such as PDSA. Our QI staff and PIP team provide support to the departments and staff involved in the intervention. We engage in collaborative pilots to test the interventions.

Using the PDSA cycle, we continuously review the impact of our PIPs; determining whether changes in measures are meaningful, significant, and attributable to the interventions; assessing what has been learned and how to modify the plan to achieve maximum results – including identifying gaps in the current intervention strategy and assessing how can those be eliminated, and determining a plan of action for the next measurement cycle.

We will document each PIP's progress in a variety of ways including quarterly updates in the QI Work Plan, updates on the PDSA findings, and interim results in the PIP template/report that is submitted annually to the Agency and EQRO. Our experience suggests that most PIPs are best designed as three-year projects.

The final PIP report will include an abstract of the project including topic, rationale and aim, methodology, intervention, detailed results, a discussion including limitations, Enrollee participation, financial impact, next steps including lesson learned, and plans for dissemination of findings and a plan for sustaining improvements. Once a project is completed we continue to monitor annually for continued improvement.

EXAMPLES OF QUALITY IMPROVEMENT PROJECTS

Below we describe quality improvement projects that demonstrate our experience and ability to use data analytics identify a QI opportunity that aligns with our QI program and goals, design and implement a targeted quality improvement initiative, evaluate the intervention’s impact, and develop follow-up steps to address barriers and enhance successes.

PROJECT #1: IMPROVING COMPREHENSIVE DIABETES CARE

In Kentucky, HbA1c testing rates fell from 90.78% in MY 2014 to 83.19% in MY 2015. This rate was below the state mean of 85.94% and our Quality Compass (QC) goal of 90th percentile. Data review flagged this decline, resulting in an improvement project geared to improve testing and our ability to address blood glucose issues before they exacerbate, thereby reducing preventable events. The quality team took the following steps:

• Developed an interdisciplinary team of Lighthouse staff that interacted with both Enrollees and providers to develop, implement, monitor, and revise interventions;
• Conducted an analysis of the population to determine any trends or social determinants; rural counties noted decreased testing as compared to the urban counties;
• Shared results with our provider quality committees and asked for feedback and recommendations on how to improve the screening rate. Feedback noted the provider offices are challenged to track all the screenings (a workflow issue) and Enrollee lack of knowledge regarding the importance of the screening and long-term impact of non-controlled HbA1c;
• Shared results with the Enrollee quality committee and asked for feedback and recommendations on how to improve the screening rate. Feedback noted the Enrollee does not fully understand the reason for screening and an Enrollee incentive could encourage Enrollees to get screenings completed after they complete the provider office visit.
• The interdisciplinary team developed and implemented the following interventions:
• Partnered with the state diabetes association to provide providers with a Diabetes Tracking Tool developed by the Kentucky Diabetes Network to track all of the American Diabetes Association recommended diabetic screenings including the results. This allowed providers some workflow tools to assist the office staff in completing the required screenings. We assisted some providers with modifying the tool and adapting it to their specific EMR.
• Conducted general Enrollee education via the newsletter and on-hold message regarding the importance of regular health screenings to monitor their health and to talk to their doctor about if they should have any screenings
• Conducted targeted education to Enrollees with a Diabetes diagnosis regarding the ADA recommended screenings, how often each of the should be done, encouraged regular follow-up

with their assigned PCP and specialists, what is a HbA1c test, what does it mean, how can they improve their scores, long term complications of blood sugar non-compliance, the screening is free (covered benefit) ,that they could earn a Enrollee reward for getting their screening completed, and offered assistance in scheduling appointment, if they needed. This was conducted via mailings (quarterly), IVR reminder calls (monthly), and telephonic outreach by HP staff.
• Revised the high risk and newly diagnosed Enrollee educational tools into a booklet. This booklet was used by the clinical staff to educate both the Enrollee and their caregivers regarding diabetes and also intended to be a resource the Enrollee /caregiver could refer to as needed.
• Provided Care Gap Reports on a monthly basis to assigned PCP that included diabetes screenings
• Used the Disease Management Program to outreach to newly diagnosed Enrollees to coordinate care and educate the Enrollees/caregivers about diabetes
• Used the Disease Management Program to outreach to Enrollees identified as high risk based on ER visits, inpatient stays, or lack of outpatient care with a diagnosis of diabetes, outreaching and developing a plan of care to eliminate barriers to care, engaging the Enrollee with PCP/specialist care, educating on diabetes care and management, and helping the Enrollee access community resources, if needed.
• Revised the Enrollee incentive to include several of the recommended diabetic screenings and increased the amount of the reward to encourage completion of the screenings.

PROJECT #2: MOMMY STEP PROGRAM
The Kentucky managed care plan ranked above the Regional and State mean for the Timeliness of Prenatal Care component of the Prenatal and Postpartum Care (PPC) HEDIS measure and the Frequency of Ongoing Prenatal Care (FPC) measure in measurement year (MY) 2015 the plan continued to strive to improve prenatal care for their pregnant Enrollees with the Mommy Steps Program in 2016.

The Mommy Steps Program was designed to improve prenatal, infant, and maternal outcomes for pregnant Enrollees through improved compliance of both Obstetric (OB) clinicians and Enrollees with the Lighthouse Perinatal Care Clinical Practice Guidelines, which are based on the American Congress of Obstetricians and Gynecologists (ACOG) Guidelines. The program aims to increase the percentage of Enrollees who receive prenatal and postpartum care, increase the average number of prenatal visits and decrease the number of preterm and low birth weight infants with a goal was to achieve the 2017 Quality Compass® 90th Percentile for the PPC and FPC measures.

Eligible Enrollees were identified and passively enrolled in the Mommy Steps Program. Enrollees may “opt-out” of the Program and elect not to receive services by notifying a Mommy Steps representative or the Care Connector Program, either telephonically or in writing.

The Mommy Steps Program strategies were designed to decrease birth outcomes such as low birth weight (LBW), very low birth weight (VLBW) and premature deliveries and Healthy People 2020 and the goals were set as benchmarks for these birth outcome measures.
When barriers were encountered in The Mommy Steps Program, opportunities were identified and multiple strategies were developed for outreach to providers, Enrollees and the community to educate and motivate them to improve the health and birth outcomes of pregnant Enrollees.

PROVIDER ENGAGEMENT

Collaboration with Provider Relations to educate OB clinicians during all site visits promotes a relationship with both the OB clinicians and office managers. Continued collaboration and engagement of OB providers that encourages the practice to notify the Mommy Steps Program of Enrollees identified with modifiable risk factors or if the Enrollee becomes high risk. Utilization Management (UM) OB embedded Case Managers in high volume hospitals reach, support and educate pregnant and postpartum Enrollees.

OB Clinicians receive status updates on Enrollees enrolled in the Mommy Steps Program and provide reference information on the Perinatal Care Clinical Practice Guidelines, which are based on the ACOG Guidelines located on the Lighthouse website.

ENROLLEE ENGAGEMENT

Lighthouse supports maternity care through a variety of Enrollee engagement activities and communication channels. Written and telephonic communication are made to Enrollees who miss appointments assists with rescheduling and assessing barriers to care, including education about resources (i.e., transportation) to assist with keeping appointments. Auto-dialer technology, Care Message, educates Enrollees regarding the importance of regular prenatal care and postpartum visits. Enrollees who contact the 24/7 Nurse Advice Line Report, who might be pregnant or have a pregnancy question, are also provided education on the importance of early and regular prenatal care. Enrollee education includes importance of prenatal care to identify complications early and warning signs during pregnancy and when to call the OB clinician. Education venues include face-to-face outreach, Enrollee newsletters, on-hold messages, the website and printed educational materials. Lastly, collaboration with embedded OB Case Managers at physician offices reaches, supports and educates pregnant and postpartum Enrollees.
The Enrollee Incentive Program encourages early and regular prenatal care as well as timely postpartum care and financially rewards Enrollees who schedule and keep needed check-ups. A partnership with the Lincoln Trail Health District splits the cost of the ‘Crib Program’. This program provides Pak-n-Play cribs to Enrollees in need and promotes ‘Safe Sleep’, a crib that is safe, and educates Enrollees on the ABC’s of Safe Sleep to decrease the number of infant deaths that occur due to co-sleeping or unsafe sleep habits.

COMMUNITY ENGAGEMENT

Opportunities to increase community awareness of the Mommy Steps Program are fostered through collaboration with community partners such as Healthy Start, Lincoln Trail’s Health Access Nurturing Development Services (HANDS), and the local Department of Health. Participation in and distribution of educational material at community coalitions and education programs also increases awareness of The Mommy Steps Program and are sponsored by Healthy Mothers, Healthy Babies, the March of Dimes, the Fetal and Infant Mortality Review (FIMR) Committee. Pregnant Enrollees who want to quit smoking are encouraged to participate in the 1-800-QUIT-NOW Program and Mommy Step program staff including nurse case managers and program coordinators make telephonic outreach calls to pregnant Enrollees affected by substance use disorder who reside at Freedom House, a women’s residential addiction recovery program. A 24/7 Nurse Advice Line provides education and assists with pregnancy related questions and issues.

RESULTS PROJECT #1: IMPROVING COMPREHENSIVE DIABETES CARE

In Measurement Year (MY) 2016 our testing rate improved to 86.73%, a 4.26% increase from the previous year. We developed interventions that could sustain the continued improvement and PDSA process in order to achieve our goal. Also as result of the increased screening, we experienced improvements in the proportion of the diabetic population with an A1c value less than 8 percent and less than 7 percent, which will help to prevent further exacerbation of health problems.

HbA1c <8 percent:
MY 2015 HEDIS percentile = 45.42% exceeded the Kentucky State mean of 44.80%
MY 2016 HEDIS percentile = 50.91% exceeded the Kentucky State mean of 45.41%

HbA1c <7 percent:
MY2015 HEDIS percentile = 31.94% was slightly below the Kentucky State mean of 32.25%
MY2016 HEDIS percentile = 38.70% exceeded the Kentucky State mean of 33.04

RESULTS PROJECT #2: MOMMY STEPS PROGRAM

HEDIS –

Results for HEDIS® 2017 (MY2016) met the 2017 Quality Compass® 33.33rd Percentile and indicated a small decrease of 5.83 percentage points for Timeliness of Prenatal Care. Timeliness of Postpartum Care continued to meet the 2017 Quality Compass® 50th Percentile. Frequency of Prenatal Care > 81% met the 2017 Quality Compass® 66.67th Percentile, despite showing a slight decrease of 5.02 percentage points.

HEALTHY PEOPLE 2020

LBW, VLBW, and Preterm Deliveries are below the Healthy People 2020 goals. According to the most recent statistics, LBW rates are below state and national rates. For LBW it should be noted there was a slight increase of 0.25 percentage points, VLBW had a slight decrease of 0.70 percentage points and Preterm Deliveries ≤ 37 weeks had a significant decrease of 4.71 percentage points in 2016. 2015 Birth Outcomes data was based on an eight month claims runout; 2016 Birth Outcomes data was based on a three-month claims runout, which may have resulted in an artificially low rate of premature and VLBW babies.

ENROLLEE INCENTIVE PROGRAM

The Kentucky plan referenced above utilizes an Enrollee Incentive Program similar to the Enrollee incentives proposed by Lighthouse. The program is targeted toward increasing clinician and Enrollee awareness of the importance of prenatal and postpartum care. Enrollees who attended all six (6) prenatal visits and return their incentive form received $50. Enrollees who had a C-Section and return their incentive form received $10. Enrollees who kept their postpartum check-up within three (3) to eight (8) weeks after delivery and returned their incentive form received $50. For 2016, a total of 1,790 Enrollees took advantage of these rewards. There were 953 Enrollees who had at least six (6) prenatal visits, 604 Enrollees who had a postpartum screening and 233 Enrollees who had their C-Section incision checked.

RISK STRATIFICATION

In 2016, an average of 2,739 Enrollees per quarter were enrolled in the Mommy Steps Program, with an average of 1,210 Enrollees per quarter that were identified as new Enrollees, a 10% increase from 2015. There was an average of 405 Enrollees per quarter identified as high risk. They are selected to be both high risk and most likely to be assisted by active Case Management. This required a reassessment of our triage protocol to ensure that our efforts were being increasingly directed toward those Enrollees most likely to benefit from active Case Management. An average of 781 high risk Enrollees per quarter were actively engaged and received one-on-one telephonic contact and educational materials from a High-Risk OB Case Manager, a 57% increase from 2015.

There was an average of 471 Enrollees per quarter who received postpartum outreach calls, an 82% increase from 2015. An average of 377 referrals per quarter was made to WIC, HANDS and Healthy Start, a 6% decrease from 2015. New Enrollees received individual educational mailings. The Mommy Steps High Risk OB Case Managers collaborated with UM OB Embedded Case Managers in hospitals to ensure Enrollees needs and resources were provided.

PROJECT #2 MOMMY STEPS: IMPROVING BIRTH OUTCOMES

The Mommy Step Program was designed to improve prenatal, infant and maternal outcomes and was successful in lowering the Low Birth Weight (LBW), the Very Low Birth Weight (VLBW) and Preterm deliveries of their pregnant Enrollees below the Healthy People 2020 goal. According to the most recent statistics, LBW rates for the Kentucky plan are below state and national rates. For LBW it should be noted there was a slight increase of 0.25 percentage points, VLBW had a slight decrease of 0.70 percentage points and Preterm Deliveries ≤ 37 weeks had a significant decrease of 4.71 percentage points in 2016.

Babies born preterm or at a low birth weight are at increased risk of immediate life-threatening health problems as well as long-tern complications and developmental delays. A focus on interventions that engage and activate physician practices and Enrollees and draw upon community resources makes a difference in birth outcomes. Additional focus to improve Healthy Kentuckian (HK) results for pregnant women are based on the eight focus areas of the Healthy Kentuckian Prenatal Assessment Counseling and Education initiative. HK is Kentucky's commitment to the national prevention initiative Healthy People 2020. This prenatal initiative focuses on the areas that directly impact birth outcomes such as nutrition, and tobacco, alcohol and drug use. The Mommy Steps Program has nearly 100% participation and is an ongoing program that continues to strive to improve birth outcomes and the health and quality of life of infants and their mothers.

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates that the medical director has substantial oversight in the assessment and enhancement of quality improvement activities, and the Chief Executive Officer is actively involved in quality management.

2. The adequacy of the respondent's approach to incorporating quality improvement activities into the culture and operations of the organization.

3. The extent to which the respondent describes proactive processes and strategies that are utilized to recognize and solve problems before they occur or are exacerbated.

4. The extent to which the respondent provides two examples of completed quality improvement projects that incorporated a data-driven quality improvement cycle.

5. The extent to which the respondent provides data on the results of the quality improvement projects that demonstrates the efficacy of the interventions.

6. The extent to which one of the quality improvement projects described by the respondent is related to reducing potentially preventable events or improving birth outcomes.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-a
GENERAL SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

SRC# 36 – Health Plan Accreditation (See Section 409.966, Florida Statutes) (Statewide):

The respondent shall specify its current accreditation status by a nationally recognized accrediting body. This shall include the name of the accrediting body, the most recent date of certification, the effective date of the accreditation, the type and/or level of accreditation, and the status of accreditation (i.e., provisional, conditional, etc.). The respondent shall attach documentation that supports this information.

Response:

As a new provider services network, we are not yet accredited by a nationally recognized accrediting body, but will apply for NCQA accreditation once selected. Lighthouse Health Plan's operational model adheres to all NCQA requirements for Medicaid Managed Care plans. With the support of its NCQA-accredited subcontractor, Evolent Health, we will achieve Interim NCQA accreditation within the first year of the health plan launch, and receive full NCQA accreditation with 2 years.

Lighthouse will leverage the experience of Evolent Health to achieve NCQA accreditation in a timely manner. Evolent's commitment to quality is demonstrated by achieving three accreditations from NCQA in:
• Complex Case Management (9/27/16-9/27/19)
• Patient and Practitioner Oriented Disease Management for Asthma, Congestive Heart Failure, Coronary Artery Disease, Coronary Obstructive Pulmonary Disease and Diabetes (1/26/16-1/26/19)
• Utilization Management (1/25/17-1/25/19)

Documentation of Evolent's accreditations are provided as Attachment SRC 36-1 Evolent NCQA Accreditations and include three NCQA certificates and three letters of accreditation.

Our subcontractor Access Behavioral Health received NCQA Full Accreditation as a Medicaid Managed Behavioral Health Organization through 2/13/20. This certificate is provided in Attachment SRC 36-2 Access NCQA Certificate.

Evaluation Criteria:

1. Evidence that the respondent has:

(a) Full health plan accreditation by a nationally recognized accrediting body; e.g., full three (3) year accreditation for the National Committee for Quality Assurance (NCQA), full three (3) year accreditation for Utilization Review Accreditation Commission (URAC), or full three (3) year accreditation for Accreditation Association for Ambulatory Health Care, Inc. (AAAHC); or

(b) Partial/conditional health plan accreditation (e.g., provisional for NCQA, conditional or provisional for URAC, or one (1) year or six (6) months for AAAHC); or

(c) No health plan accreditation or denied accreditation.

Score: This section is worth a maximum of 5 raw points as outlined below:

(a) 5 points for full health plan accreditation.

(b) 3 points for partial/conditional health plan accreditation.

(c) 0 points if health plan accreditation denied or no accreditation.

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EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least (3) three Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group A tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)

RESPONDENT NAME:	Lighthouse Health Plan, LLC					
	Group A					
	State #1:	Kentucky	State #2:	Maryland	State #3:	Illinois
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	53.11	35.45	NB	30.61		44.31
Antidepressant Medication Management - Acute Phase	58.00	50.10	NB	37.31		54.71
Comprehensive Diabetes Care - HbA1c Control (<8%)	45.42	50.91	59.85	53.10		44.28
Controlling High Blood Pressure	53.76	59.95	71.19	64.27		52.07
Follow-Up After Hospitalization for Mental Illness - 7 day	62.05	66.79	NB	2.98		21.10
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation - Total	27.97	32.64	NB	NB		42.41
Medication Management for People with Asthma - 75% Compliance - Total	34.48	29.13	25.84	26.75		32.42
Children and Adolescents' Access to Primary Care Practitioners - 12-24 months	97.84	97.45	95.25	91.99		96.20
Children and Adolescents' Access to Primary Care Practitioners - 25 months - 6 years	88.51	88.17	90.03	85.48		85.14

EXHIBIT A-4-a-1
SRC# 6 - GENERAL PERFORMANCE MEASUREMENT TOOL (10-2-2017)

Group A						
	State #1:	Kentucky	State #2:	Maryland	State #3:	Illinois
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Children and Adolescents' Access to Primary Care Practitioners - 7-11 years	92.47	90.91	92.02	91.39		84.41
Children and Adolescents' Access to Primary Care Practitioners - 12-19 years	91.40	89.85	90.60	88.77		86.42
Adults' Access to Preventive/Ambulatory Health Services - Total	80.20	79.08	79.66	63.84		75.07

Total Points	160

Exhibit A-4-a-3
SRC# 10 - ADDITIONAL EXPANDED BENEFITS TEMPLATE (REGIONAL)

Benefit Category	Procedure Code Description	Procedure Code	Min Age	Max Age	Current Florida Medicaid Coverage (Adults)	Expanded Benefit Coverage (Units)	Co-payment Requirements	PMPM Cost	Eligible Populations	Rationale for Offering this Benefit
Expanded Physician Home Visits	DOMICIL/R-HOME VISIT EST PAT	99334	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	DOMICIL/R-HOME VISIT EST PAT	99335	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Physician Home Visits	DOMICIL/R-HOME VISIT EST PAT	99336	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	DOMICIL/R-HOME VISIT EST PAT	99337	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Physician Home Visits	DOMICIL/R-HOME CARE SUPERVIS	99339	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	DOMICIL/R-HOME CARE SUPERVIS	99340	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Physician Home Visits	HOME VISIT NEW PATIENT	99341	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	HOME VISIT NEW PATIENT	99342	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Physician Home Visits	HOME VISIT NEW PATIENT	99343	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	HOME VISIT NEW PATIENT	99344	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Physician Home Visits	HOME VISIT NEW PATIENT	99345	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	HOME VISIT EST PATIENT	99348	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Physician Home Visits	HOME VISIT EST PATIENT	99349	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Physician Home Visits	HOME VISIT EST PATIENT	99350	18	N/A	Not covered	Unlimited visits for the supervision of a chronic condition in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs The medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit.	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Expanded Home Health Services	HOME HEALTH AID OR CERTIFIED	S9122	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	[illegible] care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	NURSING CARE IN HOME RN	S9123	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	NURSING CARE IN THE HOME; B	S9124	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	PERSONAL CARE SER PER 15 MIN	T1019	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	PERSONAL CARE SER PER PER DIEM	T1020	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	HH AIDE OR CN AIDE PER VISIT	T1021	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	RN HOME CARE PER DIEM	T1030	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.

Expanded Home Health Services	LPN HOME CARE PER DIEM	T1031	18	N/A	Not covered	Up to four intermittent visits per day for non-pregnant adults age 18 and older in homebound enrollees. Requires prior-authorization by plan.	$0	$0.49 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Are under the care of an attending physician and have a physician's order for home health services Have a medical condition or disability that substantially limits their ability to perform ADLs or IADLs Require services that can be safely, effectively, and efficiently provided in the home or other authorized setting	Reduce avoidable emergency room visits and admissions/readmissions to the hospital by providing medical services and support in home.
Vaccines	IMMUNIZATION ADMIN	90471	18	N/A	Not covered	1 for first vaccination given to patient	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	IMMUNIZATION ADMIN EACH ADD	90472	18	N/A	Not covered	1 per each additional vaccination given to patient	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VACC IIV3 NO PRESERV ID	90654	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VAC NO PRSV 3 VAL 6-35 M	90655	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VACCINE NO PRESERV 3 & >	90656	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VACCINE 3 YRS IM	90657	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VACCINE NASAL	90660	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VACC CELL CULT PRSV FREE	90661	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompan ying document ation detailing cost developm ent.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VACC PRSV FREE INC ANTIG	90662	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompan ying document ation detailing cost developm ent.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VACC PANDEMIC INTRANASAL	90664	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VAC PANDEM PRSRV FREE IM	90666	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VAC PANDEMIC ADJUVANT IM	90667	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VAC PANDEMIC SPLT IM	90668	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	PNEUMOCOCCAL VACC 7 VAL IM	90669	18	N/A	Not covered	AS MEDICALLY ADVISED; NEEDS PLAN APPROVAL FOR ENROLLEES AGES 18-65	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults age 65 and older Adults age 65 or younger if at risk for serious pneumococcal infection based on Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendations	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	PNEUMOCOCCAL VACC 13 VAL IM	90670	18	N/A	Not covered	AS MEDICALLY ADVISED; NEEDS PLAN APPROVAL FOR ENROLLEES AGES 18-65	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults age 65 and older Adults age 65 or younger if at risk for serious pneumococcal infection based on Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendations	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VACCINE 4 VALENT NASAL	90672	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All Adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VACC RIV3 NO PRESERV	90673	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All Adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	FLU VAC NO PRSV 4 VAL 3 YRS+	90686	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All Adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	FLU VACC 4 VAL 3 YRS PLUS IM	90688	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All Adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	PNEUMOCOCCAL VACC 23 VAL IM	90732	18	N/A	Not covered	AS MEDICALLY ADVISED; NEEDS PLAN APPROVAL FOR ENROLLEES AGES 18-65	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults age 65 and older Adults age 65 or younger if at risk for serious pneumococcal infection based on Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	ZOSTER VACC SC	90736	18	N/A	Not covered	AS MEDICALLY ADVISED; NEEDS PLAN APPROVAL FOR ENROLLEES AGES 18-60	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Adults age 60 and older	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Vaccines	ADMIN INFLUENZA VIRUS VAC	G0008	18	N/A	Not covered	1 per enrollee per year of any of the Flu Vaccine codes which include: 90654 90655 90656 90657 90657 90660 90661 90662 90664 90666 90667 90668 90672 90673 90686 G0008	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All Adults	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation
Vaccines	ADMIN PNEUMOCOCCAL VACCINE	G0009	18	N/A	Not covered	AS MEDICALLY ADVISED; NEEDS PLAN APPROVAL FOR ENROLLEES AGES 18-65	$0	$0.09 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	All adults age 65 and older Adults age 65 or younger if at risk for serious pneumococcal infection based on Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation	Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) Recommendation

Pet Therapy/Art Therapy	ACTIVITY THERAPY	G0176	0	10	Not covered	Plan will determine number of visits allowed.	$0	$0.01 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Enrollees requiring medically necessary activity therapy	Improve the physical, psychosocial, and cognitive functioning of enrollees for whom the therapy is medically necessary.
Home Delivered Meals	HOME DELIVERED PREPARED MEAL	S5170	N/A	N/A	Not covered	10 MEALS NEEDS PLAN APPROVAL	$0	$0.06 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Enrollees who have been discharged from a hospital or skilled nursing facility (SNF) may receive up to 10 meals following their discharge. Benefit is limited to four hospital/ SNF admissions per year.	To reduce readmission following an inpatient stay at a hospital of SNF by ensuring that enrolless have access to meals that are adequately nutritious to promote healing/rehabilitation

Home Delivered Meals	MEALS PER DIEM	S9977	N/A	N/A	Not covered	$100 A DAY FOR UP TO 21 DAYS FOR MEMBERS AND THEIR FAMILY; INCLUDES LODGING AND UP TO 2 MEALS/DAY; ONLY IF TRAVELING MORE THATN 150 MILES FROM MEMBER'S HOME; NEEDS PLAN APPROVAL.	$0	$0.06 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Enrollees who have been discharged from a hospital or skilled nursing facility (SNF) may receive up to 10 meals following their discharge. Benefit is limited to four hospital/ SNF admissions per year.	To reduce readmission following an inpatient stay at a hospital of SNF by ensuring that enrolless have access to meals that are adequately nutritious to promote healing/rehabilitation
Home Delivered Meals	MEALS WHEN RECEIVE SERVICES	T1010	N/A	N/A	Not covered	10 MEALS NEEDS PLAN APPROVAL	$0	$0.06 PMPM benefit cost is developed in aggregate not at CPT level. Please see accompanying documentation detailing cost development.	Enrollees who have been discharged from a hospital or skilled nursing facility (SNF) may receive up to 10 meals following their discharge. Benefit is limited to four hospital/ SNF admissions per year.	To reduce readmission following an inpatient stay at a hospital of SNF by ensuring that enrolless have access to meals that are adequately nutritious to promote healing/rehabilitation

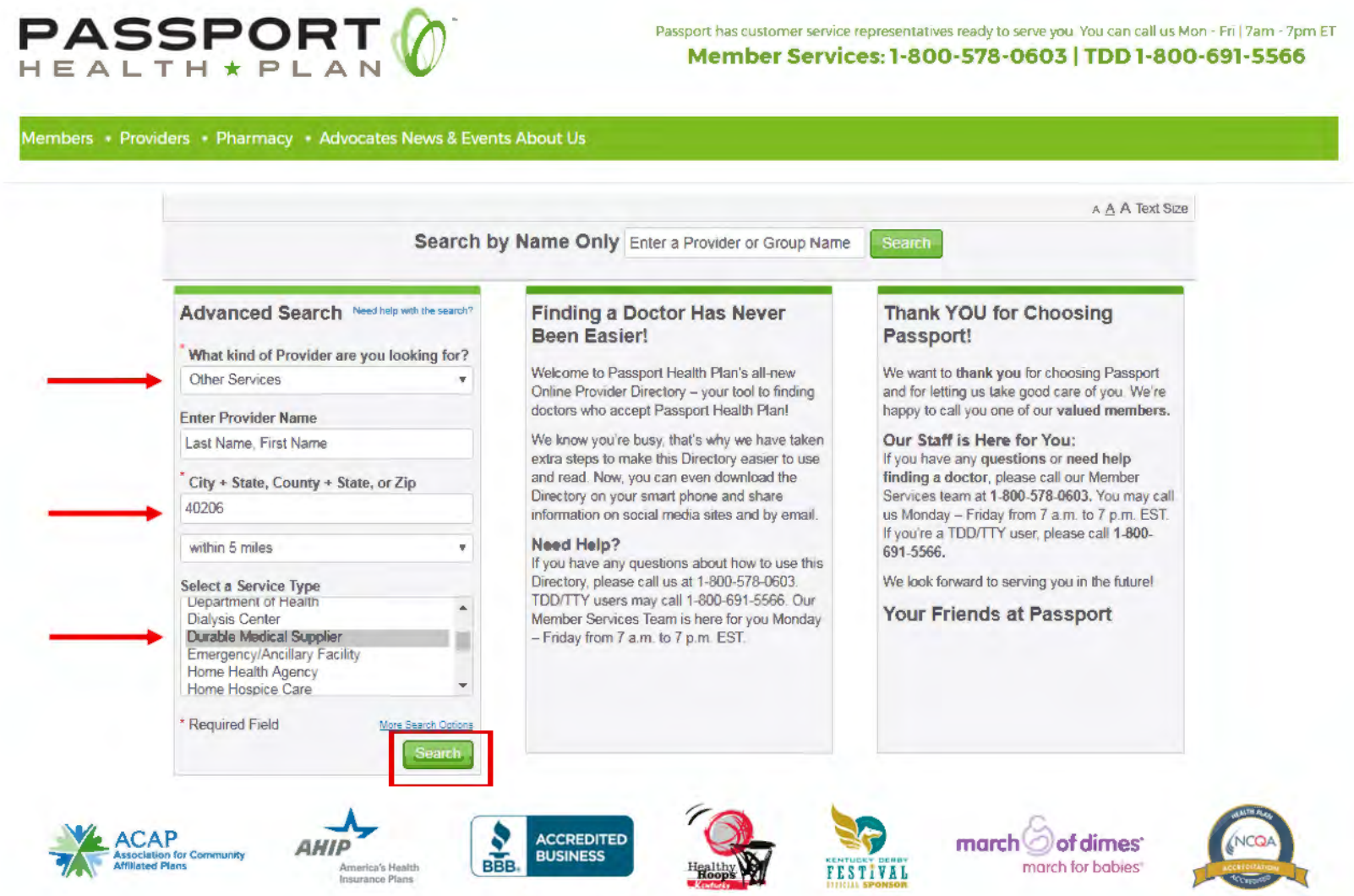
Attachment SRC 11-1 Online Provider Directory Screenshots

From Homepage, Click 1: Find a Doctor

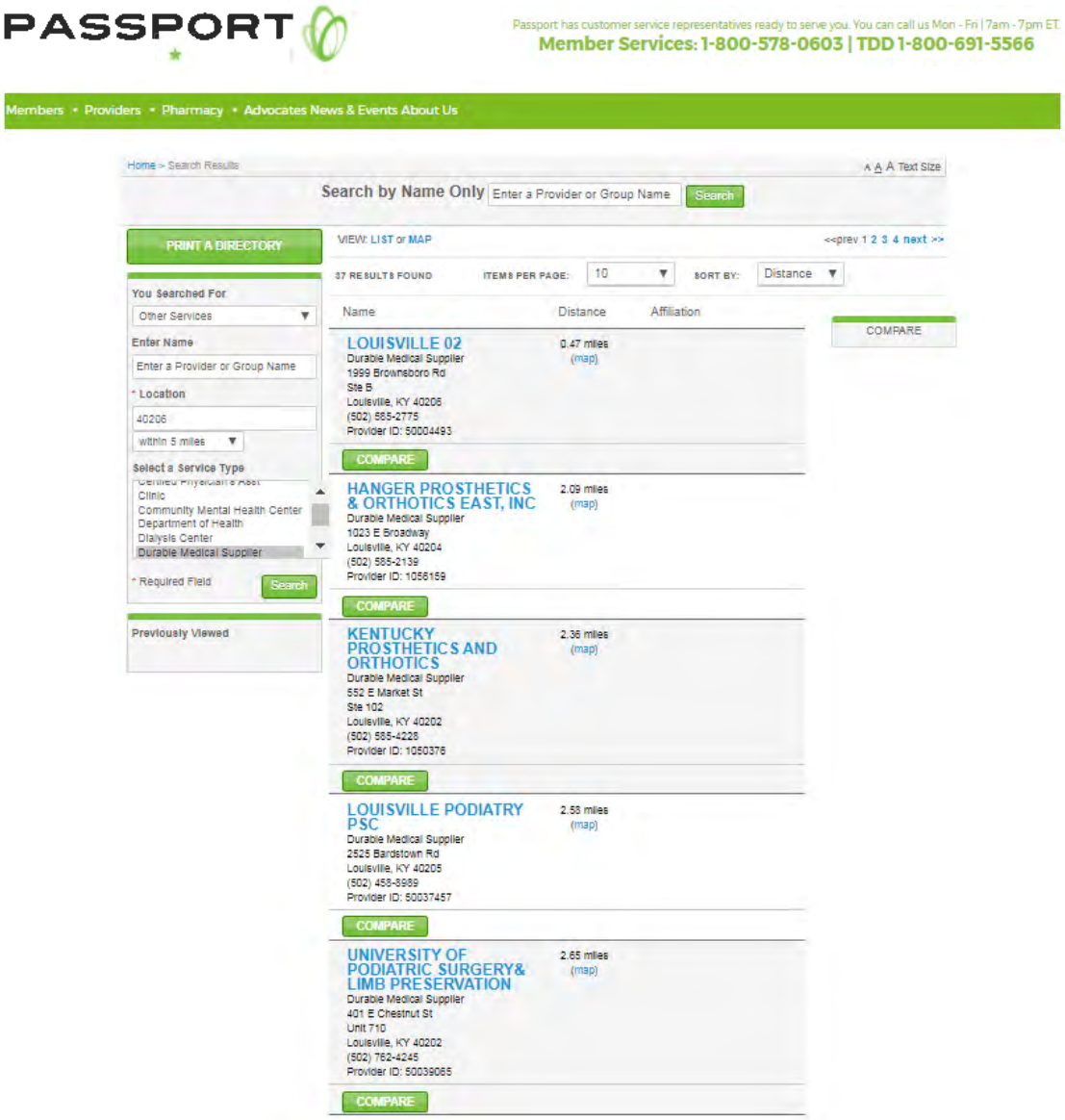
Click 2: Find a Doctor

Select “Other Services” and Select “Durable Medical Supplier” and enter zip code.

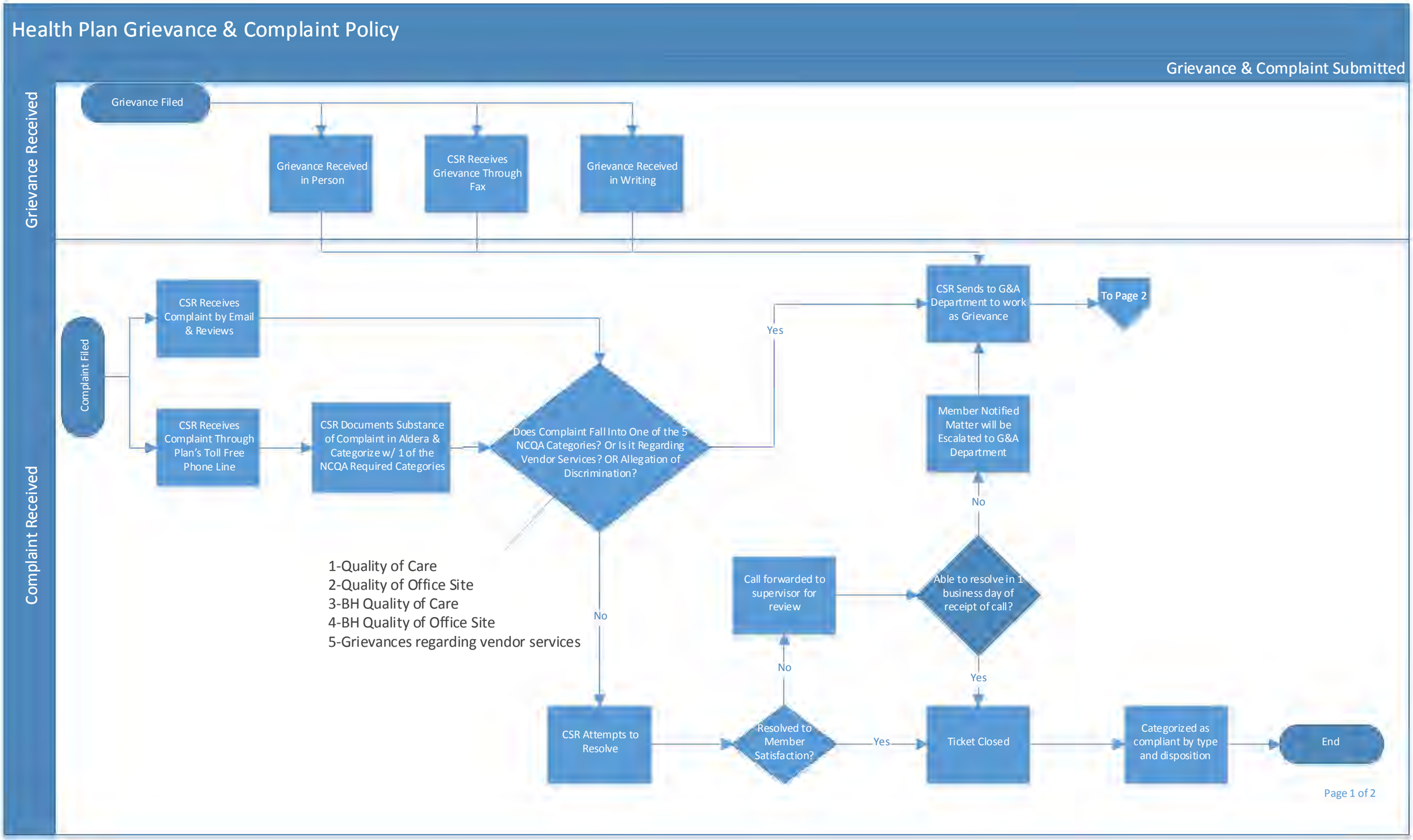
Click 3: “Search”

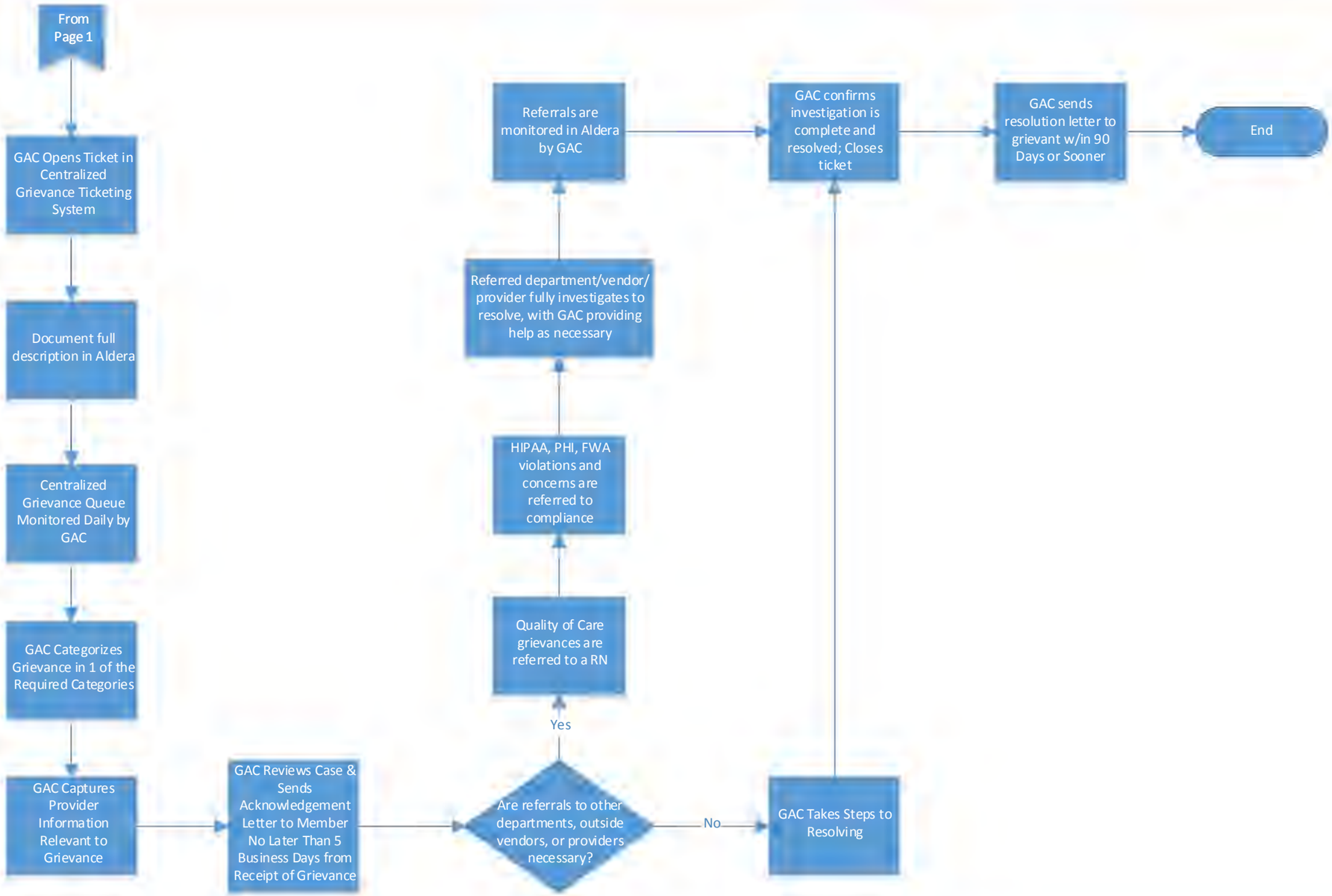


Search Results:



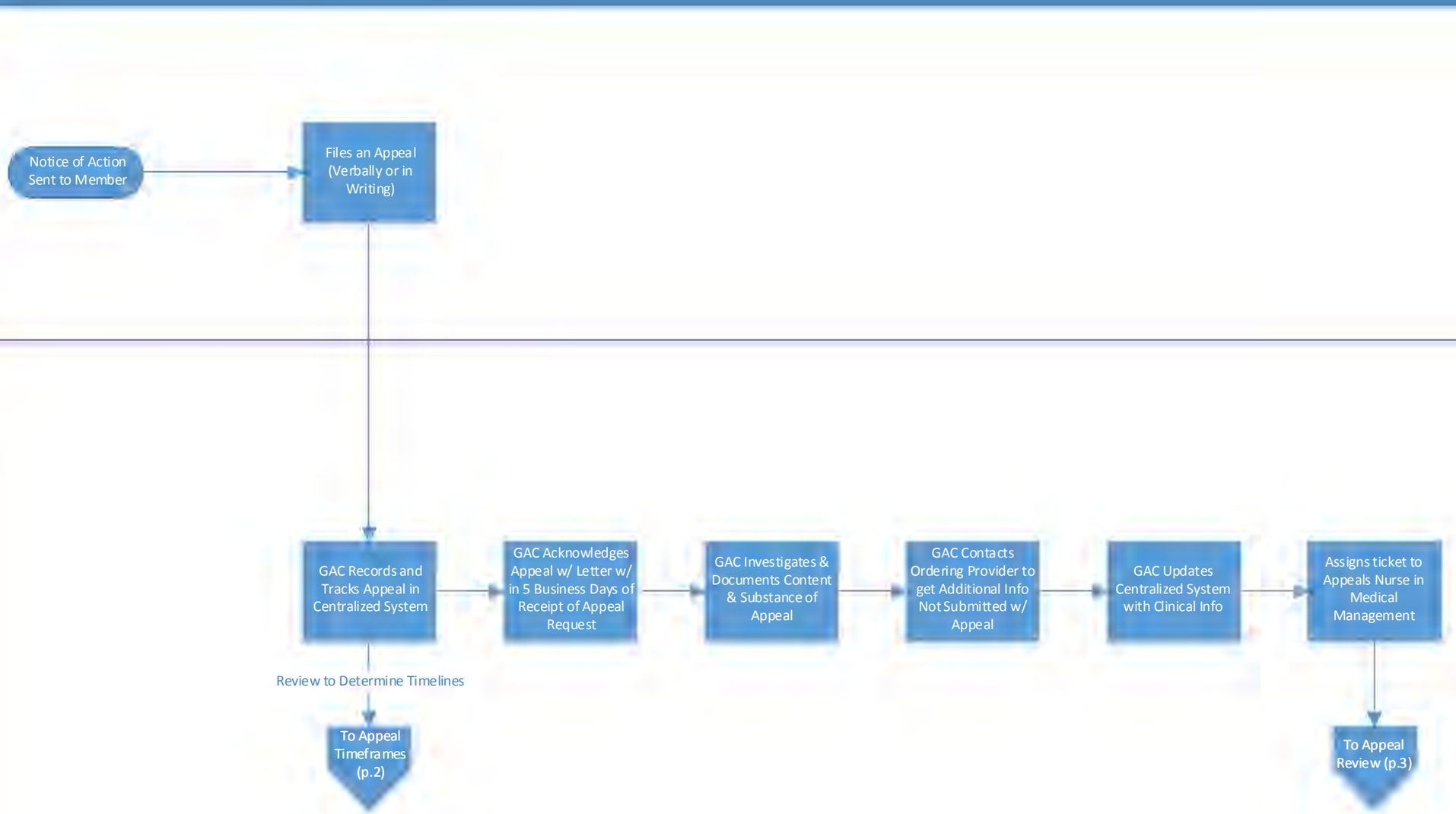
Health Plan Grievance & Complaint Policy




From Page 1
GAC Opens Ticket in Centralized Grievance Ticketing System
Document full description in Aldera
Centralized Grievance Queue Monitored Daily by GAC
GAC Categorizes Grievance in 1 of the Required Categories
GAC Captures Provider Information Relevant to Grievance
GAC Reviews Case & Sends Acknowledgement Letter to Member No Later Than 5 Business Days from Receipt of Grievance
Are referrals to other departments, outside vendors, or providers necessary?
Yes
No
Quality of Care grievances are referred to a RN
HIPAA, PHI, FWA violations and concerns are referred to compliance
Referred department/vendor/ provider fully investigates to resolve, with GAC providing help as necessary
Referrals are monitored in Aldera by GAC
GAC Takes Steps to Resolving
GAC confirms investigation is complete and resolved; Closes ticket
GAC sends resolution letter to grievant w/in 90 Days or Sooner
End

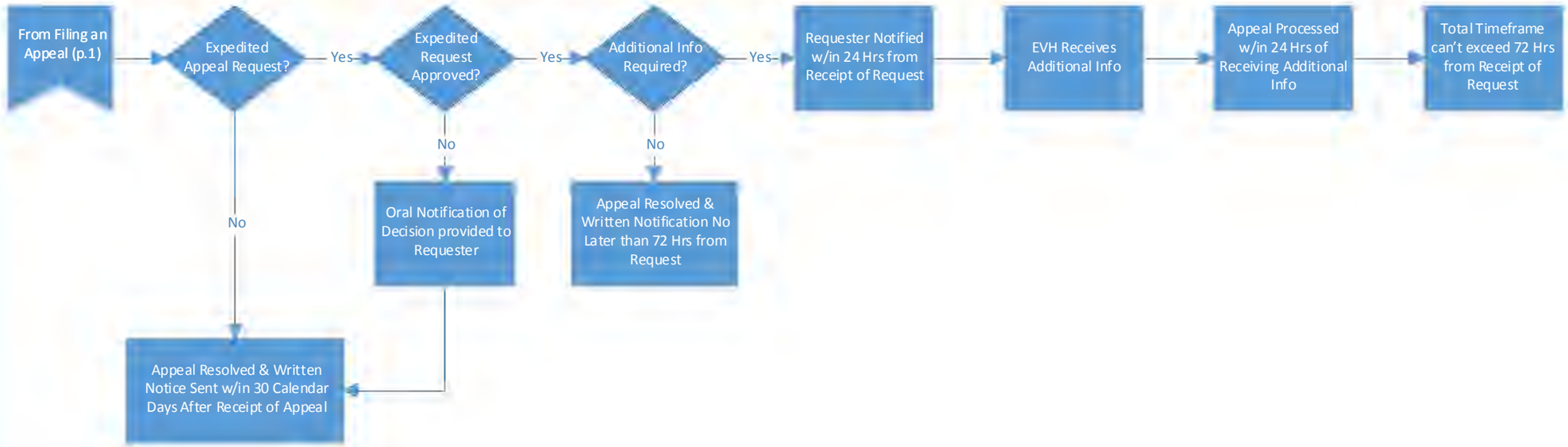
Health Plan Appeals Policy

Filing an Appeal & Intake/Acknowledgement Process



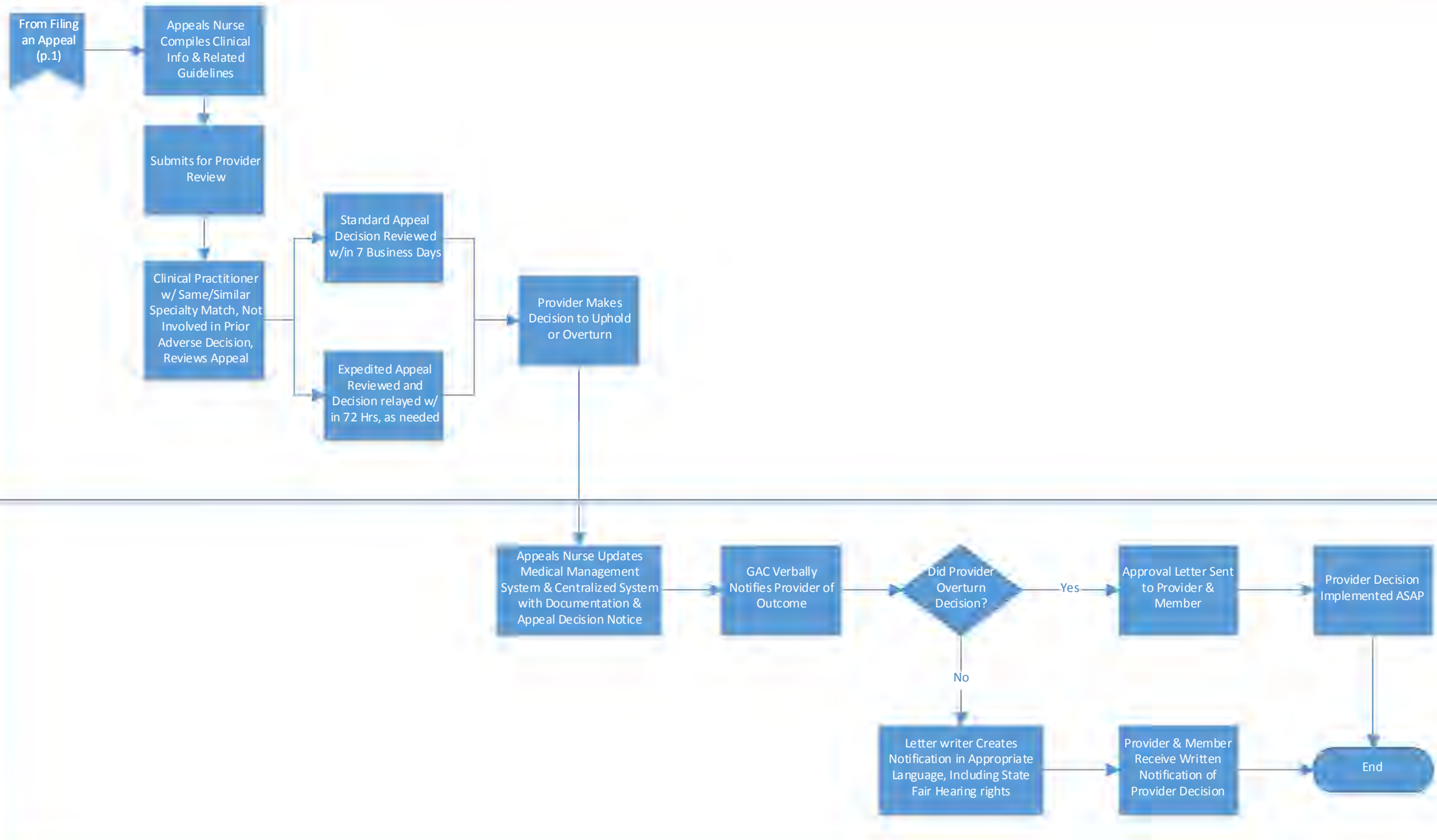
Appeal Timeframes

Timelines



Health Plan Appeals Policy

Appeal Review Process

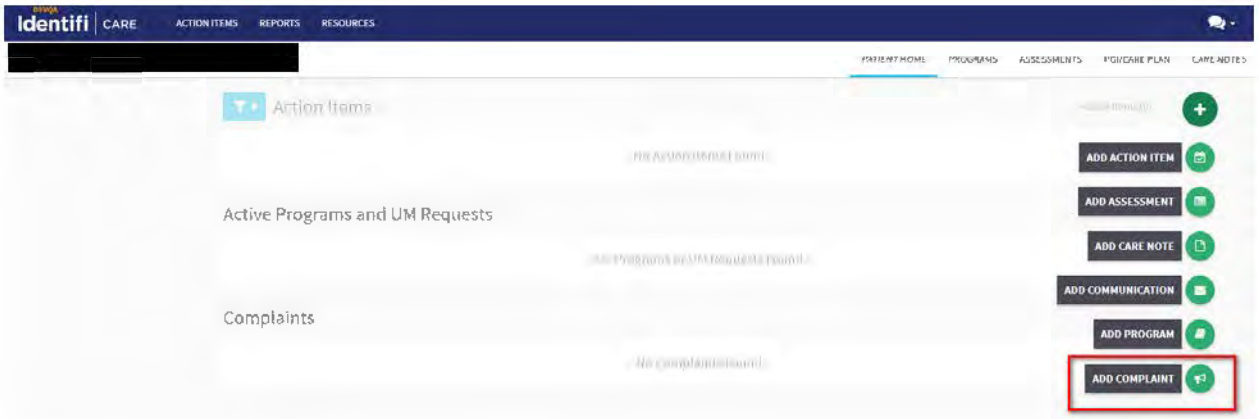


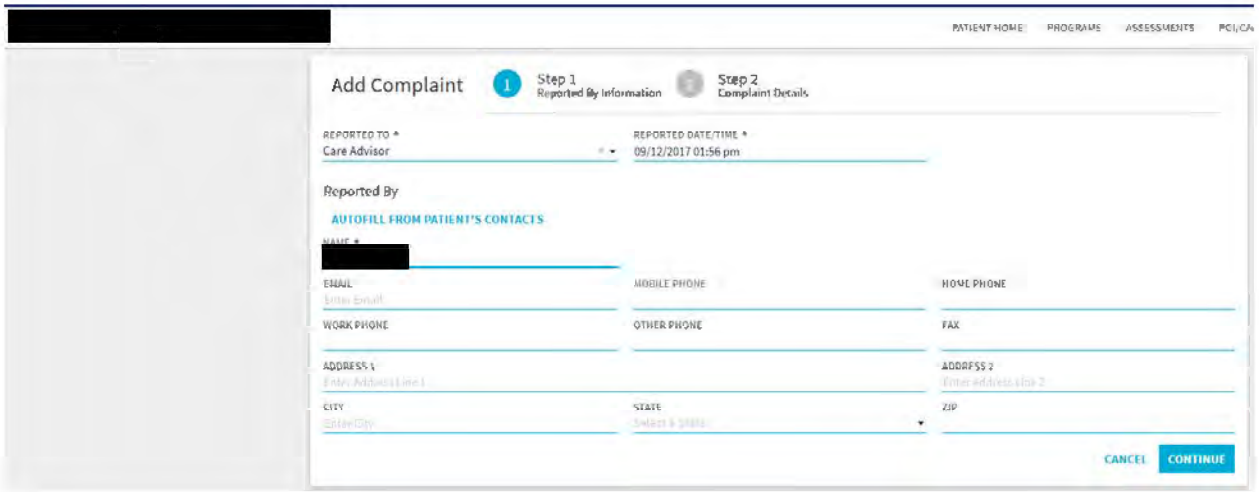
State Fair Hearing

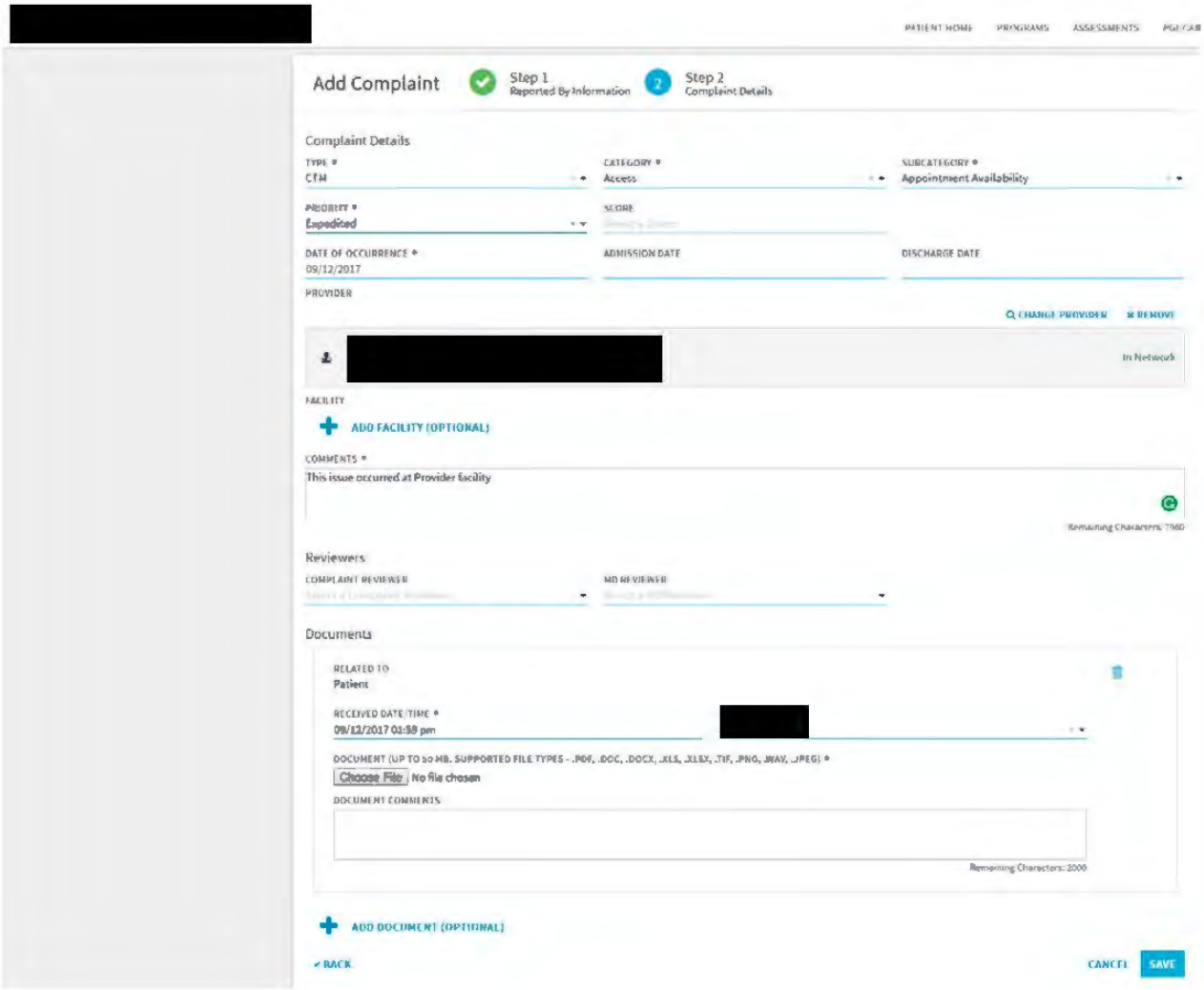
Health Plan

Complaints Workflow

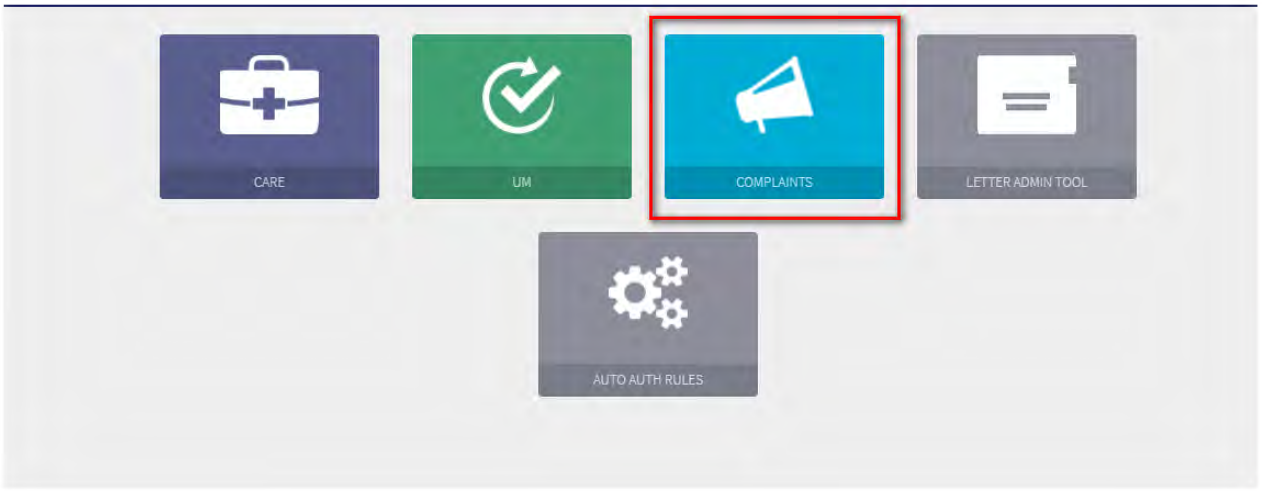
1. Add a Complaint



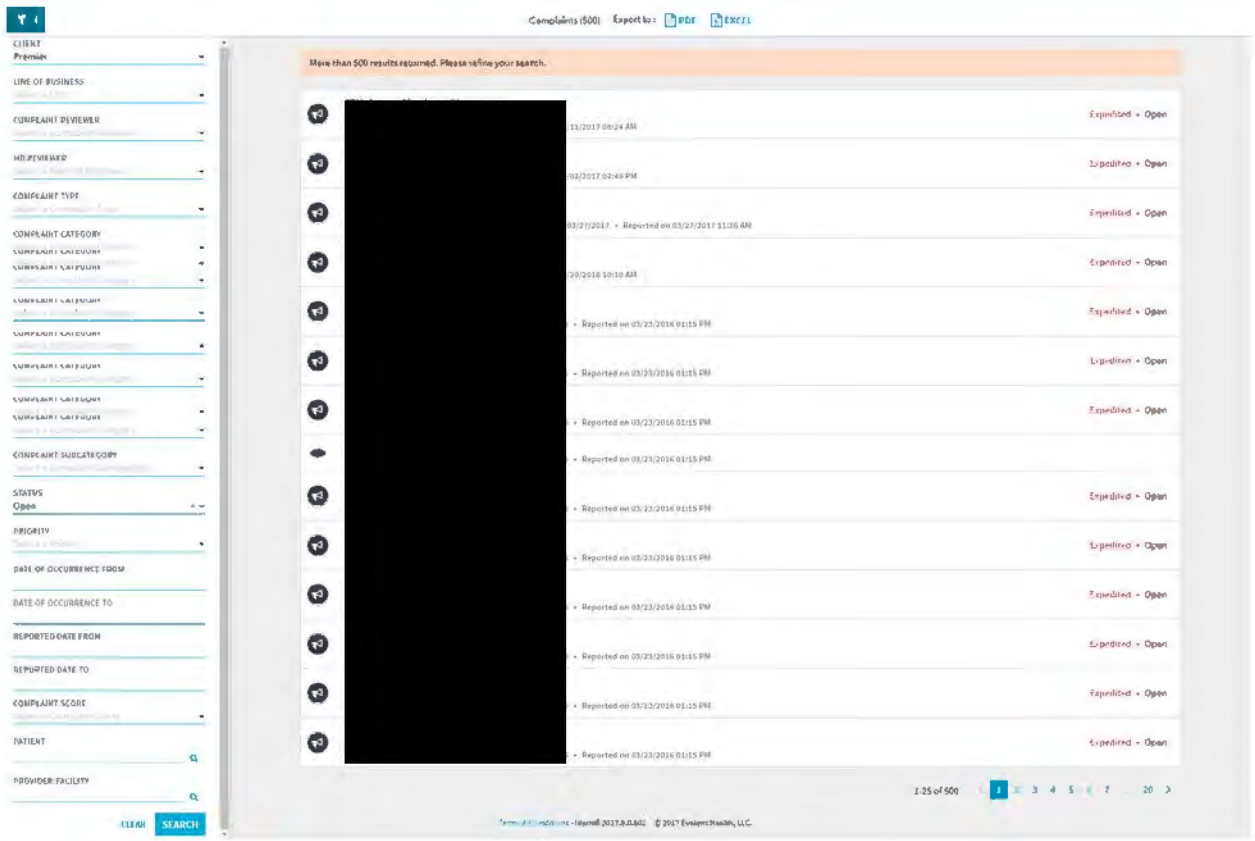




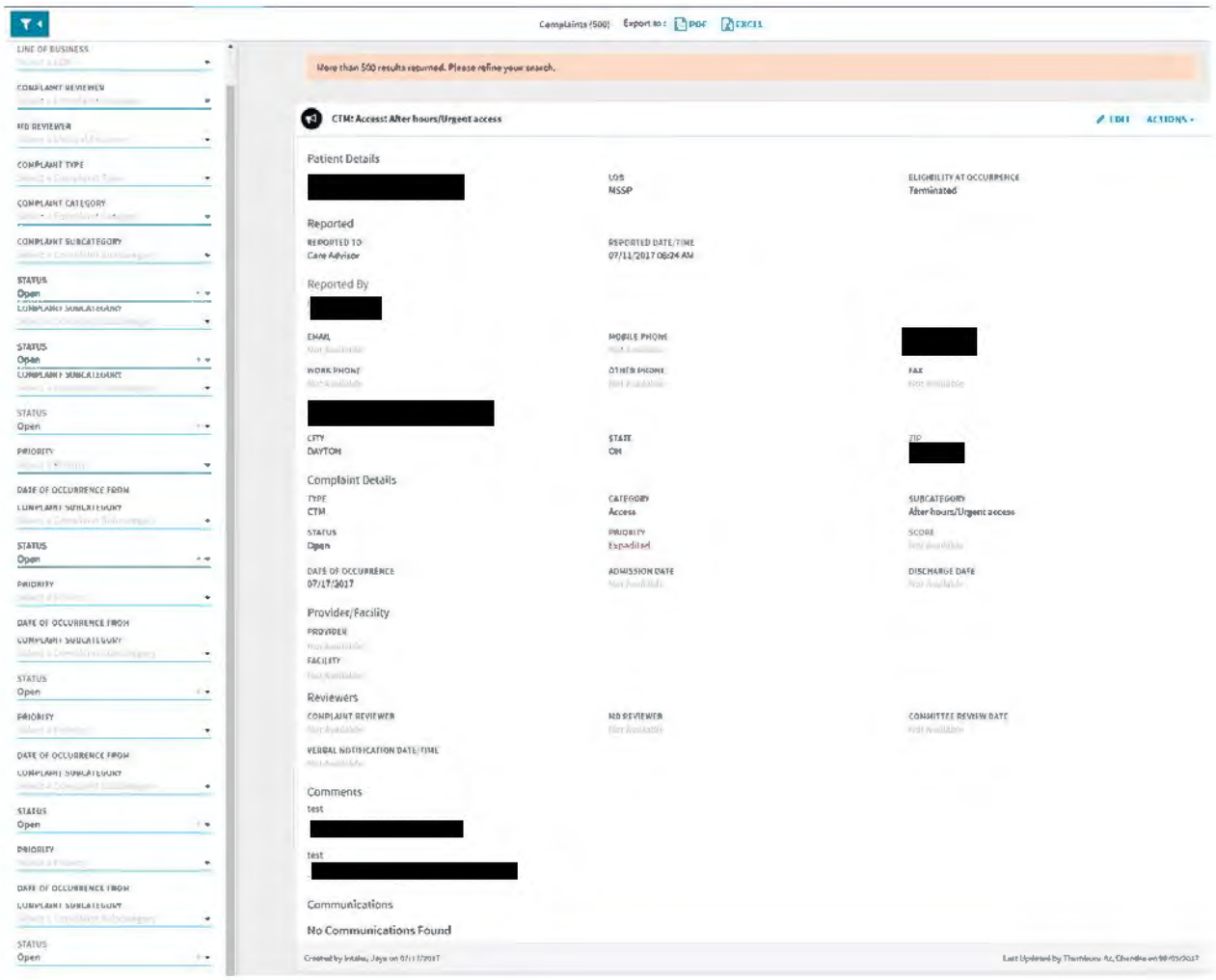
2. Complaints Launcher View



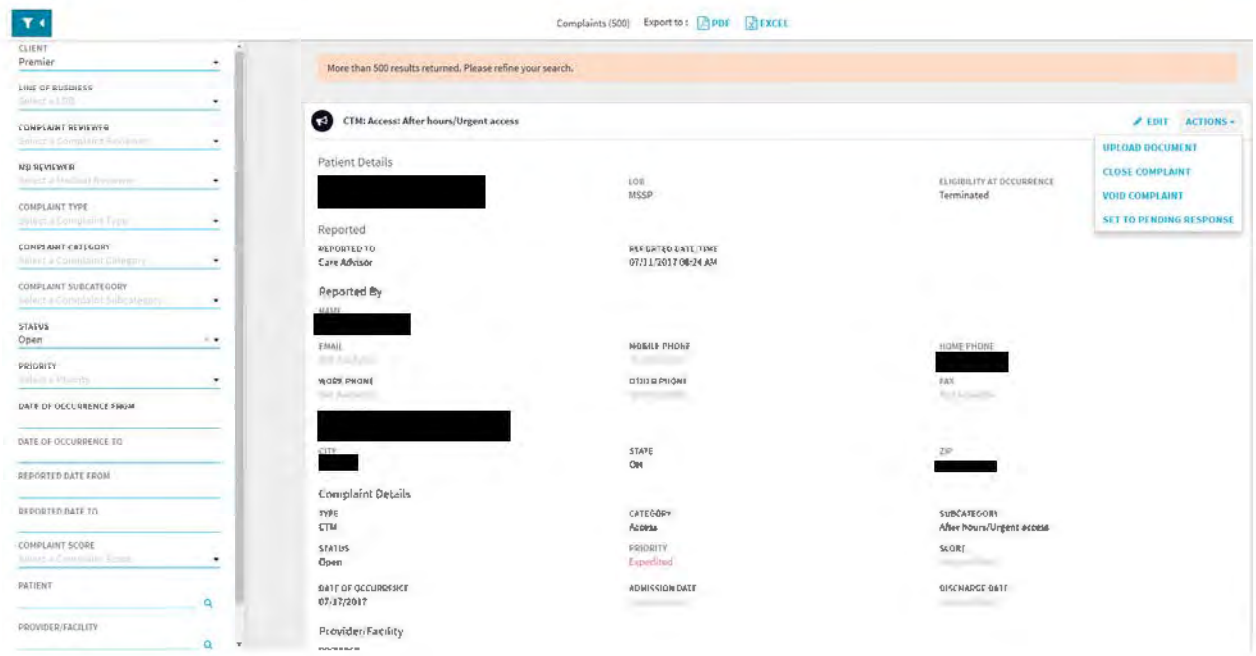
3. Landing Page view

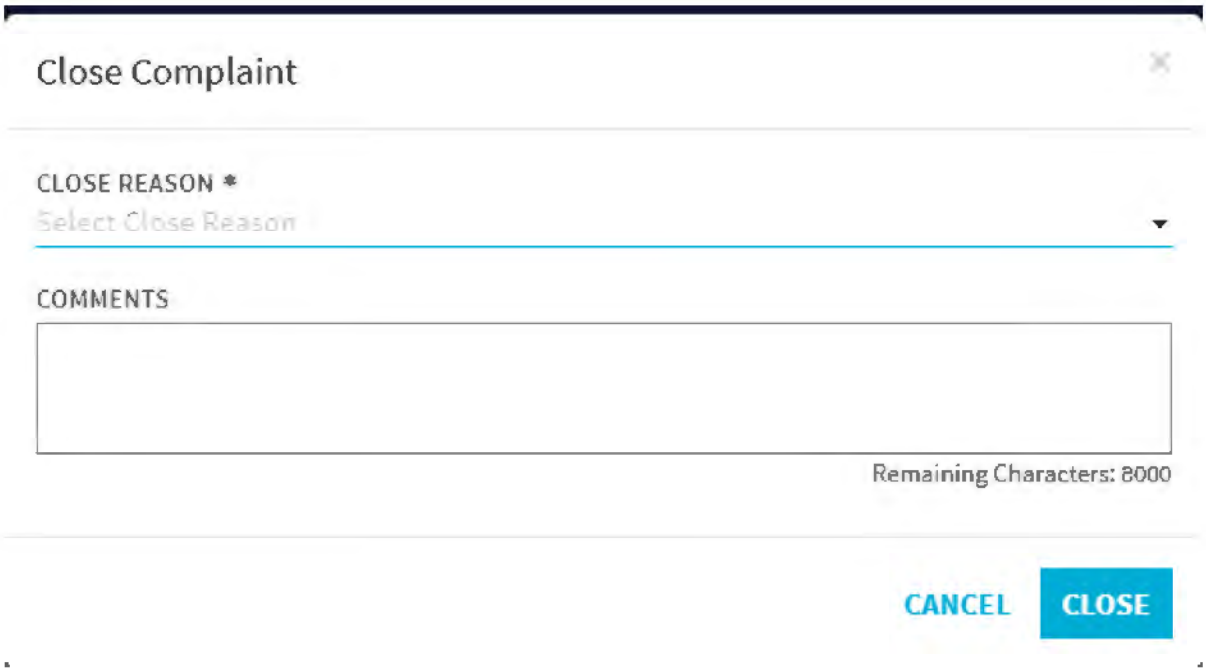


4. Complaint details view

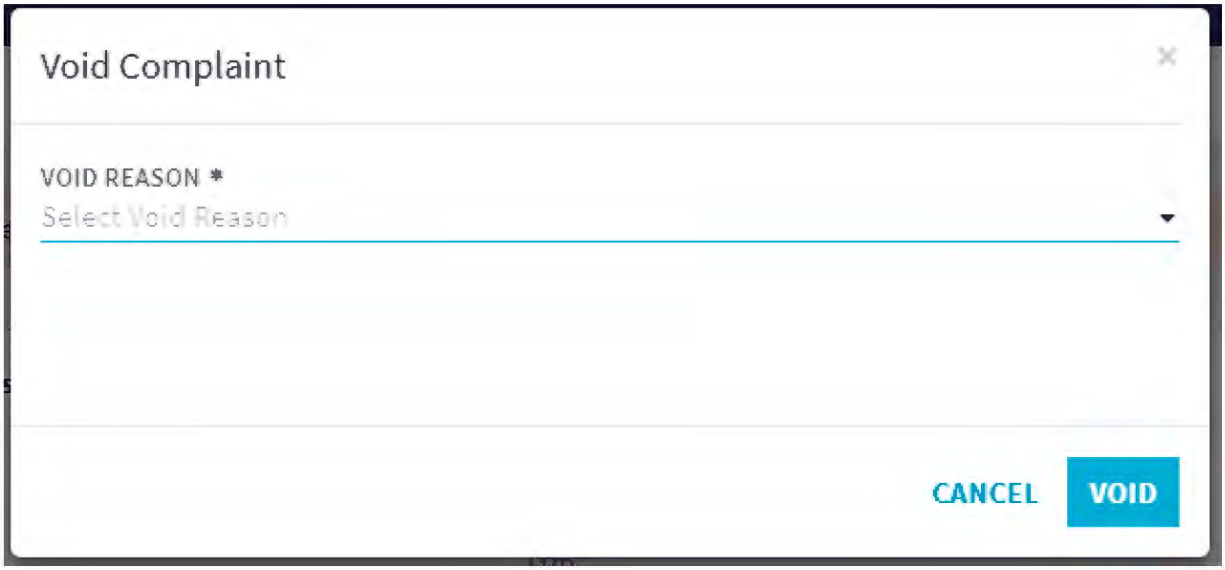


5. Close Complaint

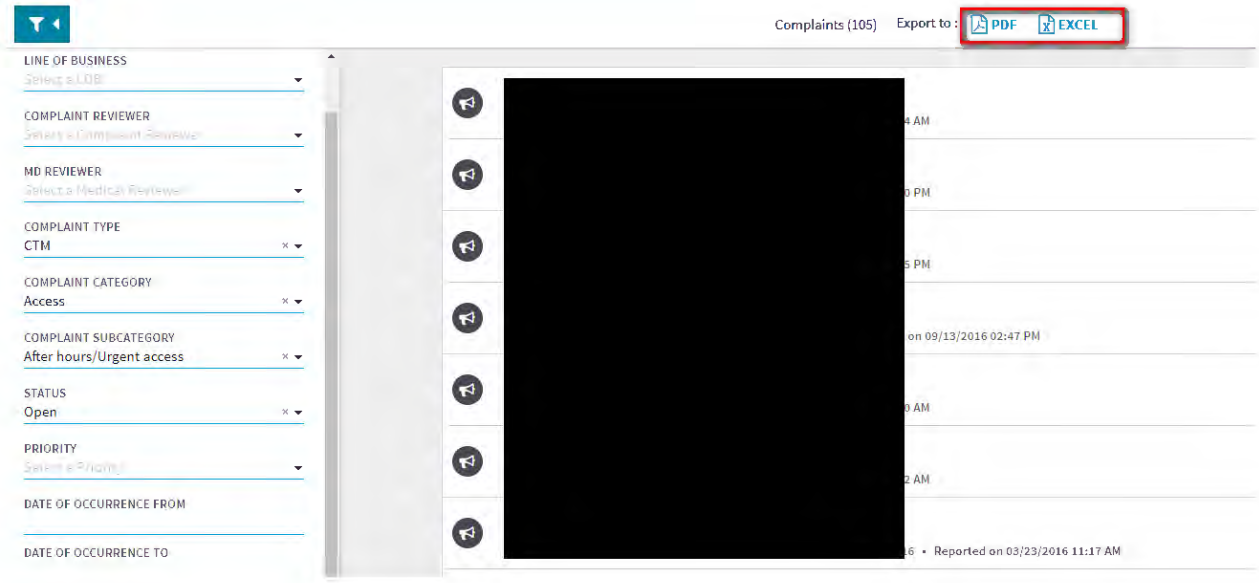


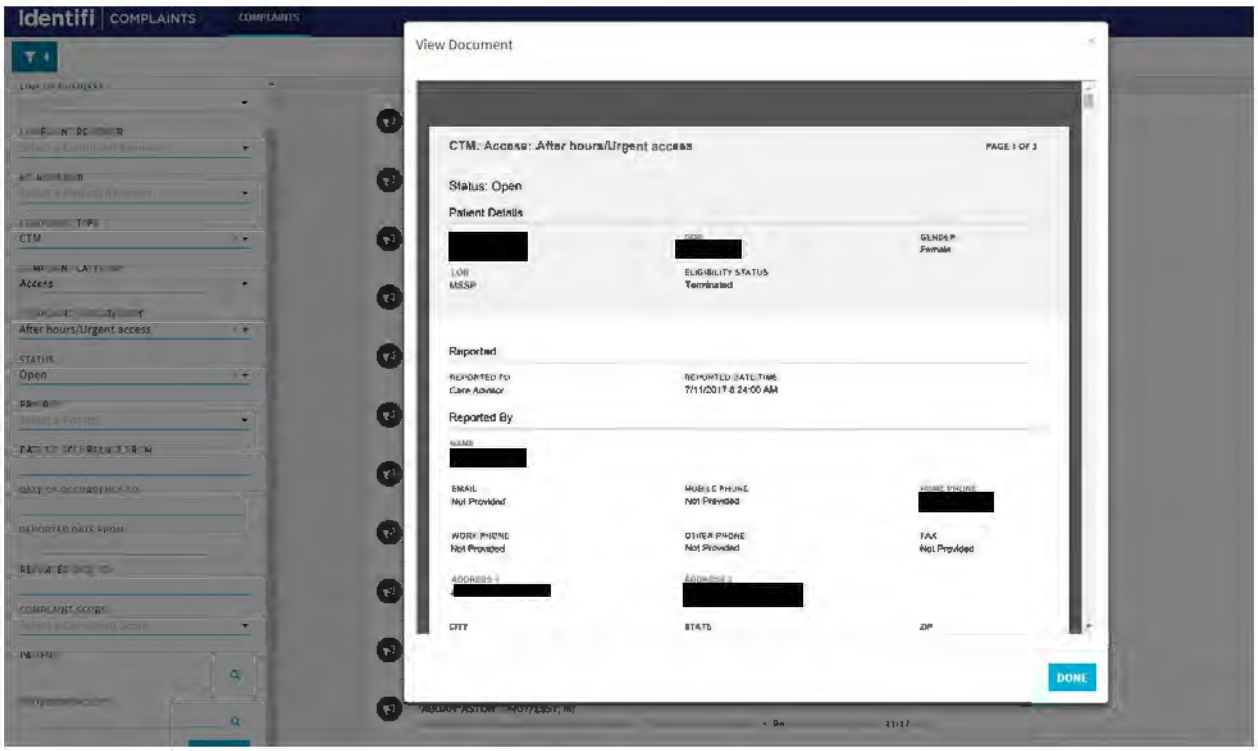


6. Void Complaint



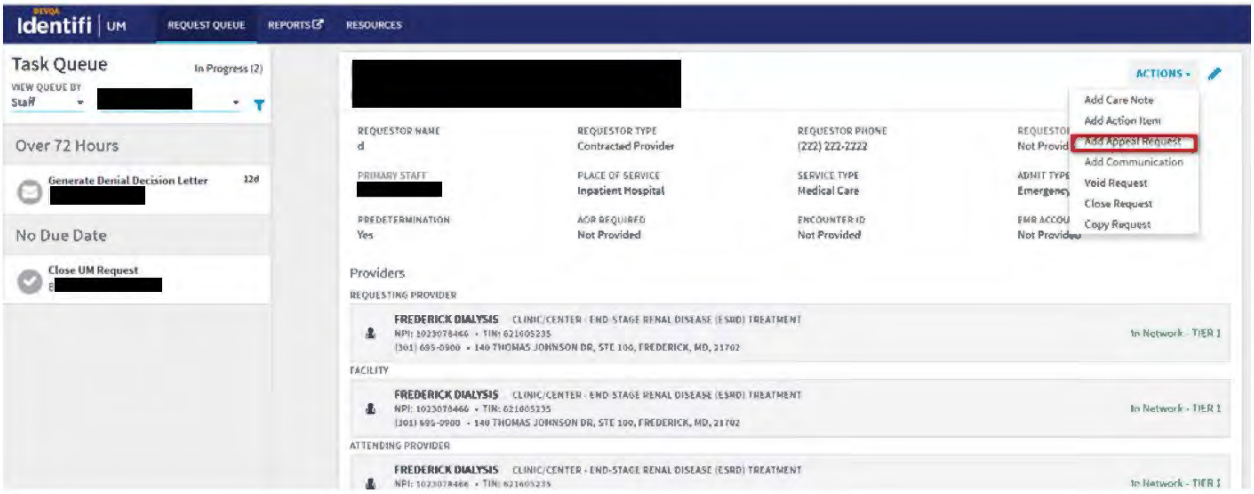
7. Print Complaints

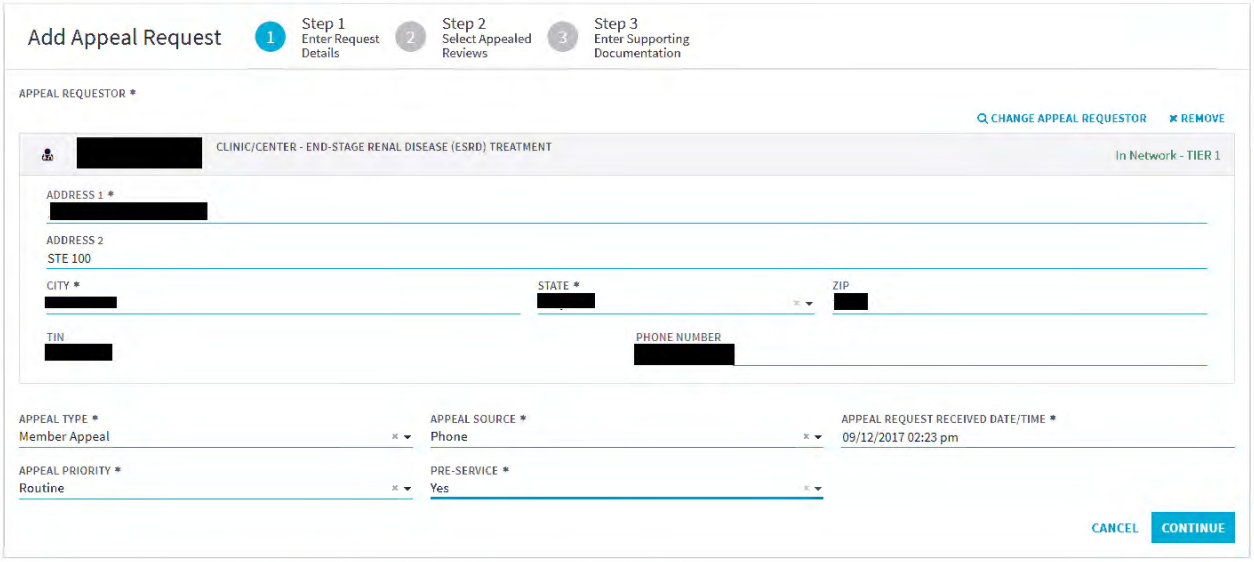


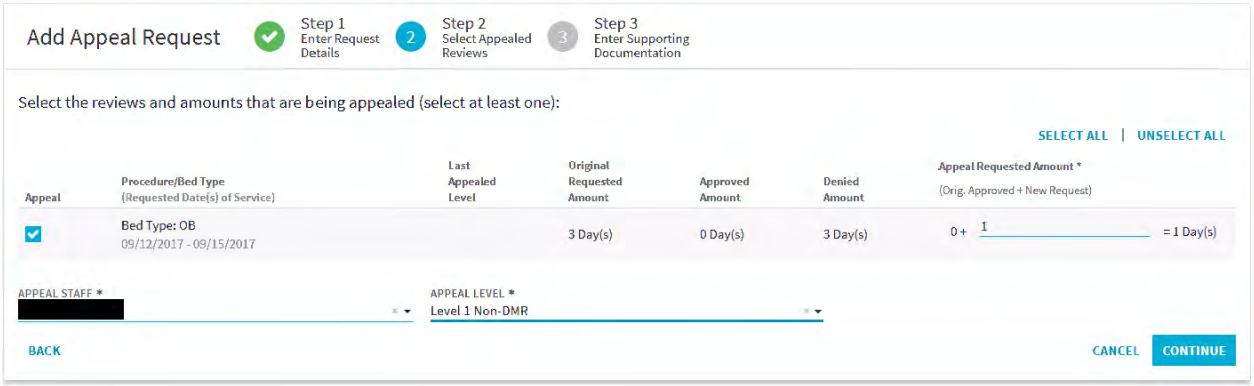

Identifi
COMPLAINTS
COMPLAINTS
CTM
Access
After hours/Urgent access
Open
View Document
CTM: Access: After hours/Urgent access
Status: Open
Patient Details
LOB
MSSP
ELIGIBILITY STATUS
Terminated
GENDER
Female
Reported
REPORTED TO
Care Advisor
REPORTED DATE/TIME
7/11/2017 8:24:00 AM
Reported By
EMAIL
Not Provided
MOBILE PHONE
Not Provided
WORK PHONE
Not Provided
OTHER PHONE
Not Provided
FAX
Not Provided
CITY
STATE
ZIP
DONE

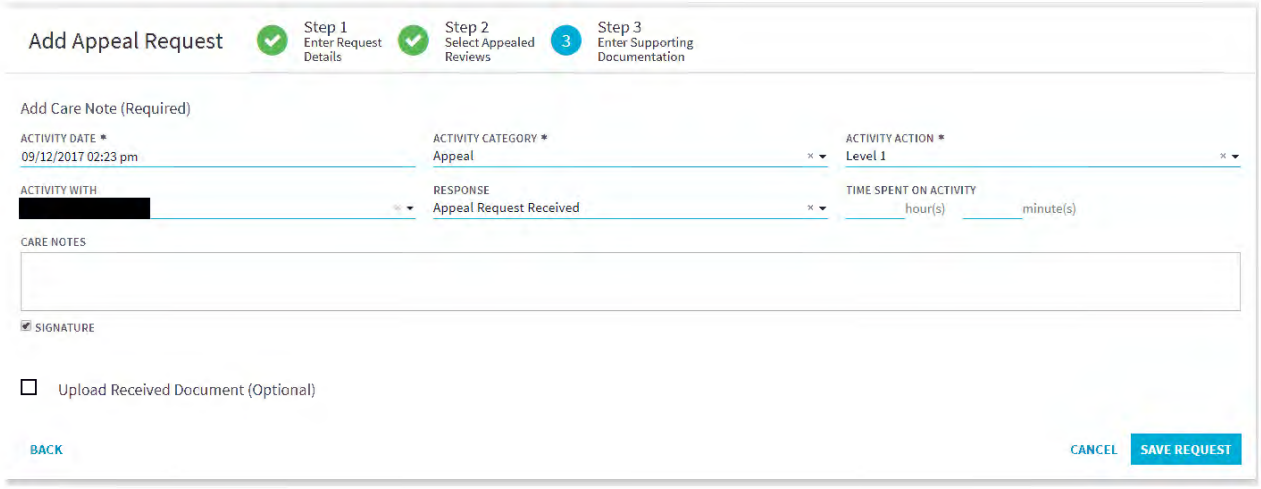
Appeals Screenshots

1. Add Appeal Request

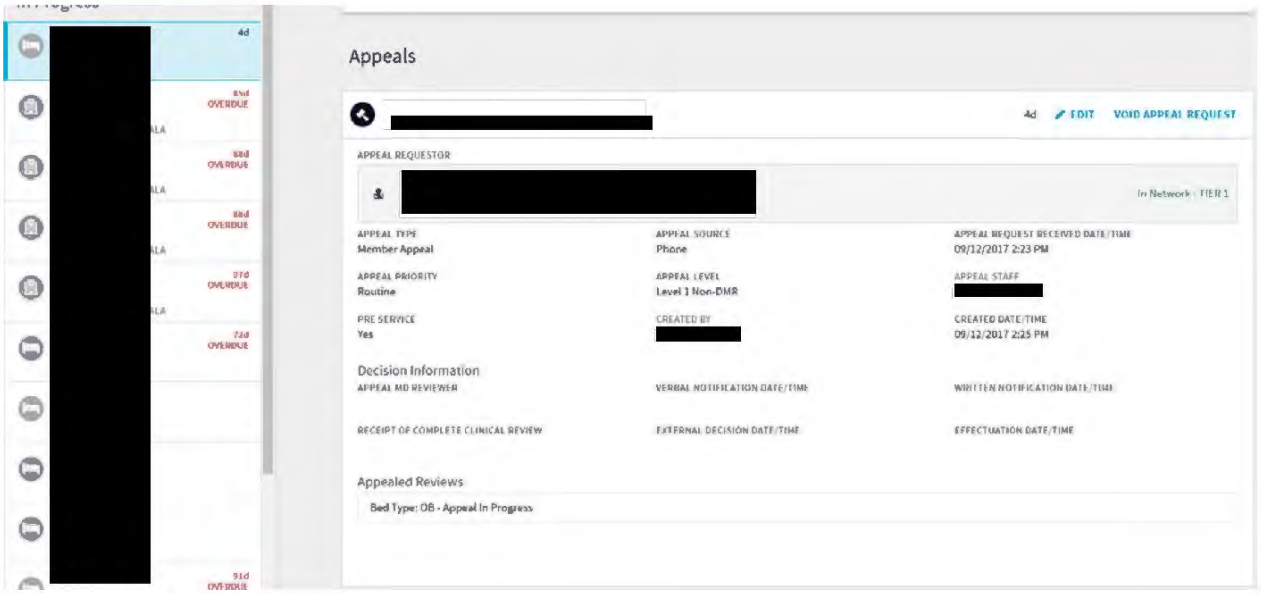


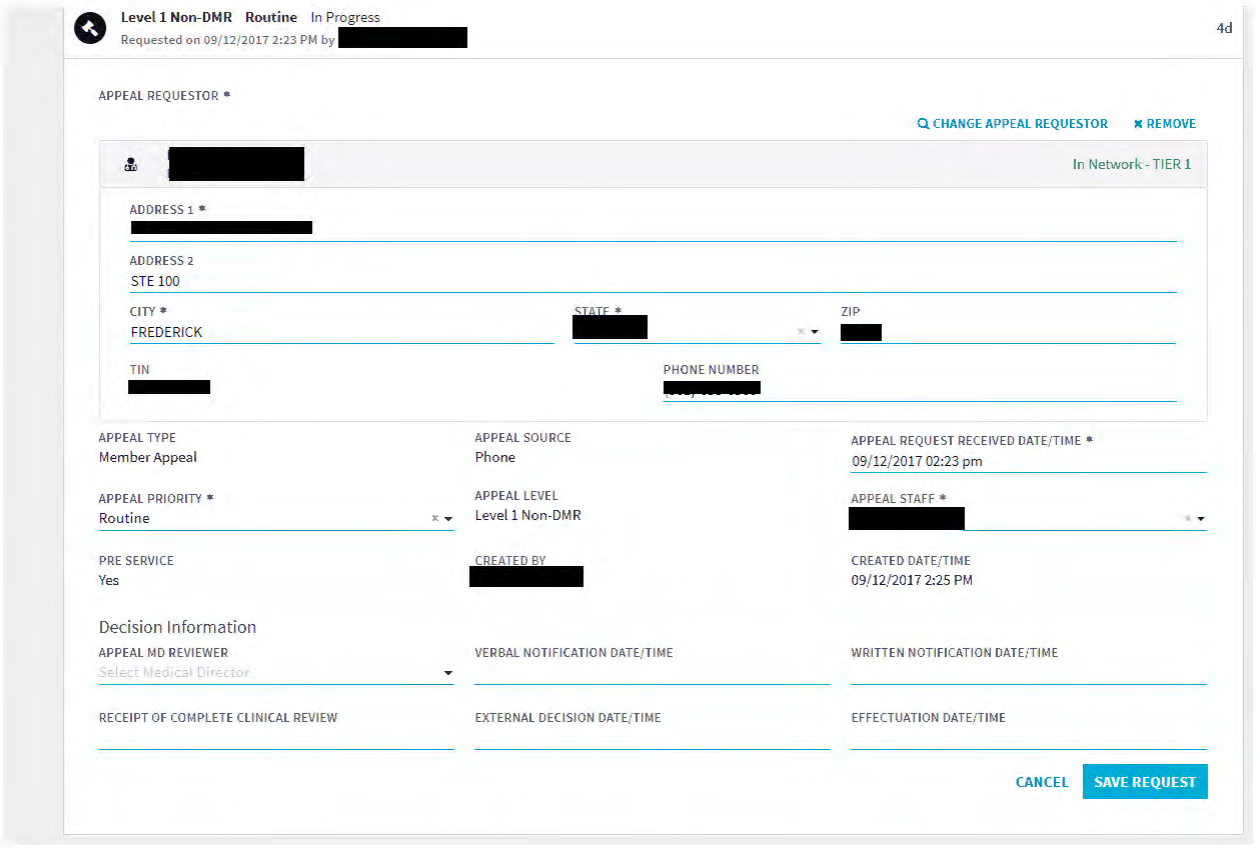




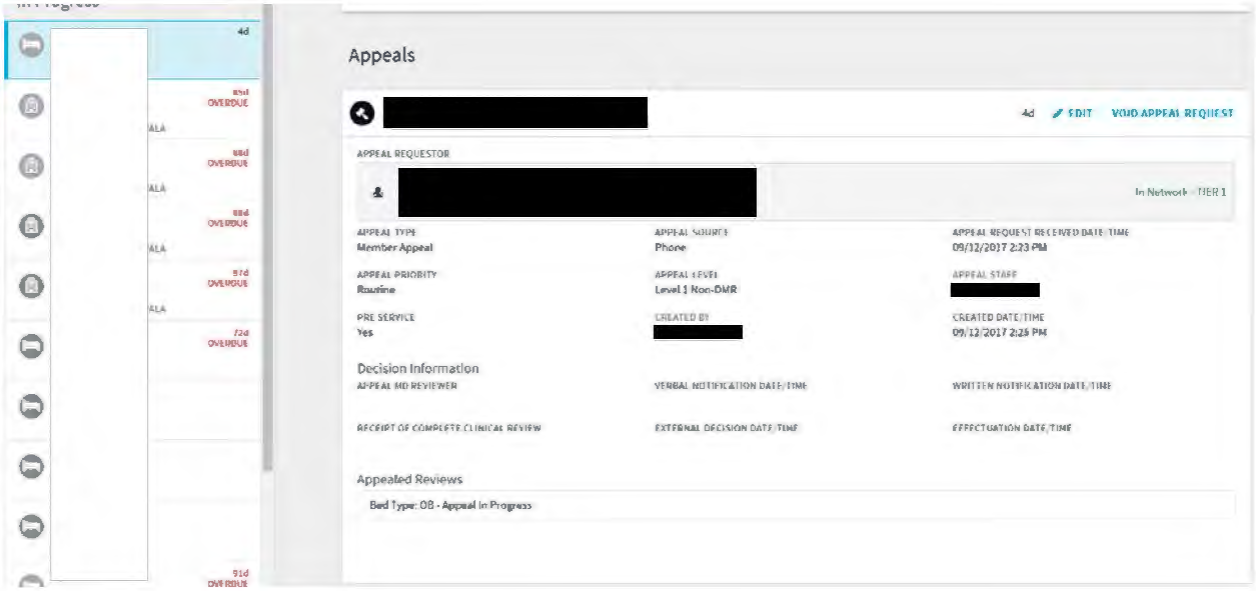


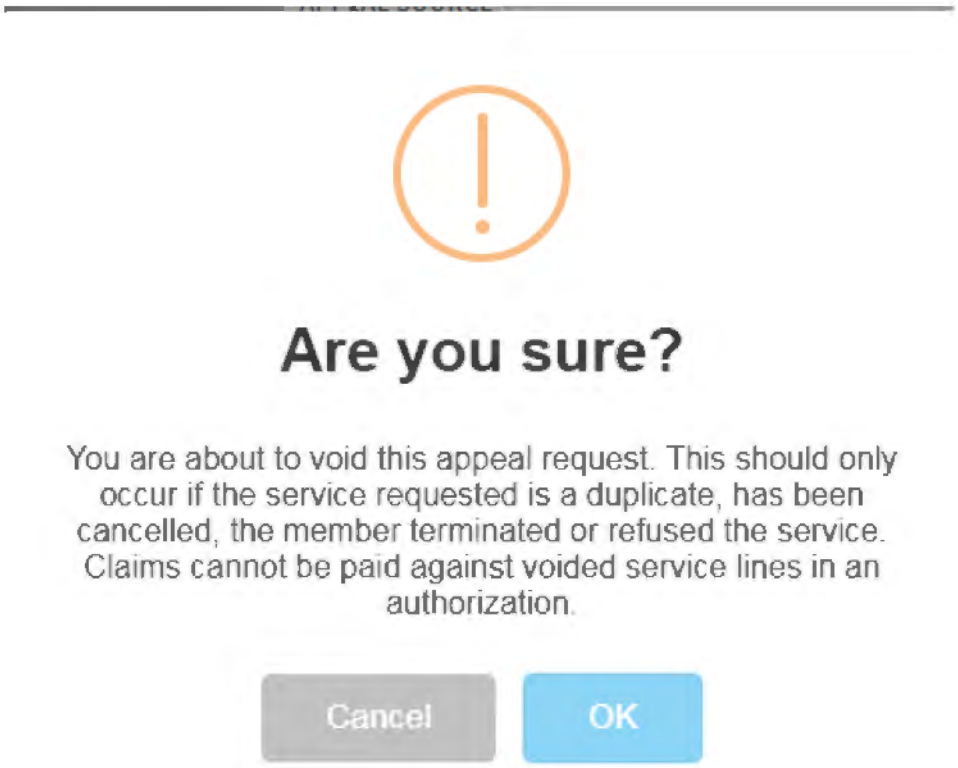
2. Edit an Appeal



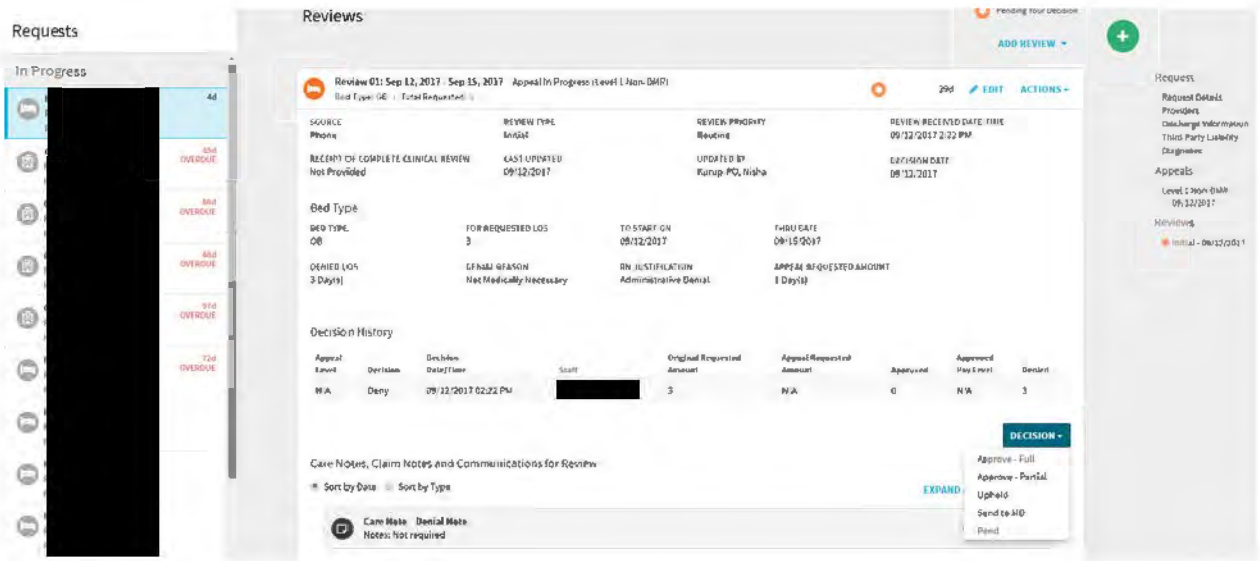


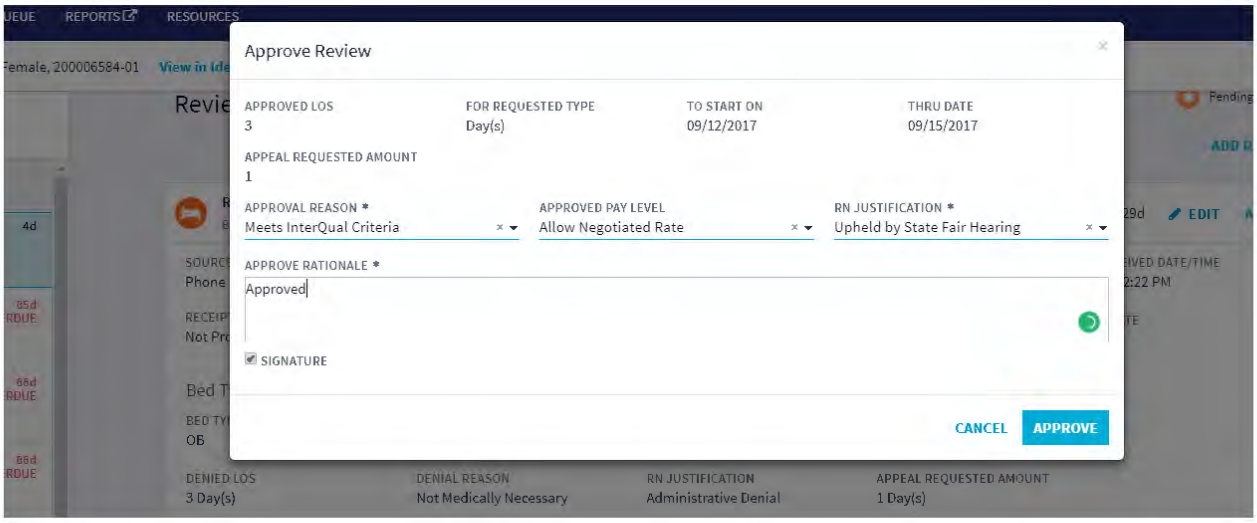
3. Void Appeal Request



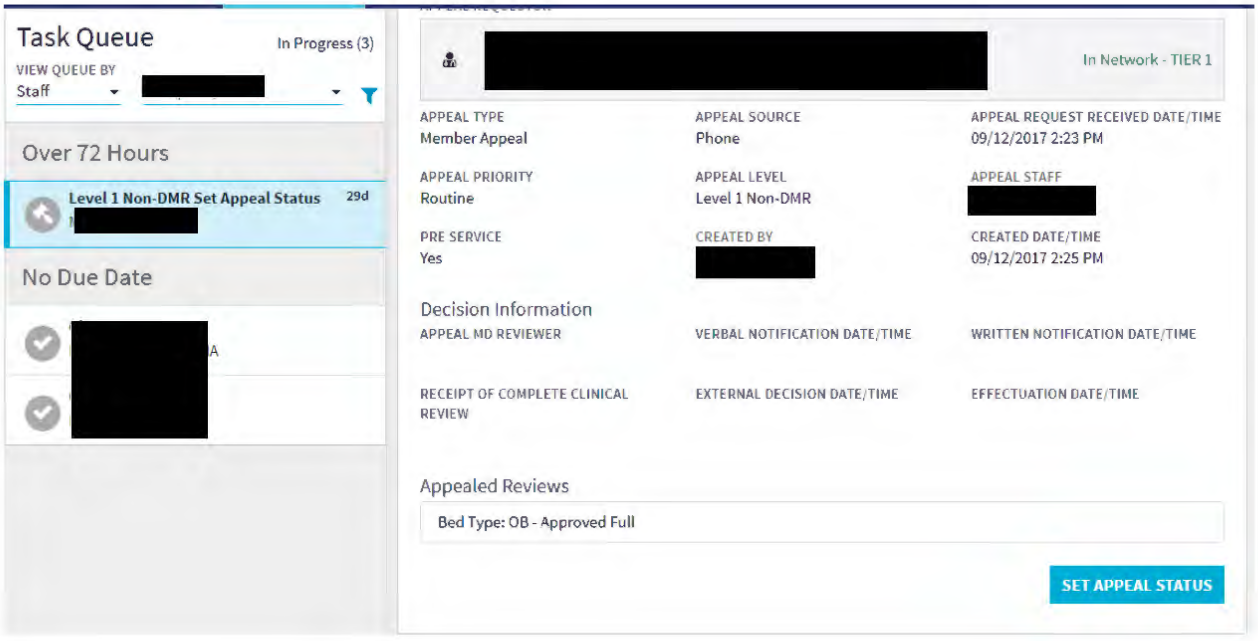


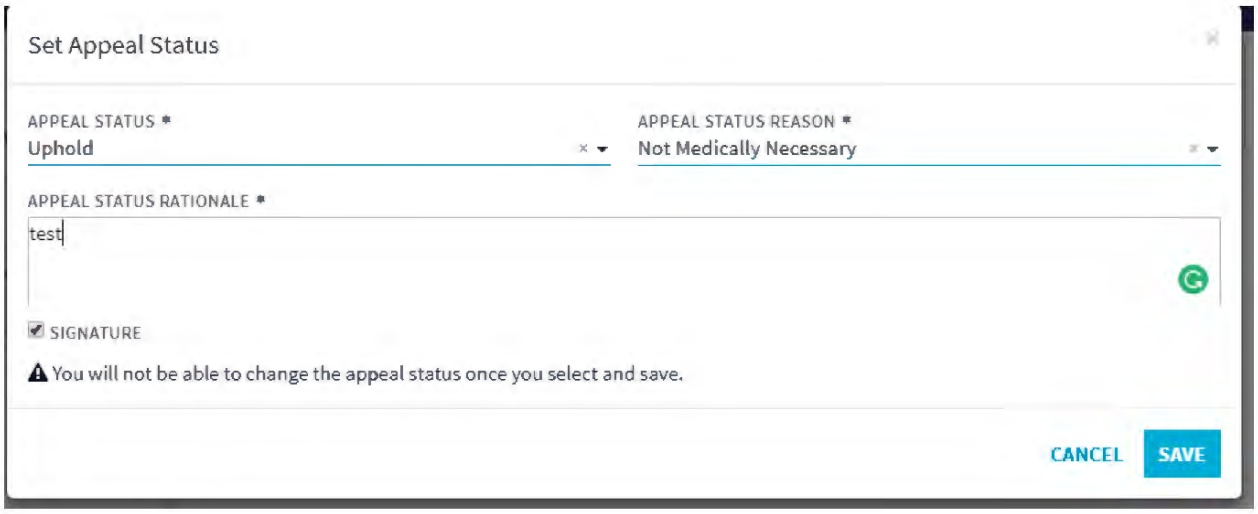
4. Make decision on an Appeal



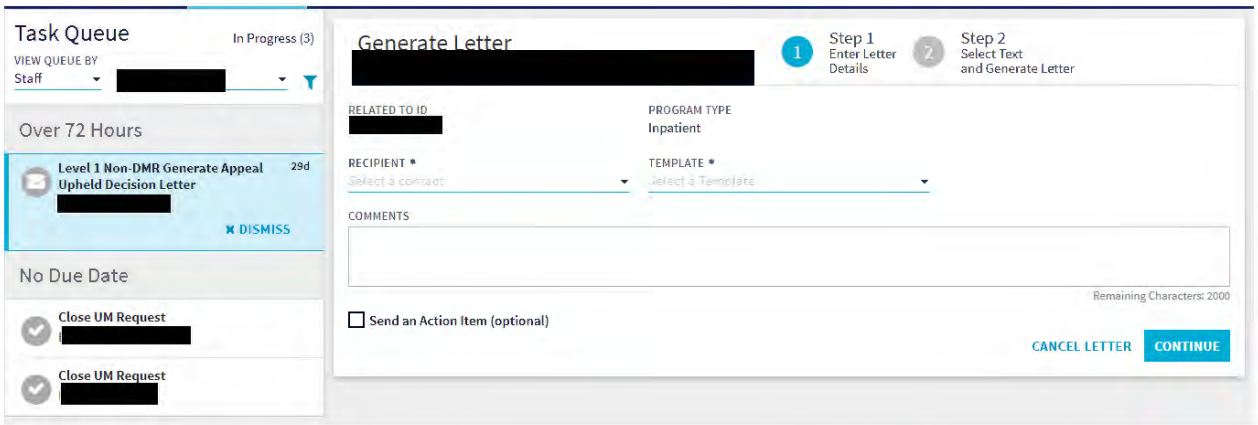


5. Set Appeal Status





6. Generate Appeal decision letter



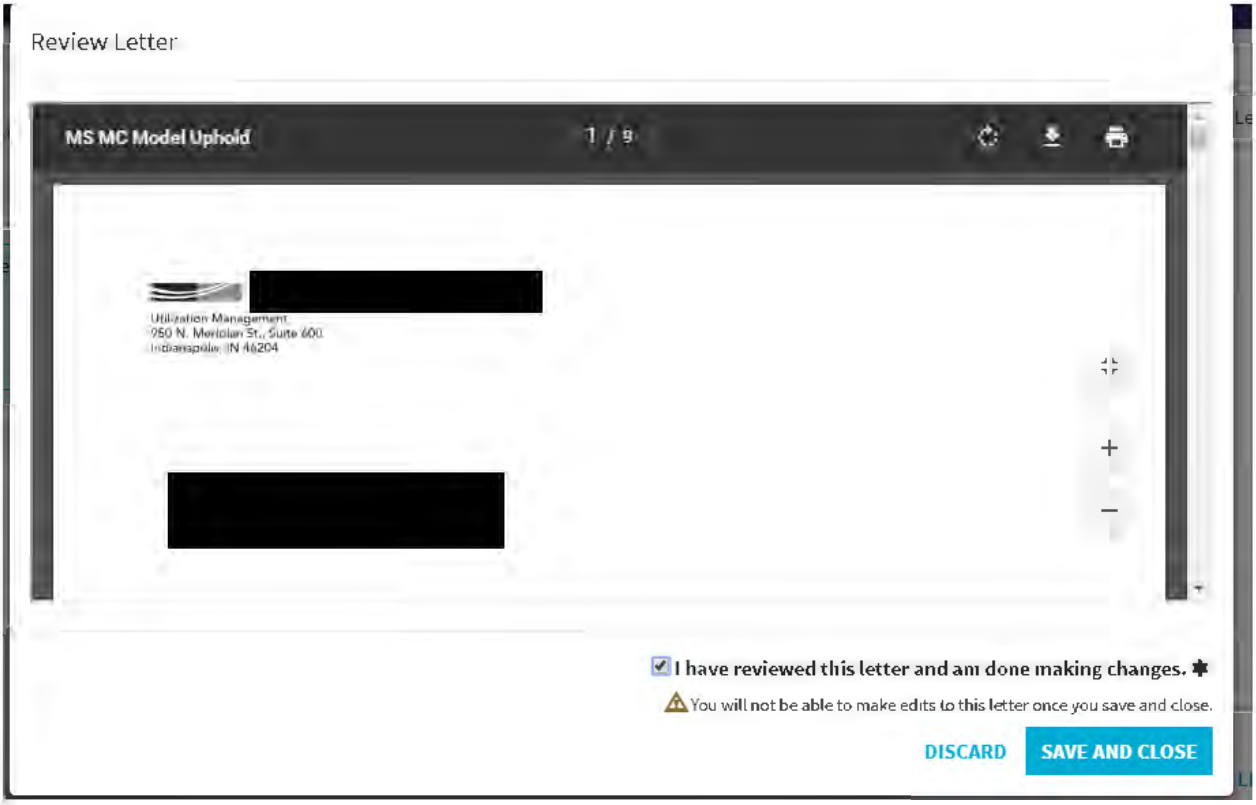

Review Letter
MS MC Model Uphold
1 / 9
[redacted]
Utilization Management
950 N. Meridian St., Suite 600
Indianapolis, IN 46204
[redacted]
I have reviewed this letter and am done making changes. *
You will not be able to make edits to this letter once you save and close.
DISCARD
SAVE AND CLOSE

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

INSTRUCTIONS:

Respondents should provide results for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) items/composites specified below for the 2017 survey for its adult and child populations for the respondent's three (3) largest Medicaid contracts (as measured by number of enrollees).

If the respondent does not have Medicaid CAHPS results for at least three (3) states, the respondent shall provide commercial CAHPS results for the respondent’s largest Contracts. If the respondent has Florida Medicaid CAHPS results, it shall include the Florida Medicaid experience as one (1) of three (3) states reported.

The CAHPS items/composites that the respondent is required to report on are located in the CAHPS Results tab.

Use the drop-down box to select the state for which you are reporting and enter the CAHPS results (to the hundredths place, or XX.XX) for that state's Medicaid population for the 2017 survey.

EXHIBIT A-4-a-4
SRC#14 - STANDARD CAHPS MEASUREMENT TOOL

RESPONDENT NAME: Lighthouse Health Plan, LLC

	State #1:	Kentucky	State #2:	Maryland	State #3:	Illinois
CAHPS Item/Composite	**2017 Adult**	**2017 Child**	**2017 Adult**	**2017 Child**	**2017 Adult**	**2017 Child**
Rating of Health Plan (the percentage of respondents rating their plan an 8, 9, or 10 out of 10)	**81.18**	**89.76**			**80.72**	**83.92**
Rating of Health Care (the percentage of respondents rating their health care an 8, 9, or 10 out of 10)	**76.15**	**85.82**			**75.32**	**81.86**
Getting Needed Care Composite (the percentage of respondents reporting it is usually or always easy to get needed care)	**83.73**	**88.17**			**80.02**	**80.03**
Getting Care Quickly Composite (the percentage of respondents reporting it is usually or always easy to get care quickly)	**82.99**	**91.59**			**82.44**	**82.41**
Getting Help from Customer Service Composite (the percentage of respondents reporting it is usually or always easy to get help needed from customer service)	**92.07**	**89.72**			**88.39**	**83.48**

Total Points	**14**

Attachment SRC 26-1: Subcontractor List

<table>
<tr><th>Subcontractor Name</th><th>Ownership</th><th>Services to be provided, including percentage of total</th><th>Qualifications</th><th>How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements</th><th>Service Level Agreements (SLAs) if any</th></tr>
<tr><td>Evolent Health LLC</td><td>Public</td><td>Evolent Health is Lighthouse Health Plan, LLC”s Medicaid managed care operations subcontractor. It will conduct benefit management; utilization management; quality management; eligibility; enrollment; member services; provider services; provider network management; population health management; information technology; claims; subrogation; third party liability; fraud, waste, and abuse activities; and subcontractor oversight. The services as described above</td><td>Evolent offers sophisticated health plan operations experience and Medicaid-specific expertise. Of the 2.5 million covered lives managed by Evolent systems and services, more than 1.4 million are Medicaid beneficiaries. Evolent supports its clients’ ability to provide community-based managed care services with local operational support, including local, state-based staff.

• Evolent provides Medicaid care management services for more than 300,000 Kentucky Medicaid beneficiaries on behalf of Passport Health Plan, the top ranked Medicaid Managed Care Plan in the Commonwealth of Kentucky according to</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance via the Board of Directors as well as the Delegation Oversight Committee (DOC). The DOC will manage and oversee all day to day delegated subcontractor oversight, which includes pre-delegation audits, annual oversight audits and intermittent focused audits. The Board of Directors will be the executive authority overseeing Evolent with assistance from the Chief Compliance Officer, the General Counsel, and the DOC. All delegation agreements will be in compliance with applicable regulatory and accreditation requirements and will include Medicare, state Medicaid and/or NCQA required terms as appropriate. Lighthouse Health Plan, LLC Health screens all delegates and vendors that provide services in support of Medicaid health plan clients against sanction databases, monthly, as detailed within the</td><td>
<table>
<tr><th>Service Level Number and Name</th><th>Measure Description</th><th>Frequency</th><th>Goal</th></tr>
<tr><td>AHCA and NCQA timeframe requirements</td><td>All turnaround times for Client's Medicaid product are completed within AHCA and NCQA requirements for:

1) Non-Emergent/Non-Urgent Requests
2) Emergent/Urgent Requests
3) Retrospective Review
4) Standard appeal (routine)
5) Expedited appeal (urgent)</td><td>Monthly</td><td>90%</td></tr>
<tr><td>Complex Care Assessment</td><td>Percent of new members (in existing lines of business) where a good faith effort has been made to reach members identified for Complex, Catastrophic and Condition Care management. A good faith effort shall be defined as:

A) Initial telephonic outreach made within 10 business days. If the member is not reached, a second telephonic outreach is attempted.

B) 14 business days following the initial call, a second call is made within 5 business days from the initial phone call, on a different day and time. If the member is not reached, an Unable To Contact letter requesting the member’s response is mailed.

C) If a member is reached following such attempts, an initial assessment and care plan will be completed within 14 business days."

If a new line of business is added, the Parties agree to develop timeframes depending on the size of the new population requiring contact.</td><td>Quarterly</td><td>80%</td></tr>
<tr><td>Worklist Stratification</td><td>Run Complex Care (Complex, Catastrophic and Condition) stratification profiling tool at least quarterly in order to include new members and generate worklists.</td><td>Quarterly</td><td>85%</td></tr>
<tr><td>Provider Notification of Member Engagement</td><td>Percent of attributed PCPs that receive a quarterly engagement summary report of all referred Covered Members.</td><td>Quarterly</td><td>80%</td></tr>
</table>
</td></tr>
</table>

<table>
<tr><th>Subcontractor Name</th><th>Ownership</th><th>Services to be provided, including percentage of total</th><th>Qualifications</th><th>How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements</th><th colspan="4">Service Level Agreements (SLAs) if any</th></tr>
<tr><td></td><td></td><td>will be delegated at 100%.</td><td>NCQA Health Plan rankings.
• In Texas, Evolent provides claims processing and customer service support as well as analytical insights and program design assistance to its client Driscoll Health Plan, a provider-sponsored Texas Medicaid health plan that serves 165,000 Medicaid and CHIP members.
• In Illinois, Evolent provides Medicaid health plan operations to its client, CountyCare, an Illinois Medicaid health plan with 140,000 members.
• Evolent provides care management services to 127,000</td><td>Exclusion List Checking Policy and Procedure. Lighthouse Health Plan, LLC has developed a strategy to monitor and audit its delegates to ensure that they are in compliance with all applicable laws and regulations, and to ensure they monitor and audit the compliance of the downstream entities with which they contract. Evolent will be accountable as any other subcontractors in being required to confirm to all ACHA requirements as well as financial audits performed by Lighthouse Health Plan, LLC. In conducting the monitoring and audits, Lighthouse Health Plan, LLC Health uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance.</td><td colspan="4"><table>
<tr><td>Transitions Care Outreach</td><td>Percent of referred (based on predictive model) Covered members with attempted outreach within 5 business days of notification of discharge.</td><td>Monthly</td><td>75%</td></tr>
<tr><td>Member Outreach</td><td>Urgent (Referral to Program an Action Item: “Need Today”); attempted member outreach is within 24 hours or one business day (Medicaid only);

Non-urgent (Referral to Program an Action Item: “High, Medium or Low”), attempted member outreach is within 5 business days (Medicaid only).</td><td>Monthly</td><td>85%</td></tr>
<tr><td>Systems Platform (Identifi Availability) Normal Business Hours</td><td>(Scheduled Available Minutes – Unavailable Minutes) / Scheduled Available Minutes.</td><td>Monthly</td><td>>95%</td></tr>
<tr><td>Systems Platform (Identifi Availability) Maintenance Window Hours</td><td>(Scheduled Available Minutes – Unavailable Minutes) / Scheduled Available Minutes.</td><td>Monthly</td><td>>90%</td></tr>
<tr><td>Customer Service: Average Speed to Answer</td><td>Percent of inbound calls answered within contractually required timeframe from when inbound call is received by representative.</td><td>Monthly</td><td>>/=80%</td></tr>
<tr><td>Customer Service: Abandonment</td><td>Percent of inbound calls abandoned (caller hangs up before call agent answers) in accordance with AHCA contractually required standards.</td><td>Monthly</td><td></=5%</td></tr>
<tr><td>Grievances: Response Time</td><td>Percent of member grievances responded to within 30 calendar days of receipt of grievance from Client.</td><td>Quarterly</td><td>90%</td></tr>
</table></td></tr>
</table>

<table>
<tr><th>Subcontractor Name</th><th>Ownership</th><th>Services to be provided, including percentage of total</th><th>Qualifications</th><th>How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements</th><th colspan="4">Service Level Agreements (SLAs) if any</th></tr>
<tr><td></td><td></td><td></td><td>Washington, D.C. Medicaid and Maryland Medicaid beneficiaries on behalf of its client MedStar Health.
Evolent Health has NCQA accreditation in Utilization Management and Disease Management (Asthma, COPD, CAD, Diabetes, Heart Failure), and is in the process of applying for Case Management accreditation. Additionally, Evolent supported accreditation of 12 health systems and six provider-sponsored health plans.</td><td></td><td colspan="4"><table>
<tr><td>Enrollment</td><td>Adheres to all NCQA guidelines, including turnarounds times for applicable Provider Enrollment activities (NCQA).</td><td>Quarterly</td><td>95%</td></tr>
<tr><td>Enrollment</td><td>Adheres to applicable state requirements for turnaround times for Provider Enrollment activities (State).</td><td>Quarterly</td><td>95%</td></tr>
<tr><td>Enrollment</td><td>Responds to inquiries no later than two (2) business day for key provider inquiries as identified.</td><td>Monthly</td><td>90%</td></tr>
<tr><td>Encounters</td><td>Achieves a monthly encounter acceptance rate.</td><td>Monthly</td><td>95%</td></tr>
<tr><td>Reimbursement</td><td>Responds to requests for provider claims and payment language updates within 14 calendar days of receipt.</td><td>Quarterly</td><td>90%</td></tr>
<tr><td>Claims Projects</td><td>Reprocesses all claims, including those initiated by Providers or Provider Relations Representatives, within 45 days of management approval.</td><td>Quarterly</td><td>90%</td></tr>
</table></td></tr>
</table>

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any
One Call Care Management	Private	Lighthouse Health Plan, LLC will contract with One Call to provide non-emergent medical transportation services (NEMT). One Call will conduct benefit management; utilization management; quality management; member services; provider services; provider network management; claims payment and appeals; fraud, waste, and abuse activities; complaints and grievances resolution. The services as described above will be delegated at 100% for all NEMT services.	Founded in 1985 One Call is just that a transportation vendor who can service all members in Florida with “one call” easing member and Lighthouse Health Plan, LLC frustration with the Transportation process. With One Call Care Transport care managers, and members can connect easily and reliably to national, high-quality, credentialed transportation services. One Call is headquartered in Jacksonville, FL.	Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all	Additional SLAs between One Call and Lighthouse Health Plan, LLC will be mutually agreed to by the end of Q1 2018.

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any
				subcontractors as outlined in the Delegation Oversight Policy and Procedure. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance. This allows the Lighthouse Health Plan, LLC delegation oversight activities to include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following: 1. Baseline Risk Assessment and updates to the Risk Assessment. 2. Development of an annual Monitoring and Audit Work Plan that is updated as additional areas of risk are identified. This Audit Work Plan includes an annual delegation review and compliance review of delegates.	

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any
				3. Routine ongoing monitoring of compliance operational risk areas. 4. Focused audits based on results of the Risk Assessment. If the DOC were to find during their ongoing oversight activities any non-compliance with the subcontractor's agreement with Lighthouse Health Plan, LLC or with any state, federal, or accreditation requirements the Lighthouse Health Plan, LLC shall follow our Corrective Action Plan Policy and Procedure to ensure correction or penalty up to and including termination take place. The vendor management team will monthly review all reports submitted by subcontractor to ensure they are meeting service level requirements and supporting Lighthouse Health Plan, LLC's goals. The vendor management team will meet with the subcontractor and the DOC no less than monthly to review all	

Attachment SRC 26-1: Subcontractor List

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any
				reports as required by the agreement. All subcontractor agreements will be in compliance with applicable regulatory and accreditation requirements and will include Medicare, state Medicaid and/or NCQA required terms as appropriate. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance.	

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any
Avesis	Private	Lighthouse Health Plan, LLC will contract with Avesis to provide dental, routine vision, and hearing benefit management. Avesis will conduct benefit management; utilization management; case management; quality management; member services; provider services; provider network management; claims payment and appeals; fraud, waste, and abuse activities; complaints and grievances resolution. The services as described above will be delegated at 100% for all Dental, Hearing,	Founded in 1978, Avēsis Third Party Administrators, Inc., now a wholly owned subsidiary of The Guardian Life Insurance Company of America, is a licensed third party administrator providing all of the administrative services including but not limited to provider network management; credentialing; claims processing, adjudication and payment; utilization management; provider and member complaints, appeals and grievances support; quality assurance; customer service; reporting and implementation and account management for the managed dental and eye care programs. Since 2006, Avesis has focused on providing essential benefits to Medicaid Members. Today, Avesis' government-sponsored essential benefit programs cover over 7.5 million members throughout the country.	Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor's as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all	Lighthouse Health Plan, LLC and Avesis will have SLAs agreed upon by the end of Q1 2018.

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any
		and Routine Vision services.		subcontractors as outlined in the Delegation Oversight Policy and Procedure. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance. This allows the Lighthouse Health Plan, LLC delegation oversight activities to include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following: 1. Baseline Risk Assessment and updates to the Risk Assessment. 2. Development of an annual Monitoring and Audit Work Plan that is updated as additional areas of risk are identified. This Audit Work Plan includes an annual delegation review and compliance review of delegates.	

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				3. Routine ongoing monitoring of compliance operational risk areas. 4. Focused audits based on results of the Risk Assessment. If the DOC were to find during their ongoing oversight activities any non-compliance with the subcontractor's agreement with Lighthouse Health Plan, LLC or with any state, federal, or accreditation requirements the Lighthouse Health Plan, LLC shall follow our Corrective Action Plan Policy and Procedure to ensure correction or penalty up to and including termination take place. The vendor management team will monthly review all reports submitted by subcontractor to ensure they are meeting service level requirements and supporting Lighthouse Health Plan, LLC's goals. The vendor management team will meet with the subcontractor and the DOC no less than monthly to review all	

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HMS	Private	Lighthouse Health Plan, LLC contracts with HMS to provide cost avoidance and COB recoveries. The percentage of cost avoidance and COB recovery services provided will be 100% of initiatives provided.	HMS has provided COB for Medicaid MCOs since 1985 and it is their core competency. Their IT infrastructure and data mining algorithms were custom-built for Medicaid COB and payers. They include a balanced approach to cost avoidance and recovery. They continually receive refreshed coverage information from more than 1,000 plans, including major medical, dental, prescription drug, and vision payers. The information is consistently verified for accuracy. HMS can pursue recovery for any healthcare claim that was paid inappropriately. They submit Medicaid COB claims directly to insurers, third party administrators, pharmacy benefit managers, large employers, and other claims processing entities.	Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor's as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all	Lighthouse Health Plan, LLC and HMS will have SLAs agreed upon by the end of Q1 2018.

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				processing system to reflect other coverage to appropriately ensure coordination of benefits to ensure Medicaid is the payer of last resort in accordance with federal regulations which prohibit cost avoidance due to TPL in limited circumstances. Evolent Health will provide monthly claim data to HMS for submission to third parties. Evolent will track the COB recoveries for financial as well as regulatory reporting. The recoveries will also be sent to eligibility for additional comparison to the members to ensure they have been set up and reflect other coverage for cost avoidance.	

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<tr><td>CVS/Caremark</td><td>Public</td><td>Lighthouse Health Plan, LLC will contract with CVS to provide pharmacy benefit management. CVS shall provide provider services; provider network management; claims payment and appeals; fraud, waste, and abuse activities; complaints and grievances resolution. The services as described above will be delegated at 100% for all pharmacy services.</td><td>CVS is an URAC and NCQA accredited health care organization providing support to managed Medicaid clients since 1988. They support nearly 21 million managed Medicaid plan members in 33 states. The member populations include individuals who are Aged, Blind and Disabled, require Temporary Aid to Needy Families for adults, pregnant women and those under the age of 21; children eligible for coverage through the Children’s Health Insurance Program; individuals and families that qualify for Essential or Basic Health Plans; members with special needs or behavioral health conditions and those eligible for both Medicaid and Medicare. CVS/pharmacy was the first national pharmacy to receive the Community Pharmacy Accreditation. Their Medicaid specific formulary and clinical programs are geared toward reducing fraud waste and abuse, improving quality, while managing cost and</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>Lighthouse Health Plan, LLC and CVS/Caremark will structure the following SLAs to meet all Florida State Medicaid service level requirements by the end of Q1 2018.
<table>
<tr><th>Guarantee Name</th><th>Guarantee</th></tr>
<tr><td>POS Availability</td><td>Greater Than or Equal to 99%</td></tr>
<tr><td>Electronic Claims Processing Accuracy (Client)</td><td>Greater Than or Equal to 99%</td></tr>
<tr><td>Retail Network Pharmacy Access</td><td>Meet all network access requirements 100% of time</td></tr>
<tr><td>ID Card-Maintenance</td><td>Greater Than or Equal To 98% within 5 Business Days</td></tr>
<tr><td>Eligibility Updates</td><td>Equal to 100% within 1 Day</td></tr>
<tr><td>Written Inquiry TAT</td><td>Greater Than or Equal To 97% within 5 Business Days</td></tr>
<tr><td>Paper Claims Average Turnaround Time</td><td>Less than or Equal to 90% within10 Business Days</td></tr>
<tr><td>Plan Administration Accuracy</td><td>Equal to 100%</td></tr>
<tr><td>Formulary Changes Test Plans</td><td>Equal to 100%</td></tr>
<tr><td>Formulary Accuracy</td><td>Equal to 100%</td></tr>
<tr><td>Plan Administration Turnaround Time</td><td>Equal to 100% within 10 days</td></tr>
<tr><td>Formulary Administration</td><td>Equal to 99% within 7 business days</td></tr>
<tr><td>Account Management Satisfaction</td><td>Greater Than or Equal to rating of 3 on 5-point scale</td></tr>
<tr><td>Action Log</td><td>Greater Than or Equal to 99%</td></tr>
<tr><td>Quarterly Meetings</td><td>Equal to 100%</td></tr>
<tr><td>Non-Specialty Meeting Materials</td><td>Equal to 100% within 5 Business Days prior</td></tr>
<tr><td>Specialty Meeting Materials</td><td>Equal to 100% within 5 Business Days prior</td></tr>
<tr><td>Specialty Meeting Materials</td><td>Equal to 100% within 7 Calendar Days prior</td></tr>
<tr><td>Modeling/Forecasting - Plan Design</td><td>Equal to 100% within 10 Business Days</td></tr>
<tr><td>Modeling/Forecasting - Formulary Rebate</td><td>Equal to 100% within 10 Business Days</td></tr>
<tr><td>Member Satisfaction Survey</td><td>Greater Than or Equal to 90%</td></tr>
<tr><td>Average Speed of Answer</td><td>Less than or Equal to 30 Seconds</td></tr>
<tr><td>First Call Resolution</td><td>Greater Than or Equal to 90%</td></tr>
<tr><td>Telephone Average Live Voice Answer - Specialty</td><td>Less than or Equal to 30 Seconds</td></tr>
<tr><td>Call Blockage</td><td>Less than or Equal to 1%</td></tr>
<tr><td>Telephone Abandonment Rate</td><td>Less than or Equal to 4%</td></tr>
<tr><td>Telephone Abandonment Rate - Specialty</td><td>Less than or Equal to 3%</td></tr>
</table></td></tr>
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<tr><td>Mail Service Accuracy - Std</td><td>Greater Than or Equal to 99.99%</td></tr>
<tr><td>Mail Service Accuracy - Specialty</td><td>Greater Than or Equal to 99.99%</td></tr>
<tr><td>Mail Turnaround Time - Clean</td><td>Less than or Equal to 2 Business Days</td></tr>
<tr><td>Mail Turnaround Time - Non Clean</td><td>Less than or Equal to 5 Business Days</td></tr>
<tr><td>Specialty On-Time Delivery</td><td>Greater Than or Equal to 98%</td></tr>
<tr><td>Management Report Timeliness-Standard</td><td>Equal to 100% within 15 Calendar Days</td></tr>
<tr><td>Reporting for Specialty Pharmacy</td><td>Equal to 100%</td></tr>
<tr><td>Materials Distribution</td><td>Equal to 100%</td></tr>
<tr><td>Account Management Responsiveness</td><td>Equal to 100% within 2 Business Days</td></tr>
<tr><td>Encounter Data Timeliness</td><td>Equal to 100%</td></tr>
<tr><td>Encounters - Error Corrections</td><td>Less than or Equal to 30 Calendar Days</td></tr>
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<tr><td>CVS Pharmacy Inc., d/b/a OTC Health Solutions (OTCHS)</td><td>Public</td><td>Lighthouse Health Plan, LLC Assurance will contract with CVS/Caremark to provide Over The Counter medical supplies benefit management to include network composition, member services, member ordering and processing, and complaints and grievance resolution. The percentage of OTC services provided will be 100% of pharmacy services.</td><td>CVS is an URAC and NCQA accredited health care organization providing support to managed Medicaid clients since 1988. They support nearly 21 million managed Medicaid plan members in 33 states. The member populations include individuals who are Aged, Blind and Disabled, require Temporary Aid to Needy Families for adults, pregnant women and those under the age of 21; children eligible for coverage through the Children’s Health Insurance Program; individuals and families that qualify for Essential or Basic Health Plans; members with special needs or behavioral health conditions and those eligible for both Medicaid and Medicare. CVS/pharmacy was the first national pharmacy to receive the Community Pharmacy Accreditation. Their Medicaid specific formulary and clinical programs are geared toward reducing fraud waste and abuse, improving quality, while managing cost and</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><th>Performance Category</th><th>Performance Criteria</th><th>Performance Standard</th><th>Measures</th><th>Measurement Frequency</th><th>Penalties for Non-Compliance</th></tr>
<tr><td>Member Phone Service Level</td><td>80% of all Member Services calls shall be answered in 30 seconds or less.</td><td>The answering criteria shall be applied to all calls. This measurement excludes IVR calls and calls abandoned by the member in less than 30 seconds.</td><td>OTCHS shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>If in any given quarter OTCHS does not meet call center metrics two (2) out of three (3) months OTCHS shall apply an addition 2% discount to all orders placed those two months. The penalty applies if there are more than 100 calls during the month measured.</td></tr>
<tr><td>Telephone Abandon Rate</td><td>If five(5) % or more of all incoming calls to OTCHS are abandoned prior to being picked up by OTCHS.</td><td>The telephone abandon rate shall be applied to all incoming calls.</td><td>OTCHS shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>If in any given quarter OTCHS does not meet call center metrics two (2) out of three (3) months OTCHS shall apply an addition 2% discount to all orders placed those two months. The penalty applies</td></tr>
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<tr><td>Phone Abandonment Rate</td><td>All inbound calls to OTCHS shall be answered in two (2) minutes or less</td><td>All calls are measured.</td><td>OTCHS shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>If in any given quarter OTCHS does not meet call center metrics two (2) out of three (3) months OTCHS shall apply an addition 2% discount to all orders placed those two months. The penalty applies if there are more than 100 calls during the month measured.</td></tr>
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<tr><td>Aperture</td><td>Private</td><td>Lighthouse Health Plan, LLC will contract with Aperture to provide primary source credentialing verification (CVO) services. The percentage of CVO services provided will be 100% of initiative services.</td><td>Aperture Credentialing, Inc. provides credential services for healthcare providers. The company’s services include application gathering, primary source verification, credentialing, review committee, reporting and delivery, and ongoing sanctions monitoring. It manages various types of providers various types of provider networks, such as payers, providers, and government. The company was incorporated in 1996. Aperture is URAC and NCQA accredited.</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><th>Performance Category</th><th>Performance Criteria</th><th>Performance Standard</th><th>Measures</th><th>Measurement Frequency</th><th>Penalties for Non-Compliance</th></tr>
<tr><td>Non-Responder Rate</td><td>% of total practioner files sent to Customer with non-responder status PSV004</td><td>10% or Less</td><td>Total number of practioner files with a PSV004 status/total number of files sent.</td><td>Monthly</td><td>For those files which exceed the standard, Aperture shall provide a credit of 10% of the PSV004 fee.</td></tr>
<tr><td>Incomplete Profile</td><td>% of total practioner and facility files sent to Customer sent with a PSV005 (incomplete status) status</td><td>10% of Less</td><td>Total number of practioner files with a PSV004 status/total number of files sent.</td><td>Monthly</td><td>For those files which exceed the standard, Aperture shall provide a credit of 20% of the PSV005 fee.</td></tr>
<tr><td>Processing Time</td><td>% of total completed practioner files sent to Customer within thirty (30) days (for initial credentialing only)</td><td>97% or greater within thirty (30) calendar days, 100% within forty five (45) calendar days</td><td>Measured from date completed application is received by Aperture.</td><td>Monthly</td><td>For those files which fail to meet the standard, Aperture shall provide a credit of 50% of the completed file fee.</td></tr>
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<tr><td>Health Dialog</td><td>Public</td><td>Lighthouse Health Plan, LLC will contract with Health Dialog to provide nurseline services 24/7/365 for member seeking non-emergency nurse advice. The percentage of nurseline services provided will be 100% of the initiative services.</td><td>Health Dialog, part of the Rite Aid family of healthcare companies, provides total population health services to risk bearing organizations such as health plans, providers, and self-insured employers. We help our clients improve quality of care and reduce healthcare costs while empowering their individual members to make informed health and wellness decisions. Our integrated, multi-channel health coaching services—including member engagement programs, multi-channel health coaching, and shared decision making tools—are powered by best-in class analytics and administered by our highly-trained healthcare professionals.</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><th>Service Level Name</th><th>Measurement Calculation</th><th>Service Level Metric</th></tr>
<tr><td>Average Speed of Answer</td><td>Specialty Customer Service – Average Speed of Answer. Calls to Health Dialog’s toll-free customer service lines shall be answered within an average time of thirty (30) seconds or less. This measurement excludes calls routed to an IVR. The guarantee shall be reported and measured monthly on Health Dialog’s book of business. Penalty: Should Health Dialog fail to meet the above stated guarantee, Health Dialog shall credit Client 3% of the PMPM fee.</td><td>ASA 30 seconds</td></tr>
<tr><td>Call Blockage Rate</td><td>Health Dialog will guarantee a blockage rate of 0.5% or less. Penalty: Should Health Dialog fail to meet the above stated guarantee, Health Dialog shall credit Client $3,000.</td><td>0.5%</td></tr>
<tr><td>Percent of Calls Abandoned</td><td>Call Abandonment. Health Dialog guarantees calls to Health Dialog’s Nurse Line toll-free customer services lines shall have an abandonment rate of 3% or less. Measurement excludes calls abandoned by members within the first thirty (30) seconds. The guarantee shall be reported and measured monthly on Health Dialog’s book of business. Penalty: Should Health Dialog fail to meet the above stated guarantee, Health Dialog shall credit Client $3,000.</td><td>3% of incoming calls</td></tr>
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				3. Routine ongoing monitoring of compliance operational risk areas. 4. Focused audits based on results of the Risk Assessment. If the DOC were to find during their ongoing oversight activities any non-compliance with the subcontractor's agreement with Lighthouse Health Plan, LLC or with any state, federal, or accreditation requirements the Lighthouse Health Plan, LLC shall follow our Corrective Action Plan Policy and Procedure to ensure correction or penalty up to and including termination take place. The vendor management team will monthly review all reports submitted by subcontractor to ensure they are meeting service level requirements and supporting Lighthouse Health Plan, LLC's goals. The vendor management team will meet with the subcontractor and the DOC no less than monthly to review all	

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<tr><td>MedSolutions, Inc. d/b/a eviCore healthcare (eviCore)</td><td>Private</td><td>Lighthouse Health Plan, LLC will contract with Evicore to provide radiology benefit management. Evicore shall conduct non-emergency radiology utilization management review for all members, provider and member customer service, and complaint and grievance resolution. The percentage of radiology benefit management services provided will be 100% of the initiative services.</td><td>Founded in 1994, eviCore healthcare provides evidence-based healthcare solutions for managed care organizations, self-insured entities, and risk-bearing provider organizations. It offers various specialty benefit management programs in the areas of radiology, musculoskeletal and therapy, cardiology, radiation therapy, medical oncology, sleep management, and laboratory management. Currently, eviCore manages nearly 19M unique Medicaid lives across all of their solutions. eviCore’s approach is to have a seamless integration and implementation process. As an illustration, in 2008, eviCore implemented a Radiology solution with a Medicaid client without a single provider complaint, and not one provider left the client’s program as a result of the implementation.</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><td>Telephone Average Speed of Answer (ASA)</td><td>All Member and Provider Services calls shall be answered in 30 seconds or less.</td><td>The answering criteria shall be applied to all calls Monday-Friday during normal business hours</td><td>Evicore shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>If the ASA is 30 seconds or more for three consecutive moths a penalty of $2,000 a month shall be paid by Evicore until ASA is less than 30 seconds.</td></tr>
<tr><td>Telephone Abandon Rate</td><td>If seven (7) % or more of all incoming calls to Evicore are abandoned prior to being picked up by eviCore.</td><td>The telephone abandon rate shall be applied to all incoming calls.</td><td>Evicore shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>If the abandon rate is more than 7% for three consecutive moths a penalty of $2,000 a month shall be paid by Evicore until the abandon rate is less than 30 seconds.</td></tr>
<tr><td>Authorization Request Turn Around Time</td><td>All non-emergency CUM decisions shall be rendered within two business days from receipt of</td><td>90% of all non-emergency decisions shall be made upon receipt of a complete request.</td><td>Evicore shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>If the average decision turn around time is more than two days for three consecutive moths a</td></tr>
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<tr><td></td><td></td><td></td><td></td><td>subcontractors as outlined in the Delegation Oversight Policy and Procedure. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance. This allows the Lighthouse Health Plan, LLC delegation oversight activities to include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following:
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2. Development of an annual Monitoring and Audit Work Plan that is updated as additional areas of risk are identified. This Audit Work Plan includes an annual delegation review and compliance review of delegates.</td><td colspan="6"><table>
<tr><td></td><td>sufficient clinical records to make a decision.</td><td></td><td></td><td></td><td>penalty of $2,000 a month shall be paid by Evicore until the abandon rate is less than 30 seconds.</td></tr>
<tr><td>Blocked Calls</td><td>The number of incoming calls blocked rate shall not exceed zero (0) % for three consecutive months</td><td>Number of monthly blocked calls.</td><td>Evicore shall report metric to Lighthouse Health Plan, LLC monthly.</td><td>Monthly</td><td>The following month(s) service fees shall be reduced by $2,000 until the blocked rate falls below zero (0) %.</td></tr>
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Lakeview Center, Inc. d/b/a Access	Private	Lighthouse Health Plan, LLC will contract with Access to provide dental, routine vision, and hearing benefit management. Access will conduct benefit management; utilization management; case management; quality management; member services; provider services; provider network management; claims payment and appeals; fraud, waste, and abuse activities; complaints and grievances resolution. Member Services shall include a crisis line staffed 24/7/365 by a qualified	Founded in 1996 and based in Pensacola, FL Lakeview Center, Inc. d/b/a Access is fully owned by Baptist Health Care. The programs and services offered by Lakeview Center's Behavioral Health division are designed to: Support the recovery, health and well-being of the persons or families we serve, Enhance quality of life for our clients and the community, Reduce symptoms or needs and build resilience, and Help the people we serve return to and participate in the life of the community. Provided by skilled professionals, their Behavioral Health Services are geared toward recovery and based on methods that research has shown to be most effective. Our emphasis is on achieving positive clinical outcomes and excellent customer satisfaction. We have multiple service lines, each providing a progression of care that allows us to meet our clients' changing needs as they move toward	Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor's as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all	SLAs have not been mutually agreed to by Access and Lighthouse Health Plan, LLC at this time; however they will be mutually agreed to by the end of Q1 2018.

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		clinician. The services as described above will be delegated at 100% for all Behavioral Health services.	recovery. Lakeview Center's services are designed to promote self-sufficiency, recovery and overall wellness for people with serious and persistent mental illness. We believe people have a right to be in charge of their own lives, and that staff and clinicians must be responsive to our clients' needs, on the clients' terms, and in ways that are unique to each client's individual personality and preferences.	subcontractors as outlined in the Delegation Oversight Policy and Procedure. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance. This allows the Lighthouse Health Plan, LLC delegation oversight activities to include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following: 1. Baseline Risk Assessment and updates to the Risk Assessment. 2. Development of an annual Monitoring and Audit Work Plan that is updated as additional areas of risk are identified. This Audit Work Plan includes an annual delegation review and compliance review of delegates.	

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<tr><td>Clarity Software Solutions Inc.</td><td>Private</td><td>Lighthouse Health Plan, LLC contracts with Clarity Software Solutions for member fulfillment, EOBs and Invoicing services. The percentage of these services provided will be 100%.</td><td>EOB’s - Clarity has a comprehensive solution to produce Explanation of Benefits (EOBs) for health plans that makes administering communications more efficient. They can create plan and member specific. EOB templates and their online interface allows us to archive previous versions and create new designs.

Invoices - Clarity has a comprehensive solution to produce Invoices for health plans that helps develop brand recognition, promote products and services, and convey a commitment to member service. They can customize invoices and messaging by lines of business.

ID Cards & Welcome Packets- Clarity has a comprehensive solution to produce ID Cards and new member Welcome Letters to support new enrollment members and</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><td>ID Card Printing</td><td>Must send ID Cards within two (2) business days upon receipt of Lighthouse Health Plan, LLC membership file.</td><td>The criteria shall be applied to all ID cards printed for the health plan.</td><td>Clarity shall report the printing times annually for penalty.</td><td>Clarity shall send health plan reports monthly.</td><td>First Occurrence 3% Second Occurrence 5% Third Occurrence 7% Fourth and Subsequent Occurrences 10%</td></tr>
<tr><td>Member Guide Printing</td><td>Must send Member Guides within three (3) business days upon receipt of Lighthouse Health Plan, LLC membership file.</td><td>The criteria shall be applied to all Member Guides printed for the health plan.</td><td>Clarity shall report the printing times annually for penalty.</td><td>Clarity shall send health plan reports monthly.</td><td>First Occurrence 3% Second Occurrence 5% Third Occurrence 7% Fourth and Subsequent Occurrences 10%</td></tr>
<tr><td>EOB Printing</td><td>Must send EOBs within three (3) business days upon receipt of Lighthouse Health Plan, LLC EOB file.</td><td>The criteria shall be applied to all EOBs printed for the health plan.</td><td>Clarity shall report the printing times annually for penalty.</td><td>Clarity shall send health plan reports monthly.</td><td>First Occurrence 3% Second Occurrence 5% Third Occurrence 7% Fourth and Subsequent Occurrences 10%</td></tr>
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<tr><td>Smart Data Solutions (SDS)</td><td>Private</td><td>Lighthouse Health Plan, LLC contracts with Smart Data Solutions for Paper Claim scanning, with data capture, and batching, PO Boxes and scanning of all correspondence and HIPAA compliant destruction of scanned and batched physical material. The percentage of these services provided will be 100%.</td><td>Smart Data Solutions has been a leader in mailroom management for almost 20 years. The Smart Data Mailroom is a trusted partner for over 100 healthcare payer clients. Their HIPAA compliant facility based out of Eagan, MN is adjacent to their IT and Corporate headquarters. This allows our technical and operational staff to work very effectively reducing implementation and testing cycles for our clients. From intake, document prep, scanning, document storage, onsite destruction, and outbound mail, SDS can handle it all. SDS handles the most complex document sorts and identification cost effectively.

All mail that SDS receives is processed in their HIPAA compliant facility. SDS has restricted access into our facility which is monitored by security cameras and provide 24-hour video surveillance.</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><td>Paper claims and all correspondence</td><td>All paper claims and correspondence must be processed and transmitted by 2pm the second business day following receipt.</td><td>The criteria shall be applied to all paper claims and correspondence.</td><td>SDS shall send monthly reporting to Lighthouse Health Plan, LLC</td><td></td><td>If the volume of the Paper Claims received by Company on a particular Business Day does not exceed one hundred-thirty percent (130%) of the average daily volume of claims taken over the previous thirty (30) days of service, and Company fails to transmit claim batches by 2:00 p.m. on the second (2nd) business day thereafter for four (4) consecutive days during any seven (7) days within the same thirty (30) day period, Evolent</td></tr>
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<tr><td></td><td></td><td></td><td>All SDS employees must pass background checks prior to working in the mailroom and all guests must sign an NDA and remain in the company of an SDS employee. SDS also has weekly on-sight document destruction so we never have any PHI that leaves our facility.</td><td>subcontractors as outlined in the Delegation Oversight Policy and Procedure. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance. This allows the Lighthouse Health Plan, LLC delegation oversight activities to include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following:
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<tr><td></td><td></td><td></td><td></td><td></td><td>shall receive a seven and one-half percent (7.5%) discount on the following month’s Paper Claim fees.</td></tr>
<tr><td>Lighthouse Health Plan, LLC correspondence with SDS</td><td>All correspondence by Lighthouse Health Plan, LLC with SDS shall be responded to within 1 business day.</td><td>All correspondence, inclusive of phone and email.</td><td>N/A</td><td>N/A</td><td>N/A</td></tr>
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<tr><td>Instamed</td><td>Private</td><td>Lighthouse Health Plan, LLC contracts with InstaMed to provide Electronic and paper checks payments as well as Explanation of Payments and Electronic Remittance Advises for provider claim payments. The percentage of provider claim payment services provided will be 100% of initiatives provided.

Lighthouse Health Plan, LLC may also contract with InstaMed to provide a portal to accept member premium payments by ACH, Debit or Credit cards.</td><td>Lighthouse Health Plan, LLC contracts with InstaMed to provide Electronic and paper checks payments as well as Explanation of Payments and Electronic Remittance Advises for provider claim payments. The percentage of provider claim payment services provided will be 100% of initiatives provided.

Lighthouse Health Plan, LLC’s partners may also contract with InstaMed to provide a portal to accept member premium payments by ACH, Debit or Credit cards. The percentage of member premium payment services provided will be 100% of initiatives provided.</td><td>Lighthouse Health Plan, LLC will manage subcontractor's compliance mostly via the Delegation Oversight Committee (DOC). The DOC manages and oversees all delegated subcontractor oversight, which includes pre-delegation assessment, annual financial audits, annual oversight audits and intermittent focused audits. The pre-delegation assessment is when the DOC reviews and approves the use of all subcontractor’s as detailed within the Pre-Delegation Assessment Policy and Procedure. Next, the Lighthouse Health Plan, LLC prescreens all delegates and subcontractors who provide services in support of our membership against all required sanction databases, and again monthly, as detailed within the Exclusion List Checking Policy and Procedure. Once approved for use by Lighthouse Health Plan, LLC The DOC continues to oversee all</td><td>
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<tr><td>“Availability” is the percentage of the time per calendar month that Customers have access to and use of the Application Services (e.g., 24 hours/7days per week).</td><td>“Downtime” is defined as the unscheduled inability of fifty percent (50%) or more of the total number of InstaMed customers to access and use the Application Services due to an event within InstaMed's reasonable control.</td><td>The Availability of the Application Services shall be equal or exceed 99.9%.</td><td>The percentage of Availability will be calculated as follows: Total time in a month (7days/week, 24 hours/day) in minutes, less the time in a month for scheduled maintenance in minutes, less the time in a month for Downtime (as applicable) in minutes, divided by total time in a month (7days/week, 24 hours/day) in minutes minus the time in a month for scheduled maintenance in minutes. When performing the</td><td>Monthly</td><td>N/A</td></tr>
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</table>

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any					
		The percentage of member premium payment services provided will be 100% of initiatives provided.		subcontractors as outlined in the Delegation Oversight Policy and Procedure. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance. This allows the Lighthouse Health Plan, LLC delegation oversight activities to include an ongoing evaluation of delegates related operational activities to detect and correct potential violations at the lowest level of non-compliance through the use of the following: 1. Baseline Risk Assessment and updates to the Risk Assessment. 2. Development of an annual Monitoring and Audit Work Plan that is updated as additional areas of risk are identified. This Audit Work Plan includes an annual delegation review and compliance review of delegates.						
							calculation above, "time in a month for scheduled maintenance in minutes" will be the time actually spent by InstaMed to perform scheduled maintenance.		
					Provider Payment Disbursements (ACH)	If ACH disbursements are funded from a designated processing account, InstaMed will submit 98% of the ACH disbursements within one (1) banking business day after file approval (e.g., if file approval occurs before banking cut time on Monday, InstaMed will submit the ACH disbursement by close of business on Tuesday). If ACH	InstaMed will submit 98% of the ACH disbursements within one (1) banking business day after file approval.	InstaMed shall send a monthly report on ACH TimeFrames	Monthly	N/A

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any					
				3. Routine ongoing monitoring of compliance operational risk areas. 4. Focused audits based on results of the Risk Assessment. If the DOC were to find during their ongoing oversight activities any non-compliance with the subcontractor's agreement with Lighthouse Health Plan, LLC or with any state, federal, or accreditation requirements the Lighthouse Health Plan, LLC shall follow our Corrective Action Plan Policy and Procedure to ensure correction or penalty up to and including termination take place. The vendor management team will monthly review all reports submitted by subcontractor to ensure they are meeting service level requirements and supporting Lighthouse Health Plan, LLC's goals. The vendor management team will meet with the subcontractor and the DOC no less than monthly to review all		disbursements are funded from any account other than a designated processing account, InstaMed will submit 98% of the ACH disbursements within two (2) business days after file approval (e.g., if file approval occurs before banking cut time on Monday, InstaMed will submit the ACH disbursement by close of business on Wednesday). If approval is sent on a non-business day, the approval date is the following business day.			
					Printed Materials Processing	InstaMed will complete 98% of the printing, inserting, and mailing of paper checks, Explanation of	InstaMed will complete 98% of the printing, inserting, and mailing of paper checks, Explanation of	InstaMed will provide the Application Services substantially in accordance with the	Monthly	N/A

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any					
				reports as required by the agreement. All subcontractor agreements will be in compliance with applicable regulatory and accreditation requirements and will include Medicare, state Medicaid and/or NCQA required terms as appropriate. In conducting the monitoring and audits, Lighthouse Health Plan, LLC uses federal and state regulatory guidance, published best practices and internal policies and procedures as measurements of compliance.		Payment (EOPs) and Explanation of Benefits (EOBs) within two (2) business days after receipt, provided that receipt cut-off on a given day for purpose of this Section 4.A. is 12:00 P.M. EST. If approval is sent on a non-business day, the approval date is the following business day.	Payment (EOPs) and Explanation of Benefits (EOBs) within two (2) business days.	published released and finalized Documentation.		
					Telephone Support	InstaMed will provide Customers direct Customer Service support with eighty percent (80%) of phone calls answered within twenty (20) seconds with an abandon rate (meaning those Customer calls that are terminated by Customer after twenty (20)	InstaMed will provide Customers direct Customer Service support with eighty percent (80%) of phone calls answered within twenty (20) seconds with an abandon rate (meaning those Customer calls that are terminated by Customer after twenty (20)	InstaMed Shall include this metric in monthly reporting to Lighthouse Health Plan, LLC.	Monthly	N/A

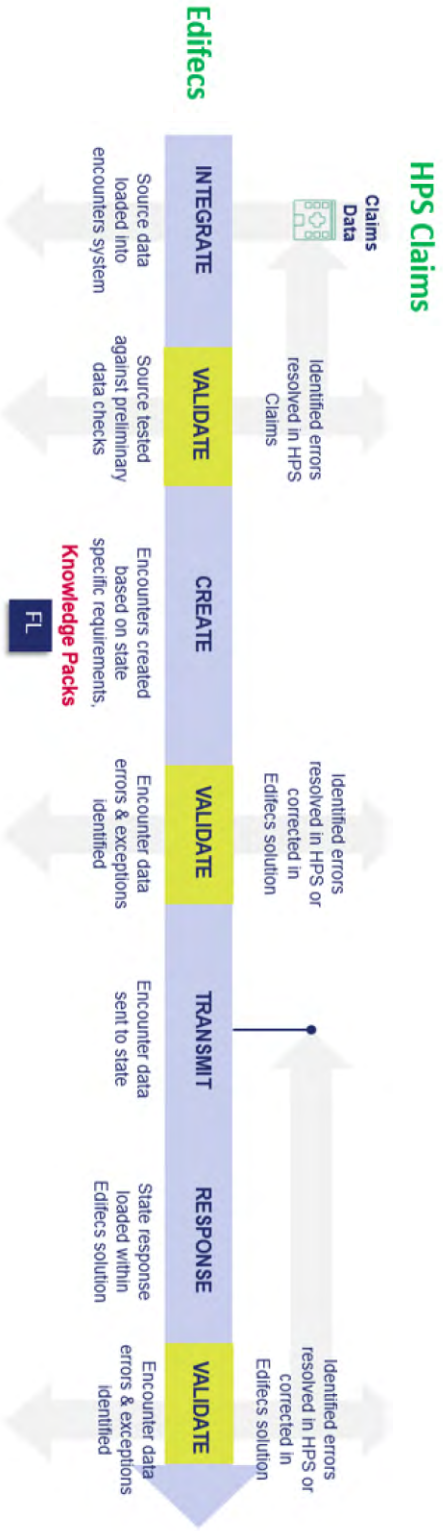
Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any					
						seconds and prior to speaking to an InstaMed customer support representative) of no more than five percent (5%). Live InstaMed Customer Service agents will be available from 7:00 a.m. to 9:00 p.m. Eastern Time during business days.	seconds and prior to speaking to an InstaMed customer support representative) of no more than five percent (5%). Live InstaMed Customer Service agents will be available from 7:00 a.m. to 9:00 p.m. Eastern Time during business days.			
					Expedited Severity	Within one (1) business day of either InstaMed's designation of the Issue as an Expedited Severity Issue or the Parties mutually agreeing that the Issue is an Expedited Severity Issue, InstaMed shall, for ninety percent (90%) of Expedited Severity Issues,	An incident/problem that renders the Services, or mission critical functionality of the Services, to be inoperable, or causes a significant and ongoing interruption to the Customer's business activities. This severity level is reserved for rare system wide outages for			

Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any						
						resolve the Issue or provide a reasonable workaround.	which a work-around is not available and which results in Downtime, as defined in Section 3 of this Schedule.				
					High Severity	Within two (2) business day of either InstaMed's designation of the Issue as a High Severity Issue or the Parties mutually agreeing that the Issue is a High Severity Issue, InstaMed shall, for ninety percent (90%) of High Severity Issues, resolve the Issue or provide a reasonable workaround.	An Issue that causes a business' critical service to be inoperative, disrupted or malfunctioning and that materially interferes with the Customer's ability to process and a workaround is not available.				
					Medium Severity	Within four (4) business day of either InstaMed's designation of the Issue as a Medium Severity Issue or the Parties	Issues not completely impacting the Customer's ability to process. At this level of severity, typically the system is not				

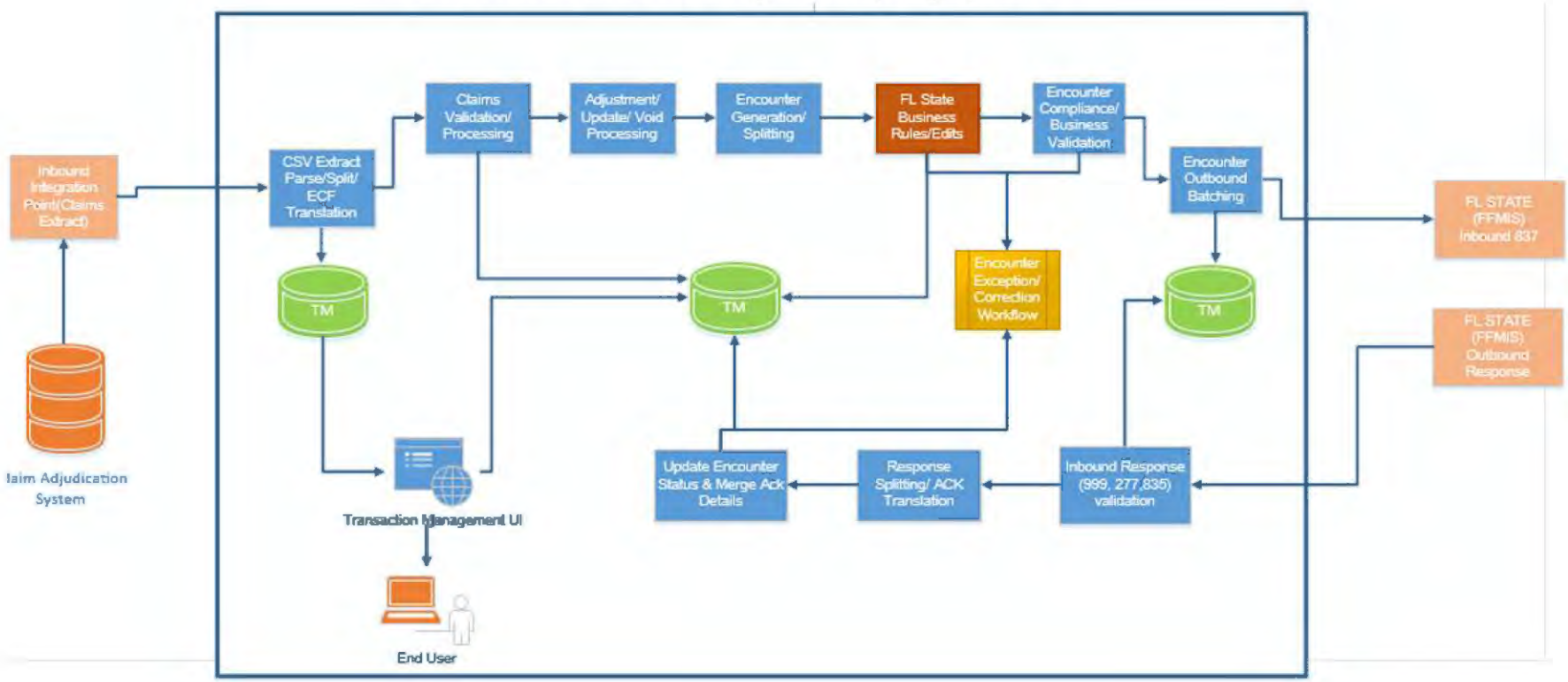
Subcontractor Name	Ownership	Services to be provided, including percentage of total	Qualifications	How Lighthouse Health Plan, LLC will manage the subcontractor to ensure compliance with all requirements	Service Level Agreements (SLAs) if any						
						mutually agreeing that the Issue is a Medium Severity Issue, InstaMed shall, for ninety percent (90%) of Medium Severity Issues, resolve the Issue or provide a reasonable workaround.	inoperable or a workaround is available until a solution can be deployed.				
					Low Severity	Within six (6) business day of either InstaMed's designation of the Issue as a Low Severity Issue or the Parties mutually agreeing that the Issue is a Low Severity Issue, InstaMed shall, for ninety percent (90%) of Low Severity Issues, resolve the Issue or provide a reasonable workaround.	Any general questions and Issues not impacting the Customer's ability to process. At this level of severity, typically the system is not inoperable or an existing workaround is in effect or software fix/enhancement has been requested for a future software release.				

ATTACHMENT SRC 29-1 ENCOUNTER DATA SUBMISSION FLOW CHARTS

Process Flow and Encounter Management System:



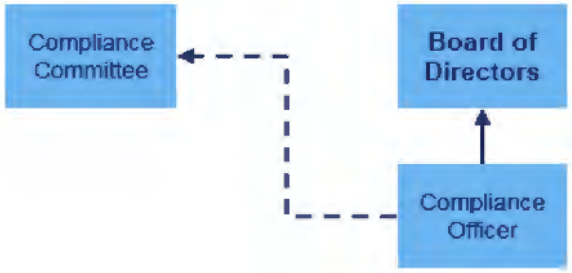
Edifecs Encounter Management (EM) System



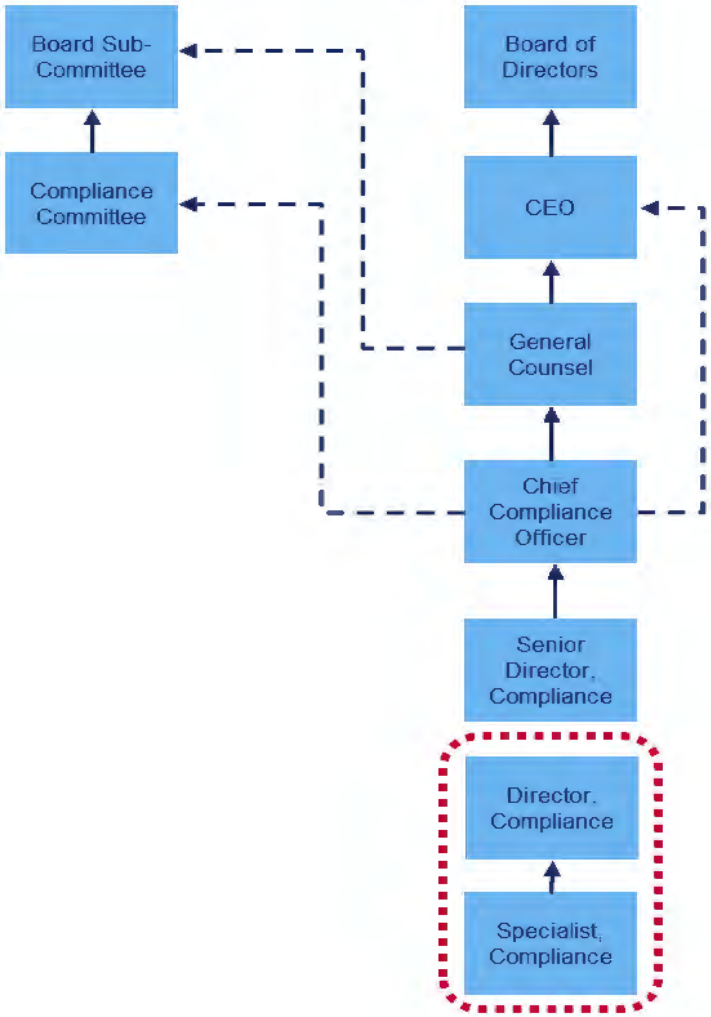
Subcontractor Encounters Process Flow:

ATTACHMENT SRC 31-1

LIGHTHOUSE HEALTH PLAN COMPLIANCE STRUCTURE



EVOLENT HEALTH (TPA SUBCONTRACTOR) COMPLIANCE STRUCTURE



*Highlighted in red = dedicated to Florida Medicaid

Elizabeth C. Callahan
1215 North Reus Street
Pensacola, Florida 32501
liz.callahan@bhcpns.org

EDUCATION

- University of Florida College of Law, Gainesville, Florida
  - J.D. (With Honors) – 2000
- University of North Carolina, Chapel Hill, North Carolina
  - B.A. (With Distinction, Phi Beta Kappa) – 1996
  - Major: English

BAR ADMISSION

- Florida, 2000
- U.S. District Court Northern District of Florida, 2004

PROFESSIONAL ASSOCIATIONS AND MEMBERSHIPS

- American Health Lawyers Association
- The Healthcare Roundtable, General Counsel Section
- Florida Bar, Health Law Section

PROFESSIONAL EXPERIENCE

Baptist Health Care, Pensacola, Florida (January 2012 – Present)

- General Counsel overseeing:
  - In-house legal department
  - Corporate Compliance
  - Risk management, including clinical risk management
  - Insurance and loss prevention
  - Claims
  - Internal audit
  - Contract review
  - Government Relations
- Baptist Health Care Corporation is a community owned not for profit health system with approximately $800million in annual revenues that includes three acute care hospitals, two physician joint ventured ambulatory surgery centers, a community mental health facility, and approximately 250 employed providers.

Beggs & Lane, RLLP, Pensacola, Florida (October, 2001 - December, 2011)

- Partner
- Practice concentrated primarily on the representation of health care providers including hospitals, group practices, hospices, mental health providers, and ambulatory surgery centers. Advice to clients on a broad range of health care matters including regulatory, fraud and abuse, managed care, and medical staff matters such as credentialing and fair hearings. Focus on health care related transactional and contracting issues.

Presentations:

- Frequent speaker and educator in-house on topics such as EMTALA, Stark, HIPAA, Advanced directives.
- Presenter, February 2014 International Performance Management Initiative – Healthcare Law and Compliance Conference, “Co-Management: The Untold Truth”
- Presenter, October 2014 Panhandle FHIMA Association “Advanced Directives”
- Presenter, September 2016, Alabama Health Law Section and Cumberland School of Law Conference, “Bundled Payments and Value Based Care Initiatives”

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Evolent Health LLC

its highest accreditation status of

Case Management Accreditation — 3 Years

for service and quality that demonstrates strong performance of NCQA's rigorous requirements for case management.

David Chin, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

September 27, 2016	September 27, 2019
DATE GRANTED	EXPIRATION DATE

September 28, 2016

Frank Williams, BA, MBA
Chief Executive Officer
Evolent Health LLC
23 Geary St. Suite 300
San Francisco, CA 94108

Dear Mr. Williams:

We are pleased to inform you that based on the information gathered during your recent CM survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded Evolent Health LLC the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, can be accessed by visiting https://irt.ncqa.org. Please select your organization's project on the Dashboard and then select "View Final Report" from the actions menu. If this section does not appear, please follow the instructions in the attached documents entitled "Log In and Dashboard" and "User Management" and update your user rights.

Evaluation Product	Status	Effective Date	Expiration Date
Case Management	Accredited-3 years	September 27, 2016	September 27, 2019

Case Management Programs:
Complex Case Management

The NCQA Case Management Report Card will be updated to reflect this status by no later than the 15th of October. A certificate reflecting your accreditation status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org. Please refer to the Guidelines for Advertising NCQA CM Survey Accreditation, enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or accreditation outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2014 *Standards and Guidelines for the Accreditation of Case Management*. This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for CM Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

In order to maintain your accreditation status(es), Evolent Health LLC will need to participate in a survey approximately three months prior to the expiration date. Your next survey will be on the standards in effect at the time of the survey. It will also be conducted on two different platforms and in using both NCQA's Interactive Survey System (ISS) and Interactive Review System (IRT). The first, or offsite, stage will begin immediately upon submission of your organization's completed Survey Tool. During this stage, NCQA reviews the organization against most of the standards and elements, thus reducing the duration of the second, or onsite, stage which will be scheduled to begin seven weeks after your Survey Tool is submitted to NCQA. NCQA will provide additional information on the two platforms noted above closer to the time of your submission.

We have tentatively reserved July 2, 2019 as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set August 19, 2019 for your one-day onsite survey. If the proposed dates present a problem for you or if you have any questions regarding these dates, please contact Cindy Francis, Program Manager, Accreditation, at (202) 955-5147 or e-mail francis@ncqa.org.

If you have questions about the ISS, please contact NCQA Customer Support at (888) 275-7585 or via my.ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this accreditation survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Gerald Stewart
Assistant Vice President, Accreditation

Enclosures

NCQA
Measuring quality.
Improving health care.

National Committee for Quality Assurance

has awarded

Evolent Health LLC

this Certificate of

Patient and Practitioner Oriented
Disease Management Accreditation

for the following disease management programs: *Asthma, CAD, CHF, COPD, Diabetes*.

CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

January 26, 2016	*January 26, 2019*
DATE GRANTED	EXPIRATION DATE

January 27, 2016

Frank Williams, BA, MBA
Chief Executive Officer
Evolent Health LLC
23 Geary St., Suite 300
San Francisco, CA 94108

Dear Mr. Williams:

We are pleased to inform you that based on the information gathered during your recent DM Accreditation survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded **Evolent Health LLC** the accreditation status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://iss.ncqa.org and looking under the section entitled Survey and Results.

Evaluation Product	**Certified Status**	**Effective Date**	**Expiration Date**
Patient and Practitioner Oriented	Accredited	January 26, 2016	January 26, 2019

Disease Management Programs:

Asthma	CAD
CHF	COPD
Diabetes	

The NCQA Disease Management Accreditation & Certification Status List will be updated to reflect this status by no later than the 15th of February. A certificate reflecting your accreditation status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA certification seal by visiting our Web site at www.ncqa.org. Please refer to the Guidelines for Advertising and Marketing, enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or certification outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2014 *Standards and Guidelines for Disease Management.* This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for DM Accreditation Survey, "Pricing Methodology and Cancellation

Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

In order to maintain your certification status(es), Evolent Health LLC will need to participate in a survey approximately three months prior to the expiration date. Your next survey will be conducted in two stages using NCQA's Interactive Survey System (ISS) and standards in effect at the time of the survey. The first, or offsite, stage will begin immediately upon submission of your organization's completed Survey Tool. During this stage, NCQA reviews the organization against most of the standards and elements, thus reducing the duration of the second, or onsite, stage which will be scheduled to begin seven weeks after your Survey Tool is submitted to NCQA.

We have tentatively reserved October 16, 2018, as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set December 17, 2018 for your one-day onsite survey. If the proposed dates present a problem for you or if you have any questions regarding these dates, please contact Cindy Francis, Program Manager, Accreditation, at (202) 955-5147 or e-mail francis@ncqa.org.

If you have questions about the ISS, please contact NCQA Customer Support at (888) 275-7585 or via my.ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this certification survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Dayna Bell, MBA, MS
Assistant Vice President, Accreditation

Enclosures

NCQA
Measuring quality. Improving health care.

National Committee for Quality Assurance

has awarded

Evolent Health LLC

NCQA Certification in

Utilization Management

For demonstrating compliance with NCQA's requirements
in the area of Utilization Management.

CHAIR, BOARD OF DIRECTORS	PRESIDENT	CHAIR, REVIEW OVERSIGHT COMMITTEE

January 25, 2017	*January 25, 2019*
DATE GRANTED	EXPIRATION DATE

January 25, 2017

Frank Williams BA, MBA
Chief Executive Officer
Evolent Health LLC
800 N. Glebe Rd. Suite 500
Arlington, VA 22203

Dear Mr. Williams:

We are pleased to inform you that based on the information gathered during your recent Certification in UM and CR Survey survey, the National Committee for Quality Assurance (NCQA) Review Oversight Committee has awarded **Evolent Health LLC** the certification status(es) listed below. The final assessment report, which incorporates relevant changes made in response to your organization's earlier comments, is now ready for your review. You may now access the final report and results online by visiting https://irt.ncqa.org. The final results are available by selecting your organization's project on the Dashboard and going to "View Final Report" from the actions menu**.** If this section does not appear, please follow the instructions in the attached documents entitled "Log In and Dashboard" and "User Management" and update your user rights.

Evaluation Product	**Certified Status**	**Effective Date**	**Expiration Date**
Certification in Utilization Management	Certified	January 25, 2017	January 25, 2019

The NCQA Utilization Management and Credentialing Report Card will be updated to reflect this status by no later than the 15th of February. A certificate reflecting your certification status(es) is enclosed in recognition of your achievement. Also, for your convenience, you may download the NCQA accreditation seal by visiting our Web site at www.ncqa.org. Please refer to the 'Guidelines for Advertising and Marketing,' enclosed.

If you have reason to believe that the compliance scoring of any standard or standards does not accurately reflect your organization's compliance with the standards, you have the opportunity to request a reconsideration of compliance designations and/or certification outcome by the NCQA Reconsideration Committee. To proceed with reconsideration, NCQA must receive within the next 30 days a written request for reconsideration that addresses at least one of the grounds for appeal identified in the Reconsideration section of the "Administrative Policies and Procedures" of the 2016 *Standards and Guidelines for Certification in UM and CR.* This request must not exceed five pages in length and must include a listing of the standards for which reconsideration is being requested. A fee, as specified in the Agreement for Certification in UM and CR Survey Survey, "Pricing Methodology and Cancellation Policy" (Exhibit A), is charged for reconsideration. The fee must be paid at the time reconsideration is requested.

In order to maintain your certification status(es), Evolent Health LLC will need to participate in a survey approximately three months prior to the expiration date. Your next survey will be on the standards in effect at the time of your survey. It will also be conducted in two stages using both NCQA's Interactive Survey System (ISS) and Interactive Review System (IRT). The first, or offsite, stage will begin immediately upon submission of your organization's completed Survey Tool. During this stage, NCQA reviews the organization against most of the standards and elements, thus reducing the duration of the second, or onsite, stage which will be scheduled to begin seven weeks after your Survey Tool is submitted to NCQA.

We have tentatively reserved **October 30, 2018**, as the submission date of the completed Survey Tool to NCQA. NCQA has tentatively set **December 17, 2018** for your onsite survey.

If you have questions about the ISS, please contact NCQA Customer Support at (888) 275-7585 or via my.ncqa.org. You can also visit www.ncqa.org for additional information.

While it is our understanding that the results of this certification survey may satisfy a state regulatory requirement, NCQA assumes no responsibility for transmitting copies of this report to relevant state agencies.

We wish to acknowledge your quality improvement efforts, which were evident throughout the survey process. NCQA looks forward to working with you and your staff again in the future.

Sincerely,

Gerald Stewart
Assistant Vice President, Accreditation

Enclosures

NCQA
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Improving health care.

National Committee for Quality Assurance

has awarded

Access Behavioral Health

Medicaid MBHO

the status of

Full

ACCREDITED
NCQA
MANAGED BEHAVIORAL HEALTHCARE ORGANIZATION
FULL

for the development and maintenance of a clinically effective

managed behavioral healthcare delivery system

which maintains as its primary objective the delivery of

high quality member care and service.

David Chrisman, MD
CHAIR, BOARD OF DIRECTORS

Margaret E. Oj
PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

10/19/2017
DATE GRANTED

02/13/2020
EXPIRATION DATE

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

RESPONDENT NAME: Lighthouse Health Plan, LLC

A. RESPONDENT BACKGROUND/EXPERIENCE

No SRCs in this Category for MMA.

B. AGENCY GOALS

MMA SRC# 1 – Potentially Preventable Events (Regional):

The respondent shall describe its organizational commitment to quality improvement as it relates to reducing potentially preventable events. More specifically, the respondent shall describe its overall approach and specific strategies that will be used to ensure a reduction in potentially preventable hospital admissions and readmissions, a reduction in the use of the emergency department for non-emergent/urgent visits, and a reduction in the use of unnecessary ancillary services during hospitalization and outpatient visits. The respondent's approach shall also include:

- A description of the respondent's assessment (using available data sources) of hospital utilization rates and the potential for improvement;
- A description of performance benchmarks for each area of focus;
- A description of incentives that will be implemented for providers and enrollees aimed at diverting care to more appropriate and cost-effective settings; and
- A description of evidence-based interventions and strategies that will be used to target super-utilizers, particularly related to pain management and behavioral health conditions.

Response:

Lighthouse Health Plan is committed to continual quality improvement in reducing potentially preventable events (PPEs) including potentially preventable hospital admissions (PPAs), potentially preventable hospital readmissions (PPRs), potentially preventable emergency department visits (PPVs) and unnecessary ancillary services rendered in inpatient or outpatient settings. We meet this commitment through the use of a system-wide quality improvement activities to identify opportunities to reduce PPEs and implement programs and interventions to seize those opportunities.

APPROACH TO REDUCING POTENTIALLY PREVENTABLE EVENTS

Lighthouse, working with our subcontractor Evolent and its partners, will implement a multifaceted and targeted approach to reducing PPEs, focusing resources on using advanced data analytics to identify members with PPEs and intervening early to reengage members with their primary care providers, redirecting care to the primary care and outpatient settings when clinically appropriate. We do this by:

• Analyzing all available data including extensive social data sets, recognizing that social determinants of health increase a member's risk for avoidable service use

• Using predictive analytics to identify not only super utilizers but members who have "rising risk", so we can intervene proactively to avoid PPEs
• Engaging members in care management programs that focus on care coordination and members' health education and self-management skills development, using evidence-based care management interventions. We focus our interventions based on a member's risk level and implement specialized interventions for members with chronic conditions, complex physical and behavioral health needs, and high-risk pregnancies.
• Connecting members and providers to local, multidisciplinary care teams that promote member and primary care provider (PCP) engagement and the member's adherence to their treatment plan
• Designing member and provider incentives that promote appropriate service use and quality care, driving reductions in PPEs
• Enrolling members transitioning from hospital to home or skilled facility to home in our highly effective transitions of care program. Interventions for this program are designed to avoid unnecessary emergency department or readmissions

Assessment of Hospital Utilization Rates and Potential for Improvement –

Our review of the current regional cost and utilization experience data provided in the data book and the Agency's "Quarterly Statewide Medicaid Managed Care Report" (Spring 2017) reveals opportunities to reduce potentially preventable events that we believe are especially relevant to our program design.
• Almost 40 percent of potentially preventable hospital admissions (PPAs) were potentially treatable in the primary care setting and 42 percent using outpatient care.
• Over 60 percent of children with PPAs were identified as potentially treatable in the primary care setting.
• Almost 58 percent of potentially preventable ER visits were for conditions potentially treatable in the primary care setting and 34 percent using outpatient care. Forty-two percent were potentially preventable with care management.
• Schizophrenia was the top condition driving potentially preventable readmissions (PPRs) at eight percent and over 27 percent of all PPRs were attributable to behavioral health conditions. PPRs related to Cesarean sections were among the top 10 PPRs for 10 of 11 standard MMA plans.

Our comprehensive approach is designed specifically to support and strengthen the provider/member relationship and target resources based on a member's identified risk or projected future risk. Our care management model is fully integrated, addressing member's physical health needs, behavioral health needs and social determinants of health, and includes care management programs for members at risk of readmission (Transitions of Care) and high-risk Maternity Care management, as well as care management for members with comorbid and complex conditions (Complex Care) or who have a serious and persistent mental illness (SPMI care management). Central to the success of our model is intensive coordination of care with both the member, family members and member's provider. Care management staff are aligned with specific providers and their patients and in high-volume offices and hospitals, embedded with the provider office. In addition, clinical staff and providers work within a single web-based system, Identifi, that supports exchange of information with the provider's EHR and streamlines coordination of care. A recent analysis of the impact of these clinical programs at two provider led health plans showed decreases in ambulatory care sensitive conditions, inpatient admissions and emergency room visits.

• Among patients who were receiving care management prior to implementation of the model, ACSCs inpatient admissions decreased 38 percent and ER use decreased 51 percent.
• Among patients who had not previously received care management prior to implementation of the model, ACSCs inpatient admissions decreased 66 percent and ER use decreased 51 percent.

Based on our experience in other markets, we project the clinical model will achieve reductions in PPEs and related cost savings. For example, in Region 1, we project costs savings on a PMPM basis of 2.3%.

During our review of the data book we also noticed several areas of under-utilization in particular lower utilization of primary care visits and adherence/utilization of prescription drugs. Low rates of preventive services lead to reduced quality outcomes, lower adherence rates to treatment plans and pharmacy medication, and higher utilization of services in non-preferred settings such as emergency department and inpatient facilities. Our approaches to reducing PPE's includes a focus on the increased use of these important preventive services.

Specific Localized Opportunities for Improvement –

Based on the available data, and consistent with the experience of Lighthouse's sponsoring health system we have identified the following opportunities to impact PPE's in Region 1.

Opportunities to reduce hospital admissions (PPAs) –

The top conditions driving PPAs include Chronic Obstructive Pulmonary Disorder (COPD), Congestive Heart Failure, and Diabetes. As a result, our Condition Care Disease Management programs will focus on these conditions, identifying enrollees who are at risk of their condition worsening and providing supports to prevent the need for hospitalization. This will include increased symptom monitoring, better engagement with primary care, improved medication adherence and lifestyle changes that can improve the enrollee's ability to manage their chronic conditions. Our sophisticated analytics and predictive modeling capabilities leverage a variety of data sources to ensure that we identify enrollees who need these supports before acute utilization occurs.

Opportunities to reduce hospital re-admissions (PPRs) --

Bipolar Disorders are the leading driver of re-admissions in Region 1, followed by COPD and pancreas disorders. In addition to the disease management programs referenced above, our transitions of care program will provide targeted supports to enrollees identified as being at high risk of readmission. This will include patients with BH diagnoses and those with COPD. For enrollees with BH diagnoses including bi-polar disorder and depression, our transition care intervention will pay particular attention to connecting the enrollee to appropriate BH providers. This includes ensuring a visit with a BH practitioner within 7 days of discharge. By improving post-discharge follow-up visits we believe re-admission can be avoided. In addition to ensuring compliance with follow-up care, our post-discharge supports for enrollees with COPD will include referral into the disease management programs referenced above, if the enrollee is not already participating, and additional supports for lifestyle changes including smoking cessation. Pancreas disorders can be caused by chronic alcohol consumption, if this is a factor for an individual

enrollee our post-acute supports will include referral to treatment for potential alcohol dependence.

Opportunities to reduce emergency department visits (PPVs) –

Region 1 has the highest rate of PPVs statewide. Our programs targeted towards preventing preventable use of the ED are especially important in this community. Upper respiratory infections are the leading driver of ER visits statewide, and account for 24.6% of visits in Region 1. Other drivers include gastrointestinal issues including vomiting and abdominal pain. All of these conditions are potentially treatable in a primary care setting. While we are careful to discourage enrollees from going to the ER if they feel that they are experiencing an emergency, we will educate enrollees on common symptoms and encourage them to contact their PCP before going to the ER. Additionally, we provide enrollees with access to a 24x7 Nurse advice line that they can call if they are not sure how to handle a health concern including symptoms associated with these conditions. By improving the connection between our enrollees and their PCPs we believe we can address these preventable ER visits.

Overcoming Barriers –

A community health needs assessment conducted in 2016 in Escambia and Santa Rosa Counties identified concerns related to poor health including low health literacy impacting self-management ability, poor lifestyle choices including alcohol abuse, overeating and sedentary lifestyles, and a lack of public transportation. All of these factors are barriers to decreasing PPE's.

Lighthouse's approach to care management addresses each of these. Through our social media messaging including texting programs, Facebook and Twitter, we aim to improve health literacy and support decision making leading to enrollees seeking care in appropriate settings. Our Care Management programs reinforce healthy lifestyles and address diet and exercise while our analytics uses data sources such as the U.S. Dept. of Agriculture data to identify enrollees who may have trouble access healthy food. Finally, throughout our innovative approach to non-emergent medical transportation that leverages shared ride services like Uber and Lyft to help ambulatory enrollees access preventive services we can prevent enrollee's chronic conditions from worsening and avoid services in acute settings.

Additionally, Lighthouse's sponsor, Baptist Health has taken the following actions to improve the wellbeing of communities in Region 1:
• Tobacco Use – Baptist leads a community-based tobacco cessation program which includes on-site tobacco cessation classes
• Healthiest Weight – Baptist hosts free nutrition based cooking classes at the Northwest Florida YMCA
• Access to Care – Baptist provides opportunities for community health education; developed and distributed a passive education tool to improve the understanding of access to care (i.e. accessing the right level of care in the right setting at the right time)

Baptist Health has also implemented several programs that target patients with complex needs or who are high cost to support improved coordination of their inpatient care and discharge, including:

• Our post-acute hospitalist program, staffed by an internist, geriatrician and seven advanced practice nurses covering nine facilities focus on managing patent's length of stay to transition patients home or to the next level of care as expeditiously as clinically appropriate. This program has not only reduced lengths of stays but has steadily increased the proportion of patients discharged directly home, from 23 percent in the second quarter of 2015 when we started this program, to 78 percent in the third quarter of 2017.
• Screening patients before discharge using the LACE index that identifies patients at risk for readmission or death within 30 days of discharge. We deploy inpatient care coordinators to work with patients who score greater 13, scheduling a follow-up visit before discharge and helping to arrange transportation when needed. The care coordinators have access to the outpatient EHR to support on-demand scheduling. For patients discharged to palliative care, the care coordinators arrange a post-discharge home visit from the post-acute hospitalist program advanced practice nurse to ensure the patient and family/caregiver understand the patient's care and emotional support needs.
• Baptist tracks frequent ED users and intervenes to keep them out of the hospital through their LEAP (Linking, Engaging, Accessing, and Planning) program. Baptist's care coordinator will be able to connect Medicaid-eligible ED users to the local care management team while the enrollee is in the ED, and arrange an in-person visit with a Lighthouse care manager. Navigators work with individuals while at the ED coordinating appointments with specialists, transportation and home health agencies, and work closely with the Escambia Community Clinics (ECC) social workers to address the needs of Medicaid or uninsured patients served at an ECC clinic.

Lighthouse will build on the success of these initiatives as part of our strategy to overcome barriers to reducing PPE's.

Performance Benchmarks --

We propose benchmark performance pegged to the statewide average except for metrics where the current regional performance is already better than the statewide average in which case the benchmark is based on the regional performance. Our proposed benchmarks are as follows:

Risk Adjusted PPA Rate per 1,000 enrollee months:
• Statewide average: 2.14
• Current Region 1 performance: 1.61
• Proposed Benchmark: 1.53 (5% improvement on regional performance)

Risk Adjusted PPR Rate
• Statewide average: 87.11
• Current Region 1 performance: 88.69
• Proposed Benchmark: 82.72% (5% improvement on statewide average)

Risk Adjusted PPV Rate per 1,000 enrollee months:
• Statewide Average: 24.08
• Current Region 1 performance: 32.98
• Proposed Benchmark: 22.88 (5% improvement on statewide average)

MEMBER AND PROVIDER INCENTIVES

Enrollee and Provider Incentives are an important tool to impact PPE's below are our proposed enrollee and provider incentives that will support meeting the benchmarks described above.

Provider Financial Incentives –

Lighthouse believes that alignment of financial incentives for providers is essential to achieving an effective and efficient healthcare system. As a result, we plan to include value-based purchasing provisions in nearly all of our provider contracts. We offer a variety of VBP payment models to PCPs, specialists and hospitals all designed to encourage improved care coordination and delivery of preventive services in support of reducing PPEs. Our VBP programs include provider incentives in the form of outcomes-driven scorecard incentives tied to specific quality metrics, enhanced payment rates to PCPs for being a certified Patient Centered Medical Home or achieving performance on specified quality metrics, and shared savings/shared risk arrangements that include a requirement to achieve performance on quality metrics to qualify for shared savings payments. Our shared risk programs also include multi-specialty provider collaboratives similar to Accountable Care Organizations which we call Integrated Delivery Arrangements.

Payment across all of these programs is tied to performance on quality metrics, or the Measures that Matter. Examples of measures from this set that have particular impact to preventing PPE's include:

For PCP's:
• Follow up visit made within 7 days following post-acute stay
• Admission Rate
• ER Utilization Rate
• Plan All-Cause Readmissions (Adult & Peds)
• Ambulatory Care Sensitive ED Rate (Adult & Peds)
• Use of Imaging Studies for Low Back Pain (Adult Only)
• Completion of screenings designed to identify members who need specific interventions such as the PHQ-9 for detection of depression in the primary care setting or completion of the Edinburgh Depression Scale for women who screen positive or are identified with post-partum depression
• Appropriate Treatment of children with Upper Respiratory Infection
• Expanded Office hours outside the hours of 8am-5pm.

For Hospitals:
• Transition Visit w/in 5 days of discharge
• All-Cause readmission rate

For Specialists:
• Hospital re-admission at 30, 60, 90, and 180 days (including psych)
• Follow up after hospitalization (all types)
• Medication management including follow-up targeting specific types of drugs

Non-Financial Incentives for Providers --

In addition to the financial incentives listed above, Lighthouse will utilize non-financial incentives to encourage providers to improve care coordination and achieve better outcomes related to PPE's.

Lighthouse will give preference providers with high quality scores during the auto-assignment process. Providers who do not meet the plan's minimum standards for quality, including meeting the 50th percentile for HEDIS and meeting appointment access standards may be removed from receiving auto-assigned enrollees. Enrollee Service Representatives will also recommend our highest quality providers to members.

Providers will be assigned a quality score using an internal algorithm that draws on a combination of factors including:

Access Measures --
• Proportion of enrollees seen at least once per year
• Average wait time to schedule an appointment
• Proportion of new members seen within 90 days of enrollment
• Proportion of members with chronic conditions seen at least twice per year

Member Patient Safety Scores --
• Proportion of members with provider preventable conditions
• Conditions Sentinel Events

Quality and Outcome Measures --
• HEDIS measure performance (including preventive services measures)
• Proportion of members with avoidable hospital admissions/ readmissions
• Proportion of members with avoidable ER visits
• Audit compliance performance

Member Experience Satisfaction --
• Member-rated quality
• CAHPS results
• Member grievances
• Disenrollment survey outcomes

Enrollee Incentives --

Lighthouse also actively encourages healthy behaviors and adherence to recommended care for our enrollees. In addition to our enrollee education efforts, enrollees can earn incentives to engaging in activities that improve their health and decrease the risk of PPEs.

Members may earn $25 per qualifying activity up to a maximum of $50 a year distributed on a reloadable card. Qualifying activities are:
• Completion of prenatal and postnatal visit (must attend all prenatal and post-natal visit with a provider)
• Completion of well child visits (must attend all well child visits per AAP for age)
• Care gaps closure (must have all necessary care gaps closed based on age, gender, race)

• Comprehensive diabetes care (must be compliant with appropriate care for diagnosis: eye exam, foot exam, HbgA1c)
• Medication compliance for people with asthma (if identified as asthmatic through care programming, must be compliant with medication regimen including provider visits)
• Compliance with psychotropic medication regimen (if identified through care programming must be compliant with medication regimen including provider visits)
• Participation and graduation from specific care management program
• Completion of a dental visit and completed treatment plan
• Successful participation in a medically-approved smoking cessation program
• Successful participation in a medically directed weight loss program
• Successful participation in a medically approved alcohol or substance abuse recovery program

EVIDENCE-BASED INTERVENTIONS AND STRATEGIES TARGETING SUPER UTILIZERS

Our care management (care coordination and case management) protocols implement proven Population Health techniques that integrate physical health and behavioral health services and recognize that a person's total needs, including social support needs, must be met if meaningful gains are to be made in improving a person's health and functional outcomes. Our evidence-based interventions:
• Deliver the appropriate level of care management support based on a member's identified needs and risk level, incorporating the impact of social determinants of health
• Focus our interventions on the factors most likely to improve member's health outcomes and quality of life: member education on self-management, primary care provider (PCP) engagement and support, and coordination of the member's services and supports that address identified health needs and social determinants of health.
• Our model includes local, multidisciplinary care management teams aligned with specific PCPs and their patients, and embedded in high volume practices, that support the PCP/member relationship and implementation of the PCP's treatment plan.
• Support member engagement through a local, multidisciplinary care team aligned with the member and his or her primary care provider
• Identify member's needs through a comprehensive assessment across all domains that includes evidence-based assessment modules, such as the PHQ2 and 9 and Morisky medication adherence assessments. The assessment results help the care manager confirm the member's initial stratification level and recommended care management program is appropriate (or identify the alternative care management program assignment based on identified needs) and forms the basis for the development of a personalized care plan.
• Deliver care management interventions through a combination of in-person, telephonic and SMS outreach, and in high-volume practices and hospitals, at the point of care delivery
• Use proven approaches to support members with a range of needs, including members with chronic conditions or acute inpatient episodes, including evidence-based models such as:
• Wagner's Chronic Care Model focused on prepared, proactive, productive interactions
• Lorig's Self-Management Support Model that actively engages members in their care
• Project Red for care transitions
• Coleman's Care Transitions Model
• Trauma Informed Care for case managers
• Integrated Care Management
• Our care management system offers a pre-loaded, clinical program workflow that focuses care managers on the highest risk members and the most effective interventions. Evidence-based

clinical content drives the creation of structured and understandable person-centered care plans, and the application supports cross-functional collaboration with the entire care team. We have a team of dedicated staff that focus exclusively on building clinical programs and clinical content (assessments and problems, goals and interventions) incorporating the latest evidence-base.
• All care management programs deliver interventions that address potentially preventable events (PPEs). Care coordinators and care managers intervene with members who have a PPE to identify the root cause and implement solutions that prevent recurrence. We also implement in-hospital interventions in high-volume hospitals, placing social workers and care managers in select emergency rooms or on inpatient units to collaborate with hospital staff and the local care management team in addressing and reducing the drivers of avoidable hospital use.
• We evaluate the opioid risk by reviewing claims data for days of opioid prescriptions, number of overlap days, number of pharmacies and prescribers of the opioid scripts and average daily milligram morphine equivalents to assess patient's high behavior health risk and likelihood of incurring future cost. Including this in our model allows us to identify patients at possible risk for over-utilization or dependence on opioid medications and quickly do outreach and engagement.

We enroll members who are not otherwise identified for a care management program, but who require assistance with service coordination, into care coordination. Care coordination is provided by community health workers (CHWs) working with other members of the local care team including RNs and social workers when needed, and includes addressing barriers to care like transportation, adequate housing, and nutrition needs. Care coordination focusses on:
• Connections to school-based, community, and state agency resources
• Health behaviors - interventions encourage members to develop healthy behaviors (e.g. nutrition and activity) and reduce unhealthy behaviors (e.g., quit tobacco use).
• Psychosocial issues – interventions address factors that impact a member's adherence to the healthcare plan, such as social, emotional, or financial barriers.
• Caregiver support – interventions support caregiver's emotional resources, providing external/ community based resources such as caregiver support groups, respite, and development of coping skills.

Because members may meet the targeting criteria for more than one care management program, we use an enrollment hierarchy which is, from the most intensive to less intensive program:
• Complex Care
• Catastrophic Care
• Advanced Illness Care
• High-Need BH Care Management
• Care Management for Members with Special Health Care Needs
• Lower-Need BH Care Management
• Condition Care (DM)
• Care Coordination

Enrollment in longer term care management programs is suspended if a member needs transitional care or has a high-risk pregnancy. Following completion of an episodic program, we reassess and re-stratify the member to ensure they are re-engaged in the appropriate program.

Risk stratification –

The Identifi data platform continuously analyzes all available sources of data, including claims and pharmacy data, electronic medical record (EMR) data, socioeconomic data, data from the member enrollment file including existing authorizations when available, and results of health risk screenings and health risk assessments, to accurately stratify the entire membership into three risk levels: low risk, moderate risk, and high-risk groups. Our statistical models focus on predicting highly specific events, based on the population type. For Medicaid, these events include preterm deliveries, infants born with neonatal abstinence syndrome and behavioral health related ER visits and inpatient admissions. We have also developed a New Enrollee Model to identify and triage new high-risk Medicaid members moving between health plans within 60 days of enrollment using data that is more readily available.

Many traditional case management programs use guidelines or algorithms that focus exclusively on identifying members who have high acuity medical conditions and increased utilization or who are high cost. Typically, the member is identified in year one when the cost is high and then in year two the cost significantly drops. Importantly, this drop is in the absence of a case management intervention. This phenomenon is known as “regression to the mean”, a statistical term meaning if a variable is extreme on its first measurement, it will tend to be closer to average on its second. In other words, the high cost of the member is most likely decreasing in year two because they were identified after the high cost event occurred.

Our Population Health focused methodology is different and is designed to find members before the event occurs. These members are projected to have high future costs (or “rising risk”) and we assign these members into moderate or high-risk levels depending on their risk score, allowing us to intervene early and change a member’s trajectory. This group of members may not appear to be as sick today as other moderate or high-risk members, but we know they will be in subsequent years in the absence of population health interventions. By intervening before the member’s acuity increases, we avoid negative health outcomes and cost in the second year.

In addition to the proactive approach described above, we do offer supports to Enrollees who are identified as “super-utilizers” based on their condition or utilization patterns. Multiple data sources, identified below, are utilized to identify super-utilizers.

The presence of either of the following two criteria: 1) Total sum of inpatient length of stay days across all inpatient encounters in the last 12 months is greater than or equal to 6 days and the presence of at least one of the following diagnoses; or 2) A financial threshold of total amount paid greater than or equal to $100,000 in the last 12 m *

- Amyotrophic Lateral Sclerosis
- Hemophilia and Coagulation Disorders
- Gauchers Disease
- Guillain-Barre Syndrome
- Liver Failure
- Cystic Fibrosis
- Respiratory Failure
- Ventilator Dependency
- Burns >20% Total Body Surface Area or 2nd/3rd Degree Burns
- Spinal Cord injuries and “plegias” (mono di para and quadra)
- Severe Cognitive Functional Impairment
- Sickle Cell Disease

- Head and Neck Tumors
- Pulmonary /thoracic tumors (including breast)
- Gastrointestinal/abdominal tumors (including colorectal)
- Lymphatic and hematopoietic (blood) system
- Genitourinary/pelvic tumors
- Endocrine Tumors
- Cerebrovascular Accident and Hemorrhage
- Acute and Chronic Osteomyelitis
- Sepsis (all cause)

Evolent leverages both automated (rules-based) and manual (query and clinical referral based) processes to identify super-utilizers. The data sources below are used in a proprietary predictive model that analyzes the severity of diagnoses across three dimensions – 1) diagnosis progression, 2) management interventions, and 3) addressing complications -- to target clinically those patients in which an impact is possible.

The following data sources are used within the predictive model and run on a monthly basis. Other data sources, indicated below, are factored into the model based on availability.
Data Source and Update Frequency:
1. Medical Claims Monthly
2. Pharmacy Claims Monthly
3. Health Risk Appraisal/Patient Questionnaire Annually
4. Electronic Medical Record data (when available) Weekly
5. Data collected in Identifi from Condition Care or Practitioners As available
6. Hospital Admission, Discharge & Transfer feeds Daily
7. Laboratory Values, as available as available

In addition to the above data sources, enrollees can be identified as a super-utilizer by:
- The Utilization Management team
- The staff managing the patient as part of other Evolent Health Population Management Programs, such as the Complex and Condition Care, Transition Care or Unplanned Care Program
- A discharge planner
- Internal departments, such as Pharmacy
- The 24-hour nurse advice line (health information line), as applicable
- Patient, family or caregiver, self-referral
- Practitioners, including behavioral health providers
- Ancillary providers, behavioral health managed care organizations, pharmacists, disability management programs, employer groups, or staff from community agencies

IDENTIFYING MEMBERS FOR THE CORRECT LEVEL OF CARE MANAGEMENT ENGAGEMENT

We identify members for care management engagement using a variety of methods, including from claims and other data analysis, predictive modeling, and internal and external referrals. Members may be identified based on diagnosis (e.g., have a serious mental illness), service utilization characteristics (e.g., high service utilization, frequent inpatient use), risk (e.g., predicted to be high-cost in the future) or from a combination of these factors.

Our algorithm identifies member/program matches and applies the care management program hierarchy enrolling the member in the most intensive program for which they qualify. In addition, we accept internal and external care management referrals: the local care team identifies the most appropriate program for each referred member based on information from the referral source (PCP, family member, 24/7 Nurse Line staff, UM staff, hospital discharge planners and others) and a review of available data.

IMPROVING DATA EXCHANGE TO IMPROVE CARE COORDINATION

Our integrated approach brings care teams, providers and UM staff together working on a single platform, Identifi, which includes care management, utilization management and provider-facing applications with available EMR integration. Identifi supports real-time communication, alerts and information sharing across providers, settings and levels of care.

Through Identifi Practice and the provider portal we deliver comprehensive member-specific information to help PCPs meet members' total health care needs. The provider portal provides access to the PCP's member roster, member assessments, service authorizations, care plans, member admissions, discharges and transfers, and service utilization data including prescribed drug utilization. Identifi Practice offers full interoperability with EMRs, connecting provider practices to our member-centered data warehouse to support real-time communication and coordination of care.

Using Identifi Practice, providers can see their patients with active conditions, and their patients' diagnoses and risk stratification score, in a single view. Identifi Practice can be used to guide providers' patient assessments and documentation.

Office staff can use Identifi Practice to stratify their patients for early outreach and scheduling and estimate appointment length, helping to ensure patients receive timely preventive care and chronic condition treatment and increasing efficiency. Identifi Practice also gives providers throughout the state, including in remote locations, real time access to population health measures and other valuable data and analytics. It supports providers' quality improvement efforts, tracking each provider's progress toward defined targets and quality goals and incentive status.

We also give providers critical data they need to help close patient care gaps. Any member of the care management team can communicate with the provider through EMR messaging with updates on member status and progress on care plan goals, barrier resolution, clinical needs, care coordination needs, and questions for the provider. Importantly, the Identifi Practice application can also be used to support communication between providers. When a provider accesses an enrollee record on Identifi Practice they can see records of the enrollee's recent utilization with other providers as well as any notes that those other providers have added to the Member's care plan.

USING THE AGENCY'S EVENT NOTIFICATION SYSTEM.

Admission, Discharge and Transfer (ADT) feeds are included in our data warehouse and becomes part of our comprehensive data set that populates our tools and systems. The

warehouse will collect ADT data from the Florida HIE Event Notification System (ENS) as soon as that data is available to aid in coordinating care.

Throughout the day, ADT alerts will be sent to our data warehouse and then through a rules-based system, transmitted into desktop and smart phone notifications to pre-determined staff or care teams. These rules-based alerts will be used to direct notifications for members enrolled in our care management programs, driving outreach and enrollment of members at risk for readmission into our Transitions of Care program and alerting care managers to their members' hospitalization. In addition to driving the care transition process, timely alerts offer the possibility of preventing admissions by allowing a care manager to receive a direct notification from a hospital and engage with the member and ER to determine if there is an alternative to admission. It may even be possible to direct a member to a primary care clinic for an urgent care visit rather than continuing at the ER.

The importance of real-time information about other provider interactions with our members is essential and laborious and expensive to build on a hospital by hospital basis. Currently all facilities within the Baptist Health system are transmitting ADT information to the Florida HIE. Lighthouse will promote the establishment of feeds to send ADT data to the Florida HIE from all of our PSN network hospitals.

INDICATORS OF EFFECTIVENESS IN MANAGING THE NEEDS OF SUPERUTILIZERS

We know from our population health experience that super-utilizers typically have multiple and complex physical and behavioral health needs and unmet social needs, including having a lack of social supports, adequate housing, and employment. Indicators used to evaluate the effectiveness of our evidence-based programs and interventions include:

• Reduced emergency room visits
• Reduced inpatient admissions and days (including for inpatient psychiatric stays)
• Increased primary care visits and increased use of other outpatient services
• Improved medication adherence
• Improved symptoms assessed using the GAD-7 and PHQ-9
• More stability in the community (for example, having more time at school, fewer shelter days, less time in jail, or gaining employment)

Evaluation Criteria:

1. The extent to which the respondent identified specific localized opportunities for improvement in achieving a reduction in potentially preventable events and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care (i.e., medical, behavioral health).

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify super-utilizers.

3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for high-risk enrollees, using specific local examples.

4. The extent to which the respondent plans to include the use of the Agency's Event Notification System as a means to extract relevant data from hospitals.

5. The adequacy of the respondent's description of specific indicators or measures that will be used to evaluate the effectiveness of evidenced-based programs and interventions that target super-utilizers.

6. The extent to which the respondent describes financial and non-financial provider and enrollee incentives that are aimed at diverting care to more appropriate and cost-effective settings (e.g., incentives for primary care providers that agree to extended or after-hours clinic care for their Medicaid patients).

7. The extent to which the respondent proposed local performance benchmarks for:

(a) Reducing potentially preventable hospital admissions and readmissions;
(b) Reducing use of the emergency department for non-emergent/urgent visits; and
(c) Reducing the use of unnecessary ancillary services during hospitalization and outpatient visits.

Score: This section is worth a maximum of 45 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 2 – Birth Outcomes (Statewide):

The respondent shall describe its organizational commitment to quality improvement as it relates to pregnancy and birth outcomes. More specifically, the respondent shall describe its overall approach, and specific strategies, that will be used to address prematurity prevention, improve perinatal outcomes, and reduce unintended pregnancies, including:

- A description of performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries;
- A description of incentives that will be implemented for providers and enrollees aimed at improving birth outcomes; and
- A description of strategies to decrease unintended pregnancies (e.g., increase in the use of long acting reversible contraceptives).

Response:

Baptist Health, as the parent organization of Lighthouse Health Plan (Lighthouse), is committed to improving women's preconception health, pregnancy and birth outcomes through the provision of high-quality obstetrical care, enrollee education and maternity care management. Evolent, with its partners, has been supporting pregnant women throughout their pregnancy and during the initial post-partum period for almost 20 years through their Maternity Care Program. Lighthouse will implement this successful approach to Maternity Care Management through local Maternity Care Managers, a centralized support line staffed with OB clinical experts and trained support staff, and a maternity education program that includes mailings, outreach calls, apps and text messaging

Through the Maternity Care Management Program, the maternity team contacts every pregnant enrollee and enrolls high risk pregnant women in care management. Enrollees identified initially as low risk, receive program information as well as general pregnancy care information, and are encouraged to contact our care managers if they experience complications or need additional help during their pregnancy.In addition, because risk profiles change throughout pregnancy, we contact members newly identified as high risk to enroll them in high risk pregnancy case management program.

The Maternity Care Program is designed to improve prenatal, infant, and maternal outcomes through improved compliance of both OB clinicians and pregnant enrollees with Perinatal Care Clinical Practice Guidelines and contract requirements, such as provider assessment of pregnant women's nutritional needs, family planning education, and counseling and testing for conditions like HIV. Clinical practice guidelines are based on the American College of Obstetricians and Gynecologist (ACOG) and Society for Maternal Fetal Medicine guidelines.

The Maternity Care Program supports healthy maternal and infant outcomes through promotion of timely prenatal care, identification of risk factors, the prevention of complications, and early identification and treatment of complications. It includes:
• Aggregating and analyzing enrollee data from multiple data sources, including claims data, assessments, and available EHR information;
• Identifying and stratifying pregnant women into risk levels, and continually updating the stratification as new data becomes available;

• Building enrollee-specific care plans based on an assessment of the woman's needs, inclusive of mental health and substance use issues;
• Connecting and engaging women through outreach calls, text messaging, mailings, and in-person visits for the highest risk women;
• Reassessing the woman's needs through all five stages of pregnancy, and updating her risk stratification and care plan;
• Coordinating interventions closely with the woman's OB provider; and
• Coordinating and improving compliance with postpartum medical recommendations, such as attendance at postpartum visits, pregnancy spacing, and life planning, as well as addressing the many social determinants of health that impact moms and their new babies.

Issues contributing to high risk pregnancy extend beyond the traditional trimesters of gestation. We address risk factors prior to pregnancy, during the three trimesters of pregnancy, and in the postpartum period as well. In this way, the continuum of women's health is best addressed to reduce complications not only in the current pregnancy, but in future ones as well. Additionally, health factors identified during pregnancy can be addressed following delivery in a manner that better ensures that chronic diseases are managed effectively preventing future complications.

Maternity Care Program goals include:
• Education of all pregnant enrollees during pregnancy and post-pregnancy to increase the rate of deliveries at ≥ 37 weeks gestation;
• Increase in the frequency of prenatal visits for gestational age ensuring pregnant women receive evidence-based prenatal care;
• Increase in the frequency of postpartum visits to prevent postpartum complications;
• Reduction in the rate of low birth weight and very low birth weight infants;
• Decrease in the frequency of elective delivery at < 39 weeks gestation;
• Decrease in smoking rates;
• Decrease in the rate of maternal and infant postpartum readmissions; and
• Improvement in the mother's and infant's quality of life.

A dedicated team of Maternity Care Managers and support staff work with obstetrical clinicians, Health Start Coalitions, Women, Infant, and Children (WIC) programs, local health departments, home health agencies, and others to identify and meet pregnant enrollees' psychosocial, nutritional and educational needs. Women with identified high-risk conditions – based on the provider's completed assessment or plan outreach – are enrolled into the high-risk component of the program. Local Maternity Care Managers are assigned to the woman who promotes access to prenatal services, coordinating all covered and non-covered services and connecting women to community supports. The program seeks to reduce the incidence of preterm deliveries, increase compliance with a schedule of appropriate prenatal visits based on gestational age and risk factors, increase compliance with evidence-based maternity care guidelines and decrease the incidence of elective (non-medically indicated) delivery at less than 39 weeks gestation. The model includes embedded Maternity Care Managers in high-volume or high-risk OB practices that serve primarily Medicaid recipients to further enhance identification and engagement of women with high-risk pregnancies. PCPs, OB providers, care managers or other health care professionals are encouraged to refer a woman who is determined to be at risk or who may be at risk for preterm birth or a poor pregnancy outcomes, to maternity care staff for outreach, assessment and care management enrollment.

The care team holds regular meetings face-to-face with providers to ensure compliance with best practices and support their efforts. The most popular approach with providers is a practice site "Care Conference." This consists of an onsite conference once a month where team members meet with the practice and review data such as the number of low birth weight and very low birth weight infants, the use of elective of C-sections, the number of enrollees receiving prenatal care in each trimester, and postpartum visit follow up data inclusive of monitoring for post-partum depression screening. The review includes data trends, identification of best practices and PDSA rapid process improvement cycles to improve operational processes and data collection.

SPECIFIC STRATEGIES

Participating OB providers complete an assessment of pregnant enrollees according to ACOG guidelines early in pregnancy to identify her risk factors. Providers submit the completed assessment via fax or through the embedded care team that includes notification of the woman's pregnancy and any risk factors. Maternity Care Program participants may also be identified by referral from their PCP or other health care professional; by self-referral; or by referrals from UR nurses, care management staff and 24/7 Nurse Advice Line. In addition, pregnant women may be identified from claims analysis from medical encounters, prescription medication information and through utilization of services.

Once notification that an enrollee may be pregnant is received, the enrollee is called to verify the pregnancy, provide education on prenatal care and complete an assessment. Outreach staff make three attempts to contact pregnant enrollees within 30 days of enrollment. If the enrollee cannot be reached or current contact information is not available, the enrollee's PCP is contacted to obtain updated contact information.

We encourage pregnant women to see an obstetrician or certified nurse midwife as early in their pregnancy as possible and if the woman has not yet scheduled a visit, help the woman identify an obstetrical practice and schedule these visits as needed. Our staff also coordinate access to transportation for those enrollees who need this service. All enrollees have access to help with their pregnancy and post-partum related needs by calling our maternity team.

Through mobile apps and mailings all pregnant women have access to a library of educational content (including video). We can also text women with brief healthy pregnancy messages and share pregnancy milestones via social media. Our maternity app and text message service provides access to a 24/7 maternity nurse line for enrollees to use to avoid an ER visit.

The maternity app, through Lucina's Firefly technology, will enable ongoing communication between the Maternity Care Manager and care team, and the enrollee. The app consists of SMS/text functionality for gestational age and condition specific educational content and questionnaires that allow for feedback and alerts to the Maternity Care Manager and care team. If an alert is sent to the care team, it will appear in their work list triggering outreach to the pregnant woman as necessary. In addition, based on the woman's response to the questionnaire, the tools provide real time updating of the clinical risk score for the care team and propose adjustments to the woman's care plan.

CARE COORDINATION PROTOCOLS AND RISK STRATIFICATION

Using proprietary software, we determine a pregnant enrollee's risk based on past claims and results of the assessment. We stratify enrollees based on condition and risk score. The Maternity Predictive Risk Score identifies those at highest risk for preterm birth and pregnancy complications by using predictive science that goes beyond a traditional risk and cost approach. We use medical claims, pharmacy claims, lab claims, EHR data, eligibility information, and information collected during the enrollee's assessment to analyze and stratify the risk level of all women of childbearing age.

Our algorithm includes over 200 predictors, including social determinants of health, to generate the mother's maternity risk score of 0-100. A unique feature is the collection of enrollee feedback from SMS texting/enrollee facing app that is also incorporated into risk scoring. Risk associated with the predictors vary based on which trimester they occur. Enrollee risk is generated through the "Five Stages of Pregnancy" which includes pre-risk calculations based on conditions and history that exist over three months prior to conception and then for each trimester as well as the post-partum period. Examples of how risk stratification impacts specific interventions include:

- The enrollee's unique risk profile results generate individualized recommended care management plans
- Continuous data analysis supports rapid identification of new conditions and generates alerts to the care team enabling earlier outreach to women with rising risk if needed.
- Outreach is automatically scheduled and prioritized based on risk score.

The risk stratification drives resources and interventions, directing the most intensive support and care coordination to the highest risk women identifying the small percentage of pregnancies that drive the largest percentage of cost as well as are associated with the poorest outcomes. Customizable high-risk triggers initiate clinical workflow that includes an initial referral call during which the care manager completes a maternity specific clinical assessment. This assessment then triggers automated call scheduling, recommended pertinent mailings, external referrals, and care needs (which come together to form the Care Plan).

Risk levels, examples of conditions associated with each risk level and summary interventions are provided below.

Level 1 –

Low risk enrollees include women with no known high or moderate risk conditions. We message low risk pregnant women twice weekly encouraging completion of prenatal care and delivering educational messages about healthy habits during pregnancy.

Women also receive educational materials – a Welcome Packet that includes "My Pregnancy Month by Month" booklet and information on available services and resources. This information describes:

- The WIC program
- The local Healthy Start Coalition services and contact information
- Text4Baby
- Transportation services
- Smoking cessation
- Dental and vision care
- How to get help if there is domestic violence

• Substance use treatment
• Legal aid services

We mail the packet within seven days of learning an enrollee is pregnant and mail postpartum educational materials following delivery. We begin outreach sooner for pregnant women with high risk pregnancies and other high-risk factors such as homelessness. We attempt contact and delivery of the packet within 24 hours to ensure early intervention with this high-risk enrollee.

We also mail educational materials to enrollees as needed, upon request or on the recommendation of the Maternity Care Manager, on the following specific topics:

• Car seat recommendations
• Conditions a woman may experience during pregnancy such as anemia, high blood pressure, nausea and vomiting, preterm labor, urinary tract infection
• Smoking cessation and the dangers of second-hand smoke to the unborn child
• Breastfeeding

Level 2 –

Moderate risk enrollees include pregnant women who smoke or who are obese. In addition to level 1 interventions, health coaches call the women to provide health education, make referrals to local programs such as those offered through the Healthy Start Coalition and web-based programs for smoking cessation, weight control and nutritional programs, support groups for single parents, and programs for group prenatal visits.

Level 3 –

High risk women have a history of preterm birth or preterm labor, diabetes, hypertension, incompetent cervix, pre-eclampsia, substance use, homelessness, domestic violence, and/or behavioral health conditions or are a pregnant teenager. Interventions include Level 1 educational materials and outreach and assignment to a local Maternity Care Manager who provides health education and coordinates all the woman's services and supports working closely with the woman's OB provider.

Maternity care program staff refer pregnant women to non-covered services and carved-out services providers with close coordination between our Maternity Care Managers and external case managers and providers. For example, we complete a WIC referral form and refer pregnant, breastfeeding and post-partum women to the local WIC program office to ensure their nutritional needs are met and to the local Healthy Start Coalition for pregnancy-related local classes and support, coordinating services and ensuring we do not duplicate case management or care coordination activities. We also help connect pregnant teens to local Teenage Parent Programs offered through their school and other teen-focused supports. In addition, all enrolled participants receive an outreach call each trimester to monitor risk status, identify any unmet needs and during the postpartum period, complete a depression screening.

If a pregnant or postpartum woman is not actively engaged in our Maternity Care Program, we implement outreach based on her level of risk, including sending educational mailings, making additional outreach calls, or sending a CHW or the Maternity Care Manager to the enrollee's home

to encourage participation and offer in-person assistance. We may also authorize regular home health visits for our highest-risk enrollees to support program participation and address a woman's developing high-risk conditions.

We update risk scores daily as we receive new information through claims and EHRs and reassign women to higher risk levels when they experience any condition that places them at risk for an adverse birth outcome.

INTERVENTIONS FOR HIGH-RISK PREGNANT ENROLLEES

High risk pregnant women receive comprehensive support from their assigned Maternity Care Manager who:

• Assesses and reassesses the enrollee's needs using a maternity-specific assessment;
• Coordinates care with the clinician involved in the enrollee's care and assists with follow-up care with a specialist, if needed;
• Establishes and maintains contact with the enrollee to evaluate and revise the plan of care as needed;
• Educates the enrollee and/or caregiver on the importance of medication adherence, attending scheduled appointments, adherence with self-monitoring activities, and adherence with screenings/lab tests;
• Educates the enrollee and/or caregiver on lifestyle changes that may improve the enrollee's birth outcome such as diet/weight management, medication adherence, exercise, smoking cessation, avoidance of drugs and alcohol, and regular clinicians' visits;
• Conducts the Patient Health Questionnaire (PHQ) 2 at postpartum as a depression prescreening tool and based on the results, completes the Edinburgh Postnatal Depression Scale (EPDS) Assessment, to identify enrollees in need of referral for behavioral health services;
• Provides the enrollee with assistance/information regarding available community resources; and
• Provides the enrollee and/or caregiver with additional written and/or verbal information targeted to the enrollee's specific diagnoses.

The Maternity Care Manager establishes realistic goals with each woman, shares educational information, and makes referrals to community resources such as local childbirth classes. The nurse also helps women reschedule missed OB appointments and overcome barriers that may contribute to further missed appointments, such as transportation and language barriers.

Telephonic teaching and educational materials focus on:
• Nutrition, healthy maternal weight gain, physical activity, medication adherence, smoking cessation, avoidance of drugs and alcohol, regular clinicians' visits, self-management, and breastfeeding promotion
• Trimester expectations and milestones
• Newborn care and postpartum self-care

The care team selects automated referrals to facilitate care coordination with other providers including behavioral health providers, social workers and community resources such as shelters and smoking cessation programs. We also use technology to connect with high-risk women and provide them tools to take control of their health. Through our mobile application, Identifi Engage,

we support the connection between high-risk pregnant enrollees, her Maternity Care Manager, and members of the care team. Identifi Engage includes the following features:

- View of the enrollee's care team
- Bi-directional messaging (chat) capability between the care team and enrollee
- Ability to influence enrollee behavior by pushing the right interventions to the enrollee
- Real time tracking of key health measures (such as weight and blood pressure) by the enrollee
- Ability to view trends for their measures
- Enrollee education
- Enrollee assessments

CARE PLANNING

We developed our standardized care plan content with input from Medicaid maternity care managers and Medical Directors, across multiple states (including Kentucky, Indiana, Texas, Illinois, and Ohio) resulting in fewer low birth weight babies and very low birth weight babies, and reduced elective C-section rates. The assessment and care needs composing the Care Plan address physical, behavioral health and social concerns including substance use, domestic violence and social determinants of health. Because the PHQ-2 and Edinburgh screening tools are built into the maternity assessment, related care needs populate the care plan including perinatal and postpartum depression interventions that address co-management with behavioral health providers. In addition, we collaborate with the Substance Use Disorder continuum of care—inpatient to outpatient - with long term follow-up and support for abstinence and medication assisted recovery. Our Community Health Workers, social workers, or Care Managers will accompany an enrollee to a substance use visit as needed and make home visits following discharge from the hospital to check on the home environment and assess mother and baby.

The Care Plan allows the enrollee to prioritize care needs that are important to them and helps the Maternity Care Manager identify and document barriers to completing interventions. A Patient Care Plan Summary is available to the enrollee and provides a simple review of what was discussed during the call with the Maternity Care Manager. A copy of the care plan can be sent to the provider via mail or email. We continue to conduct outreach to high-risk women throughout the 90-day period following delivery.

Communication Between Providers --

Evolent's Identifi Practice module was designed by physicians for physicians and includes EHR integration for ease of use. Identifi Practice gives all providers involved in the care of an enrollee with a high-risk pregnancy visibility into the woman's care plan, care gap workflows, risk stratification score (which is continually updated), and assigned Maternity Care Manager, supporting communication between providers.

In addition, the Maternity Care Manager's role includes functioning as the "quarterback" facilitating contact from provider to provider. Through case rounds and quarterly huddles as well as communication with each provider, the Maternity Care Manager supports the enrollee's coordinate care throughout her pregnancy. When the woman is admitted to the hospital for delivery or to treat complications of pregnancy, or goes to the ER, ADT feeds from participating facilities alert the care team. The care team notifies the woman's providers and the Maternity Care

Manager implements outreach to complete a reassessment and identify and address the woman's new or developing needs, working closely with the OB provider to support communication between the hospital and woman's providers.

Performance Benchmarks --

A reduction in non-medically indicated induction of labor or cesarean section prior to 39 weeks is achievable through enrollee education regarding risks of early delivery and the benefits of term pregnancy and requiring documentation of the medical indication for delivery prior to 39 weeks gestation prior to scheduling the delivery (either cesarean section or vaginal delivery by induction).

We have found that our rules for authorizing exceptions to requiring a 39-week gestation before delivery should be liberal enough to permit early delivery for any condition which places either the mother or baby at increased risk for adverse outcome if the pregnancy is continued until after 39 weeks. While some health plans provide lists of example conditions these are often misinterpreted as being an all-inclusive list of conditions for which early elective delivery is permissible. Since it is impossible to list all conditions which would appropriately indicate earlier delivery, such a list is always incomplete and results in unnecessary angst and administrative difficulties, in addition to physician resistance.

As a result, we propose a list of examples, clearly posted as guidelines which are not all-inclusive. In addition, we will make it clear that simply because a diagnosis or condition is included on the list does not make it a standard of care to deliver prior to 39 weeks. Our guidelines will be permissive but not directive regarding early delivery.

We will require OBs use the ACOG early delivery form, or a similar form, and that this form be on file at the delivering institution to schedule the early delivery. This would substantiate the medical indication for the early delivery and permit appropriate auditing for compliance.

We will also track and trend physicians and physician groups, as well as institutions for early delivery rates, and audit those retrospectively which exceed a benchmark, in addition to performing routine spot checks for compliance with all providers by auditing the hospital ACOG early delivery forms.

Local medical directors and population health managers will work with physician offices to understand the practice's opportunities and disseminate local and national best practice strategies to improve performance in identified areas. These population health managers are critical resources for the practice to help make sure pregnant women are receiving the right level of support from the Maternity Care Team and OB and to enable them to fully utilize the Identifi tools analytics and reporting capabilities to better manage the physicians' panel of patients.

The regional Physician Accountability Council (PAC) also plays a critical role as a senior physician governance body in helping support the deployment of best practices across physician groups in the areas of how to create workflow and protocols to maximize the number of enrollees engaging in care management, establishing care conferences with providers and staff to discuss opportunities to close gaps in care and manage complex enrollees, and to help prioritize important health plan clinical initiatives. They will also play a critical role in disseminating best practices at both the office and individual patient level to improve quality scores.

This de-centralized approach will foster a sense of accountability and commitment among local providers to improve outcomes and achieve incentive payments.

Required Documentation of Early Elective Deliveries and Cesarean Sections --

We work with obstetricians to promote adherence to evidence-based guidelines for appropriate cesarean sections and to identify factors that can be modified to reduce cesarean section use when medically appropriate. Compliance with clinical practice guidelines and best practices is dependent on buy in by physician groups. We will work closely with our OB and hospital providers, the Florida section of ACOG, the Florida Medical Association, and the Florida Hospital Association to agree upon uniform protocols for management, physician reporting and data collection, and incentives to increase the likelihood of success statewide across systems of care and providers. This approach is important not only in relation to delivery itself, but in management of multiple high-risk conditions and complication in pregnancy.

In conjunction with state and regional professional organizations we will pursue agreed upon management protocols for such issues as:
• Short cervix without contractions
• Common antepartum conditions
• Development of alternative sites of service for repeat episodes of threatened preterm labor
• Development of alternative modes of service delivery (centering pregnancy, joint midwife/physician practices, and alternative sites of delivery for low risk women ensuring adequate safe transfer and consultation

Our medical director will review cesarean section-related clinical notes to ensure the procedure was medically necessary, thoroughly documented and no appropriate or more conservative delivery methods were feasible. Examples of modifiable conditions associated with cesarean section use and related documentation requirements include:

• Suspected macrosomia: ensure parameters for estimated fetal weight are reasonable and documented
• Arrest of dilation/suspected cephalopelvic disproportion: ensure the provider adhered to guidelines for ensuring the woman was in the active phase of labor, had adequate uterine contractions, and the provider documented appropriate lack of progress in labor
• Fetal intolerance to labor: ensure appropriate documentation of fetal intolerance to labor not resolved by conservative means
• Multiple gestation: documentation of presentation of each twin, consideration for vaginal delivery, informed consent from the patient vertex
• Abnormal presentation: ensure the provider obtained the woman's informed consent for the cesarean section and external version was considered

Provider Profiling to Support Improvement --

We will profile providers' use of primary cesarean sections by reviewing the rate of cesarean section in the following sub-groups of women:

• Term gestation, vertex presentation, singleton pregnancy, primigravida
• Term gestation, vertex presentation, singleton pregnancy, multigravida
• Term gestation, suspected macrosomia
• Education and support for enrollees related to risks of cesarean sections, and benefits of vaginal deliveries for the current pregnancy and future ones.

We will monitor women who had a single previous low transverse uterine incision cesarean without recurrent conditions in this pregnancy for appropriate management in the current pregnancy. For women undergoing a trial of labor, we will monitor to ensure that appropriate guidelines for staffing, patient safety, and protocols for management are followed.
Women with two or more cesarean sections or other than low transverse uterine incisions are poor candidates for trial of labor. This group of women is unlikely to be delivered vaginally and attempts to significantly reduce the rate in this group without increased complications is not reasonable.

Tracking by physician, physician group, and hospital will identify providers who are outliers in relation to their peer groups as well as benchmarks to target those providers for education and compliance with best practices.

Proposed Benchmarking --

Reasonable initial goals are the achievement of either a 21-23 percent rate of cesarean section for the sub-groups of patients previously mentioned (primary cesarean sections in designated sub-groups) or a reduction of at least10 percent from the baseline rate in this group of patients.

Outcomes --

The Maternity Care Program implemented in Kentucky, where Evolent supports a Medicaid managed care plan, has reduced the percentage of deliveries that are low or very low birth weight deliveries and decreasing preterm deliveries.

• Low birth weight (LBW) deliveries decreased from 7.0% in 2012 to 6.90% in 2016. The LBW rate in 2016 surpassed the Healthy People 2020 goal of 7.8%.
• Very Low Birth Weight (VLBW) deliveries have decreased nearly 67% from 1.5% in 2012 to 0.5% in 2016. The VLBW rate in 2016 was well below the Healthy People 2020 goal of 1.4%.
• Preterm deliveries (less than 37 weeks) have decreased by 33% since 2012 (from 11.2% to 7.5%). The 2016 rate of 7.5% exceeded the Healthy People 2020 goal of 11.4%.
• The C-section rate declined from 34.2 % in 2015 to 32.3% to date in 2017.

Provider and Enrollee Education and Incentives --

Provider and enrollee incentives are designed to improve compliance with evidence-based interventions and drive positive health outcomes.

OB Provider Incentives –

We plan to implement obstetrics bundled payments offering OB providers an at-risk episode percent of premium global payment for prenatal care. The full payment will be paid 30 days after

pregnancy confirmation rather than after the postpartum visit. To qualify for payment, providers will be required to meet an OB-specific clinical quality gate (QG) tied to CMS Core Measures of Frequency of Ongoing Prenatal Care (FPC), Prenatal and Postpartum Care (PPC), timeliness of visits, and C-section rate for Nulliparous Singleton Term Vertex (NSTV). The goals will use the HEDIS benchmark 50th, 75th, and 90th percentile target where available and Healthy People 2020 target rate of C-section of 23.9% and potentially an analytically derived definition of 50th and 75th percentile. Incentives will be tied to measure performance at each percentile level allowing for tiered physician compensation.

We believe achieving all quality metrics, following evidence based guidelines, and engaging providers in higher levels of coordination of care will lead to less complications, improved outcomes and patient satisfaction, and potentially reductions in caesarian sections.

Incentives for Pregnant Women –

Enrollees may earn $25 per activity up to a maximum of $50 a year distributed on a reloadable card for completion of qualifying activities. Activities targeting improved outcomes for pregnant women are:
• Completion of prenatal and postnatal visits (must attend all prenatal and post-natal visits with a provider)
• Participation and graduation from specific care management program
• Successful participation in a medically-approved smoking cessation program
• Successful participation in a medically directed weight loss program
• Successful participation in a medically approved alcohol or substance abuse recovery program

Both smoking and substance use place pregnant women at higher risk for premature birth, delivery of low or very low birth rate newborns, stillbirth and for neonatal complications such as fetal alcohol syndrome and other withdrawal syndromes. These babies are at greater risk of sudden infant death syndrome, developmental delays, and the development of chronic conditions later in childhood such as asthma.

Strategies to Decrease Unintended Pregnancies --

Many of the women at highest risk for early repeat pregnancy and the associated increase in poor outcomes are also those not likely to keep postpartum appointments. For this reason, the insertion of long acting reversible contraceptive (LARC) devices while women are still in the delivery room or in the postpartum phase is markedly effective. Our approach to increasing the use of contraceptives includes:

• Capturing information regarding the enrollee’s previous and planned use of contraception. The automated Care Plan content provides educational content on developing a plan for contraception (including LARCs) following delivery.
• Including educational information on contraception and covered contraceptives, including how to access contraceptives, in our educational materials for pregnant women and reviewing this information during outreach or case management contacts as appropriate. Women may also call Maternity Care Managers or their OB Provider at any time to obtain personal assistance with their contraceptive needs.

• Educating obstetricians, PCPs, and hospitals about their role in supplying voluntary family planning and covered contraceptives information, including LARCs, and related billing information, such as how to bill for the LARC and related insertion separate from the labor and delivery fee.
• Tracking of postpartum visits and contraceptive counseling and intervention by physician, physician group and facility to make sure women receive appropriate preventive counseling and appropriate contraception. We do this through a review of pharmacy data and encounter claims and random chart audits.
• Reporting of postpartum visits and contraceptive counseling and intervention by physician, physician group and facility to identify and recognize those employing best practices as well as those who lag in this measure.

Maternity Care Managers also identify, through coordination with a woman's OB provider, those women at greatest risk for poor birth outcomes with subsequent pregnancies or because of inadequate pregnancy spacing. The Maternity Care Manager provides targeted outreach to these women and may send a community health worker or health educator to make a home visit when needed to provide in-person information and help accessing the covered contraceptive of their choice.

Measuring Effectiveness of Interventions to Reduce Unintended Pregnancies --

We will determine the effectiveness of our approaches to reduce unintended pregnancies by comparing inter-pregnancy intervals for a statistically valid sample of enrolled women comparing the number of overall pregnancies in each age grouping and in selected high-risk groups such as women who experienced medical complications during pregnancy or who used substances during pregnancy.

We will work with hospitals to ensure women have access to immediate post-partum sterilization for those women who request this service. We will work with each hospital to remove barriers to access coordinating access to an operating room, anesthesia and an OB/GYN available to perform the procedure.

Evaluation Criteria:

1. The extent to which the respondent identified opportunities for improvement in achieving the benchmarks and subsequent steps the respondent will implement to overcome any barriers across and within different systems of care.

2. The extent to which the respondent describes specific care coordination protocols, including a description of the risk stratification algorithm used to identify high-risk pregnancies (including enrollees with co-occurring behavioral health conditions).

3. The extent to which the respondent describes strategies to improve data exchanges and communications between practitioners to improve care coordination efforts for pregnant enrollees that are determined to be high-risk.

4. The adequacy of the respondent's description of specific evidenced-based programs and interventions that will be used to decrease the number of unintended pregnancies and the associated indicators or measures that will be used to determine their effectiveness.

5. The extent to which the respondent describes financial and non-financial provider and enrollee incentives for evidence-based practices that will contribute to hitting the benchmarks.

6. The adequacy of the respondent's proposed performance benchmarks for reducing non-medically indicated cesarean sections and early elective deliveries.

7. The extent to which the respondent describes its experience implementing successful strategies that resulted in a reduction in non-medically indicated cesarean sections and early elective deliveries. In order to receive all points for this component, the respondent must include outcome data on specific performance metrics.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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MMA SRC# 3 – Patient Centered Medical Homes (Regional):

The respondent shall describe its experience with patient centered medical homes (PCMHs) including the respondent's efforts toward the solicitation of PCMH-recognized practices to improve access, facilitate care integration and improvement in quality measures. Specifically, the respondent shall describe programs and initiatives utilizing PCMHs to promote the Agency's goals.

Response:

Lighthouse Health Plan recognizes the impact that provider-driven care coordination can have on improving care integration and health outcomes. As a Provider Services Network, we will leverage the experience of our sponsors, who currently deliver care through Patient Centered Medical Home (PCMH) models to expand the use of such models throughout our provider network. Our network development efforts to date in Region 1 have already resulted in contracts with 12 primary care sites that are certified PCMH's which include 179 primary care providers delivering services through the integrated, coordinated PCMH model of care.

Lighthouse will offer tools and supports to network providers who are operating as PCMH's as well as to those practices that are transforming their clinical processes to align with PCMH concepts.

• Our aligned care team community health workers and care managers locate and engage members, connect members to covered services and community resources, and schedule routine appointments. They also provide information on how to decrease no-show rates.
• The care team helps connect members to care management and disease management (Condition Care) programs based on each member's risk score and identified needs, helping PCPs target resources to members at risk for specific outcomes such as hospital readmission.
• Using Identifi Practice, providers can see their patients with active conditions, and their patients' diagnoses and risk stratification score, in a single view. To make sure members receive proactive care and interventions before they experience an adverse health event, we review the PCP's patients' risk stratification with the PCP quarterly. Identifi Practice can be used to guide providers' patient assessments and documentation. Office staff can use Identifi Practice to stratify their patients for early outreach and scheduling and estimate appointment length, helping to ensure patients receive timely preventive care and chronic condition treatment and increasing efficiency. Identifi Practice also gives providers throughout the state, including in remote locations, real time access to population health measures and other valuable data and analytics. It supports providers' quality improvement efforts, tracking each provider's progress toward defined targets and quality goals and incentive status.

EXPERIENCE WITH PATIENT CENTERED MEDICAL HOMES

Lighthouse's provider network partner, Escambia Community Clinics (ECC), an FQHC operates seven NCQA Level II-certified Patient Centered Medical Homes. These clinics have taken steps to improve care coordination including:
• Incorporated standing orders - clinical staff are empowered to order things they know are required, like A1Cs, foot checks, and annual eye exams for diabetics

• Piloting visit planning - system will tell team for each patient what they're missing (e.g., screenings, etc.)
• Implementing an after-hours program to increase availability of appointments
• Improved quality reporting capabilities through an enhancement to the EMR.
• Use of the Plan, Do, Study, Act (PDSA) process for quality improvement initiatives
• Instituting daily huddles (to look at patients for the day; review hospital discharges, care gaps, standardized orders needed for specified disease state, and other "care alerts" sent through the EMR.
• Daily Review of patients currently admitted to the hospital ensuring hospital follow-up visits are made.
• Focus on fluoride varnish for children per state goals as well as BMI with nutritional and exercise counseling supports (HEDIS measure)

As a result of this experience, we have established processes, now being revised to incorporate the latest NCQA requirements, that can be implemented in additional primary care practices to help them achieve PCMH recognition and learn from the best practices being implemented by ECC.

Lighthouse's health plan administration subcontractor, Evolent Health, is experienced in managing provider networks that include PCMHs to enhance access, provide better coordinated, integrated care and achieve improved quality outcomes.

Lighthouse and our network of PCMH's enhance access by:
• Acting as the enrollee's assigned medical home coordinating all medical care and facilitating access to needed community services.
• Ensuring timely appointments for routine and urgent care
• Facilitating access to specialty services and partnering with Lighthouse to address potential gaps in the network for needed specialties.
• Offering telemedicine connections to specialties that are hard to access.

Lighthouse and our network of PCMH's deliver better coordinated and integrated care by:
• Using on-site care managers to assist members with chronic disease management and care coordination needs.
• Delivering interventions based on actionable information regarding ED visits and hospital discharges that prevent avoidable visits and readmissions
• Collaborating with other servicing providers by sharing care plan information via Identifi Practice.

Lighthouse and our network of PCMH's improve quality outcomes by:
• Actively closing gaps in care identified through Identifi analytics, including routine health screenings, immunizations and other HEDIS measures.
• Supporting enrollee education on health lifestyle choices and chronic condition self-management techniques
• Bridging the gap between physical health and behavioral health services through enhanced referral processes, telemedicine connections to BH providers and, where feasible, co-location of services.

THE ROLE OF PCMH'S IN REDUCING POTENTIALLY PREVENTABLE EVENTS

Using the PCMH model will aid in prevention of avoidable events due to tighter oversight of patients with chronic conditions, patients with gaps in care, patients using the hospital and emergency departments, as well as those not filling their prescriptions. With a systematic way to use data, it allows us to direct our work in a more proactive manner, rather than reactive, which has been our process historically. Using the real-time data from ADT feeds will allow us to identify and quickly intervene with patients utilizing the ED or inpatient services. Ensuring appropriate follow-up with the patient centered medical home will ensure care coordination and adherence to discharge plans as an example.

RN care coordinator transition of care interventions have helped reduce hospital readmission rates, which have steadily declined from 15.2 percent in 2015 to 13.9 percent to date for 2017 (year to date through September 2017) across participating practices. Patient satisfaction has also improved year over year.

As we support additional practices' progress toward PCMH recognition we can help them achieve enhanced access for their patients, coordinated and integrated care, and improved quality outcomes. We recognize and support the many paths to value-based care, ranging from targeted initiatives to reduce hospital readmissions to more intensive programs like PCMHs.

• Our community health workers and care managers locate and engage members, connect members to covered services and community resources, and schedule routine appointments. They also work with providers, practice staff, and members to improve visit compliance and decrease no-show rates. By putting CHWs in the community, we have seen a no show rate of 33% in one community to 27% over the course of 4 months.
• The care team helps connect members to care management and disease management (Condition Care) programs based on each member's risk score and identified needs, helping PCPs target resources to members at risk for specific outcomes such as hospital readmission.
• We also deliver customized ER over utilization reports, care management reports, care gap reports, medication fill reports, and overall practice cost and use reports. Clinical Health Educators and Care managers work with providers and their patients to decrease readmissions, close gaps in care, and focus on self-management support.
• Through the use of Population Health Managers directly supporting practices we have found that we are able to improve preventive care and quality metrics. The role of the Population Health Manager is not one that just shares data, but focuses on interpreting the data, and looking for practice/process optimization strategies to improve data. As an example, we had a practice with one physician who had an incredibly high ER utilization rate compared to his colleagues within the same practice location. When we interpreted the data, we realized the visits were primarily occurring during routine business hours. When we tracked the contact points for some of the patients specifically we realized there was a breakdown in process around how to schedule this physician's patients for same day appointment needs that are truly non – emergent. This PDSA cycle was lead, start to finish, by the Population health manager. We were able to alter the process for patients when they call in for same day needs, and as a result, this specific provider was able to see his panel's emergency room utilization decrease overall (~reduction was 12% in six months).

THE ROLE OF PCMH'S IN IMPROVING BIRTH OUTCOMES

Our PCMH teams refers to our maternity program to ensure all of our pregnant enrollees have the education and tools they need regardless of risk level during their pregnancy. Once they are referred to the maternity program they are assessed for risk score and necessary level of intervention and support that may be best suited for that specific member. Lighthouse engages PCMH's to collaboratively support enrollees who are pregnant.

Our care team holds regular meetings face-to-face with providers to ensure compliance with best practices and support their efforts. Our most popular approach with providers is a practice site "Care Conference." This consists of an onsite conference once a month where we meet with the practice and review data such as the number of low birth weight and very low birth weight infants, the use of elective of C-sections, the number of members receiving prenatal care in each trimester, and postpartum visit follow up data inclusive of monitoring for post-partum depression screening. Together, we review data for trends, identify best practices, and implement a PDSA rapid process improvement cycle to improve operational processes and data collection.

PCMH's are well positioned to work with the enrollee's OB provider to address barriers to care that may drive poor birth outcomes while also monitoring their patient's adherence to prenatal care schedules.

Evaluation Criteria:

1. The extent to which the respondent's description demonstrates experience that includes contracts with patient centered medical homes in the network serving populations similar to the target population of this solicitation and demonstrates:

(a) Enhanced access;
(b) Coordinated and/or integrated care; and
(c) Achievement of improved quality outcomes.

2. The extent to which the respondent's description of recognizing PCMHs addresses the reduction of potentially preventable events for enrollees assigned to a PCMH for their PCP.

3. The extent to which the respondent's description of recognizing PCMHs addresses methodologies and processes to improve prenatal care and birth outcomes for enrollees assigned to a PCMH as their PCP.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 4 – Telemedicine (Regional):

The respondent shall describe its overall approach to utilizing telemedicine services to promote the Agency's goals, in particular as it relates to enhanced access to the following providers within the plan's network:

a. Primary Care;
b. Licensed mental health clinicians;
c. Psychiatrists;
d. Cardiologists;
e. Pulmonologists;
f. Endocrinologists; and
g. Internists.

The respondent shall describe any limitations placed on telemedicine services within its network and the percentage of providers with the network that are authorized to provide telemedicine services for the specialty types referenced above and those actually providing telemedicine.

Response:

The use of telemedicine as a cost-effective strategy to increase access to health care services has increased in Florida and around the country. Lighthouse Health Plan will leverage telemedicine to provide better access to care particularly for specialties that are less accessible in some parts of Region 1. As a Provider Services network, we will leverage the experience of our sponsor, Baptist Health, in delivering care using telemedicine technology, extend the availability of telemedicine visits and consults across the Lighthouse network, and augment our provider network with a national telemedicine vendor.

APPROACH TO TELEMEDICINE

Lighthouse will take a deliberative approach to integrating telemedicine into our provider network. We will build on the success of the initiatives that already exists within our PSN, and use a data-driven strategy to expand telemedicine capabilities in areas that will provide the most value to our membership. We will establish a telemedicine steering committee that includes representation from clinical leadership, care management, and provider network development. This committee will review and assess gaps in access to care, and the feasibility of addressing those gaps with telemedicine solutions. They will also recommend credentialing criteria to qualify network providers who will be permitted to deliver services through telemedicine technology.

IDENTIFYING TELEMEDICINE PROVIDERS AND ADDRESSING BARRIERS TO ADOPTION

Even though telemedicine offers the potential to address network gaps and expand access, providers are still needed to provide the service. One barrier to the effective deployment of telemedicine is the identification of providers who are willing and available to provide telemedicine visits. Our strategy for addressing this challenge is to identify telemedicine providers first from within the Baptist Health System, then from providers among our broader PSN network, and finally filling gaps with appropriately-licensed providers affiliated with our national telemedicine vendor.

Lighthouse will ask providers as part of the onboarding process if they want to be an active participant in the telehealth network. We will ensure that our network providers have "right of first refusal" as a part of a telehealth network ensuring patient access with providers who understand their geographical needs first before expanding to seek a wider network of providers based in FL.

Lighthouse will develop a specialized telemedicine credentialing process which will ensure our providers are prepared for successful telehealth encounters. Providers will receive unique Telehealth privileges by completing the following requirements: successful completion of a Telehealth Orientation Module for orientation/review of telehealth equipment, evidence of two Simulated or Live Telemedicine encounters, and the completion of a telehealth addendum to the credentialing application. Providers will be required to complete re-credentialing every two years. Telehealth Credentialing forms then follow the medical staff credentialing process.

The other major barrier to the adoption of telemedicine is the availability of technology. To support Enrollee access to telehealth technology, our telehealth solutions will be available on computers, laptops, tablets and mobile devices. Lighthouse will assist Enrollees in obtaining mobile devices subsidized by the Lifeline program through a partnership with Tracfone. These smartphones can accommodate the mobile applications necessary to access our telemedicine platforms. For targeted telemedicine initiatives, such as post-acute care programs leveraging telemedicine, Enrollees can be provided with a web-enabled tablet in order to access the service. We will look for opportunities to replicate this model where it will have the best impact on telemedicine utilization and improved outcomes. Finally, we will locate telemedicine equipment in select primary care clinics to facilitate access to specialty services through technology.

NETWORK PROVIDERS EXPERIENCED IN TELEMEDICINE

As a new entity, we are still building our provider network, but our BH network through Access Behavioral health includes 13 physician level and two masters level practitioners providing BH services through telemedicine. These providers have served 142 patients since the program was implemented in 2014.

Lighthouse will leverage a subcontractor who will provide a telemedicine platform that will be integrated with the Lighthouse website and mobile application. In addition to expanding the availability of primary care providers and licensed mental health clinicians, our telemedicine subcontractor will bring a network of appropriately licensed specialists including Psychiatrists, Cardiologists, Pulmonologists, Endocrinologists and Internists.

As we expand the number of providers who are authorized to deliver telemedicine services across our Network, Lighthouse will build upon several successful telemedicine initiatives currently in place within Baptist Health. These include:

Mental/Behavioral Health --
Lighthouse's affiliate and BH subcontractor, Access Behavioral Health, currently offers Telemedicine as well as individual, group, and family therapy via telehealth. This improves doctor/patient ratios as well as access to services for those who live in more rural areas, which subsequently reduces inpatient services for those Enrollees. ABH credentials Behavioral Healthcare providers and practitioners who conduct telemedicine with the proper interactive electronic systems that protect the confidentiality of client information and audio and visual data

transferred during the provision of telemedicine services. Currently the ABH network has Psychiatrists in four Provider Organizations (60% of Organizational Provider Network) who conduct Telemedicine services (Lakeview Center, Inc., Bridgeway Center, Inc., Chautauqua Healthcare Services, and Children's Home Society of Florida); however, 100% of Psychiatrists and Licensed Mental Health Clinicians are eligible to provide Telemedicine services as soon as they implement the required technology. There are no limitations on Telemedicine services as long as providers and practitioners who conduct telemedicine have the proper interactive electronic systems that protect the confidentiality of client information and audio and visual data transferred during the provision of telemedicine services, and the Enrollee consents to Telemedicine services.

Tele-consults with the Mayo Clinic --

Baptist Health participates in a telehealth program with the Mayo Clinic providing their physicians with access to world class specialists for consultation on patient cases. As a member of the Mayo Clinic Care Network, Baptist physician experts are able to connect with those at Mayo Clinic on questions of complex medical care using an electronic consulting technique called eConsults. Baptist providers also have 24/7 access to Mayo-vetted medical information and guidelines through AskMayoExpert, a Web-based resource created for physicians and other health care providers.

Evaluation Criteria:

1. The extent to which the respondent describes an approach on the use of telemedicine services within its provider network that supports achievement of the Agency's goals.

2. The extent to which the respondent describes the methodology it will use to identify providers eligible for participation, limitations/barriers in its proposed use of telemedicine and proposed strategies to overcome those limitations/barriers.

3. The extent to which the respondent has already made significant achievements in the deployment of telemedicine within its network as evidenced by:

(a) The percentage of providers authorized to provide telemedicine services for the provider types referenced; and

(b) The percentage and type of authorized providers that provided telemedicine services during the 2016 calendar year.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 5 – Provider Network Development (Statewide):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to primary and specialty care services, necessary to promote the Agency's goals, including:

a. Identification of network gaps (time/distance standards, after-hours clinic availability, closed panels, etc.);
b. Strategies that will be deployed to increase provider capacity and meet the needs of enrollees where network gaps have been identified;
c. Strategies (including a description of data sources utilized) for measuring timely access to appointments with the following provider types:

(1) Cardiologists (pediatric and adult);
(2) Pulmonologists (pediatric and adult);
(3) Endocrinologists (adult);
(4) Internists (adult);
(5) Psychiatrists (pediatric and adult);
(6) Obstetricians/Gynecologists (adult); and
(7) Licensed mental health clinicians (pediatric and adult).

d. Strategies for recruitment and retention efforts planned for each provider type, including the quality and/or performance metrics that will be used to determine a provider's success in making progress towards the Agency goals.

Response:

Lighthouse Health Plan will maintain and enforce a comprehensive network development and management plan to ensure timely access to primary and specialty care services for our enrollees. The network development plan meets all requirements delineated in Section VIII.B.2 of the SMMC model contract, and it will be updated and submitted to the Agency by September 1 of each contract year. We describe the key components of the network development plan in the following pages.

As a provider service network, Lighthouse has a deep commitment to finding innovative ways to fill gaps in care in Northwest Florida. Our founding health system, Baptist Health Care, has been serving the Northwest Florida community since 1951 when it opened Baptist Hospital. Baptist has consistently been on the forefront of increasing access to care from establishing the first hospital based emergency helicopter program in Florida, to opening the first inpatient child psychiatric unit in the region, to becoming the first healthcare provider in Northwest Florida to offer ECMO. Lighthouse is a natural extension of Baptist Health Care's dedication to meeting the needs of the community.

Our initial and ongoing recruitment strategy builds on our deep roots in the community and an active outreach campaign, supported by cutting edge analytics used to identify and contract with primary and specialty care providers. Our analytics, secret shopper, Enrollee Services and Population Health teams continually monitor access to care to identify network gaps, while population projections allow us to anticipate and plan for future needs. Our Utilization

Management (UM) and Care Management (CM) processes facilitate authorization and access to out-of-network (OON) providers when necessary and appropriate. Finally, our Identify Practice tools enable network providers to assess their performance and progress toward the Agency's goals.

NETWORK DEVELOPMENT AND MONITORING

For our initial network development, our Provider Network Team aggregated our provider data for our affiliated providers, and applied Quest Analytics tools, an industry-standard software platform that combines dynamic time and distance access standards with minimum provider requirements to evaluate our overall network adequacy and identify gaps. We then used external data sources including the ACHA Master Provider List, Enclarity, and Strenuus to identify community providers for network recruitment in order to meet or exceed network standards outlined in Section VIII.A of the SMMC model contract. We also contracted with Rural Health Clinics (RHCs), Federally Qualified Health Clinics (FQHCs), and Statewide Essential Providers as they provide a critical safety net to the Medicaid population. We have added the EPSDT form to the PCP provider agreement to ensure all PCPs can mark their practices as EPSDT status providers.

Lighthouse enrollees will benefit from the commitment that Baptist Health Care has shown to growing behavioral health and substance abuse services in Northwest Florida. Enrollees will receive care through Access Behavioral Health (ABH) and Lakeview Center. Access Behavioral Health will offer enrollees a fully adequate network of psychiatrists and licensed mental health providers. Lakeview Center provides the most comprehensive set of services for people with mental health issues, drug and alcohol dependencies, or intellectual disabilities in the region. These services range from inpatient and residential treatment to a gamut of outpatient programs including trauma services, psychiatry, counseling, day treatment, and intensive, round-the-clock outpatient services to help people with severe mental illnesses safely remain in the community.

We continue to assess network adequacy on an ongoing basis and look for opportunities to improve access for our enrollees. Each month our provider network team reapplies Quest Analytics tools to identify gaps based on network standards, and uses the ACHA Master Provider List, Strenuus, and Enclarity to identify community providers for potential recruitment. The provider network team reviews claims data on a quarterly basis to determine which out of network providers were seen by enrollees during the previous quarter. The provider network team reviews all access related feedback from enrollees, referring providers, care managers, and utilization managers.

Identifi Network, our web-based provider data management tool, maintains our provider file, populates the provider directory and supports network adequacy analytics. Identifi Network allows our network administrators and managers as well as providers to create, track, maintain and access interactions with network providers.

The provider network team also reviews referrals and collect feedback from Care Management, Enrollee Services, and the Population Health Management departments regarding access issues and unmet clinical or social factors that affect patient care such as language, ethnicity, gender, or special needs. For example, while Lighthouse may meet the adequacy standard in our Region, there may be insufficient providers who speak a certain language. In addition, quarterly secret shopper and onsite access reviews identify access barriers to specific providers or practices such

as long wait times, lack of after-hour appointments, and closed panels; these are escalated to the provider network team and other relevant departments for action (described further below). Based on all of these data sources, our provider network team develops a recruitment work plan and conducts outreach to recruit high quality providers to the network to fill all gaps. Short term needs are escalated for authorization of out of network providers, described below.

PROVIDER RECRUITMENT AND NETWORK PLANNING

Our provider network team conducts provider recruitment outreach via site visits, phone calls, or email to inform providers about our plan and present participating provider agreements. For this outreach, we have developed standard scripts describing the reason for the contact and details regarding the health plan and an invitation to participate. Pre-and post-execution work teams meet weekly to ensure open communication and a smooth transition for providers into our networks.

Being a provider service network is a tremendous advantage in recruiting providers, maintaining the network, and meeting community needs. Our relationships with providers in the community allows us to partner in formal and informal ways to bring clinical resources to underserved areas or to extend admitting privileges to expedite care for enrollees. Our sponsoring organizations' executives (CEOs, CFOs, CMOs, etc.) communicate on Lighthouse's behalf to their medical staffs, to other health delivery systems and community providers about the benefits of participating in our unique provider-sponsored plan.

Our relationships with providers in the community also help us to project future enrollee needs and build our network accordingly. Our primary care, FQHC/RHC, and emergency room providers are often the very first to identify new or increasing public health issues, changes in the population demographics, other enrollee needs. By engaging regularly with these providers, and maintaining formal relationships such as through our Quality Improvement Committee, we ensure that our network is continuously prepared to meet the needs of enrollees.

Because Lighthouse believes that having a primary care home is central to enrollees' overall health and avoiding preventable events, our provider network team conducts special outreach to primary care providers. On a monthly basis, the team encourages PCPs to maintain open panels and continue to accept enrollees from Lighthouse. Our PCP agreements include financial incentives to encourage PCPs to offer evening and weekend hours, promoting access to care.

ACCESS TO OUT-OF-NETWORK (OON) PROVIDERS

We will ensure that enrollees can access medically necessary care including services from OON when needed and appropriate. Immediate service needs are addressed through our policies on OON coverage for emergency services. Short term needs for OON services are addressed through single case agreements, and our long-term approach involves recruitment of OON providers into our network.

Should an enrollee require immediate, emergent or urgent care services and they are not near or cannot access a contracted provider, they are advised to go to the nearest treatment facility. This is supported by Lighthouse policies and communicated through our contracted providers, Enrollee Services, and enrollee handbook. Out of network emergency services are available without any financial penalty to the enrollee.

When an enrollee needs to access non-urgent care outside of the Lighthouse network, the primary care physician or OON provider will contact the utilization management (UM) Department to secure an authorization. During the authorization process, the UM team will remind the OON provider of the timely access requirements for urgent and routine appointments. If the enrollee has any issues securing a visit with a specialty care provider, Enrollee Services or Care Management staff can assist the enrollee by contacting the OON provider to help secure a timely appointment that meets the Agency's standards.

Our UM and Care Management (CM) processes coordinate services from OON providers, with the goal of ensuring the services are appropriate and consistent with an enrollee's identified needs. Our OON service authorization includes review by a UM Nurse, a care coordinator or the enrollee's Care Manager (if enrolled in care management), and as appropriate the Medical Director. The UM nurse confirms the requested service is medically necessary and is not available or accessible from a network provider. The Care Coordinator or Care Manager coordinates the OON services with the enrollee's other providers, including the PCP, and provides appropriate medical records, including copies of the enrollee's care plan, to the OON provider. The Medical Director validates the need for OON services and is available for peer to peer consultation with the OON provider and the enrollee's other treating providers. The Provider Services Call Center is available to respond to OON provider's questions and assist them with the OON service authorization process.

The UM nurse also notifies provider network staff about requests and authorizations for OON services. Provider network staff then contact the identified OON provider and invite the provider to join the network. If the provider is agreeable, a provider network specialist works to initiate the contract and enrollment process. If the provider is not willing to immediately join the network, a single case agreement is created, and the provider network staff instructs the OON provider on how to obtain access to the Lighthouse website, which includes resources the provider can use to join the network at any time. The provider network specialist can also provide materials to the provider via fax or by mail if the provider has no internet access. OON providers also have access to provider manuals that include enrollee rights and responsibilities, our coverage policies and provider updates. Provider network staff will also initiate provider recruitment and contracting efforts to identify available providers of the same specialty type able to meet the enrollee's needs and are willing to join our network. We will continue to authorize OON services for as long as medically necessary and until we can meet the enrollee's need with an in-network provider. To ensure continuity of care, we may choose to extend the OON authorization until the enrollee's course of treatment is complete, even if an in-network provider is identified.

MEASURING TIMELY ACCESS TO CARE

Timely access to urgent and routine appointments is fundamental to Lighthouse's medical home model. We use secret shoppers, on-site access reviews, and Enrollee Services data and grievance monitoring to identify issues with wait times, and then target interventions accordingly.

Each quarter Lighthouse will use trained secret shoppers to conduct calls to a randomly selected, statistically valid sample of primary care, specialty, and behavioral health providers including:
• Cardiologists (pediatric and adult);
• Pulmonologists (pediatric and adult);

• Endocrinologists (adult);
• Internists (adult);
• Psychiatrists (pediatric and adult);
• Obstetricians/Gynecologists (adult); and
• Licensed mental health clinicians (pediatric and adult).

The secret shoppers will pose as Lighthouse enrollees who are "shopping" for a health care provider to schedule appointments. The secret shoppers document the wait times for urgent care, routine sick care, and well- care appointments. Providers who cannot be reached at the phone number listed in the provider directory or who do not offer an appointment within the timeframe outlined in Section VIII.A.8 of the SMMC model contract will be escalated to the provider network team for an onsite access review.

In addition to targeting providers flagged by the secret shoppers, the provider network team will randomly select a statistically significant number of providers on a quarterly basis for on-site access reviews. During the on-site review, the Provider Network Representative will assess the following:
• Physical accessibility and office appearance including handicapped/wheelchair access, general cleanliness, adequate seating, and posted office hours
• Wait time for a patient to see a provider upon arrival at the office
• Availability of new patient appointments
• Number of routine office visits scheduled per provider per hour
• Number of hours available to patients per week
• Next available routine appointment, urgent care appointment
• Review of historical appointment scheduling trends for routine and urgent appointments
• Provider's method of answering phone (staff enrollee, answering service, voicemail, etc.) including afterhours phone policies and number of minutes to return patient calls
• Office policies and standards for reporting of communicable diseases, privacy protection, and maintenance of complete and accurate medical records, reduction of fraud and abuse,
• HIPAA audit- location of fax/copier, password protection of computers, use of encrypted emails

Any Primary Care Provider (PCP) who is found to be out of compliance with the timely access standards during an onsite access review will removed from receiving enrollees through the PCP auto-assignment process. For primary, specialty, or behavioral health care providers found out of compliance with wait time standards, Lighthouse will send a letter to the provider to outline areas of where the provider was out of compliance, and inform them that they will be resurveyed within 90 days. If a provider fails both the initial and 90-day follow-up surveys, their information will be sent to the Credentialing Committee for additional recommendations or actions. Our priority is to help the provider to adhere to the standards, but if efforts fail, providers may be terminated from the network.

In addition, our Enrollee Services team will monitor enrollee grievances, calls, and complaints related to access. All access complaints will be referred to the provider network team for investigation. If a PCP office receives multiple complaints they will be removed from the PCP auto assignment processes until an on-site access review is completed. Enrollee Services representatives will assist enrollees in changing primary care or other providers, locating an alternate network provider, or will outreach to the PCP, specialist, or behavioral health provider

office on behalf of the enrollees to assist with scheduling appointments as needed until the office is brought back into full compliance.

RETAINING HIGH QUALITY PROVIDERS

All health plans experience some occasional dissatisfaction by network providers, commonly related to difficulties or delays with billing, claims payments, or service authorizations, or challenges serving high risk Medicaid enrollees. Lighthouse uses proven technologies and processes to minimize such difficulties, and we leverage our role as a provider service network to build relationships to retain high quality providers in our network. Our Medical Directors are available to providers for consultation, peer-to-peer discussions regarding treatment plans or service authorization requests and other patient care questions or concerns. Our providers will be invited to join the Lighthouse Medical Directors at regional meetings on best practices, to discuss specific community and population needs, and to participate in the Lighthouse quality committees such as the Quality Improvement and Credentialing Committees. These peer-to-peer interactions promote communication to identify provider issues and address them early, as well as to continually build commitment to Lighthouse and strengthen network retention.

Lighthouse will have a robust provider support network that includes the following:
• Provider network representatives, including field-based representatives who help providers with operational issues including claims submission and payment
• Embedded Care Managers for high volume or high-risk practices, who work with providers and enrollees at the point of care
• Population Health Managers, who will provide in-person support to PCPs and practice managers, including analyzing practice data and helping practices make full use of data available through the provider portal, EHR, and Identifi Practice tools; and facilitating workflow improvements.

Our provider network team also works with our specialist and behavioral health providers to ensure that they remain committed to serving our enrollees. This team works with the offices to facilitate Lighthouse administrative processes, informing them about our electronic referral process, the Provider Services Call Center, authorization services, and prompt claims payment through Electronic Funds Transfer. These features have been identified as critical by our specialist and behavioral health providers in previous provider satisfaction surveys. As a result of consistent communication with our specialist providers, our retention rate in other markets where this model has been used exceeds 99%.

PROVIDERS' ACCESS TO PERFORMANCE METRICS

We will utilize the Identifi Practice platform to offer network providers the ability to track their progress toward achieving Agency and Lighthouse goals in real time. Identifi Practice is our provider-facing population health portal that allows providers to identify gaps in care and have a better understanding of enrollees' overall health and current care management progress. Identifi Practice is an interactive population dashboard displaying the full panel of patient enrollees attributed to a given provider. It enables providers to:
• Monitor quality by viewing performance measures compared to targets
• Identify gaps in care and opportunities to close care gaps at the time of service, using recommended care and patient fact sheets to focus on "what is due" for the patient

• Identify risk adjustment opportunities
• Display care management activities including care plans
• View a complete list of patients, including risk scores and condition lists.

Identifi Practice is powered by real time data from our Enterprise Data Warehouse. Data elements that are updated real time include:
• Gaps in care based on claims data
• Updates to an Enrollee's care plan and notes from the Enrollee's Care Team
• Pharmaceutical claims and Medication adherence information.

The platform provides transparency around performance management, enabling providers to view, track, and improve their performance.

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities for network development based on identified gaps and future needs projection.

2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.

3. The adequacy of the respondent's approach for measuring timely access for the specified provider types and the extent to which the respondent's approach includes clear methodology for determining the following:

(a) Average wait time for an urgent appointment; and
(b) Average wait time for a routine appointment.

4. The extent to which the recruitment efforts outline the frequency and specific measures to be used to track the need to deploy recruitment activities for the provider types listed.

5. The extent to which the retention efforts outline the approach to keeping providers satisfied and in good-standing with the respondent.

6. The extent to which the quality and/or performance metrics it will use to gauge progress toward the Agency goals are transparent to providers, including the frequency with which providers will be able to access their progress.

Score: This section is worth a maximum of 40 raw points with each of the above components being worth a maximum of 5 points each.

5 additional points will be awarded to respondents who demonstrate that providers shall have real-time access to their progress in achieving quality and/or performance metrics.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS AND EVALUATION CRITERIA (10-2-17)

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 6 – Provider Network Agreements/Contracts (Regional):

The Agency has identified some of the key network service provider types that will be critical in order for the respondent to promote the Agency's goals.

The respondent shall demonstrate its progress with executing agreements or contracts it has with providers in the region by submitting **Exhibit A-4-b-1**, Provider Network Agreements/Contracts (Regional):

Response:

To promote the Agency for Health Care Administration's goals and adequately serve our enrollees, Lighthouse Health Plan, LLC has contracted with key service provider types. The percentage of provider network agreements/contracts is detailed in Attachment MMA SCR 6: Exhibit A-4-b-1. For Region 1, the percentage of agreements or contracts per network service provider type is as follows:

• Board Certified or Board Eligible Adult Psychiatrist -- XX%
• Board Certified or Board eligible Child Psychiatrist -- XX%
• Cardiology -- XX%
• Cardiology (PEDS) -- XX%
• Cardiovascular Surgery -- XX%
• Endocrinology -- XX%
• Endocrinology (PEDS) -- XX%
• Internal Medicine -- XX%
• Obstetrics/Gynecology -- XX%
• Pulmonology -- XX%
• Federally Qualified Health Center -- XX%
• Rural Health Clinic -- XX%

Evaluation Criteria:

For each service provider type the respondent may receive up to 20 points as described below. Points for each service provider type will be awarded as outlined in the table below:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	5
25.1%- 50%	10
50.1%- 75%	15
75.1% or greater	20

Score: This section is worth a maximum of 240 raw points based on the above point scale.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 7 – MMA Physician Incentive Program (MPIP) (Statewide):

The Agency has designed the MMA Physician Incentive Program with the expectation that Managed Care Plans should be able to increase compensation for physicians, using funds achieved through savings from effective care management, as specified by Section 409.967(2)(a), Florida Statutes. The respondent shall describe its plan for ensuring physician compensation rates are equal to or exceed Medicare rates for MMA covered services. Specifically, the response shall include detailed descriptions of quality initiatives the respondent intends to implement or maintain that produce savings by promoting the Agency's goals, as well as other areas where the respondent has evidence that a potential for savings and increased quality exists.

Response:

As a Provider Services Network, Lighthouse Health Plan believes strongly that aligning provider financial incentives can drive improved quality outcomes and costs savings that support enhanced provider reimbursements. We recognize that the Agency is requiring an incentive program that allows providers to earn up to at least 100% Medicare rates by meeting certain value-based metrics. This certainly aligns with our mission and goals as a provider services network. It is our intent to leverage experience in our existing programs that reduce impactable utilization that provide an opportunity for savings to support payment at Medicare rates. Below, we identify those quality initiatives, programs or interventions that increase quality and redirect costs through either improved performance on quality measures, reducing preventable events, improving prenatal care and birth outcomes, or achieving other efficiencies that drive savings. These savings will be used to ensure that eligible physicians (primary care, pediatrics, ob/gyn and pediatric sub-specialties) will have the opportunity to earn up to 100% Medicare rates by meeting or exceeding the PCMH and or HEDIS metrics as further described below.

We further recognize that the Agency has given managed care plans the flexibility to design their own Individual Health Plan Incentive Program (IHP) or use the Agency Alternative Program (AP) standard format. Based on the review of other plans in FL across every region, it appears that almost all of them have a standard incentive plan with only a few variations in HEDIS measures and some variation among types of providers who are eligible for the incentive. Consistent with the approaches that providers are used to in the market, and in compliance with the Agencies guidelines, we plan to offer a similar program that will apply to:

- Pediatric PCPs (including pediatricians, family practitioners, and general practitioners), regardless of specialty or board certification
- OB/GYNs
- Pediatric sub-specialties (as outlined below)

REDIRECTING COSTS TO PAY HIGHER PHYSICIAN RATES

Delivering high quality, coordinated care not only drives improved health outcomes for our Enrollees, it also contributes to program savings by promoting preventive care and supporting efforts to reduce potentially preventable events. To recognize the role physicians play in the programs outlined below, we have aligned enhanced payment to certification as a PCMH or performance on key quality metrics.

Pediatric Primary Care (PCP) --

Providers designated as PCPs (including pediatricians, family practitioners, and general practitioners), regardless of specialty or board certification, practicing within a group with at least 100 Lighthouse Medicaid Enrollees under the age of 21 years, at a site recognized as a Patient-Centered Medical Home, on by one of the following organizations:
• National Committee for Quality Assurance (NCQA), Level 2
• Accreditation Association for Ambulatory Health Care (AAAHC)
• The Joint Commission (TJC)
• Utilization Review Accreditation Commission (URAC)
OR
The site must also achieve the following access and quality measures using HEDIS 2017 specifications within the measurement period:
• Lead Screening: > Medicaid 50th percentile
• Child Access to Primary Care (3 of 4 age bands): > Medicaid 50th percentile
• ER Utilization: <650 visits per 1000 Enrollees
• After-Hours Availability: appointment availability after 6pm or on weekends

OB/GYNs:

Providers designated by Lighthouse as OB/GYN physicians, board certified in obstetrics and gynecology by the American Board of Obstetrics and Gynecology or the American Osteopathic Board of Obstetrics and Gynecology, practicing within a group with at least 10 deliveries for Lighthouse Medicaid Enrollees at a site that achieves the following access and quality measures within the measurement period:
• Frequency of Ongoing Prenatal Care: >Medicaid 75th percentile
• Postpartum Care: > National Medicaid Mean
• Cesarean Section Rate: <35%

Pediatric Sub-Specialties –

In order to promote access to care, all network providers designated by Lighthouse as a physician board certified in one of the following pediatric specialties will receive 100% of Medicare.
• Pediatric Cardiologist
• Pediatric Endocrinologists
• Pediatric Nephrologists
• Pediatric Neurologists
• Pediatric Psychiatrists

REDIRECTING COSTS BY REDUCING POTENTIALLY PREVENTABLE EVENTS

The work that our providers do is integrated with supports provided by Lighthouse that drive improved Enrollee health and savings through the reduction of potentially preventable events.

Across our care management programs, including Disease Management support for a variety of conditions through our Condition Care program and Care Coordination for Enrollees with complex health needs through our Complex, Catastrophic, and Advanced Illness Care programs, our

interventions focus on transitions of care and Emergency Department utilization focusing on highly impactable avoidable utilization that drives savings.

Transitions of Care: Our program includes targeted care coordination for Enrollees admitted to an inpatient facility who are identified through risk stratification as at-risk of readmission. Identification includes consideration of social determinants of health. Enrollees may also be enrolled upon referral from a nurse or BH care manager and/or the hospital discharge planner when Enrollees lack natural supports in the home, there are barriers to linking the Enrollee back with his or her PCP, or there are other factors that could increase the risk of ER visits or readmission. Our Care Management team engages with the Enrollee while they are still in the hospital, and follows the Enrollee post-discharge to address risk factors for re-admission.

Through this program we impact the following metrics which contribute to savings to support enhanced provider reimbursement.
• Follow up visit made within 7 days following post-acute stay
• Plan All-Cause Readmissions (Adult & Peds)
• All-Cause readmission rate
• Risk-adjusted average length of stay
• Hospital re-admission at 30, 60, 90, and 180 days (including psych), Primary savings are driven through this Clinical Program, with secondary savings in other Clinical Programs
• Follow up after hospitalization (all types)

Based on our team's experience implementing this model in other Medicaid markets, our Transitions of Care efforts are expected to generate net cost savings of 1.5% of inpatient fee-for-service expenditures.

Complex Care: For Enrollees of all ages identified through risk stratification as having "rising risk" – being at high risk for a future inpatient admission or emergency room (ER) visit that can be avoided with the additional support from a nurse or behavioral health care manager, as applicable. Enrollees stratified at this level are able to learn and use self-management skills.

We assess for chronic conditions that are not being adequately managed, relationship and use of primary care provider, adherence and compliance with treatment regimen, conditions that may indicate poorly treated chronic pain, assess for behavioral health and substance use disorder.

Enrollees identified as being at risk for avoidable ED utilization receive targeted support to address the root causes of their use of the ED. Through this program we impact the following metrics which contribute to savings to support enhanced provider reimbursement.
• ER visit rate
• Avoidable hospital admissions
• Ambulatory Care Sensitive ED Rate (Adult & Peds)
• Connection to a Medical Home
• Assessment for other applicable clinical programs

Based on our team's experience implementing the Complex Care program in other Medicaid markets we expect to achieve net cost savings of .5% of inpatient fee-for-service expenditures.

High-Need Behavioral Health Care Management: For Enrollees who have a serious mental illness and co-morbid conditions that significantly impair functioning. A BH care manager works with Enrollees to develop a recovery and resiliency plan, provide intensive coordination of all of the Enrollee's services and social supports, and to ensure the Enrollees complex and co-morbid needs are addressed. An RN assesses Enrollees for co-morbidities and completes medication reconciliation. Enrollees receiving Targeted Case Management (TCM) from a mental health provider will be co-managed. Our care managers will participate in multi-disciplinary care rounds, providing notifications for admissions alerted through ADT feeds, serving as a liaison between the mental health provider and PCP, and performing medication reconciliation activities. Through this program we impact the following metrics which contribute to savings to support enhanced provider reimbursement.

• Completion of screenings designed to identify Enrollees who need specific interventions such as the PHQ-9 for detection of depression in the primary care setting or completion of the Edinburgh Depression Scale for women who screen positive or are identified with post-partum depression
• Antidepressant Medication Management- Acute Phase
• Hospital re-admission at 30, 60, 90, and 180 days (including psych), This indicator is Primarily impacted by another Clinical Program, but this indicator is impacted secondarily through this Clinical Program.
• Initiation and engagement of alcohol and other drug dependence treatment (IET)
• Antidepressant medication management (AMM)
• Follow-up care for children prescribed ADHD medication (ADD)

Based on our team's experience in other Medicaid markets, the BH care management program along with our condition care programs for chronic disease are expected to generate net cost savings of .5% of inpatient fee for service expenditures.

REDIRECTING COSTS RELATED TO PRENATAL CARE AND BIRTH OUTCOMES

Our Maternity Care Program supports healthy maternal and infant outcomes through promotion of timely prenatal care, identification of risk factors, the prevention of complications, and early identification and treatment of complications. Our program includes:

• Aggregating and analyzing Enrollee data from multiple data sources, including claims data, assessments, and available EHR information;
• Identifying and stratifying pregnant women into risk levels, and continually updating the stratification as new data becomes available;
• Building Enrollee-specific care plans based on an assessment of the woman's needs, inclusive of mental health and substance use issues;
• Connecting and engaging women through outreach calls, text messaging, mailings, and in-person visits for the highest risk women;
• Reassessing the woman's needs through all five stages of pregnancy, and updating her risk stratification and care plan;
• Coordinating interventions closely with the woman's OB provider; and Coordinate and improve compliance with postpartum medical recommendations, such as attendance at postpartum visits, pregnancy spacing, life planning, etc., as well as addressing the many social determinants of health care in these women and their new babies.

We consider the issues of high risk pregnancy to extend beyond the traditional trimesters of gestation. We address risk factors prior to pregnancy, during the three trimesters of pregnancy, and in the postpartum period as well. It is in this way that the continuum of women's health is best addressed in order to reduce complications not only in the current pregnancy, but in future ones as well. Additionally, health factors identified during pregnancy can be addressed following delivery in a manner that better ensures that chronic diseases are managed effectively prior to complications resulting from them developing.

Our Maternity Care Program impacts the following metrics that contribute to cost savings supporting enhanced provider payment:
• Education of all pregnant Enrollees during pregnancy and post-pregnancy to increase the rate of deliveries at ≥ 37 weeks gestation;
• Increase in the frequency of prenatal visits for gestational age ensuring pregnant women receive evidence-based prenatal care;
• Increase in the frequency of postpartum visits to prevent postpartum complications;
• Reduction in the rate of low birth weight and very low birth weight infants;
• Decrease in the frequency of elective delivery at < 39 weeks gestation;
• Reduction in non-medically indicated cesarean sections; and
• Decrease in the rate of maternal and infant postpartum readmissions;

OTHER QUALITY INITIATIVES AND EFFICIENCIES THAT GENERATE SAVINGS

Lighthouse's overall operations are oriented towards improving health outcomes while utilizing Medicaid resources more efficiently. In addition to the clinical quality programs described above, we will achieve savings through smart utilization management and an effective pharmacy program.

Our UM Program:
1. Increases access to medically appropriate services;
2. Ensures provision of medically necessary physical health and behavioral health services at the right intensity, duration and level of care
3. Assesses and ensures Enrollees receive care that conforms to established clinical practice guidelines and evidence-based practices
4. Monitors over-utilization, under-utilization, inefficiency, access to and delays in care, and fraud and abuse, implementing corrective actions where necessary;
5. Improves Enrollees' health status; and
6. Supports the Enrollee/provider relationship and treatment plan.

Effective management of utilization generates savings by preventing payment for services and treatments that are inappropriate, ineffective or inefficient. UM also improves quality by ensuring the Enrollees are getting the right services in the right setting. Savings achieved through effective UM supports the enhanced provider payments described in this section.

Our pharmacy program --

Our pharmacy program, administered by CVS Health, is designed to deliver effective prospective and retrospective Drug Utilization Review (DUR) and improve medication adherence.

For prospective and concurrent drug utilization review, we utilize CVS's Concurrent Drug Utilization Review (CDUR) program. The CDUR program takes a comprehensive approach to helping network pharmacists identify and evaluate drug therapy related problems prior to dispensing. The CDUR program is designed to identify patient safety issues as well as possible misuse before a medication is dispensed through real time edits and alerts. CVS's claim system can perform up to 500 concurrent DUR edits on every prescription, in real time, to help ensure the prescription meets both administrative and Enrollee safety criteria. The system is designed to reduce wait time and help eliminate disruption for Enrollees. The concurrent DUR program reviews the following areas:

- Conformity with plan design
- Drug-allergy interactions
- Enrollee eligibility
- Drug-gender interactions
- Drug-pregnancy interactions
- Refill and dosage limits
- Dispensing accuracy and consistency
- High and low dose alerts
- Drug-drug interactions
- Therapeutic duplications
- Formulary compliance

These edits serve as job aids while still permitting pharmacists to override select DUR edits if deemed clinically appropriate or in consultation with the prescriber.

Our Retrospective DUR Program revolves around review and identification of potentially inappropriate medication utilization. These reviews will occur no less frequent than quarterly. The program will be managed by the Pharmacy Director, Pharmacy Analyst, and the Account Manager. Components of the Retrospective DUR program will include:

- Identify potentially inappropriate or medically unnecessary prescribing and Enrollee drug utilization patterns (e.g. generic utilization, therapy duplication, over/under utilization, drug safety)
- Educate prescriber and pharmacist on identifying and reducing the frequency and patterns of fraud, abuse, or medically inappropriate or unnecessary care
- Achieve specific pharmacy utilization management and financial goals
- Participate in DUR board meetings by our Pharmacy Director, who will also initiate implementations
- Submit a detailed description of our DUR program to the Agency on an annual basis

Our Pharmacy team identifies and targets patients that are most at risk for medication non-adherence for outreach. Our adherence predictive modeling incorporates over 50 key variables including pharmacy claim predictors, Enrollees' condition(s), utilization predictors, social determinants of health, and adherence predictors. Results of the modeling include a prioritized list of potentially non-adherent Enrollees to hypertension, cholesterol, and diabetes medications. Our program includes a multi-modal outreach through automated calls, mailings, and live calls with Pharmacists and Pharmacy Technicians. Through this outreach, we will engage Enrollees, caregivers, prescribers, and pharmacies to improve the Enrollees' adherence to both new and existing medication therapy. Examples of interventions include; (1) counseling patients on how to overcome adherence barriers, such as transportation, low health literacy, and how to properly administer medications (2) contacting the dispensing pharmacy to synchronize fills of chronic

medications, initiate auto-refill enrollments, and dispense pill boxes; and (3) optimizing dosing and reducing complexity of medication regimen with prescribers.

These pharmacy DUR programs support appropriate utilization management and control of overall drug spend, while preventing adverse effects that may drive avoidable utilization of acute care services. Medication adherence programs not only improve health outcomes but they generate cost savings by preventing avoidable utilization that results of medication non-adherence. The savings supported by these programs will contribute to our ability to offer providers enhanced payments.

Evaluation Criteria:

1. The extent to which the respondent's proposal to improve quality can be tied to redirecting costs to pay higher physician rates.

2. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by reducing potentially preventable events.

3. The extent to which the respondent incorporates quality initiatives that will result in redirecting costs by improving prenatal care and birth outcomes.

4. The extent to which the respondent identifies other areas for quality initiatives or efficiencies that will result in potential cost savings.

Score: This section is worth a maximum of 20 raw points with each of the above components being worth a maximum of 5 points each.

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C. RECIPIENT EXPERIENCE

MMA SRC# 8 – Primary Care Providers (PCP) Assignment (Statewide):

The respondent shall describe its overall process of assigning enrollees to primary care providers (PCPs), including its assignment algorithm. The response shall include the quality and/or performance metrics used to determine high quality PCPs, and the timeframes associated with processing an enrollee's request to change PCPs.

Response:

As a Provider Service Network, Lighthouse Health Plan ("Lighthouse") understands the critical role that primarily care providers (PCP) play in the health and wellbeing of enrollees and is committed to assigning enrollees to high quality primarily care providers (PCP's). PCP assignment is important to our medical home model, encourages preventive care, and may reduce the use of Emergency Room or other acute care settings for urgent or non-emergent healthcare needs. Our program for PCP assignment is currently being used in six (6) other states for Medicaid beneficiary management of over 1.4 million Medicaid enrollees.

SOLICITING ENROLLEE CHOICE

Lighthouse Health Plan believes that the strongest PCP relationships occur when an Enrollee selects their own preferred provider. Upon receipt of the monthly 834 file, we will make outbound calls to all new Enrollees welcoming them to Lighthouse, educating them on available services and validating or requesting PCP selection. Upon receipt of the Agency for Health Care Administration's (AHCA's) 834 enrollment file we assign Enrollees to their previous provider if one is listed and the provider is participating in the network. In cases where a PCP is not listed on the 834 file, we take proactive steps to facilitate an Enrollee's selection of a PCP. Enrollee Services Representatives will follow a welcome call script approved by the Agency that will walk the Enrollee through PCP selection and offer assistance in scheduling an initial visit with the selected PCP. Included in the script is a stepped approach for determining Enrollee preferences for optimal PCP assignment. We will ask about previous providers, familiar providers, family Enrollees' providers, cultural and linguistic needs, and office locations close to the Enrollee's work, home or school. The Enrollee services representative will identify a list of high-quality providers who meet the enrollees needs within their geographical area.

Should the Enrollee reveal that they are pregnant or have other unique healthcare needs, the Enrollee Services Representative will consult with the CM department and potentially make an assignment to a specialist for delivery and/or coordination of all primary care services. Pregnant enrollees may choose an obstetrician as PCP. If the Enrollee has not selected a PCP for their newborn by the beginning of the last trimester Lighthouse shall assign a pediatrician as the newborn's PCP.

In addition to the welcome calls, the Lighthouse Health Plan Welcome Packet includes instructions for Enrollees to call a Enrollee Services Representative if they have not yet selected a PCP. Additionally, our website, will include instructions and contact details for PCP selection or change.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

FACTORS FOR AUTOMATING ASSIGNMENT TO A HIGH-QUALITY PCP

If the enrollee has not selected a PCP within 30 days of enrollment, we will assign the PCP via our auto-assignment process within Identifi HPA. Excluded from the PCP assignment process are enrollees who are dual eligible and have an existing Medicare primary, foster care, and disabled children under the age of 18. Children and adolescents will be assigned to a pediatric or adolescent specialist, if one is available in the Enrollee's geographic region. Any special medical needs will be taken into consideration during the assignment process, including pregnancy, any language needs made known to Lighthouse, area of residence, and access to transportation.

If no PCP has been selected within thirty (30) days of enrollment, we will assign the PCP via our auto assignment process within Identifi HPA. The Identifi PCP auto-assignment process considers the following criteria:

- Geographic proximity of the provider to the Enrollee's residence
- Highest quality provider with an open panel
- The Enrollee's language needs
- The Enrollee's age and gender
- Panel size and panel limits
- Known PCP assignment of other Enrollees of the household
- Any previous association with a PCP that can be identified from claims history or HIE data

For returning Enrollees, we will reconnect them to their previous PCP, if age and gender are still appropriate, and it has been less than a year since the term date of the previous PCP segment. The date of assignment will also be considered the effective date. If reconnecting a returning enrollee with their previous PCP is no longer age or gender appropriate, the Enrollee will be treated as a New Enrollee for purposes of auto-assignment.

For New Enrollees whose family members are assigned to a PCP, panel size limitations can be over-ridden. However, the assignment must still be age and gender appropriate and the date of assignment will still be considered the effective date.

For New Enrollees, Geo Access function will be used to assign to the nearest PCP. The Geo Access standard should not exceed thirty (30) miles or thirty (30) minutes from the Enrollee's residence in an urban area or within forty-five (45) miles or forty-five (45) minutes from the Enrollee's residence in a rural area. Factors of age, gender and panel size limitations are considered, however, previous PCPs of new Enrollees, if applicable, will be considered the Enrollee's preference. Enrollees 15 years of age and under will be assigned to a pediatric or adolescent PCP.

For Adult Enrollees who have SSI without Medicare, Lighthouse will send information regarding the requirement to select a PCP or one will be assigned to them. If the Enrollee has not selected a PCP after thirty (30) days from enrollment notification, Lighthouse will select one for the Enrollee. With the exception of Enrollees who were previously enrolled, Lighthouse cannot auto-assign a PCP to an SSI Enrollee within the first ninety (90) days from the date of the Enrollee's initial enrollment.

DEFINING A HIGH QUALITY PRIMARY CARE PROVIDER

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Lighthouse Health Plan will give preference providers with high quality scores during the auto-assignment process. Providers who do not meet Lighthouse's minimum standards for quality, including meeting the 50th percentile for HEDIS and meeting appointment access standards may be removed from receiving auto-assigned enrollees. Enrollee Service Representatives will also recommend our highest quality providers to Enrollees.
Providers will be assigned a quality score using an internal algorithm that draws on a combination of factors including:

Access Measures --
• Proportion of enrollees seen at least once per year
• Average wait time to schedule an appointment
• Proportion of new Enrollees seen within 90 days of enrollment
• Proportion of Enrollees with chronic conditions seen at least twice per year

Enrollee Patient Safety Scores --
• Proportion of Enrollees with provider preventable conditions
• Conditions Sentinel Events

Quality and Outcome Measures --
• HEDIS measure performance (including preventive services measures)
• Proportion of Enrollees with avoidable hospital admissions/ readmissions
• Proportion of Enrollees with avoidable ER visits
• Audit compliance performance

Enrollee Experience Satisfaction --
• Enrollee-rated quality
• CAHPS results
• Enrollee grievances
• Disenrollment survey outcomes

ENROLLEE PATHWAY TO CHANGE AUTO-ASSIGNMENT

On an ongoing basis, we will use interactions with enrollees to verify assignment and emphasize the importance of establishing an active enrollee/provider relationship with their PCP. When an enrollee selects a PCP, or changes their selected PCP, the Enrollee Services Representative will complete a PCP change request in our system and a new ID card with the updated PCP selection information will be sent to the enrollee, via our fulfillment vendor, within 3 business days of selection.

.All Enrollee ID cards sent to our Enrollees who have been auto-assigned will contain a sticker providing directions to Enrollees on what steps to take to select a different PCP. Enrollees will be assigned at the individual level however this rolls up to the group level for access and ID card purposes. The number of records returned for assignment should be evenly divided among PCP's within Enrollee's zip code area.

LEVERAGING DATA TO STRENGTHEN ENROLLEE-PCP RELATIONSHIP

Identifi HPA contains reports on Enrollees who either have no PCP assignment, or have a placeholder provider ID on their record in our core system pending a PCP assignment. Our Enrollee Services Department reviews these reports daily. As a safeguard, if any Enrollee appears on the report as enrolled over 50 days without a PCP assignment, Enrollee services staff conduct a manual review to correct the error and determine root cause.

Notifying providers of the Enrollees who have chosen or have been assigned to them as their PCP is necessary to verify the provider's accountability for managing the healthcare services delivered to those Enrollees. The PCP Medical Home model is most effective when the PCP and the Enrollee have an active and collaborative relationship. This is only possible if providers are well informed about the patients they should be serving. We will communicate with providers about their assigned patient rosters through our provider portal. Provider panel reports will be made available through the portal and providers will receive alerts each time a new Enrollee is assigned to them as well as a monthly panel listing. Lighthouse will report on the number of Enrollees assigned to each participating PCP, pursuant to Florida Statute §409.973(4). Our network PCPs will receive training on managing their Lighthouse panel during initial provider orientation and through ongoing visits from the Provider Network Management team. Additionally, information about using the Provider Portal to manage a PCPs panel will be included in the Lighthouse Health Plan Provider Manual.

Evaluation Criteria:

1. The extent to which the respondent's description includes how quality and/or performance metrics are defined and utilized in the assignment process.

2. The extent to which the respondent's algorithm includes assignment of enrollees to high quality PCPs.

3. The extent to which the respondent can process requests for PCP changes within three (3) business days.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 9 – PCP Timely Access Standards (Statewide):

The respondent shall describe the process and monitoring plan it uses to ensure compliance with the timely access standards as defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.**, Provider Services **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards. The respondent shall also describe the process and methodology it uses for determining whether a PCP has the capacity to accept new patients.

Response:

Timely access to urgent and non-urgent primary care services is fundamental to Lighthouse Health Plan's ("Lighthouse") medical home model. Lighthouse strives to identify and mitigate potential access gaps before they impact Enrollees. Lighthouse uses multiple avenues of review to measure providers' patient capacity and adherence with appointment availability standards.

PROCESS AND MONITORING PLAN TO ENSURE COMPLIANCE WITH TIMELY ACCESS STANDARDS

Each quarter Lighthouse Health Plan will use trained secret shoppers to conduct outbound calls to a randomly selected, statistically valid sample of primarily care providers. The secret shoppers will pose as Lighthouse Enrollees who are "shopping" for a health care provider to schedule urgent care, routine sick care, and well care appointments. Providers who cannot be reached at the phone number listed in the provider directory, even after hours, or who do not offer an appointment within the timeframe outlined in Exhibit B-1, Managed Medical Assistance (MMA) Program, Section VIII., Provider Services, Item A., Network Adequacy Standards, Sub-Item 8 Timely Access Standards, will be escalated to the local Provider Network team for an onsite access review. In addition, all primary care providers who are escalated by the secret shoppers, the Provider Network team will randomly select a statistically significant number of primary care providers on a quarterly basis for on-site access reviews.

During the on-site review, the Provider Network Representative will assess the following:
• Physical accessibility and office appearance including handicapped/wheelchair access, general cleanliness, adequate seating, and posted office hours
• Wait time for a patient to see a provider upon arrival at the office
• Availability of new patient appointments
• Number of routine office visits scheduled per provider per hour
• Number of hours available to patients per week
• Next available routine appointment, urgent care appointment
• Review of historical appointment scheduling trends for routine and urgent appointments
• Provider's method of answering phone (staff member, answering service, voicemail, etc.) including afterhours phone policies and number of minutes to return patient calls
• Office policies and standards for reporting of communicable diseases, privacy protection, and maintenance of complete and accurate medical records, reduction of fraud and abuse,
• HIPAA audit- location of fax/copier, password protection of computers, use of encrypted emails

The Provider Network team and secret shoppers evaluate providers based on the Timely Access Standards defined in the contract. The PCP must provide coverage of services, consultation, or approval for referrals 24 hours per day, seven days per week by a Medicaid-enrolled PCP. For

urgent medical or behavioral health care services, an appointment must be provided within 48 hours, unless prior authorization is required, in which case an appointment must be provided within 96 hours. For non-urgent care services, appointments must be provided:

• Within seven days post-discharge from an inpatient behavioral health admission for follow-up behavioral health treatment
• Within 14 days for initial outpatient behavioral health treatment or ancillary services for the diagnosis or treatment of injury, illness, or other health condition
• Within 30 days for a primary care appointment
• Within 60 days for a specialist appointment after the appropriate referral is received by the specialist

The review will also determine if the provider is maintaining required policies and procedures related to office wait times, “No Show” appointments, and patient appointment reminders.

MITIGATING IDENTIFIED ACCESSIBILITY ISSUES

The Enrollee services team will monitor for Enrollee complaints related to access. All access complaints will be referred to the Provider Network team for investigation. If a single primarily care provider or office receives multiple complaints they will be removed from the PCP auto assignment processes until an on-site access review is completed. Enrollee services representatives will assist Enrollees in changing PCP’s or will outreach to the PCP’s office on behalf of the Enrollees to assist with scheduling appointments as needed until the office is brought back into full compliance.

Should an Enrollee need to use emergent and urgent care services and they are not near a contracted provider, the Enrollee (or Enrollee’s caregiver) are advised to go to the nearest treatment facility. This is supported by Lighthouse policies and communicated through our contracted providers should they be contacted. In other instances, when an Enrollee needs to access care outside of the Lighthouse network, the primary care physician will contact UM Department to secure an authorization to the medically appropriate medical provider or facility. During the authorization process, the utilization management team will remind the OON provider that they need to schedule the appointment within 30 days to meet the State of Florida requirements. If the Enrollee has any issues securing a visit to specialty care provider, an Enrollee Services Care Coordinator can assist the Enrollee by contacting the non-contracted provider to help secure a timely appointment that meets the Agency’s standards

Any Primarily Care Provider who is found to be out of compliance with the timely access standards during an onsite access review will be removed from receiving Enrollees through the PCP auto-assignment process. Lighthouse will send a letter to the provider to outline areas of where the provider was out of compliance. Lighthouse will notify these Providers that they will be resurveyed within 90 days. If a provider fails both the initial and 90-day follow-up surveys, their information will be sent to the Credentialing Committee for additional recommendations or actions to be taken up to termination from the network.

PROCESS AND METHODOLOGY FOR DETERMINING WHETHER A PCP HAS CAPACITY TO ACCEPT NEW PATIENTS

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

As a Provider Service Network, Lighthouse Health Plan has unique insight into the balance that primarily care practices must maintain between meeting the increasing needs of the community and remaining effective as clinicians. Upon initial enrollment with Lighthouse, the provider submits an initial panel size request. This initial request is reviewed along with their initial application by the credentialing team. We require that there be at least one (1) FTE PCP per one thousand five hundred (1,500) Enrollees. The practice may increase the physician's ratio by seven hundred and fifty (750) Enrollees for each FTE Advanced Registered Nurse Practitioners (ARNP) or Physician's Assistant (PA) affiliated with the physician's office. Our claims system, Identifi HPA, includes panel size limits in the PCP auto-assignment algorithm. This acts as a hard stop to ensure that no provider receives more Enrollees than has been approved by Lighthouse.

Lighthouse believes that the best indicator of a practice's capacity to accept new patients is the quality of care that its current patients are receiving. The PCP serves as the Enrollee's initial and most important contact for receiving medically necessary covered services. The PCP has primary responsibility for arranging and coordinating care for the Enrollee. Initially, the PCP provides continuity of care for Enrollees by serving as a PCP, maintaining a current medical record for Enrollees. At a minimum, the PCP must:

- Provide periodic physical exams as outlined in the Preventative Health Guidelines
- Provide routine injections and immunizations
- Maintain records of periodic preventive services and provide timely reminders to Enrollee when services are due
- Provide health education and information
- Assist Enrollees to needed specialty care and other medically necessary services
- Arrange and/or provide necessary inpatient medical care at participating hospitals
- Discuss advance medical directives with Enrollee as appropriate, and if Enrollee has executed advanced directives, document it in medical records
- Consider Enrollee input proposed treatment plans
- Provide services in a culturally competent manner

In addition to the above standards, to further assess whether a PCP has capacity to accept new patients, we look to the following quality outcomes:

Access Measures --

- Proportion of Enrollees seen at least once per year
- Average wait time to schedule an appointment
- Proportion of new Enrollees seen within 90 days of enrollment
- Proportion of Enrollees with chronic conditions seen at least twice per year

Enrollee Patient Safety Scores --

- Proportion of Enrollees with provider preventable conditions
- Conditions Sentinel Events

Quality and Outcome Measures --

- HEDIS measure performance (including preventive services measures)
- Proportion of Enrollees with avoidable hospital admissions/ readmissions
- Proportion of Enrollees with avoidable ER visits
- Audit compliance performance

Enrollee Experience Satisfaction --
• Enrollee-rated quality
• CAHPS results
• Enrollee grievances
• Disenrollment survey outcomes

Each month the Provider Network team will receive a report of primary care providers that are achieving high quality outcomes and have closed panels. The Provider Network team will outreach to these offices to encourage them to accept additional Lighthouse Enrollees. The Provider Network team will also receive a report of primary care providers that are not meeting Lighthouse's minimum quality standards. These providers will be removed from PCP auto assignment and referred to the QI committee for review.

Evaluation Criteria:

1. The extent to which the respondent's process and monitoring plan ensure that enrollees have access to urgent or non-urgent services within the timely access standards defined in **Exhibit B-1**, Managed Medical Assistance (MMA) Program, **Section VIII.,** Provider Services, **Item A.**, Network Adequacy Standards, **Sub-Item 8.**, Timely Access Standards.

2. The extent to which the respondent's monitoring plan includes specific mitigation steps it will take if there is a potential accessibility issue identified.

3. The extent to which the respondent's process and methodology for determining PCP capacity clearly outline the steps and data used for determining whether a PCP has the capacity to accept new patients.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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MMA SRC# 10 – Transitions of Care (Statewide):

The respondent shall describe how it will address the transition of care between service settings, including transitions from hospital to nursing facility rehabilitation and from hospital or nursing facility rehabilitation to home. Identify specific methodologies for ensuring that transition planning ensures appropriate primary care and behavioral health follow up, where appropriate. Provide an example of an effective transition plan.

Response:

Research findings indicate the discharge process is often non-standardized and frequently marked by poor quality. Poor documentation, incomplete test results, fragmented education and confusion over medications can all contribute to post-discharge adverse events and costly readmissions.

Baptist Health, as the parent organization of Lighthouse Health Plan (Lighthouse), has implemented a number of programs to improve transitions of care for individuals receiving inpatient care at Baptist facilities, including the following.

• Our post-acute hospitalist program, staffed by an internist, geriatrician and seven advanced practice nurses covering nine facilities focus on managing patent's length of stay to transition patients home or to the next level of care as expeditiously as clinically appropriate. This program has achieved reduced lengths of stays compared to previous management by the facility Medical Director. In addition, the program has steadily increased the proportion of patients discharged directly home as opposed to a SNF, from 23 percent in the second quarter of 2015 when we started this program, to 78 percent in the third quarter of 2017.
• We identified orthopedic surgery as a procedure that is especially challenging for physicians, patients, and their families to manage because of the post-discharge need for rehabilitative therapies, equipment and pain management. To better coordinate this process we implemented a bundled payment program for joint replacement that includes an orthopedic navigator who works with the surgeon, patient and family, from pre-admission through the initial post-discharge period, including for transitions home or to a skilled nursing facility and then home.
• We also screen patients before discharge using the LACE index that identifies patients at risk for readmission or death within 30 days of discharge. We deploy inpatient care coordinators to work with patients who score greater 13, scheduling a follow-up visit before discharge and helping to arrange transportation when needed. The care coordinators have access to the outpatient EHR to support on-demand scheduling. Patients who will be enrolled in a palliative care program on discharge are included in this scheduling and the inpatient care coordinators also coordinate a post-discharge home visit from the post-acute hospitalist program advanced practice nurse to ensure the patient and family/caregiver understand the patient's care and emotional support needs.

Lighthouse's approach to transitions of care will build on local experience and leverage Evolent's Transition of Care program that employs rigorous population health principles and evidence-based transition models described throughout this section. This approach incorporates best practices in transition coordination, including Project RED and Coleman's Care Transition Intervention TM practices, and adopts elements from the National Quality Forum (NQF), "Safe

Practice" or SP-11, an integral part of reducing readmissions and ensuring safe and effective transition from the inpatient setting.

TRANSITIONS OF CARE

Our approach to transitions of care includes the following;

• Identifying an enrollee's risk of inpatient readmission using our predictive modeling and risk stratification algorithm. Our predictive model is multi-factorial and includes key enrollee conditions and illness burden, medical expense, and key readmission risk criteria such as ED visits, previous inpatient admissions, pharmacy trends, and social determinants of health.
• Assigning enrollees at risk of inpatient readmission and enrollees transitioning from a nursing facility (NF) rehabilitative setting to home, a nurse or BH care manager, as applicable to the enrollee's primary needs, who coordinates the enrollee's transition as part of the local, multidisciplinary care team aligned with the enrollee's PCP and hospital.
• Providing enrollees at low risk of inpatient readmission or who decline care management, with care coordination assistance from the local care management team Community Health Workers (CHWs) and care coordinators.
• Coordinating transitions from inpatient to NF rehabilitation settings through close collaboration between our Utilization Review (UR) clinicians and facility discharge planners, including embedded UR clinicians at high volume hospitals.

The Transitions of Care program has been deployed in Kentucky and Indiana for over four years showing a reduction in 30, 60, and 90 day readmissions independently, as well as an increase in post discharge follow up visits with a specialist within five days, and a PCP within 10 days. Nursing facility readmissions have decreased as well following implementation of a Transitions Care Manager assigned to specific NFs and coordinating safe transition home with the NF staff, enrollee and his or her caregiver/family, when applicable.

RISK STRATIFICATION IDENTIFIES ENROLLEES AT RISK OF INPATIENT READMISSION

To ensure enrollees receive the appropriate level of support during inpatient transition and post-discharge, we risk stratify all hospitalized enrollees into low risk, at risk or high risk for readmission groups that triggers the appropriate transitions intervention.

Our predictive model was built to identify those hospitalized enrollees at greatest risk for an inpatient readmission within 30 days of discharge and assigns a risk score based on an array of factors, including an enrollee's:
• Historical length of stay
• Drug utilization
• Conditions and combined illness burden
• Hospital procedures and treatment
• CM program enrollment at the time of admission
• The Charlson comorbidity index
• Number of ED visits
• Number of previous inpatient admissions
• Social determinants of health

These enrollees include those who have the following chronic conditions or characteristics:
• Acute myocardial infarction
• Pneumonia
• Heart failure
• Coronary artery disease
• Diabetes
• 65 years of age or older with one targeted chronic condition
• Any age with three targeted conditions
• Depression with one targeted chronic condition
• Serious mental illness or, for children, serious emotional disturbance
• Combination of co-morbidity and high cost service utilization
• With a low patient activation measure (PAM) score

Our care management platform, Identifi Care, generates a list of enrollees and their respective risk score.

Upon receipt of notification of an enrollee's inpatient stay through the ADT feed or census file, or during UR activities such as inpatient or NF prior authorization, the local care team reviews the enrollee's risk score and implements Transitions of Care. Enrollees may also be enrolled by self-referral, referral from their treating provider, a hospital discharge planner or health plan clinical staff. Enrollees at a Baptist facility identified through the LACE Index as at risk for readmission will be directly referred to the embedded care manager or local care management team and coordination of community needs working with the inpatient care coordinators.

Local care team nurse care managers assigned to specific NFs identify enrollees in the NF at risk of readmission to the nursing facility working with facility staff, the enrollee and enrollee's PCP throughout the stay. The assigned care manager focuses on care plan development while the enrollee is in the facility, as well as discharge and transition planning, ensuring enrollees are only in the NF for the duration necessary for their condition. This close alignment between the NF staff, enrollee, local care manager and enrollee's PCP has reduced acute NF lengths of stay in other states more than 10 percent.

ASSESSMENT CRITERIA TO ENSURE SAFE TRANSITION HOME

As soon as we learn of an enrollee's admission to an inpatient setting, the local nurse or BH care manager reviews the enrollee's risk score and for enrollees he or she identifies as at risk or high risk for readmission, initiates development of the transition plan. For enrollees admitted to a NF or who are in a NF at the time of enrollment into our health plan, the local care manager assigned to the NF implements transition planning upon admission or enrollment, respectively.

Transition planning begins with enrollee assessment.

TRANSITION ASSESSMENT

The nurse or BH care manager, as applicable completes an assessment of the enrollee's needs in the hospital or NF and readiness for discharge to determine if the enrollee can be safely served in the community. The comprehensive assessment reviews all major domains including the

enrollee's physical health, BH and social needs, functional status, proposed living situation, social supports, and access to caregiver supports, and completes a mood and anxiety screening.
The assessment is programmed into the Identifi Care platform and prompts relevant interventions for each identified need, such as a referral to the local care team social worker to ensure equipment is ready on the date of discharge or prescriptions are filled, and referrals to BH clinicians and social workers for additional assessment and intervention for enrollees who screen positive for depression, anxiety or substance use. For enrollees with a primary BH diagnosis, the local care team BH care manager engages the nurse care manager as needed to help assess the enrollee's physical health needs, including comorbid medical conditions.

Prior to discharge, the care manager also reviews the enrollee's understanding of their discharge instructions, providers and the enrollee's statements as to what would prevent them from following discharge instructions. Examples of barriers we assess for include inability to pick up prescriptions, does not understand discharge instruction, does not have a PCP, follow-up appointments not scheduled, needs equipment, needs transportation, and needs home and community-based services.

The assessment information forms the basis for the enrollee-specific preliminary transition plan, which is part of the enrollee's care plan.

An example of how these factors work together is enrollee John D. He is 59 years old with a past diagnoses of congestive heart failure, diabetes and depression. In the past two years, he has been stable and well-managed by his primary care provider, cardiologist and BH provider. He had two ED visits within the last 6 weeks, the last one resulting in an admission for shortness of breath related to his heart failure. John was hospitalized at a facility where our team has an embedded care manager. She received an alert via Identifi notifying her of his admission. The alert included information about his care team, treating providers and past programs participation, service utilization and a pre-hospitalization medication list.

The local care manager met with the inpatient treating team to review John's needs and plan. She shared John's previously identified strengths and opportunities and notes he lived alone and has no family support in the area. His care team assisted him in securing housing in an assisted living facility in the past and he has participated in their wellness programs. He has received care for his depression from a co-located BH provider in his primary care office. The plan for this hospitalization is to discharge John home if his shortness of breath continues to improve.

The embedded care manager meets with John and completes an inpatient screen. In reviewing John's medication list, she sees that several of his medications have not been filled in the past two months, including his Lasix. John admits that he had reduced the dosing from twice a day to once a day due to night time awakening to urinate. The care manager begins to educate John about the importance of taking medication as prescribed, maintaining his fluid intake but avoiding fluids right before bedtime, and the red flags for his heart failure. This early education, reinforced at multiple points throughout this transition, will help John identify early symptoms and act on them.

After John's discharge the following afternoon, he receives a home visit from the local nurse care manager. She completes a comprehensive assessment and medication reconciliation inclusive of the medications John was taking prehospitalization, his discharge planned medications and

those medicines in his home. She finds several discrepancies and contacts his treating provider to resolve these. As part of the assessment, the care manager performs a PHQ-2 that had positive results and was expanded to a PHQ-9. Based on the score, the care manager believes John should visit his BH provider during his follow-up visit with his PCP. She assists John in scheduling those appointments. His discharge plan from the inpatient stay indicated a cardiologist visit was scheduled for later that week. The assessment indicated that John typically used public transportation for appointments but was not able to do so at this point in his recovery. She arranged transportation and gave John the information about the other times this transportation would be available to him and how to schedule this service.

From the assessments performed at the inpatient facility and his home, the care manager develops a care plan that addresses management of his heart failure, medications, and depression that leverages all his treating providers' input. She shares the plan with John at his home and his PCP by entering it into Identifi and sending a message and the care plan to the PCP via the PCP's EHR. This would also be available in Identifi Practice to the providers. She schedules follow-up calls with John for the following week. The calls to John continue with the cycle of assessment and reassessment, changing and updating his care plan and interventions to address his identified needs.

In about a month, John has returned to his prehospital state of function with a better understanding of how he can participate in his care and how to act early if he experiences symptoms that indicate his conditions are worsening. He also has a relationship with the local care management team and a number to call if he has any questions in the future.

MULTIDISCIPLINARY TRANSITION OF CARE TEAM MEETINGS

For all at risk or high-risk inpatient transition patients, the enrollee's nurse or BH care manager assigned to the hospital convenes a multidisciplinary meeting of the local care team, the enrollee and family/caregivers, enrollee's PCP, inpatient physician or psychiatrist, hospital discharge planner or NF social worker, and others involved in supporting safe transition such as an enrollee's targeted case manager or home and community-based services waiver service coordinator. Together, they develop the transition plan that is part of the enrollee's care plan and that documents the enrollee's history, and current physical health, BH, and social support needs; coordination with providers including the PCP, specialists and BH providers, as well as enrollees of the local care management team working with the enrollee following discharge, including the pharmacist, dietitian, social worker and therapist; the enrollee's short-term, and long-term goals; post-discharge support needs; authorized services; and follow-up schedule.

The plan includes:
- All services and supports to meet the enrollee's community-living needs
- Relevant community resources
- The initial PCP and specialist appointments
- A safety plan
- Medications and the enrollee's chosen pharmacy

Working together, they confirm the transition plan identifies all the enrollee's needed services, including those covered by Lighthouse, other funders and available community-based supports.

The care manager ensures the enrollee has adequate caregiver support and appropriate resources at home, and incorporates an enrollee self-management plan including when to contact the doctor. The care manager also provides comprehensive enrollee education including detailed medication education, education about his or her specific conditions, including co-morbidities, and "what to watch for" after discharge. He or she schedules the enrollee's follow-up appointments, including the first appointment with the PCP and specialist(s) post-discharge, including follow-up after hospitalization for mental illness appointments with an outpatient BH provider within seven and the n 30 days of discharge.

A member of the local team also works with the enrollee and community programs to help enrollees who need housing or other community-based living arrangements identify and secure a suitable setting and wrap-around services and supports. Environmental adaptations, equipment and adaptive technology is coordinated working with the housing provider and community resources such as local Centers for Independent Living.

Working together, the goal of all the team enrollees is to support an enrollee's timely and safe transition home with appropriate post-discharge support and coordination of outpatient care.
For enrollees transitioning from a NF to home, assisted living or other community-based setting, the care manager develops the final written transition plan within 30 days prior to discharge.

CONFIRMING SAFE TRANSITION

Care managers call or visit all at risk/high risk enrollees within 48 hours of discharge to complete a post-discharge assessment. The post-discharge assessment focuses on medication review, confirming or scheduling follow-up appointments, self-management status and understanding of discharge instructions, access to community supports, and confirms receipt of ancillary services ordered prior to discharge. All enrollees that stratify as at risk or high risk are engaged by a local nurse or BH care manager. The care manager makes a home visit within 48 hours of discharge.

During the post discharge assessment home visit, the care manager completes in-home medication reconciliation, reinforces the established discharge plan, and provides any needed care coordination and/or education. The care manager also reviews telemonitoring equipment and use available for enrollees with COPD, CHF, and/or diabetes able to use the equipment. They confirm the date for the enrollee's post discharge follow-up visit to their PCP and behavioral health clinician, as applicable. They also confirm or arrange transportation needed to get to and from home to the provider's location. A member of the care team confirms completion of the visit calling the enrollee after the scheduled date to discuss their status.

Enrollees receive ongoing care management contacts based on the enrollee's specific needs but at a minimum two contacts a month for the first six months following discharge, including at least one in-person contact with the enrollee's/representative's agreement, and monthly thereafter.

ENROLLEES AT LOW RISK OF INPATIENT READMISSION OR WHO DECLINE TRANSITIONS OF CARE CASE MANAGEMENT

The local care management team coordinates care for enrollees at low-risk of inpatient readmission or who decline care management. CHWs and care coordinators make calls and when needed visits, to coordinate services and respond to additional post-discharge needs. The

local care team nurse care manager, BH care manager, social worker, dietitian, health educator and pharmacist provide consultation as needed. The care team monitors the enrollee's transition and intervenes should the enrollee have unmet needs or experience any decline in their health status, enrolling enrollees in an appropriate care management program to proactively address these newly identified needs.

COLLABORATION AND COORDINATION WITH DISCHARGE PLANNING STAFF, PCPS, BH AND OTHER PROVIDERS

The Transitions of Care program is a collaboration between physical health and behavioral health hospital departments, NF staff, assisted living provider staff, and other facility staff either directly or indirectly involved in the discharge planning and transition of care process. We compare the daily Admission, Discharge, Transfer (ADT) census file, when available, and service authorizations to our eligibility file to identify enrollees newly admitted an inpatient, NF or other facility-based setting. The local care team, or for enrollees transitioning from an inpatient to NF rehabilitative setting, the UR clinician, works closely with the inpatient team, hospital discharge coordinator and NF admission/discharge team as applicable to support safe and coordinated transition to this next level of care. In high volume hospitals, embedded concurrent review staff work directly with hospital case management staff. The UR clinician collaborates with the discharge planning staff for enrollees transferring between an inpatient setting and NF rehabilitative setting to support both the discharging hospital and admitting NF in optimizing the enrollee's transition and reducing any delays or inefficiency.

For enrollees receiving inpatient services at a Baptist facility, the local care management team and embedded care managers will work directly with Baptist staff, including the post-discharge team, care navigators and care coordinators, to help connect enrollees to community resources and covered services and seamlessly transition support from the Baptist team to the local care management team.

The Transitions team focuses on:
• Reviewing the enrollee's needs with the inpatient team and receiving facility team or provider
• Ensuring the receiving facility or provider receives the enrollee's discharge orders and current discharge plan to make sure medications, and treatment or recovery orders are not delayed.
• Providing the enrollee and family/caregivers with information on available providers or facilities, arranging visits when feasible to potential facilities or community-based housing options, reviewing and helping the enrollee/family/caregiver understand the financial arrangements for certain settings, such as for room and board and ancillary costs, and ensuring the providers/facilities can meet the enrollee's needs.
• Notifying the enrollee's PCP of the enrollee's planned transition.

Essential discharge planning and provider-related activities for enrollees transitioning home include:
• Convening the multidisciplinary team meeting to develop the enrollee's transition plan that includes specific DME, medical supplies, therapy, and medical/surgical/behavioral clinical needs.
• Notifying the enrollee's PCP of the enrollee's planned discharge date and scheduling the first follow-up visit as well as coordinating the enrollees' needs post discharge including therapy, behavioral health, pharmacy, dietary, and social work needs.

• Notifying other providers who will be delivering community-based or outpatient services of the enrollee's planned discharge date, coordinating access to these services including service authorization, and scheduling the first follow-up visit with the enrollee's primary BH provider, when applicable.
• Arranging transportation needed to access services following transition.
• Coordinating access to carved-out services such as behavior analysis services and PPEC, facilitating communication between providers and discharge planners, the enrollee and family or caregivers

REFERRAL AND SCHEDULING ASSISTANCE

The enrollee's local care management team is responsible and available to provide referral and scheduling assistance as specified in the enrollee's transition plan and as needed. Care managers assisted by CHWs proactively monitor access to the services included in the enrollee's transition plan and use follow-up calls to confirm enrollees are receiving services, have completed scheduled appointments, are satisfied with their service providers, and their needs are met. Care managers and CHWs encourage enrollees to independently manage their health care, but are available to provide the level of assistance needed to help enrollees or their families manage referrals or schedule transportation. If an enrollee needs extensive assistance, CHWs will make in-home visits and may provide escort services when needed to help the enrollee attend his or her appointments.

As a provider service network, we are also working actively with our largest provider systems to benefit from their advanced access models like open scheduling and extended hours to make sure enrollees get timely appointments. Being able to directly schedule with providers is very efficient for local care teams and improves enrollee satisfaction with timely and easy to access appointments.

Enrollee also have access to our call center during regular business hours, Member Services Representatives can directly message the local care management team to address the enrollee's care needs. After hours, enrollees may call the 27/7 Nurse Line for care-related inquiries. If the enrollee needs to speak with a care manager after hours the 24/7 Nurse Line nurse will take a message, and notify the on-call care manager who will return the call timely. Enrollees with BH care management or services needs may call the 24/7 Behavioral Health (BH) crisis line staffed by BH clinicians who assist with emergent, urgent and routine BH-related needs, including performing triage and identifying enrollees who need emergency BH services, crisis stabilization or other services.

ENSURING APPROPRIATE FOLLOW-UP WITH PCP AND BEHAVIORAL HEALTH PROVIDERS

A member of the care team confirms the enrollee completes the first follow-up visit with his or her PCP and BH providers, calling the enrollee and the provider after the scheduled date to discuss the outcome of the visit and update the enrollee's care plan as needed.

If the enrollee did not complete the first scheduled visit, a CHW or the enrollee's care manager identifies any barriers that prevented completion, identifies solutions to prevent another missed visit and helps the enrollee reschedule the visit, including making a three-way call when needed

to the provider's office. The care manager may also arrange an escort by a CHW for enrollees who are reluctant to attend appointments or highly anxious and help the enrollee identify another available PCP or BH provider for enrollees who are unhappy with a specific provider.

In instances where enrollee with physical health and behavioral health needs repeatedly miss scheduled visits, we convene a case conference with the care team and the enrollee's PCP and BH providers to troubleshoot additional solutions. If a BH provider offers co-located primary care services or vice versa, we help schedule both visits on the same day at the single site to reduce barriers to accessing these services. For example, ECC has six licensed clinical social workers (LCSWs), including pediatric LCSWs, covering nearly all their primary care clinics. A psychiatric nurse practitioner also provides services at sites every other week. We will work with ECC to connect enrollees repeatedly missing appointments who have physical health and BH needs to appointments at these sites and help coordinate the enrollee's ongoing needs once seen by a PCP and LCSW or the psychiatric nurse practitioner, enrolling or reenrolling enrollees in DM or care management programs, when applicable. Because these enrollees are frequent no-shows, we will also connect the enrollee to a CHW for ongoing assistance and in-person visits when needed. CHWs can also accompany enrollees to their health care appointments, reducing gaps in care.

Coordination is further supported through our sophisticated cloud-based data system, Identifi, that aggregates all available data to provide the enrollee's PCP, care team, UR staff and other authorized users with a comprehensive enrollee profile and real-time health management platform. The data can also seamlessly integrate into the provider's Electronic Health Record system. The system fully supports care coordination by providing staff with the capability to perform all functions associated with medical management, including service authorizations, discharge planning activities, and care management activity. Participating, authorized providers will have access to discharge information and the care plan/transition plan through Identifi and secure messaging.

PROCESSES TO PREVENT UNNECESSARY HOSPITAL OR NURSING FACILITY READMISSIONS

Our process to prevent unnecessary hospital or nursing facility readmissions includes:

PREDICTIVE MODELING AND RISK STRATIFICATION

All our care management clinical programming focuses on reducing unnecessary inpatient or NF readmissions and begin with predictive modeling and risk stratification, identifying enrollees at risk or who are high risk for readmission. Our proprietary analytic predictive modeling tool generates multiple paths and algorithms in identifying and stratifying patients, for example, using 1) prior emergency room or hospital visits, 2) pharmacy prescriptions, 3) social determinant data and 4) gaps in care. Enrollees are assigned a risk score and we identify enrollees' risk for inpatient readmissions as well as enrollee's identification for specific care management programs. Stratification is a dynamic process, and a stratification level can change as an enrollee's condition changes, linking to the appropriate level of risk and corresponding intervention. Risk scores are refreshed as we receive new data but no less than monthly and as an enrollee completes transition helps the care team identify the enrollee's need for longer-term care management programs as well as the specific intensity, ranging from Complex Care to care coordination.

EARLY AND TARGETED CARE MANAGEMENT

An essential component of safe transitions of care is early and targeted intervention and proactive oversight, ensuring enrollees receive the level of support they need.

• Local multidisciplinary care management teams aligned with the enrollee's PCP initiate our transition of care process and provide graduated outreach to enrollees following transition through in-person visits and telephone calls to assess enrollee needs and ensure satisfactory transition home or to the next level of care.
• We begin care management and discharge planning early, as soon as we identify an admission, and engage enrollees and families/caregivers, discharge planners, the enrollee's PCP, BH providers and others involved in the enrollee's care, in development of the enrollee's transition plan.
• A key focus of the transition plan is ensuring enrollees have adequate post-discharge services and supports, working with the enrollee and service providers to identify and address any barriers to making and attending follow-up appointment(s) and meeting other needs, such as medications, special diets, equipment and housing.
• We confirm completion of PCP and BH provider follow-up appointments and the enrollee's receipt of and satisfaction with all services through follow-up calls and visits. We implement problem solving activities with enrollees who miss appointments or who are not satisfied with their services or providers and initiate multidisciplinary case conferences to troubleshoot issues for enrollees who continue to miss scheduled care or decline needed services.
• We ensure completion of critical activities such as medication reconciliation at every transition of care.

HEALTH INFORMATION TECHNOLOGY SUPPORTS

Our health information technology solutions improve quality and integrate care across settings. PCPs benefit from our identification of the patients on their panel who are at-risk or high risk through provision of actionable patient level data. We generate reporting for each PCP that identifies:

• Enrollees with recent ED visits or admissions
• Enrollees who are engaged in a care management program, the specific program (such as Transitions of Care, Maternity Care, Complex Care, High-Need BH Care Management and more) and the assigned care manager
• Enrollees who declined voluntary engagement in a recommended clinical program. We coordinate with the PCP to encourage a discussion of the benefits of the program the next time the enrollee is at the PCP's office, which can be an effective way to get the enrollee reengaged
• Enrollees with open care gaps

We create an enrollee centered record that is easily accessible to the entire care team, enrollee's PCP and other authorized users through Identifi. The enrollee's assessments, care plans, and care notes, are available to authorized users and we use secure messaging to support ongoing communication and secure record transmission when needed.

ENROLLEE AND FAMILY/CAREGIVER EDUCATION AND SELF-MANAGEMENT SUPPORT

Enrollee and family/caregiver education (as applicable) and development of self-management skills is a primary focus in all our care management programs. All care management staff are trained to deliver education at a level appropriate to each enrollee using motivational interviewing and activation based coaching approaches.

Specific activities include:
• Educating the enrollee regarding medication, need for medication, the method of obtaining and taking his or her medication(s) once discharged
• Educating enrollees on their condition, symptoms and what to do if symptoms worsen
• Providing clearly written medication instructions using health literacy concepts
• Teaching specific self-management and self-care skills identifying and addressing the enrollee's health literacy level and providing culturally appropriate training materials
• Using teach back to validate the enrollee's understanding

PROACTIVE OUTREACH AND TRANSITION MONITORING

Our model includes maintaining a "lifeline" with enrollees after discharge through periodic telephone calls and in-person visits from the local care team. We employ graduated outreach based on the enrollee's adjustment to home or other setting, calling or visiting all enrollees within 48 hours of discharge and completing additional calls and visit based on individual enrollee need. Enrollees receive ongoing contact based on the enrollee's specific needs but at a minimum two contacts a month for the first six months following discharge, including at least one in-person contact with the enrollee's/representative's agreement, and monthly thereafter.

We will use an electronic texting service, CareMessage, to deliver personalized, interactive health information via text messaging. The programs include reminders for recommended follow-up care. We can also inform enrollees about services and benefits and send administrative alerts (e.g., re- enrollment reminders) via text message. Independent evaluations of the services have demonstrated improved outcomes on several HEDIS quality measures such as immunization compliance and appointment attendance.

Enrollees and families will also have access to our secure mobile application, Identifi Engage. Identifi Engage supports convenient communication between enrollees or their families and local care management teams and can be used to:
• Locate a network provider
• Schedule appointments with providers
• Receive and send messages to and from the local care management team on a range of enrollee or family needs including closing gaps in care

SAMPLE TRANSITION PLANS

Attachments MMA SRC 10 -1 and -2 provide a sample transition plan for a 42-year-old man hospitalized for severe depression (PHQ9 of 21) and suicidal ideations. Attachment MMA SRC 10 -1 provides a summary of activities at each step of the transition process contained in the Indentifi Care notes that combined with Attachment SRC 10 -2 comprise the transition plan/care plan.

ENSURING PROTECTION OF ENROLLEE PRIVACY

Our coordination of care and transition of care processes will be performed in accordance with Privacy Regulations in the Code of Federal Regulations Title 45, Sections 160 and 164, regarding disclosure of protected health information. We will also comply with federal regulations regarding required standard electronic transactions and standards for privacy and individually identifiable health information as identified in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009 and associated regulations. Our policies and procedures reasonably limit the disclosure of protected health information for health care operations purposes to the "minimum necessary".

Informed consent is an integral element of our care management programs to ensure the enrollee's right to privacy and confidentiality. We obtain the enrollee's or legally responsible person's consent to share information. We explain informed consent and the authorization process, authorization safeguards including HIPAA requirements, the scope of an authorization, and the person responsible for release of information. Legal guardianship status and personal representative designation is documented using our technology platform and confirmed by the care team whenever we obtain written authorization for an evaluation or treatment.

Evaluation Criteria:

1. The extent to which the respondent's process and example address the following transition of care requirements:

- **(a)** Assessment criteria for making sure the enrollee can be served safely in the community;
- **(b)** Collaboration with providers' (e.g., hospitals, institutional settings, assisted living facilities, crisis stabilization unit, statewide inpatient psychiatric program) discharge planning staff;
- **(c)** Referral and scheduling assistance;
- **(d)** Coordination with PCP and behavioral health providers to ensure appropriate follow up has occurred; and
- **(e)** Processes to prevent unnecessary hospital or nursing facility readmissions.

2. The extent to which the respondent's process and example ensures the protection of the enrollee's privacy consistent with confidentiality requirements.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 11 – Provider Network – Network Development Plan (Regional):

The respondent shall submit a draft network development and management plan demonstrating how it will ensure timely access to the following services:

- Physical therapy (pediatric);
- Speech-language pathology services (pediatric);
- Occupational therapy (pediatric);
- Private duty nursing services (pediatric);
- Intermittent skilled nursing (pediatric and adult);
- Early intervention services;
- Compounding pharmacies; and
- Specialized therapeutic foster care.

The respondent's approach shall include at a minimum:

a. Identification of network gaps (time/distance output reporting, after-hour clinic availability, open/closed panels, etc.);

b. Strategies that will be deployed to increase provider capacity where network gaps have been identified;

c. Strategies for ensuring timely access to services by measuring the time in-between when services are authorized and when they are received; and

d. Strategies for updating the network development and management plan, including the data that will be used to inform improvements to increase access to services.

Response:

Lighthouse Health Plan will maintain and enforce a comprehensive network development and management plan to ensure timely access to primary and specialty care services for our Enrollees. The network development plan meets all requirements delineated in AHCA ITN 008-17/18, Attachment B, Exhibit B-1, Section VIII, and it will be updated and submitted to the Agency annually. We describe the key components of the network development plan in the following pages.

As a provider service network, Lighthouse Health Plan has a deep commitment to finding innovative ways to fill gaps in care in Northwest Florida. Our founding health system, Baptist Health Care, has been serving the Northwest Florida community since 1951 when it opened Baptist Hospital. Baptist has consistently been on the forefront of increasing access to care from establishing the first hospital-based emergency helicopter program in Florida, to opening the first inpatient child psychiatric unit in the region, to becoming the first healthcare provider in Northwest Florida to offer Extracorporeal Membrane Oxygenation (ECMO). Lighthouse Health Plan is a natural extension of Baptist Health Care's dedication to meeting the needs of the community in Region 1.

REGION-SPECIFIC NETWORK DEVELOPMENT

Our network development and recruitment strategies combine our deep roots in the community with an active outreach campaign, supported by cutting edge analytics used to identify gaps and contract with primary and specialty care providers. For our initial network development, we aggregated and formatted our provider data for our affiliated providers, and applied Quest Analytics tools, an industry-standard software platform that combines dynamic time and distance access standards with minimum provider requirements to evaluate our overall network adequacy and identify gaps. We then used the AHCA Master Provider List, Enclarity, and Strenuus to create a list of community providers for potential recruitment, ensuring that we fully cover all primary and specialty services to exceed standards. We also contracted with Rural Health Clinics (RHC's) and Federally Qualified Health Clinics (FQHC's) as well as Statewide Essential Providers as they provide a critical safety net to the Medicaid population.

Lighthouse Health Plan will offer enrollees timely access to pediatric specialists and other services through our extensive provider partnerships. Lighthouse Health Plan enrollees have access to the extensive pediatric services offered by Sacred Heart Hospital and Escambia Community Clinics including physical therapy, speech-language pathology services, occupational therapy, and early intervention services. Lighthouse Health Plan is contracting with both local and national intermittent skilled nursing companies and private duty nursing agencies. Enrollees will benefit from the commitment that Baptist Health Care has shown to growing behavioral health and substance abuse services in Northwest Florida. Enrollees will receive care through Access Behavioral Health (ABH) and Lakeview Center. Access Behavioral Health will offer enrollees a fully adequate network of psychiatrists and licensed mental health providers. Lakeview Center provides the most comprehensive set of services for people with mental health issues, drug and alcohol dependencies, or intellectual disabilities in the region. These services range from inpatient and residential treatment to a gamut of outpatient programs including trauma services, psychiatry, counseling, day treatment, and intensive, round-the-clock outpatient services to help people with severe mental illnesses safely remain in the community. Lakeview Center is also a specialized therapeutic foster care provider.

Lighthouse Health Plan will provide enrollees with access to a network of high quality compounding pharmacies. We have contracted with CVS, the largest PBM in the nation. CVS has over 15,000 compounding pharmacies in their network including approximately 250 in Florida. To ensure that enrollees receive care from compounding pharmacies that are safe and high quality, complex compounding pharmacies will be required to have additional credentialing completed prior to dispensing medications (current pharmacies in CVS network); or prior to being enrolled (new pharmacies).

USE OF MULTIPLE SOURCES TO MONITOR AND UPDATE NETWORK PLAN

On an ongoing basis, we use analytic tools, claims, Enrollee Services grievances and complaints, secret shopper activities, Care Management and Population Health input to identify gaps and proactively look for opportunities to enhance our network and improve access for our enrollees. Each month our provider network team reapplies Quest Analytics tools to identify gaps based on network standards, and uses the ACHA Master Provider List, Strenuus, and Enclarity to identify community providers for potential recruitment. The provider network team reviews claims data on

a quarterly basis to determine which out of network providers were seen by enrollees during the previous quarter. The provider network team reviews all feedback on these providers from enrollees, referring providers, care managers, and utilization managers.

Identifi Network, our web-based provider data management tool, maintains our provider file, populates the provider directory and supports network adequacy analytics. Identifi Network allows our network administrators and managers as well as providers to create, track, maintain and access interactions with network providers including viewing network adequacy reports produced by the provider data team.

Our Enrollee Services team will monitor enrollee grievances, calls, and complaints related to access, and refer this information to the provider network team for investigation on an individual basis in the short term, and for network planning to ensure network adequacy in the longer term. The provider network team also obtains data from Care Management, Enrollee Services, and the Population Health Management departments regarding access issues and unmet clinical or social factors that affect patient care such as language, ethnicity, gender, or special needs. For example, while Lighthouse Health Plan may meet the adequacy standard in our region, there may be insufficient providers who speak a certain language. In addition, quarterly secret shopper and onsite access reviews identify access barriers to specific providers or practices such as long wait times, lack of after-hour appointments, and closed panels; these are escalated to the provider network team and other relevant departments for action.

Based on all of these data sources, our provider network team develops and updates a recruitment work plan and conducts outreach to recruit high quality providers to the network to fill all gaps. Short term needs are escalated for authorization of out of network providers, described below.

ACCESS TO OUT-OF-NETWORK (OON) PROVIDERS

We will ensure that enrollees can access medically necessary care including services from OON when needed and appropriate. Immediate service needs are addressed through our policies on OON coverage for emergency services. Short term needs for OON services are addressed through single case agreements, and our long-term approach involves recruitment of OON providers into our network.

Should an enrollee require immediate, emergent or urgent care services and they are not near or cannot access a contracted provider, they are advised to go to the nearest treatment facility. This is supported by Lighthouse Health Plan policies and communicated through our contracted providers, Enrollee Services, and Enrollee handbook. Out of network emergency services are available without any financial penalty to the Enrollee.

When an enrollee needs to access non-urgent care outside of the Lighthouse Health Plan network, the primary care physician or OON provider will contact the utilization management (UM) Department to secure an authorization. During the authorization process, the UM team will remind the OON provider of the timely access requirements for urgent and routine appointments. If the enrollee has any issues securing a visit with a specialty care provider, Enrollee Services or Care Management staff can assist the enrollee by contacting the OON provider to help secure a timely appointment that meets the Agency’s standards.

Our UM and Care Management (CM) processes coordinate services from OON providers, with the goal of ensuring the services are appropriate and consistent with an enrollee's identified needs. Our OON service authorization includes review by a UM Nurse, a care coordinator or the enrollee's Care Manager (if enrolled in care management), and as appropriate the Medical Director. The UM nurse confirms the requested service is medically necessary and is not available or accessible from a network provider. The Care Coordinator or Care Manager coordinates the OON services with the enrollee's other providers, including the PCP, and provides appropriate medical records, including copies of the enrollee's care plan, to the OON provider. The Medical Director validates the need for OON services and is available for peer to peer consultation with the OON provider and the enrollee's other treating providers. The Provider Services Call Center is available to respond to OON provider's questions and assist them with the OON service authorization process.

The UM nurse also notifies provider network staff about requests and authorizations for OON services. Provider network staff then contact the identified OON provider and invite the provider to join the network. If the provider is agreeable, a provider network specialist works to initiate the contract and enrollment process. If the provider is not willing to immediately join the network, a single case agreement is created, and the provider network staff instructs the OON provider on how to obtain access to the Lighthouse Health Plan website, which includes resources the provider can use to join the network at any time. The provider network specialist can also provide materials to the provider via fax or by mail if the provider has no internet access. OON providers also have access to provider manuals that include enrollee rights and responsibilities, our coverage policies and provider updates. Provider network staff will also initiate provider recruitment and contracting efforts to identify available providers of the same specialty type able to meet the enrollee's needs and are willing to join our network. We will continue to authorize OON services for as long as medically necessary and until we can meet the enrollee's need with an in-network provider. To ensure continuity of care, we may choose to extend the OON authorization until the enrollee's course of treatment is complete, even if an in-network provider is identified.

MEASURING TIME FROM AUTHORIZATION TO SERVICE

Each month, Lighthouse Health Plan's claims team will utilize the reporting capabilities within Identifi HPA, our claims and authorization platform, to compare the date that a service is authorized with the date of service on the matching claim. A claims specialist will review cases in which the elapsed time is greater than timely access standards delineated by the Agency. The claims specialist will submit a list of providers associated with delays in rendering services to the provider relations team. The provider relations team will contact the providers, advising them of the appointment availability standards. If there is a pattern of delays in rendering services, the provider relations representative will conduct an onsite review to examine the provider's appointment availability and adherence to the access standards. If a provider is found to be out of compliance during the on-site review, Lighthouse Health Plan will send a letter outlining areas where the provider was out of compliance, and notify these providers that they will be resurveyed within 90 days. If a provider fails both the initial and 90-day follow-up surveys, their information will be sent to the Credentialing Committee for additional recommendations or actions. Our priority is to help the provider to adhere to the standards, but if efforts fail, providers may be terminated from the network.

Lighthouse Health Plan also will use secret shoppers, on-site access reviews, and Enrollee Services data and grievance monitoring to identify issues with delays obtaining services related to wait times for appointments, and then target interventions accordingly. Trained secret shoppers conduct calls to a randomly selected, statistically valid sample of primary care, specialty, and behavioral health providers. The secret shoppers pose as Lighthouse enrollees who are "shopping" for a health care provider to schedule appointments, and document the wait times for urgent care, routine sick care, and well- care appointments. Providers who cannot be reached at the phone number listed in the provider directory or who do not offer an appointment within the timeframe outlined in Section VIII.A.8 of the SMMC model contract will be escalated to the provider network team for an onsite access review - in addition to random selection of providers on a quarterly basis for on-site access reviews. The on-site review assesses wait times for appointments, wait times upon arrival at the office, and other scheduling and practice flow patterns. As noted above, offices out of compliance with timely access standards are informed of the reasons and that they will be resurveyed within 90 days. If a provider fails both the initial and 90-day follow-up surveys, their information will be sent to the Credentialing Committee for additional recommendations or actions.

DELEGATION OF PROVIDER NETWORK FUNCTIONS

At times Lighthouse Health Plan may enter into contracts with first tier, downstream or related entities (FDRs) to provide administrative or health care services, including provider network functions, for enrollees on behalf of the organization.

Lighthouse Health Plan follows a rigorous process to identify and select the best subcontractors. An entity under consideration for delegation must be audited by Lighthouse Health Plan representatives to validate their capabilities and financial stability. They must be judged to be compliant with the standards of Lighthouse Health Plan and in accordance with standards established by the NCQA. Lighthouse Health Plan staff will present pre-delegation audit results, indicating approval or denial, to its Delegation Oversight Committee. The Delegation Oversight Committee is directly accountable to the Board of Directors through the Quality Improvement Committee. Upon successful completion of the pre-delegation audit and only with the approval of the Delegation Oversight Committee, Lighthouse Health Plan's Contract Specialist will execute a contract with the subcontractor.

Lighthouse Health Plan retains ultimate accountability for delegated provider network functions performed on its behalf. Lighthouse Health Plan will monitor the performance of subcontractors on an ongoing basis including requiring that they submit reports to support operational oversight and SLA monitoring. Examples of these reports include but are not limited to:

Credentialing/Recredentialing Components
- Annual submission of a roster of practitioners and providers credentialed and recredentialed
- Annual submission of a network summary report of geographic availability
- Analysis of data
- Credentialing Committee meeting minutes
- An annual site audit conducted to review credentialing and recredentialing files (If the subcontractor is NCQA certified, the required level of oversight is reduced. No annual onsite evaluation is required as long as the subcontractor remains NCQA certified.)

Network Management Components
• Annual assessment of access and availability of practitioners
• Copies of contracts with practitioners that include an affirmative statement indicating that practitioners may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Lighthouse Health Plan also conducts an annual audit to determine if the delegated activities are being carried out in accordance with the delegation agreement and regulatory and accreditation standards. Lighthouse Health Plan utilizes standardized audit tools to conduct the annual delegation audits. Results of the annual delegation audit are presented to the Delegation Oversight Committee.

If a deficiency is identified during a monitoring activity then the subcontractor will be placed on a corrective action plan. All corrective action plans are monitored to remediation and are only closed at the direction of the Delegation Oversight Committee. Lighthouse Health Plan can terminate a subcontractor in accordance with the delegated agreement if deficiencies are identified during the oversight process.

Evaluation Criteria:

1. The adequacy of the respondent's methodology for identifying and resolving barriers and network gaps; including ongoing activities or network development based on region-specific identified gaps and future needs projection.

2. The adequacy of the respondent's plan to meet the needs of enrollees if it is unable to provide the service within its provider network; including immediate, short-term and long-term interventions.

3. The extent to which the respondent's plan includes strategies for measuring the time in-between when services are authorized and when they are received.

4. The extent to which the respondent's update of its network development and management plan is informed by multiple data sources (including complaints, grievances, etc.).

5. The extent to which the respondent's draft network development and management plan addresses the delegation of provider network functions to subcontractors and the oversight of these operations.

Score: This section is worth a maximum of 25 raw points with each of the above components being worth a maximum of 5 points each.

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D. PROVIDER EXPERIENCE

MMA SRC# 12 – Provider Credentialing (Statewide):

The respondent shall describe its proposed process to credential and recredential providers (including subcontractors' processes, if applicable), including credentialing timeframes, internal continuous quality improvement initiatives for recredentialing, transparency for providers on their application status and the steps the respondent or its subcontractors will take to ensure the respondent and the Agency have accurate provider demographic information in-between credentialing cycles.

Response:

Lighthouse Health Plan recognizes that a highly effective provider network is a critical foundation for a cost effective and quality driven delivery system. Lighthouse has contracted with Evolent Health, a NCQA accredited industry leader with over 20 years of experience in working side by side with providers to implement a provider-friendly and efficient credentialing/re-credentialing process that complies with the requirements of 42 CFR 455, 100-106; 42CFR 455, 400-470, NCQA, CMS and EQRO recommendations, and all other pertinent Federal and State Regulations. Evolent Health has a proven track record of credentialing a wide variety of practitioners delivering against high-volume, timeline driven needs, and consistently exceeds credentialing industry standard processing timeline of one hundred twenty (120) days across six state Medicaid programs in 2016 and first three quarters of 2017, including 99.5% of all credentialing/re-credentialing applications completed within 45 days or less.

Lighthouse and Evolent Health have developed a systematic method for assessing practitioner applicants against NCQA credentialing and re-credentialing standards and guidelines to ensure compliance with regulations. Unique to our approach is that we incorporate quality review, Enrollees services and provider relations teams in our credentialing and ongoing monitoring processes, which ensures a multidisciplinary review of the quality and consistency of service delivery. Our process includes regular oversight to monitor and evaluate how well staff are adhering to credentialing policies and procedures as well as regulatory requirements.

CREDENTIALING PROCESS

Our Chief Medical Officer (CMO) or designated Medical Director and Credentialing Committee oversee our credentialing program. The Credentialing Committee develops and administers credentialing and re-credentialing policies and oversees the credentialing process.

Lighthouse credentials and re-credentials providers in accordance with The National Committee for Quality Assurance (NCQA) Standards & Guidelines, including medical practitioners, allied health professionals, behavioral healthcare practitioners, organizational providers (e.g., hospitals, FQHCs), and community based service providers that are deemed eligible by the state.

Initial credentialing is conducted prior to the effective date of the provider's contract and includes application review and an onsite survey. The credentialing process begins upon receipt of the

provider's complete credentialing application, which includes the provider's attestation as to the accuracy and completeness of the application. Lighthouse accepts a Council for Affordable Quality Healthcare (CAQH) or Florida Medicaid Provider Enrollment Application (AHCA Form 2200). Eligibility is determined by the extent to which applicants meet defined requirements for education, licensure, professional standing, service availability, and accessibility, as well as conformity to the utilization and quality improvement requirements. We enroll providers in the provider network in accordance with NCQA and AHCA provider eligibility requirements and we verify that the provider has no active sanctions imposed by Medicaid or fraud investigations and required licenses and certifications are current. We collect and verify each provider's National Provider Identifier (NPI) and taxonomy. Information received through the credentialing process is considered confidential for reviewing prospective practitioner applicants for participation in the network. All information/documentation is placed in the practitioner applicant's file, which is stored in secure electronic folders.

Upon completion of the credentialing application, Primary Source Verification (PSV) begins. Lighthouse has selected Aperture, an NCQA-certified credential verification organization (CVO) to conduct PSV. PSV follows the most current version of the NCQA CVO credentialing requirements updated and refreshed annually. Our PSV process verifies credentials using the following sources:

- Federal DHHS Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) via the Medicare Exclusions file (MED);
- System of Award management (SAM);
- Federal General Services Administration (GSA) Excluded Parties Lists System (EPLS);
- State Board of Examiners, Department of Health, and/or Department of State license suspensions as well as licenses not in good standing;
- CMS' Provider Enrollment, Chain, and Ownership System (PECOS);
- The Data Bank, consisting of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB);
- Florida's listing of Sanctioned and Terminated providers

A site visit is conducted by the Lighthouse provider relations team to assess the quality, safety and accessibility of office sites where care is delivered. The Lighthouse provider relations team uses a standardized site-visit survey form to assess the provider's compliance with the following office site criteria:

Physical accessibility and appearance:
- Meets access for persons with disabilities
- A Smoke Free facility
- Proper Fire, safety and sanitation procedures.
- Well-lit waiting room.
- Adequate seating.
- Posted office hours.

Medical records, paper based:
- Secure/confidential filing system.
- Legible file markers
- Records can be easily located.

Medical Records, electronic:
- Medicines' key core capabilities:
- Health information and data. Having immediate access to key information such as patients' diagnoses, allergies, lab test results, and medications would improve caregivers' ability to make sound clinical decisions in a timely manner.
- Result management. The ability for all providers participating in the care of a patient in multiple settings to quickly access new and past test results would increase patient safety and the effectiveness of care.
- Order management. The ability to enter and store orders for prescriptions, tests and other services in a computer-based system should enhance legibility, reduce duplication, and improve the speed with which orders are executed.
- Decision support. Using reminders prompts, and alerts, computerized decision-support systems would help improve compliance with best clinical practices, ensure regular screenings and other preventive practices, identify possible drug interactions, and facilitate diagnoses and treatments.
- Electronic communication and connectivity. Efficient, secure, and readily accessible communication among providers and patients would improve the continuity of care, increase the timeliness of diagnoses and treatments, and reduce the frequency of adverse events.
- Patient support. Tools that give patients access to their health records, provide interactive patient education, and help them carry out home-monitoring and self-testing can improve control of chronic conditions, such as diabetes.
- Administrative processes. Computerized administrative tools, such as scheduling systems, would greatly improve hospitals' and clinics' efficiency and provide more timely service to patients.
- Reporting. Electronic data storage that employs uniform data standards will enable health care organizations to respond more quickly to federal, state and private reporting requirements, including those that support patient safety and disease surveillance.

Once Primary Source verification and the provider site visit has been completed, the provider's credentialing file is reviewed by the Lighthouse Chief Medical Officer (CMO)/Credentialing Committee. Lighthouse obtains meaningful advice and expertise from participating practitioners when making credentialing decisions. The Credentialing Committee is accountable for the timely and thorough review of all practitioner applications. The Credentialing Committee meetings and decision-making processes take place in face-to-face or real-time virtual meetings, e.g., telephone, video, or Web conferences with audio. The Committee reviews each application, with provider name and other demographic characteristics redacted, and votes for acceptance for participation, denial for participation, request additional information or a modified participation status. The committee is not permitted to vote for acceptance or denial based on a Provider's race, ethnic/national identity, gender, age, sexual orientation, types of procedures performed or types of patients.

Providers are notified of decisions made by the Credentialing Committee within 60 days of the date of the Credentialing Committee decision. We provide all prospective provider applicants and providers scheduled for credentialing/recredentialing process with notification of their right to review information obtained that varies substantially from the information provided by the practitioner. In addition, we also notify the provider of information obtained through the credentialing/re-credentialing process differs from the information submitted by the provider.

Providers are also notified of their right to correct erroneous information and to appeal credentialing decisions to the plan.

RECREDENTIALING AND QUALITY MONITORING

Our provider relations, enrollment, credentialing and quality teams are committed to ensuring our Enrollees have access to quality providers. Lighthouse re-credentials practitioners and organizational providers, who require credentialing, within thirty-six months of the last credentialing event. Practitioners or organizational providers may be re-credentialed earlier than thirty-six months if other quality or service data has identified the need for an earlier review. Lighthouse notifies a provider ninety (90) to one hundred and eighty (180) days prior to each re-credentialing event that they are beginning the re-credentialing process and request a newly attested CAQH or AHCA Form 2200. A Lighthouse credentialing representative will work with the provider via email, or phone to obtain any missing information needed to support the application process (e.g. updated malpractice insurance documentation or copy of current license).

Our recredentialing process is an ongoing effort to monitor and address quality of care concerns and ensure practitioner practice patterns that are not conducive to providing high quality care or services are addressed when they occur. Between recredentialing cycles, Lighthouse's Quality Management Committee (QMC) reports, tracks and trends Enrollee complaints against providers, quality of care concerns, including sentinel events. Specifically, exceed state requirements by conducting a comprehensive quality assessment of each provider against criteria listed below:

- HEDIS Measures
- ER visit overutilization rates
- Hospital Readmission rates
- Appointment Access and Availability
- Site Visit reviews
- Medical record reviews
- Complaints/Grievances
- Open and closed panel status
- Enrollee disenrollment rates

Our Quality Assurance (QA) Program is a collaboration involving Provider Enrollment, Credentialing, and Provider Data Management managers, supervisors and QA specialists to monitor and evaluate how well staff are adhering to departmental policies and procedures as well as regulatory requirements. This QA program provides a vehicle for measuring the quality and consistency of service delivery, identifying trends, service issues and training opportunities to improve enrollment and credentialing staff performance and productivity. This program also monitors and evaluates how well staff are adhering to credentialing policies and procedures as well as regulatory requirements, including Credentialing Requirement, Profile Review, CMO/Committee Sign-off and 60-day notification to providers.

Representatives from the QMC, Enrollee services and provider relations, present complaints and/or quality of care concerns during our monthly Credentialing Committee. If the Credentialing Committee feels that the practitioner's practice patterns are not conducive to

providing high quality care or services, the Credentialing Committee may recommend actions up to and including termination from the Lighthouse's provider network.

In addition, Lighthouse conducts monthly monitoring of all providers in the provider database including participating and non-participating entities on an ongoing basis for possible sanctions or disciplinary actions, possible Medicare or Medicaid sanctions/exclusions or reinstatements, or adverse action taken by the state medical licensing and/or applicable allied health boards or the Department of Health & Human Services Office of the Inspector General as well as Systems of Award Management (SAM). For sanctions or limitations taken against licensure or trends in Enrollee complaints, the Credentialing Committee utilizes policies to make determinations of participation status and to determine options available for further actions and sanctioning. In the event the Plan receives a notification originating from the state that a provider has been excluded from Medicare or Medicaid participation, the provider will be immediately terminated from the provider network.

The Credentialing Committee reviews completed applications and notifies providers within 60 days

DELEGATION

Lighthouse delegates credentialing and re-credentialing of certain provider types to Subcontractors, including dental providers (Avesis), Behavioral Health providers (Access), and transportation providers (One Call).

We maintain a formal subcontractor oversight process that ensures subcontractors comply with all federal and state credentialing and recredentialing requirements. Lighthouse subjects each subcontractor to formal review at least once a year consistent with NCQA standards. Lighthouse utilizes standardized audit tools to conduct annual delegation audits. During this evaluation, the subcontractor must make available for purpose of an audit by Lighthouse its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees. Lighthouse verifies that the subcontractor follows all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. Lighthouse's auditors prepare an audit report that details the audit findings and whether deficiencies or opportunities for improvement were identified. These findings are included in the Annual Quality Management Program Evaluation.

The report is reviewed at the next scheduled Delegation Oversight Committee meeting. DOC either recommends that Lighthouse continue to contract with the delegate, continue to contract with the delegate so long as it agrees to a Corrective Action Plan (CAP) to resolve any deficiencies identified during the annual audit, or terminate the contract. The Secretary of the DOC communicates the committee's decision to Lighthouse's Board of Directors. Any decision to terminate a subcontractor would be submitted to the Agency for review not less than thirty calendar days of Lighthouse's desire to terminate a subcontract.

An entity under consideration as a credentialing delegate is evaluated by Lighthouse, and judged to be compliant with the credentialing standards of Lighthouse, AHCA credentialing requirements and in accordance with standards established by NCQA. Lighthouse staff presents evaluation results, indicating approval or denial, to Delegation Oversight Committee.

Credentialing functions will be delegated only to entities that are found to comply credentialing standards set forth above and in accordance with regulatory/accrediting guidelines. Lighthouse reviews and evaluates regular reports as specified by the delegation agreement. A corrective action plan will be requested if deficiencies are identified. In addition to ongoing monitoring, Lighthouse conducts a comprehensive oversight review annually to monitor the compliance of the delegate's credentialing/re-credentialing process. If a delegate's performance does not meet our standards, remedies may include education, corrective action plans, or revocation of the agreement. Ongoing delegation is not automatically conferred, but rather is approved for each individual entity based on the annual oversight review.

Transportation Subcontractor's Credentialing and Recredentialing Process –

Our transportation subcontractor, One Call's, robust, national, outcomes-based network is carefully vetted to ensure only high quality, appropriately credentialed providers are admitted to and remain in their transportation network. The comprehensive depth and coverage of One Call's provider network ensures we are consistently able to coordinate the best care possible for the Enrollee, regardless of location. One Call has established and maintains long-standing relationships with our provider partners.

One Call's providers must meet strict credentialing criteria, including the requirements outlined in the solicitation for Statewide Medicaid Managed Care Scope of Services, to become an approved network provider. They must maintain the licensure required by their state. One Call requires providers carry general and professional liability insurance; required policy limits are stated in our provider contracts. These requirements are reviewed by network specialists at the time of contracting and our credentialing team requests current/updated copies of documents as they expire. As part of One Call's primary source verification, additional information is obtained from monitoring organizations, such as IRS; Office of the Inspector General's List of Excluded Individuals and Entities (LEIE); National Practitioner Data Bank (NPDB) as applicable; Background Checks, as applicable; Individual State Boards of Medical Examiners, as applicable.

Providers are required to sign a One Call provider contract as well as a business associate agreement (BAA) to ensure confidentiality. These contracts require providers to perform background checks on all employees who will provide service for or have access to information from One Call. If any provider employee has been convicted of any crime involving dishonesty, a breach of trust, violence, or sexual misconduct, they are prevented from performing any services for One Call.

One Call's credentialing timeframe is approximately 30-60 days and One Call is committed to meeting all CMS and AHCA requirements. During the credentialing process providers are given an email and telephone number should they have any questions and/or would like to check the status of their credentialing application. Upon completion of the credentialing, One Call notifies the provider and begins the onboarding process. Should a provider not become an approved provider, One Call would notify the provider via email.

A provider's credentialing status may be evaluated at any time; however, One Call's standard time frame for re-credentialing a transportation provider is annually contingent upon provider type and any state mandated requirements. Providers will be notified when they are subject

to re- credentialing. Items within our contracts that expire are reviewed and re-credentialed 30 days prior to the date of expiration. Letters and follow-ups will continue to be performed until all necessary documentation and evidence has been provided to support the provider's credentialing. One Call's weekly reports indicate if something goes 30 days past expiration which is escalated for further review and action. If One Call does not receive updated credentials prior to expiration, the provider is inactivated and will not provide services for One Call until updated credentials are received.

All applications and credentialing materials are verified by the One Call credentialing staff. A sample of Enrollee files are randomly selected and reviewed for completeness at periodic intervals.

Providers may be removed from our network due to significant grievances, service issues, low quality rating, or breach of contract. One Call actively manages our network to ensure providers comply with quality guidelines and reporting standards, which helps to ensure quality care and favorable outcomes. While we rarely remove providers from our network, it can happen due to several reasons such as provider offices may close or become acquired, the provider may terminate its agreement with One Call, or One Call may terminate its agreement with the provider. In all cases, there is formal documentation between One Call and the provider who will be removed. At the time of removal, One Call will determine if there are Enrollees scheduled for future dates of service and make arrangements for them to be re-scheduled with other network providers, if need be. One Call will also set up a process to collect any outstanding medical reports that the provider may have for Enrollees.

The Provider Quality and Credentialing Committee reviews all recommendations for provider terminations monthly. If the matter is of a grievous nature, One Call may decide to terminate the provider's contract. When this occurs, the provider receives a termination letter stating the reason for the termination and instructions regarding their right to appeal. The provider relations contractor sends an internal email to notify One Call departments of the provider termination. Providers who receive multiple complaints of a less serious nature over a short period of time are also reviewed and considered for removal from the network if they are unable to provide or implement an action plan to resolve the recurring issues in a timely manner.

The Provider Quality and Credentialing Committee (Committee) ensures enterprise provider network quality, across all of One Call. The Committee meets monthly to evaluate provider compliance with One Call policy, assess providers with sub-par performance, and act on recommendations identified through One Call operating departments. This Committee reviews and approves the providers being added to or removed from the One Call network or whose quality rating is being lowered.

Providers may be removed from One Call's network due to significant grievances, service issues, low quality rating, or breach of contract.

AHCA CONTRACTUAL REQUIREMENTS-CREDENTIALING

Lighthouse will meet or exceed each of the AHCA contractual requirements related to credentialing. We shall ensure that all providers are eligible for participation in the Medicaid

program, consistent with provider disclosure, screening, and enrollment requirements. (42 CFR 455.100-106; 42 CFR 455.400-470). We shall ensure all providers have a current provider agreement with Agency, as prescribed by the Agency. We shall require each provider to have a NPI in accordance with s. 1173(b) of the Social Security Act, as enacted by s. 4707(a) of the Balanced Budget Act of 1997. We understand that Lighthouse is not required to obtain an NPI from an entity that does not meet the definition of "health care provider" found at 45 CFR 160.103. In accordance with AHCA contract requirements.

1) Lighthouse's credentialing and re-credentialing policies and procedure, approved by the Plan's credentialing committee and Policy and Review Committee shall in include, but not limited to the following:

- Formal delegations and approvals of the credentialing process;
- A designated credentialing committee;
- Identification of providers who fall under its scope of authority;
- A process that provides for the verification of the credentialing and re-credentialing criteria required under this Contract;
- Approval of new providers and imposition of sanctions, termination, suspension, and restrictions on existing providers;
- Identification of quality deficiencies that result in the Managed Care Plan's restriction, suspension, termination, or sanctioning of a provider.

2) Lighthouse performs credentialing and re-credentialing in accordance with all AHCA and NCQA requirements. Lighthouse collects and reviews the following information during the credentialing and re-credentialing process.

- A current and valid license or authority to do business in the state in which the provider is located.
- A valid DEA and CDS certification, if applicable.
- Education and training as specified in the explanation.
- Board certification status, if applicable.
- Good standing of privileges at the hospital designated as the primary admitting
- facility by the physician or, if the physician does not have admitting privileges,
- good standing of privileges at the hospital by another physician with whom the
- physician has entered into an arrangement for hospital coverage.
- Current curriculum vitae or completed credentialing application, which includes
- at least five (5) years of work history.
- A history of professional liability claims that resulted in settlement or judgment paid on behalf of the practitioner.
- State sanctions, restrictions or revocation on licensure or limitations on scope of practice by the licensing authority in state where the provider practices or any other state, if applicable.
- Medicare and Medicaid sanctions.
- Reasons for inability to perform the essential functions of the position.
- Lack of present illegal drug use.
- History of loss of license and felony convictions.
- History of loss or limitation of privileges or disciplinary actions.
- Current malpractice insurance coverage
- Current and signed attestation confirming the correctness and completeness of the application. Information collected on the application must be no more than six (6) months old on the date the provider is approved the plan.

- Disclosure related to ownership and management (42 CFR 455.104). business transactions (42 CFR 455.105) and conviction of crimes (42 CFR 455.106); and
- A level II background check pursuant to s. 409.907, F.S.

3) Lighthouse credentialing and re-credentialing file documents includes the credentialing information identified above, findings of provider's site visit, as well as tracking and trending of all provider complaints and quality of care concerns. The provider's credentialing/re-credentialing file is an electronic file that is maintained and placed in a secure electronic folder.

4) The Lighthouse credentialing/re-credentialing process collects and verifies each provider's National Provider Identifier (NPI) and taxonomy, as applicable.

5) In the event, Lighthouse denies or terminates a provider, group of provides or organizational providers, the provider/s are sent written notification, reason for the Plan's decision and their right to appeal that decision.

6) Lighthouse submits disclosures and notifications to the State Medical Licensure Board, NPDB, Office of the Inspector General (OIG), MPI and any other required state or federal agency, in accordance with s.1128, s. 1156and s.1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, if formal sanctions are imposed for matters of professional competence or professional conduct.

7) Lighthouse does not reimburse, employ or contact with providers who are on the state or federal exclusions lists.

8) Lighthouse evaluates its' organizational providers (e.g. hospitals, Home Health, etc.) using NCQA and the Lighthouse's organizational standard.

CREDENTIALING APPROVAL PROCESS AND TIMELINESS

Our subcontractor Evolent Health has a proven track record of credentialing a wide variety of practitioners delivering against high-volume, timeline driven needs, and consistently exceeds credentialing industry standard processing timeline of one hundred twenty (120) days. In calendar year 2016 and the first 3 quarters of year 2017, they credentialed 9,347 providers and re-credentialing 9,217 providers. Their average TAT to complete primary source verifications for initial credentialed providers was 9.2 days and for re-credentialed providers was 20.5 days. 97.5% of all credentialing/re-credentialing applications were completed within 30 days or less. 99.5% of all credentialing/re-credentialing applications were completed within 45 days or less.

Evolent has served six state Medicaid programs including Kentucky, Indiana, Maryland, Illinois, Texas and the District of Columbia, maintaining a fully credentialed national network of over 30,000 Medicaid organizational and ancillary providers. They have consistently met and exceeded the contract standards in those states. During year 2017, the Evolent Health passed NCQA and external state credentialing and re-credentialing audits with 100 percent scores which included policy & procedure reviews and adherence to all NCQA CR standards, including state contractual requirements.

TRANSPARENCY OF CREDENTIALING AND RECREDENTIALING FOR PROVIDERS

Transparency and traceability of work as it flows through the enrollment and credentialing process is a key feature of our process. We provide regular updates to providers on the status of their applications in the following ways starting with the receipt of the application or data update request:

- When the provider submits an application via email or fax we send a receipt email or fax in return to indicate that their transmission has been received.
- As the coordinator reviews the application for processing, the coordinator will reach out with any additional questions about it they may have.
- Within one business day of receipt of provider applications from enrollment, we begin the primary source verification (PSV) process. At the time PSV begins, we send a letter to the provider notifying him or her that credentialing or re-credentialing process has begun. We perform no less than 3 provider outreach calls informing them of current status and of any information that may be needed or is missing from their application. Our credentialing coordinator also contacts any providers whose application has been in process at day 21.
- We provide all prospective provider applicants and providers scheduled for credentialing/re-credentialing process with notification of their right to review information obtained that varies substantially from the information provided by the practitioner. In addition, we also notify the provider of information obtained through the credentialing/re-credentialing process differs from the information submitted by the provider. We also notify providers of their right to correct erroneous information and to appeal credentialing decisions to the plan.
- If we are unable to complete PSV, we close the provider file and track via daily reports. Our credentialing coordinator reviews the application status report daily. If PSV was unable to complete, we notify the provider within 3 business days, via letter, of incomplete status with instructions how to restart process. Letters of communication to providers also include the credentialing telephone number so a provider can contact the department at any time to check status of their application.
- When we successfully complete PSV we notify all providers who have completed PSV within 60 days of the Lighthouse Credentialing Committee decision.
- In addition to additional credentialing and PSV specific communication avenues that we use, the enrollment team will send the provider a welcome letter when their application has been processed and their record has been loaded to our claims and directory system. The letter will note the availability of the Provider Handbook on the website and that we will also provide a copy during their welcome and training visit. Providers who are not approved for participation in the network receive written notice with the reason for the decision.
- Last of all, the providers can always email or call the enrollment team with questions about the status of their application.

INCORPORATING THE AGENCY'S STREAMLINED CREDENTIALING CAPABILITY

Providers with a valid Limited Enrolled or Fully Enrolled agreement with the Agency may be considered to have met all requirements for primary source verification except professional liability claims history. Our Provider Relations staff will conduct site assessments at all Primary Care offices during initial credentialing.

ENSURING STATUS CHANGES ARE REPORTED BETWEEN CREDENTIALING CYCLES

We maintain ongoing contact with providers through our provider network management team who act as a liaison between Lighthouse and providers including subcontractors. This team of provider relationship specialists will remain in regular contact with providers and will continue to remind them of the importance of notifying Lighthouse of demographic changes. We also send out reminders in Provider Portal/Website.

Additionally, we will utilize data sources such as returned mail and claims to identify and engage providers who may have not kept their demographic data up to date.

Evaluation Criteria:

1. The adequacy of the respondent's description of its credentialing and recredentialing criteria, certified credential verification organization processes, and utilization of a third party credentialing vendor.

2. The extent to which the respondent's timeframes for processing credentialing applications is more expeditious than the industry standard processing timeline of one hundred twenty (120) days.

3. The adequacy of the respondent's approach to providing transparency to providers throughout the credentialing and recredentialing processes, including how providers will be informed at each step of the application process.

4. The extent to which the respondent uses information from provider complaints, monitoring, and recommendations from its Quality Improvement Committee in its recredentialing process.

5. The extent to which the respondent and its subcontractors incorporate the Agency's streamlined credentialing capability (via promotion of limited enrollment) in its credentialing and recredentialing processes.

6. The extent to which the respondent outlines steps the respondent and its subcontractors will take to ensure provider demographic or participation status changes are reported to the plan in-between credentialing cycles.

Score: This section is worth a maximum of 30 raw points with each of the above components being worth a maximum of 5 points each.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 13 – Value Based Purchasing (Regional):

a. The respondent shall describe the continuum of value-based purchasing (VBP) contractual arrangements available for providers, delineated by primary care, specialty care and hospital-based care.

b. The respondent shall describe the volume of contracts it expects to implement or maintain through a VBP arrangement each year for each of the next five (5) Contract years, delineated by primary care, specialty care and hospital-based care.

c. The respondent shall include specific outcomes it expects to see throughout the life cycle of the VBP continuum, delineated by primary care, specialty care and hospital-based care.

d. The respondent shall describe specific VBP arrangements it intends to implement and/or maintain in an effort to promote the Agency's goals, delineated by primary care, specialty care and hospital-based care.

Response:

Lighthouse Health Plan believes that transitioning from fee-for-service payment systems that pay for volume to payment arrangement that increasingly recognize the value of services provided in terms of improved health outcomes is critical to improving the healthcare system. Better aligned financial incentives increase access by ensuring that providers are focused on the patients and challenges that need their attention the most. Paying for value also supports improved health outcomes by providing financial incentives for performance improvement, and eventually penalties and financial risk for poor quality care. Finally, value-based purchasing (VBP) helps control cost and drives towards the efficient use of Medicaid dollars by reducing expenditures on unnecessary, redundant or ineffective care. For these reasons, Lighthouse is committed to incorporating VBP components into nearly all of our provider contracts over the next five years.

CONTINUUM OF VBP ARRANGEMENTS

Lighthouse recognizes that payment transformation is a process that needs to be done deliberately and incrementally. Some VBP payment models require providers to make changes to their clinical processes to support enhanced focus on quality outcomes. Additionally, some providers are more prepared than other to accept financial risk for improved outcomes. As a result, we have developed a menu of VBP options for primary care providers (PCPs), specialists and hospitals that will support the system-wide transition of healthcare payment across the VBP continuum. Our VBP models range from traditional P4P programs rewarding improvement on targeted quality metrics to full risk sub-capitation arrangements with quality performance requirements. The continuum of VBP options is described below.

Primary Care –

PCP Scorecard Incentives (based on HEDIS measures with incentive payments for exceeding benchmarks): Lighthouse will develop a pay for performance program based on a scorecard comprised of a subset of quality metrics from our "Measures that Matter" list which is described

later in this section. PCPs who enroll in this program will agree to performance reporting requirements to support incentive payment. Incentive payments will be calculated based on the PCP's performance on the identified measures as compared to HEDIS benchmarks. Performance at or above the 75th percentile qualifies the PCP for an incentive payment. Payments to providers will be made on a per Enrollee per month basis for the performance year and will be provided in a lump sum, at the end of the year.

Lighthouse will work with the provider to ensure that this incentive payment is distributed to the staff, as they deem appropriate, who were engaged in improving quality performance or invested in the practice's population health management capabilities to enable further improvements in performance.

Enhanced reimbursement for PCMHs: PCPs who are certified as Patient-Centered Medical Homes will be paid an enhanced rate of 100% of Medicare fee schedule.

Primary Care Shared Savings Program: This program allows PCPs to share in the savings generated by controlling the Medical Expense Ratio (MER) for their attributed patient panel.

The PCP Shared Savings Program is built such that funding of the shared savings pool occur via two (2) mechanisms related to the Providers performance on Medical Expense Ratio (MER) for Enrollees attributed to that Provider. Funding occurs when Providers:

1. Show improvement in Medical Expense Ratio (MER) between the prior year (Baseline) and current (Measurement Year) – also referred to as "MER Improvement"**

AND/OR

2. Reach a desired (high-performing) Medical Expense Ratio (MER) of 85% or lower – also referred to as "MER Attainment"**.

In order to be eligible for a shared savings payment the provider practice must first pass a "Quality Gate". The Quality Gate component is designed to ensure that we do not have any specific payment or inducement for a physician or physician group to reduce, deny, discontinue or limit medically necessary services to an Enrollee.

The practice will be scored across 5 domains including:

- Prevention/Quality
- Efficiency
- Provider Citizenship
- Coding and Risk Adjustment
- Patient Satisfaction

The Shared Savings funds for Enrollees assigned to a Provider will be split 50/50 between the health plan and the Provider. Provider practices are eligible to earn the full amount of their available Shared Savings based on their Performance Scorecard results. The final score for a Provider will be weighted and aggregated to produce a "Final Measurement Year Scorecard Result". Providers must score at least 65% or higher to be eligible for any portion of their Shared Savings. Shared savings payouts range from 7.6% to 50%. Providers that score 98-100% on the scorecard will earn the full 50% of their Shared Savings.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

For purposes of the Final Scorecard Measurement Year performance as well as calculation of a Providers' Shared Savings, we will use Attributed Enrollees who were continuously enrolled during the Measurement Year plus Enrollees who were attributed to a Provider continuously from July through December of the Measurement Year. This attribution methodology is used to ensure that Providers are measured on Enrollees for which they were able to actually manage over an entire year, or new Enrollees during the last half of the Measurement Period.

Primary Care Partial Risk - The Primary Care Partial Risk program follows a similar design to the Shared Savings program described above. PCPs in the Partial Risk program can earn a higher percentage of the shared savings pool by accepting risk in the form of penalties for failing to meet MER benchmarks. Providers will have the option to share in up to 60-75% of savings and losses. The final percentage of savings earned, or losses assessed will be based on performance on the scorecard described above.

Risk readiness will be gauged based on several objective criteria, including 1) Practice has a Clinical Executive Champion 2) Practice is data-ready 3) Practice guarantees encounter submissions 4) Practice has financial capacity for risk.

Integrated Delivery Arrangements (IDA)- We believe that communities of providers can pool together to align toward a risk-based model to be shared between PCPs, Specialists and hospitals. By Years 4 and 5 – but sooner if providers are ready for the complexities, we intend to begin offering a sub-capitation IDA offering as part of our VBP strategy. IDA's may be led by a Primary Care practice, a Specialist or a Hospital according to the targeted Enrollee population. IDA's will also include a Value Bonus opportunity on top of the capitation. The sub-capitation would be based on a percentage of the total cost of care, and calculated based on prior claims experience by actuaries.

We anticipate that about half of the Value Bonus funding will be distributed to physician groups and the remaining fifty percent will be offered to the hospital entities. At a physician level, funds will be divided between Primary Care Physicians and Sub-capitated Specialty Providers with about eighty percent earmarked for the PCPs and twenty percent for the Specialists.

The Value Bonus is allocated to those primary care physicians based on the number of sub-capitated Enrollee months paid to each PCP during the measurement year. The actual payment will be calculated based on the metrics outlined below. The specialists will also be based on a spread of referrals, relative to the entire like specialty-type; hospital allocations will be based on volume of admissions relative to the entire inpatient volume for the total regional population

In order to be eligible for the Value Bonus distribution, participating providers will be required to have an active participation agreement with Lighthouse which will articulate the bonus sharing calculations as well as the reimbursement under the capitated model. At the time of the distribution, they must be continuing to accept sub-capitation. Additionally, the provider must have participated in the sub-capitation reimbursement for at least nine months of the measurement period.

Specialty Care –

Obstetrics bundled payments- For those OB providers we will be offering an at-risk episode percent of premium global payment for prenatal care. The full payment will be paid 30 days after pregnancy confirmation rather than after the postpartum visit. Our theory is that the global payment incentivizes the right care and follow-up, driving better outcomes and lower cost. This incentive has the capacity to improve OB engagement and commitment to improved birth outcomes while improving Enrollee compliance with prenatal care.

To qualify for payment, providers will be required to meet an OB-specific clinical quality gates (QG). The OB must honor expectations of the American Congress of Obstetricians and Gynecologists (ACOG). We also expect collaboration with the perinatologist. We believe this incentive approach motivates the OB provider to coordinate care with the mmaternal–fetal medicine (MFM) provider, when the condition indicates. By focusing on optimally managing health concerns of the mother and fetus prior to, during, and shortly after pregnancy, true value is created. In order to achieve full payment, the OB provider must satisfy all HEDIS measures for prenatal care (first trimester prenatal visit, frequency of prenatal care visits, 6-weeks postpartum). Finally, if the there is a full-term delivery, we plan to pay an additional nominal fee. In total, the cost of this episode global payment will be 1-2% higher than the aggregate FFS payments if all quality measures are met. We believe that by achieving all quality metrics, following evidence based guidelines, and engaging providers in higher levels of coordination of care will lead to less complications, improved outcomes and patient satisfaction, and potentially reductions in caesarian sections – all of which we believe will reduce costs in the near and long-term. Providers who do not achieve the targeted quality objectives will need to pay back the quality bonus.

BH full risk sub-capitation with Regional Care Centers (RCC): Our BH subcontractor Access also believes strongly in the importance of value-based payment arrangements with behavioral health providers to influence both the quality and the cost of care for Medicaid Enrollees. Under the capitated arrangements, ABH and a participating RCC enters into a contract to provide the full range of Medicaid benefits to enrollees in the RCCs capitated geographic areas. RCCs receive a per-member-per-month payment to cover all of the required Medicaid services and bear the financial risk for their patients for the specified services. The capitation rate reflects the behavioral health services required by Florida Medicaid and provides the incentive for a fully integrated delivery of Medicaid services. This approach incentivizes investments in care coordination, quality improvement efforts, and efficiency across the full continuum of care, and including the coordination of care with hospitals, and multi-specialty provider groups. The value-based model establishes a reimbursement system especially designed to manage Medicaid members who have persistent complex behavioral health conditions. ABH requires, by contract, that the RCCs be accountable for the full range of behavioral health services as measured by quality outcomes not utilization of services. Overall, this capitation model payment methodology offers the following:

- Alignment of incentives;
- Flexibility for providing behavioral health services;
- Improves quality of and access to behavioral health care services for enrollees; and
- Better Controlled costs

Specialist-led Integrated Delivery Arrangements (IDA)- The IDA model described above can be applied to specialist-led groups of providers. An example of a specialist led IDA would be a hematologist leading an IDA that serves a group of attributed Enrollees with sickle cell

disease. In cases where a specialist is the lead for an IDA the allocation of the Value Bonus may vary in recognition of the role the specialist plays in managing the Enrollee's overall care.

Hospitals –

Patient Safety and Clinical Quality Incentives: an acute care facilities (hospitals) incentive offering to improve patient safety and drive clinical quality improvements. In order to continue to focus on timely care coordination within our population health strategy, we are willing to offer incentives for early notification of patients in ER and inpatient admissions, and assistance with medication reconciliation. These measures will help us assess whether a hospital is full engaged in our clinical transition of care program.

Post-Acute Shared Savings/Shared Risk Programs- The hospital post-acute shared savings/risk programs are similar to the PCP shared savings and partial risk programs described above, but these programs are limited to Enrollees who have been discharged and calculates MER based on the services rendered to the Enrollee in the 60 days following discharge. Like our other shared savings and shared risk programs, Hospitals must pass a Quality Gate to be eligible for shared savings payment, and the amount of their payment will be driven by scorecard performance. The quality gate for the Post-Acute Shared Savings/Shared Risk Programs will include adherence to post-discharge follow up visits with primary care and BH practitioners as appropriate.

Enrollees who are attributed to a PCP participating in a Primary Care Shared Savings or Partial Risk program will be excluded from the Post-Acute Shared Savings/Shared Risk program as it is expected that those PCPs will assume primary accountability, and will share in associated savings related to the Enrollee's post-acute care. As these models are implemented and the overlap becomes more pronounced, our intention is to migrate these providers to Integrated Delivery Arrangements.

Hospital-led Integrated Delivery Arrangements (IDA)- The IDA model described above can be applied to Hospital-led groups of providers. Hospital-led IDA's will focus on Enrollee populations that require routine hospital-based outpatient or inpatient treatments. Some examples of these types of arrangements include but are not limited to IDA arrangements focused on total joint replacements, congestive heart failure, chronic kidney disease, and colonoscopies. Lighthouse will leverage our experience and will deploy best practices in these types of IDA and bundled payment arrangements.

Provider contract provisions related to incentives will comply with the requirements set forth in all applicable Florida relegations and statues. We will disclose annually or more frequently at the request of ACHA the following:

- Whether services not furnished by physician or physician group are covered by incentive plan;
- The type of incentive arrangements, including those that place more than 25 percent of the physician or physician group payments at risk;
- Percentage of the withhold or bonus;
- The methods used, panel size and if patients are pooled; and
- Proof of physician or physician group stop loss coverage including the amount and type of coverage if the provider is held substantially at risk financially.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

LIGHTHOUSE VBP ROADMAP

Our roadmap supports transitioning of provider payments to value-based purchasing arrangements by converting provider contracts to new payment models. Below is a summary of the percentage of contracts containing VBP arrangements. In addition to incorporating VBP elements into a broad number of our provider contracts, each year we will work to move providers along the continuum into models that drive financial accountability to the point of care.

Below are our projected percentages of overall contracts that will include some type of VBP arrangement, including those described above, for each of the five contract years:

Migration of Primary Care Physicians into Value Based Purchasing agreement (measured as % of in-network providers)

- Year One: 33%
- Year Two:43%
- Year Three:53%
- Year Four: 63%
- Year Five: 73+%

Migration of Specialty Care Physicians into Value Based Purchasing agreement (measured as % of in-network providers)

- Year One: 10%
- Year Two: 20%
- Year Three: 30%
- Year Four: 35%
- Year Five: 35%

Migration of Hospital Care into Value Based Purchasing agreements (measured as % of in-network providers)

- Year One: 30%
- Year Two: 40%
- Year Three: 50%
- Year Four: 60%
- Year Five: 70%

These projections are based on our current understanding of the prevalence of similar VBP arrangements in the market, as well as timing considerations related to building baseline data for shared savings and shared risk arrangements. Our VBP program is flexible and we will consider alternate models on an ongoing basis to capitalize on market activity and provider adoption of value-based payment in order to meet or exceed these projections.

SPECIFIC OUTCOMES TIED TO VALUE BASED PURCHASING

Provider payment models are not considered “value-based” unless payments have a strong linkage to improved outcomes and cost savings. As a result, our VBP programs include a quality “gate” (QG) that is applied based on an integrated Scorecard of the state’s clinical quality, access, satisfaction, population health, and efficiency Performance Measures. Passing the QG is a prerequisite for the provider to capture incentives through our VBP

programs and payment levels are tied to a provider Performance Scorecard. Because of this we expect to achieve better outcomes on the measures included in our Quality Gates that qualify providers for payment and our Performance Scorecards that drive payment amounts. These "Measures that Matter" for PCPs, hospitals, and specialists are described below.

PCPs' VBP Measures That Matter --

Clinical and Efficiency:
1) Follow up visit made within 7 days following post-acute stay
2) Admission Rate
3) ER Utilization Rate
4) Plan All-Cause Readmissions (Adult & Peds)
5) Ambulatory Care Sensitive ED Rate (Adult & Peds)
6) Use of Imaging Studies for Low Back Pain (Adult Only)
7) Completion of screenings designed to identify Enrollees who need specific interventions such as the PHQ-9 for detection of depression in the primary care setting or completion of the Edinburgh Depression Scale for women who screen positive or are identified with post-partum depression

Adults
1) Comprehensive Diabetes Care- Nephropathy
2) Antidepressant Medication Management- Acute Phase
3) Medication Management for People with Asthma – appropriate meds for at least 75% of treatment period

Peds
1) Medication Management for People with Asthma – appropriate meds for at least 75% of treatment period
2) Adolescent Well-Care Visits
3) Immunization Status – Combo 2
4) Appropriate Treatment of children with Upper Respiratory Infection

Population Health, Access, and Satisfaction indicators:
1) Expanded Office hours outside the hours of 8am-5pm.
2) Patient Satisfaction (Patient Experience Score)
3) Quarterly Care Plans
4) Transition Visit w/in 5 days of discharge
5) Physician attendance at Physician Engagement programs
6) Pre-Visit Planning
7) Visit made following stratification of an Enrollee into a complex care program
8) Practices adoption and use of our technology platform, Identifi Practice

Hospitals VBP Measures That Matter:
1) All-Cause readmission rate
2) Risk-adjusted average length of stay
3) Hospital-Acquired Conditions/Infections
4) Emergency to observation/inpatient escalation rate
5) Radiology service utilization

6) National Patient Safety and National Quality Improvement goals
7) Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS)
8) Mortality rate for three conditions
9) Present on admission Indicators
10) Admission notifications within 24 hours

Specialists VBP Measures That Matter:
Many of the PCP metrics and Specialist metrics can crossover to the other.
1) Hospital re-admission at 30, 60, 90, and 180 days (including psych)
2) Follow up after hospitalization (all types)
3) Caesarean section and early elective delivery rates
4) Obstetricians - prenatal care (first trimester prenatal visit, frequency of prenatal care visits, 6-weeks post-partum)
5) Medication management including follow-up targeting specific types of drugs

Behavioral Health VBP Measures That Matter:
1) Initiation and engagement of alcohol and other drug dependence treatment (IET)
2) Antidepressant medication management (AMM)
3) Follow-up care for children prescribed ADHD medication (ADD)
4) Participation in vocational rehabilitation and other measurable results

Maternity/OB Health VBP Measures That Matter:
Regarding OB Specialty, our Quality Gate would focus on OB care using Medicaid HEDIS and Joint Commission measures. We aim for HEDIS 90th percentile as target and partial points for 50th and 75th and for Joint Commission measures, we use Healthy People 2020 goal.

There are three measures we focus on for OB care to align with the agency's goals of improved birth outcomes:

1) Frequency of Ongoing Prenatal Care (FPC) -- The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received >81% expected prenatal visits.

According to AHRQ Quality Measures Clearinghouse, "Complications can arise at any time during pregnancy. For that reason, continued monitoring throughout pregnancy is necessary. Frequency and adequacy of ongoing prenatal visits are important factors in minimizing pregnancy problems. The American College of Obstetricians and Gynecologists (ACOG) recommends that prenatal care begin as early as possible in the first trimester of pregnancy (American Academy of Pediatrics [AAP] & ACOG, 2002).

Visits should follow a schedule:
- Every 4 weeks for the first 28 weeks of pregnancy
- Every 2 to 3 weeks for the next 7 weeks
- Weekly thereafter until delivery"

2) Prenatal and Postpartum Care (PPC), timeliness of visits. The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the

measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care.

- Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as an Enrollee of the organization in the first trimester or within 42 days of enrollment in the organization.
- Timeliness of Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.

3) The Joint Commission: C-Section for Nulliparous Singleton Term Vertex (NSTV). There's good research that when physicians see their own data on c-section rates vs. peers, this can drive rates downward if coupled with the right clinical leadership.

In summary, the collective metrics above, "The VBP Measures That Matter" align with CMS and HEDIS accepted clinical and quality standards and with the Triple Aim – and certainly the Agencies goals. They focus on chronic conditions, prevention, patient safety and the patient experience and engagement. We've found that a focus on them will correlate to both preventable events and improved birth outcomes, ultimately driving down readmissions, ambulatory sensitive admissions, and ultimately total cost of care. As described above, the OSVBC Program clearly shows that a focus on rewarding providers for improved quality will –in the end – drive toward a true impact on total cost of care.

In summary, across all of our value based payment strategies and comprehensive population health programs we expect to see overall net savings of 3% in inpatient costs with a corresponding 1% increase in expenditures for preventive services.

LEVERAGING VBP TO REDUCE POTENTIALLY PREVENTABLE EVENTS

The intent of our VBP programs is to align incentives with providers to ensure that both parties remain focused on activities that reduce potentially preventable events. As previously described, we have identified clinical and efficiency measures that will be incorporated in to our primary care VBP agreements that directly and indirectly reduce preventable events. Here is a recap of those Primary Care (PCP) measures:

1. Follow up visit made within 7 days following post-acute stay
2. Admission Rate
3. ER Utilization Rate
4. Plan All-Cause Readmissions (Adult & Peds)
5. Ambulatory Care Sensitive ED Rate (Adult & Peds)
6. Use of Imaging Studies for Low Back Pain (Adult Only)
7. Completion of screenings designed to identify Enrollees who need specific interventions such as the PHQ-9 for detection of depression in the primary care setting or completion of the Edinburgh Depression Scale for women who screen positive or are identified with post-partum depression

Additionally, enhanced payments to primary care practices certified as Patient Centered Medical Homes supports improved care coordination, better preventive care, and decreased potentially preventable events.

To compliment the efforts of the Primary Care providers outlined above, the Plan will also align incentives with our hospital partners by ensuring that the value based purchasing agreements continue to focus on preventable events. The following hospitals measures are examples of VBP measures that we intend to implement in VBP agreements in order to drive focus on reduction in preventable events:

1. All-Cause readmission rate
2. Risk-adjusted average length of stay
3. Hospital-Acquired Conditions/Infections
4. Emergency to observation/inpatient escalation rate
5. Radiology service utilization
6. National Patient Safety and National Quality Improvement goals
7. Hospital Consumers Assessment of Healthcare Providers and Systems (HCAHPS)
8. Mortality rate for three conditions
9. Present on admission Indicators
10. Admission notifications within 24 hours

The Plan will also focus efforts on engaging specialty providers in reducing preventable events. There is not a “broad-stroke” method to aligning all specialties – instead the Plan will focus on clinical initiatives specialty by specialty that will further compliment the efforts of the Primary Care and hospital providers as described above. The specific VBP arrangements for reduction of potentially preventable events will be tied to benchmark and/or analytically derived 50th, 75th, and 90th percentile targets. Incentives will be tied to measure performance at each percentile level allowing for tiered physician compensation.

Our BH capitation program administered by Access Behavioral Health is already in place in Region 1 and has delivered results. Readmission rates for BH-related hospitalization within 30 days are below the state averages for adults and children. This can be attributed to our value-based contracting model, coordination of care, improved access to services through telemedicine in rural areas and intensive community based models of service.

LEVERAGING VBP TO IMPROVE BIRTH OUTCOMES

The specific VBP arrangements related to improvement in birth outcomes will be tied to CMS Core Measures of Frequency of Ongoing Prenatal Care (FPC), Prenatal and Postpartum Care (PPC), timeliness of visits, and C-section rate for Nulliparous Singleton Term Vertex (NSTV). The goals will be tied to HEDIS benchmark 50th, 75th, and 90th percentile target where available and Healthy People 2020 target rate of C-section of 23.9% and potentially an analytically derived definition of 50th and 75th percentile. Incentives will be tied to measure performance at each percentile level allowing for tiered physician compensation.

These aligned financial incentives will drive better provider engagement, care coordination and ultimately birth outcomes.

VBP STRATEGIES IN PLACE WITH CURRENT PCP NETWORK

Lighthouse Health Plan is a new entity and we are still building our provider networks. Initial network development efforts with PCPs and FQHCs already include contracts with VBP components.

Our VBP program design is based on the experience of the Lighthouse team in other state Medicaid Markets. For example, in Kentucky, where our health plan administration subcontractor, Evolent, supports a Medicaid managed care plan we have had success enrolling PCPs into shared savings arrangements. The Program there includes seven (7) multi-site practices covering nearly 120,000 health plan lives (37% of total Enrollees) across 2,100 contracted primary care providers (61% of total PCPs). The intent is to scale this program across the remainder of the provider network in Year 1 and Year 2 while setting higher performance thresholds to achieve the quality gate threshold (mentioned above) with providers beginning to accept downside risk as early as Year 2.

DATA SHARING, IDENTIFI PRACTICE, AND SUPPORT TO PROVIDERS

VBP programs rarely achieve their intended goals without a robust tool kit supporting providers. Lighthouse will provide authorized providers access to its care management and reporting capabilities through Identifi Practice. This platform identifies care gaps on an Enrollee-by-Enrollee basis and allows providers to understand in near real-time precisely how to close the care gap and thereby improve their performance metrics. Identifi Practice can be offered as an integrated service with a provider Electronic Medical Record system allowing for easy, single sign on capabilities. In addition to the actionable information about care gaps, Identifi practice allows providers to coordinate with members of the care management team through bi-directional communication and notes functionality directly in the Enrollee's care plan. The tools that are a part of Identfi practice are designed to help providers address Enrollee's clinical needs in a way that drives improved health outcomes and management of financial risk. For providers who enter into partial risk or IDA arrangements, use of Identifi Practice will be required.

Our care management infrastructure also backs up the provider office to support individual care gap closure as well as help address broader areas of opportunity. Local medical directors and population health managers will work with physician offices to understand the practice's opportunities and disseminate best local and national best practice strategies to improve performance in the areas of care gap closure, identifying and conforming suspected diagnoses that will drive our risk stratification program, and engaging the most complex Enrollees in our population in the appropriate clinical management program. These population health managers are critical assets to the practices that they are assigned to as they work hand in hand with physicians, care managers, and office staff to ensure that they have access to complex Enrollee rosters, gaps in care reporting, and they are a resource to the practice to enable them to fully utilize the Identifi tools analytics and reporting capabilities to better manage the physicians' panel of patients. Other necessary supporting elements include strong data capture and normalization capabilities and robust standard and customized report generation that align to the Performance Scorecard. Our experience shows that the combination of these key components is what enables Lighthouse success partnering with providers on delivery value-based care to our Enrollees.

The regional Physician Accountability Council (PAC) also plays a critical role as a senior physician governance body in helping support the deployment of best practices across physician groups in the areas of how to create workflow and protocols to maximize the number of Enrollees engaging in care management, establishing care conferences with providers and staff to

discuss opportunities to close gaps in care and manage complex Enrollees, and to help prioritize important Lighthouse clinical initiatives. They will also play a critical role in disseminating best practices at both the office and individual patient level to improve quality scores. This de-centralized approach will foster a sense of accountability and commitment among local providers to improve outcomes and achieve incentive payments. For example, the Lighthouse team instituted this process for a plan in Indiana, A PAC at Deaconess Health System was formed to focus solely on CHF and the development of best practice clinical protocol and a co-management agreement. The program was launched in September of 2016 and is under consistent review by plan management staff in that market. The PAC continues to iterate on the early operational feedback and make program refinements to optimize outcomes with the goal of proactively managing patients with CHF and reduce unplanned ER utilization and admissions.

Evaluation Criteria:

1. The extent to which the respondent has provided the continuum of value-based purchasing arrangements available to network providers, delineated by primary care, specialty care and hospital-based care.

2. The extent to which the respondent has provided specific percentages of overall contracts, delineated by primary care and specialty care and hospital-based care, that it intends to implement or maintain through some type of VBP arrangement for each of the five (5) Contract years, including a rationale for the intended percentages.

3. The extent to which the respondent describes how its VBP arrangements incentivize quality improvement, including specific outcomes it expects at each stage on the continuum.

4. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for reduction of potentially preventable events.

5. The extent to which the respondent describes how its VBP arrangements incorporate goals or incentives for improvement of birth outcomes.

6. The extent to which the respondent provides a breakdown of specific VBP strategies employed with its current network of primary care providers.

7. The extent to which the respondent describes the approach in sharing specific data elements with providers under a VBP arrangement and the level of respondent support offered to providers to ensure progression along the continuum of VBP arrangements.

Score: This section is worth a maximum of 35 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

E. DELIVERY SYSTEM COORDINATION

MMA SRC# 14 – General HEDIS Performance Measures Experience (Statewide):

The respondent shall describe its experience in achieving quality standards with populations similar to the target population described in this solicitation. Include in table format, the target population (TANF, ABD, dual eligibles), the respondent's results for the HEDIS measures specified below for each of the last two (2) years (CY 2015/ HEDIS 2016 and CY 2016/ HEDIS 2017) for the respondent's three (3) largest Medicaid Contracts (measured by number of enrollees). If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one of three (3) states for the last two (2) years.

The respondent shall provide the data requested in **Exhibit A-4-b-2**, MMA Performance Measurement Tool (10-2-2017) to provide results for the following HEDIS measures:

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

Lighthouse Health Plan's experienced subcontractor has achieved quality standards and quality improvements for HEDIS measures for health plans in Kentucky, Maryland and Illinois (the three largest Medicaid contracts based on membership) for the following populations.

• In Kentucky, total approximately 171,400 enrollees, operating 18 years, including: TANF Adult (28,808 enrollees), Child (123,167 enrollees); Foster Care (4,077 enrollees); and SSI Adult (15,387 enrollees)
• In Maryland, total approximately 87,700 enrollees, including: TANF Families, CHIP, pregnant women (to 250% FPL), Foster Care, ACA expansion population, SSI below age 65
• In Illinois, total approximately 150,900 enrollees, operating three years, including: TANF Family and ACA expansion population (146,454 enrollees), Seniors and people with disabilities excluding Medicare (4,472 enrollees)

Attachment MMA SRC 14-1: Exhibit A-4-b-2 provides the requested HEDIS measures from Kentucky and Maryland during calendar years 2015 and 2016, and from Illinois during calendar year 2016 (the first reporting year).

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
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The Kentucky plan has over 18 years of experience collecting HEDIS measures, and has collaborated with the state's Medicaid agency to develop and collect state-specified measures, Healthy Kentuckians, since their inception in 2003. The plan also uses other nationally recognized standards to improve outcomes such as Pharmacy Quality Alliance (PQA) measures. Over nearly two decades, the health plan has realized significant improvements in access to healthcare, chronic disease management, and overall health outcomes for its population.

EXCEEDING NATIONAL AND REGIONAL MEANS

Over the past two years (calendar year 2015 to 2016), the health plans have exceeded national and regional Medicaid means in numerous prenatal, child and adolescent-related HEDIS and other performance measures. Among the measures delineated in this SRC, the plans achieved the following:

Childhood Immunization Status (Combo 3):
• In Kentucky, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Maryland, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Illinois, exceeded the regional mean in CY 2016.

Well-Child Visits in the First 15 Months (6 or more):
• In Kentucky, exceeded the national mean and regional mean in CY 2015.
• In Maryland, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.

Immunizations for Adolescents (Combo 1):
• In Kentucky, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Maryland, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Illinois, exceeded the national mean and regional mean in CY 2016.

Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life:
• In Kentucky, exceeded the national mean in CY 2015. We exceeded the regional mean in CY 2015 and CY 2016.
• In Maryland, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015.
• In Illinois, exceeded the national mean and regional mean in CY 2016.

Adolescent Well Care Visits:
• In Maryland, exceeded the national mean in CY 2015 and CY 2016, and exceeded the regional mean in CY 2015 and CY 2016.
• In Illinois, exceeded the national mean and regional mean in CY 2016.

Frequency of Ongoing Prenatal Care (>= 81% of expected visits):
• In Kentucky, exceeded we exceeded the national mean in CY 2015 and CY 2016, and we exceeded the regional mean in CY 2015 and CY 2016.

• In Maryland, exceeded the national mean in CY 2015 and the regional mean in CY 2015.

Timeliness of Prenatal Care:
• In Kentucky, we exceeded the national mean in 2015, and exceeded the regional mean in CY 2015.
• In Maryland, we exceeded the national mean in 2015, and exceeded the regional mean in CY 2015.

Our subcontractor's plans in other states have also achieved improvements over time. For example, over five years in Kentucky:
• Low birth weight (LBW) deliveries decreased from 7.0% in 2012 to 6.90% in 2016. The LBW rate in 2016 surpassed the Healthy People 2020 goal of 7.8%.
• Very Low Birth Weight (VLBW) deliveries have decreased nearly 67% from 1.5% in 2012 to 0.5% in 2016. The VLBW rate in 2016 was well below the Healthy People 2020 goal of 1.4%.
• Preterm deliveries (less than 37 weeks) have decreased by 33% since 2012 (from 11.2% to 7.5%). The 2016 rate of 7.5% exceeded the Healthy People 2020 goal of 11.4%.

Evaluation Criteria:

1. The extent of experience (e.g., number of Contracts, enrollees or years) in achieving quality standards with similar target populations, for the HEDIS performance measures included in this submission requirement.

2. The extent to which the respondent exceeded the national mean and applicable regional mean for each quality measure reported and showed improvement from the first year to the second year reported.

Score: This section is worth a maximum of 70 raw points with component 1 worth a maximum of 10 points and component 2 worth a maximum of 60 points as described below:

Exhibit A-4-b-2, MMA Performance Measurement Tool (10-2-2017), provides for forty-two (42) opportunities for a respondent to report prior experience in meeting quality standards (seven (7) measure rates, three (3) states each, two (2) years each).

For each of the seven (7) measure rates, a total of 5 points is available per state reported (for a total of 105 points available). The respondent will be awarded 1 point if their reported plan rate exceeded the national Medicaid mean and 1 point if their reported plan rate exceeded the applicable regional Medicaid mean, for each available year, for each available state. The respondent will be awarded an additional 1 point for each measure rate where the second year's rate is an improvement over the first year's rate, for each available state.

An aggregate score will be calculated and respondents will receive a final score of 0 through 60 corresponding to the number and percentage of points received out of the total available points. For example, if a respondent receives 100% of the available 105 points, the final score will be 60 points (100%). If a respondent receives 95 (90%) of the available 105 points, the final score will be 54 points (90%). If a respondent receives 10 (10%) of the available 105 points, the final score will be 6 points (10%).

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

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MMA SRC# 15 – Failure to Meet HEDIS Measures (Statewide):

In addition to providing HEDIS measure data, describe any instances of failure to meet HEDIS or Contract-required quality standards for the measures listed below and actions taken to improve performance. Describe actions taken to improve quality performance when HEDIS or Contract-required standards were met, but improvement was desirable.

- Childhood Immunization Status (Combo 3);
- Well-Child Visits in the First 15 Months (6 or more);
- Immunizations for Adolescents (Combo 1);
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life;
- Adolescent Well Care Visits;
- Frequency of Ongoing Prenatal Care (>= 81% of expected visits); and
- Timeliness of Prenatal Care.

Response:

The experiences described below exemplify comprehensive, multifaceted approaches to improving HEDIS and other performance standards when failing to meet goals, and when goals are met but improvement is desired.

ACTIONS TO IMPROVE PERFORMANCE WHEN FAILING TO MEET GOALS

A Lighthouse Health Plan team partner recognized an opportunity to improve preventative care for their infant, child and adolescent enrollees in a Kentucky Medicaid managed care plan. The Kentucky plan strives to reach the Quality Compass 90th percentile, and for HEDIS 2016, Well-Child Visits in the First 15 Month of Life (W15) were above the 66.67th percentile, Well-Child Visits in the 3rd- 6th Years of Life (W34) ranked above the 50th percentile and Adolescent Well-Care Visits were above the 33.33rd percentile.

To reach their Quality Compass 90th percentile goal, the Kentucky program developed strategies to improve infant, child and adolescent well-care focused on provider, enrollee and community outreach activities. Interventions were identified and implemented in 2017 with a goal to meet or exceed an overall 2% favorable change over the HEDIS 2016 final rates for W15, W34 and AWC HEDIS measures.

Enrollee Outreach --

Initiatives include a quarterly enrollee newsletter that features articles on the importance of infant, child and adolescent well- child visits and immunization schedules, and automated outreach calls were made to more than 14,000 enrollees in the first half of 2017. The plan collaborated with the Kentucky Department of Health (DOH) to provide home visits to outreach and educate non-compliant enrollees regarding the importance of age-appropriate screens, well-care visits and immunizations. Nearly 175 non-compliant enrollees were contacted by the DOH in Q1 and Q2 2017.

To encourage healthy choices, young enrollees earn a gift card for completing well-child/adolescent visits to the doctor appropriate to their age group. More than 1,100 adolescents

earned gift cards for well-child visits in Q1 and Q2 2017. Incentive data for Q3 2017 are not yet available.

Provider Outreach --

Community Engagement Staff and Early and Periodic Screening Diagnosis and Treatment (EPSDT) Coordinators educate physician practices on the recommended well-visits, screenings and immunizations, and they reached 36 practices in Q1 2017. The Community Engagement Staff and EPSDT Coordinators also participate in quarterly Child and Adolescent Committee meetings to discuss best practices for compliance with recommended screenings, well-care visits and immunizations, as well as barriers to care and possible interventions.

Community Outreach --

Community Engagement Coordinators engage and educate the community about the importance of preventive care. They provide orientation and education to health departments and school system family resource center staff throughout Kentucky. The school and health department staff then encourage parents/guardians to adhere to the Bright Futures guideline for preventive care screenings and well-child visits. Bright Futures is a national health promotion and prevention initiative led by the American Academy of Pediatrics (AAP) that is theory-based and evidence-driven. The Community Engagement staff also collaborates with the Louisville and Jefferson County Community Collaboration for Children Network Meeting. The interagency committee focuses on identifying and distributing resource information on children's' services available in Kentucky, specifically screenings, well-care and immunizations. Coordinators also participate in the planning of the "Ready for K" program sponsored by the Kentucky plan in 2nd quarter 2017 at the Louisville Free Public Library. The goal of the Kindergarten Countdown is to support children's transitions into kindergarten. Children's health and physical well-being is one of five of the components of the "Ready for K" preparation.

Additional Outreach through EPSDT --

EPSDT, the federally mandated program that provides comprehensive preventive health care to enrollees from birth to age 21, is a key part of Medicaid for infants, children and adolescents. Provider, enrollee and community outreach and education to increase EPSDT participation and screenings can also drive improvement in HEDIS well-care measures, W15, W34 and AWC. In an effort to improve the EPSDT screening and participation rates, and by extension the HEDIS measures, the Kentucky plan initiated an EPSDT improvement project in Q2 2017.

Interventions for the EPSDT project that can impact the HEDIS well-care measures include live agent telephonic outreach campaigns to educate enrollees and families about the importance of preventive care. Home visit outreach is made to enrollees not reached by the live agent telephonic campaign. Provider outreach by E-News educates practices regarding AAP/Bright Futures, the EPSDT guidelines and proper coding for services. The Kentucky plan distributes 'best practice' tip sheet to PCPs with pediatric enrollees regarding prevention and management of 'no show' appointments and cultural sensitivity for non-English speaking patients. EPSDT care gap reports for high volume PCP groups encourage outreach by the PCP office and group level EPSDT Quality Improvement (QI) audits identify provider groups with low EPSDT documentation compliance and provide supplemental education tools to these providers.

Current Status and Anticipated Outcomes --

Prior to the implementation of the above strategies, HEDIS 2017 results for MY 2016 indicated a decrease of 7.07 percentage points for W15, a slight decrease of 1.57 percentage points for W34 and a very slight decrease of 0.72 percentage points for AWC compared to HEDIS 2016 (MY 2015).

However, the Kentucky plan anticipates that enrollee, provider, and community strategies will increase both the EPSDT screening and compliance rates as well as the W15, W34 and AWC 2018 HEDIS measure percentages to meet or exceed an overall 2% favorable change.

ACTIONS TO IMPROVE HEDIS PERFORMANCE WHEN STANDARDS WERE MET BUT IMPROVEMENT WAS DESIRABLE

The Kentucky plan ranked above the Regional and State Mean for the Timeliness of Prenatal Care component of the Prenatal and Postpartum Care (PPC) HEDIS measure and the Frequency of Ongoing Prenatal Care (FPC) measure in measurement year (MY) 2015, and it continued efforts to further improve prenatal care for pregnant enrollees with the Mommy Steps Program in 2016.

The Mommy Steps Program was designed to improve prenatal, infant, and maternal outcomes for pregnant enrollees through improved compliance of both Obstetric (OB) clinicians and enrollees with the plan's Perinatal Care Clinical Practice Guidelines which are based on the American Congress of Obstetricians and Gynecologists (ACOG) Guidelines. The program aims to increase the percentage of enrollees who receive prenatal and postpartum care, increase the average number of prenatal visits and decrease the number of preterm and low birth weight infants with a goal was to achieve the 2017 Quality Compass® 90th Percentile for the PPC and FPC measures.

Eligible enrollees were identified and passively enrolled in the Mommy Steps Program. Enrollees may "opt-out" of the Program and elect not to receive services by notifying a Mommy Steps representative or the Care Connector Program, either telephonically or in writing. Participation Rates were at 99.9% in 2016.

The Mommy Steps Program strategies were designed to decrease birth outcomes such as low birth weight (LBW), very low birth weight (VLBW) and premature deliveries. Healthy People 2020 and the Kentucky plan's goals were set as benchmarks for these birth outcome measures, and following were the results in 2015 and 2016 (Note: 2015 Birth Outcomes data was based on an eight month claims runout; 2016 Birth Outcomes data was based on a three month claims runout, which may have resulted in an artificially low rate of premature and VLBW babies):
• LBW (1,501 grams to < 2,500 grams): Healthy People 2020 goal is 7.8%; the Kentucky plan 2016 goal is 5%; actual performance was 6.65% in 2015, and 6.90% in 2016.
• VLBW (< 1,500 grams): Healthy People 2020 goal is 1.4%; the Kentucky plan 2016 goal is 1.0%; actual performance was 1.2% in 2015, and 0.5% in 2016
• Preterm Deliveries (≤ 37 weeks): Healthy People 2020 goal is 11.4%; the Kentucky plan 2016 goal is 7.6%; actual performance was 11.81% in 2015, and 7.5% in 2016

When barriers were encountered in The Mommy Steps Program, opportunities were identified and multiple strategies were developed for outreach to providers, enrollees and the community to educate and motivate them to improve the health and birth outcomes of pregnant enrollees.

Provider Engagement --

Collaboration with Provider Relations to educate OB clinicians during all site visits promotes a relationship with both the OB clinicians and office managers. Continued engagement of OB providers encourages the practice to notify the Mommy Steps Program of enrollees identified with modifiable risk factors or if an enrollee becomes high risk. Utilization Management (UM) OB embedded Case Managers in high volume hospitals reach, support and educate pregnant and postpartum enrollees.

OB clinicians receive status updates on enrollees enrolled in the Mommy Steps Program and are provided reference information on the Kentucky plan's Perinatal Care Clinical Practice Guidelines, which are based on the ACOG Guidelines located on the plan's website.

Enrollee Engagement --

The Kentucky plan supports maternity care through a variety of enrollee engagement activities and communication channels. Written and telephonic communication with enrollees who miss appointments assist with rescheduling and assessing barriers to care, and provide education about resources (i.e., transportation) to assist with keeping appointments. Auto-dialer technology, Care Message, educates enrollees regarding the importance of regular prenatal care and postpartum visits. Enrollees who contact the 24/7 Nurse Advice Line Report, who might be pregnant or have a pregnancy question, are also provided education on the importance of early and regular prenatal care. Enrollee education includes importance of prenatal care to identify complications early, warning signs during pregnancy, and when to call the OB clinician. Education venues include face-to-face outreach, enrollee newsletters, on-hold messages, the plan's website and printed educational materials. Lastly, collaboration with embedded OB Case Managers at physician offices enhances support and education for pregnant and postpartum enrollees.

The enrollee incentive program encourages early and regular prenatal care as well as timely postpartum care and financially rewards enrollees who schedule and keep needed check-ups. Similar to what we propose to implement in Florida, enrollees received a financial reward if they completed prenatal and postpartum visits. For 2016, a total of 1,790 enrollees took advantage of these rewards.

A partnership with the Lincoln Trail Health District splits the cost of the 'Crib Program'. This program provides Pak-n-Play cribs to enrollees in need and promotes 'Safe Sleep', a crib that is safe, and educates enrollees on the ABC's of Safe Sleep to decrease the number of infant deaths that occur due to co-sleeping or unsafe sleep habits.

Community Engagement --

Opportunities to increase community awareness of the Mommy Steps Program are fostered through collaboration with community partners such as Healthy Start, Lincoln Trail's Health Access Nurturing Development Services (HANDS), and the local Department of Health.

Participation in and distribution of educational material at community coalitions and education programs also increase awareness of The Mommy Steps Program and are sponsored by Healthy Mothers, Healthy Babies, the March of Dimes, the Fetal and Infant Mortality Review (FIMR) Committee. Pregnant enrollees who want to quit smoking are encouraged to participate in the 1-800-QUIT-NOW Program and Mommy Step program. Staff including nurse case managers and program coordinators make telephonic outreach calls to pregnant enrollees affected by substance use disorder who reside at the Freedom House, a women's residential addiction recovery program. A 24/7 Nurse Advice Line provides education and assists with pregnancy related questions and issues.

Mommy Steps Early Results --

HEDIS: HEDIS® 2017 (MY2016) scores met the 2017 Quality Compass® 33.33rd Percentile and indicated a small decrease of 5.83 percentage points for Timeliness of Prenatal Care. Timeliness of Postpartum Care continued to meet the 2017 Quality Compass® 50th Percentile. Frequency of Prenatal Care > 81% met the 2017 Quality Compass® 66.67th Percentile, despite showing a slight decrease of 5.02 percentage points.

HEALTHY PEOPLE 2020: LBW, VLBW, and Preterm Deliveries are below the Healthy People 2020 goals. According to the most recent statistics, the plan's LBW rates are below state and national rates. For LBW it should be noted there was a slight increase of 0.25 percentage points, VLBW had a slight decrease of 0.70 percentage points and Preterm Deliveries ≤ 37 weeks had a decrease of 4.71 percentage points in 2016. 2015 Birth Outcomes data was based on an eight month claims runout; 2016 Birth Outcomes data was based on a three month claims runout, which may have resulted in an artificially low rate of premature and VLBW babies.

PROGRAM ENROLLMENT AND ACTIVE CASE MANAGEMENT: Despite not meeting HEDIS goals, enrollment in the Mommy Steps program is increasing, and engagement of higher risk enrollees in case management is growing. In 2016, the plan had an average of 2,739 enrollees per quarter enrolled in the Mommy Steps Program, with an average of 1,210 enrollees per quarter that were identified as new enrollees, a 10% increase from 2015. There was an average of 405 enrollees per quarter identified as high risk. They are selected to be both high risk and most likely to be assisted by active Case Management. This required a reassessment of our triage protocol to ensure that our efforts were being increasingly directed toward those enrollees most likely to benefit from active Case Management. An average of 781 high risk enrollees per quarter were actively engaged and received one-on-one telephonic contact and educational materials from a High Risk OB Case Manager, a 57% increase from 2015.

An average of 471 enrollees per quarter received postpartum outreach calls, an 82% increase from 2015. An average of 377 referrals per quarter was made to WIC, HANDS and Healthy Start, a 6% decrease from 2015. New enrollees received individual educational mailings. The Mommy Steps High Risk OB Case Managers collaborated with UM OB Embedded Case Managers in hospitals to ensure enrollees needs and resources were provided.

Improvements and Next Steps --

The Kentucky plan again ranked above the Regional mean in MY 2016 for the Timeliness of Prenatal Care component of the HEDIS PPC measure and for Frequency of Ongoing Prenatal

Care. The Mommy Steps Program noted improvement in 2016 for Birth Outcomes (VLBW and Preterm Deliveries), Counseling for Nutrition, OTC/Prescription Medication, and Domestic Violence, and maintained their near 100% participation rate. To drive further improvement in prenatal care, the plan planned new 2017 interventions that included a Preterm Birth Prevention Initiative, Smoking Cessation Screening and Education, and Enhanced Transportation Services with a more flexible notification timeline that assists enrollees traveling to medical appointments and meetings for substance abuse treatment. New collaboration efforts between the OB clinicians and Lighthouse staff were initiated with the formation of The Women's Health Committee that meets quarterly to review, discuss, and create criteria, policies and interventions to improve the health and well-being of pregnant enrollees and birth outcomes.

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way and to successfully remediate all failures for the HEDIS performance measures included in this submission requirement.

2. The extent to which the described experience demonstrates the ability to improve quality in a meaningful way even when HEDIS or Contract-required standards were met, but improvement was desirable, for the HEDIS performance measures included in this submission requirement.

Score: This section is worth a maximum of 10 raw points with each component worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 16 – HEDIS (Data Sources) (Statewide):

The respondent shall describe:

a. The extent to which it has used the following standard supplemental data sources for its HEDIS and other performance measures:

- Laboratory result files;
- Immunization data in State or county registries;
- Transactional data from behavioral healthcare vendors; and
- Current or historic State transactional files in a standard electronic format.

b. The extent to which it has used supplemental data from electronic health record vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.

c. The extent to which it has experience reporting HEDIS measures collected using Electronic Clinical Data Systems.

Response:

USE OF SUPPLEMENTAL DATA SOURCES FOR PERFORMANCE MEASUREMENT

The Lighthouse Health Plan's Quality Analytics Team considers supplemental data to be critical for capturing and measuring the quality of clinical services provided to Medicaid populations. Supplemental data increases the accuracy of a plan's HEDIS rates while decreasing the burden of medical record reviews. As a PSN, we can leverage the infrastructure of our sponsoring health system to collect supplemental data from the providers within that system to support HEDIS and other performance measurement.

A Lighthouse team partner has been using standard lab result files and immunization registry data as part of our HEDIS collection process for four years. We contract with lab vendors to receive laboratory results for our enrollee, which supports collection of Diabetes HbA1c measures, Colorectal Cancer Screening, Comprehensive Diabetes Care Nephropathy, Annual Monitoring for Patients on Persistent Medications, and Non-Recommended PSA-Based Screening in Older Men. We also take full advantage of the available state immunization registries as a standard supplemental data source, allowing us to accurately measure our immunization rates and reduce our medical record reviews.

Other standard supplemental data sources such as transactional data from behavioral healthcare vendors and state transactional files (in standard electronic format) feed into our Identifi Data Warehouse. We have been receiving data in these formats and integrating them into Identifi for 4 years. We work with an NCQA certified auditor every step of the way to ensure data completeness and to ensure the data is eligible for HEDIS supplemental data use. The Identifi Analytics and Reporting tool provides a holistic view into this data repository that includes critical data elements available for HEDIS analytics.

In the last few years, NCQA has introduced new guidelines for using supplemental data that include stricter limits and increased primary source validation for each supplemental data source. Lighthouse will bring our strong expertise, methodological operations, and proactive management of HEDIS vendor relationships to effectively use supplemental data sources in HEDIS reporting while meeting these guidelines. For example, in other states like Kentucky, Illinois and Maryland, we work with our NCQA-certified audit team during every step of the supplemental data process. This allows us to adjust our collection methods to ensure that they are in accordance with NCQA guidelines. We also partner closely with our NCQA-certified software vendor to ensure that all necessary data points are included in our data extracts. We confirm that our supplemental data is sent prior to the initial HEDIS administrative rate run to guarantee a reduction in the subsequent chart review burden. Once the rates are calculated, we run extensive quality assurance on the data to verify that each data point translates into the expected HEDIS rate increase. For nonstandard supplemental data, we maintain comprehensive records to ensure the validation process is fully completed.

Our strong supplemental data collection strategy has had concrete benefits. For example, the Adult BMI data we've received from our supplemental data sources has decreased our chart review burden by over 50 percent.

EXPERIENCE WITH EHR AND eMEASURE VENDOR DATA

EHR data is an important element in our overall HEDIS supplemental data strategy. In Kentucky, Illinois and Maryland, our Quality Analytics Team obtains all available EHR extracts for use in our HEDIS submission. Each EHR platform is a unique system with its own set of challenges. Our experience with data capture and HEDIS supplemental data expertise allow us to efficiently navigate available data options, selecting those that best inform our HEDIS rates. We involve our HEDIS auditor during every step of this process to ensure compliance with subsequent audit and validation periods. Our HEDIS software vendor's data extract requirements are analyzed and the data is formatted accordingly to ensure every data point is utilized. Our data team has the experience and expertise to handle extracts from many different types of sources and formats, including HML-7 and CCDs. Utilizing EHR data allows to access biometric data (BMI, Weight, BP, etc.) as well as prevention and screening data (colonoscopy, immunization, etc.).

NCQA has recently begun certifying eMeasure vendors, and we are in the process of evaluating and contracting with an NCQA certified eMeasure vendor for inclusion in HEDIS 2018. The advantages of using an eMeasure vendor include improved accuracy of reported rates and decrease in chart review, making collection and reporting more effective and efficient. There is also a significant decrease in the audit validation as this type of data is considered a standard supplemental data source. Once Lighthouse selects and contracts with an appropriate vendor, we will work with our HEDIS software vendor to ensure the data received is loaded and applied to our HEDIS 2018 submissions.

EXPLORING ECDS FOR REPORTING

While we currently do not report the HEDIS measures that are collected using Electronic Clinical Data Systems (ECDS), we are preparing to do so as NCQA expands the measures collected using the ECDS. Lighthouse data teams are experienced with importing data from various

formats and will accommodate the ECDS data feeds into the NCQA standards that are required for reporting.

Evaluation Criteria:

1. The extent to which the described experience demonstrates the ability to use standard supplemental data sources (lab result files; immunization data in State or county registries; transactional data from behavioral healthcare vendors; and current or historic State transactional files in a standard electronic format) for HEDIS and other performance measures.

2. The extent to which the described experience demonstrates the ability to use supplemental data from electronic health record (EHR) vendor systems and data from certified eMeasure vendors for HEDIS and other performance measures.

3. The extent to which the described experience demonstrates the ability to report HEDIS measures collected using Electronic Clinical Data Systems (ECDS).

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

MMA SRC# 17 – Coordination of Carved Out Services (Statewide):

The respondent shall describe its approach to coordinating services that are not covered by the respondent, but are covered by Florida Medicaid either through the FFS delivery system (e.g., behavior analysis services, prescribed pediatric extended care) or through a prepaid dental plan.

Response:

Lighthouse Health Plan's care coordination and case management programs provide a high level of care using a team approach that includes intensive coordination of covered, carved-out and other available supports. Care coordinators and care managers, supported by the other members of the local multidisciplinary care management team, work closely with vendors, external case managers, state, county and community agencies, and others supporting the Enrollee to help Enrollees, and families/caregivers, access the full set of available and appropriate services to meet Enrollees' needs effectively and efficiently. Our processes include informing Enrollees, their families, providers, staff and subcontractors about carved-out services and how to access these services with assistance from our health plan.

Coordination with other providers is an essential component of our care management and care coordination activities. In addition to working closely with and facilitating referrals among an Enrollee's PCP, specialists, and local hospital staff, our care management team coordinates with other agencies and programs that provide Medicaid-covered services that are carved out. For example, we coordinate with state and county agencies through sharing of information including care plans (with appropriate Enrollee authorization), case conferences, telephone calls, and in-person meetings held at a location convenient to the Enrollee and family. Close collaboration with schools, external case managers or service coordinators is an essential component of our model.

RECIPROCAL REFERRALS

Lighthouse leverages our existing processes and local relationships with state and county agencies and other delivery systems to establish and promote reciprocal referrals through sharing of information including care plans (with appropriate Enrollee authorization), during case conferences, telephone calls, and in-person meetings. We will collaborate with other agencies and delivery systems to develop and implement written agreements and protocols that will guide the referral and information sharing process.

Our model of care is designed to meet Enrollees' special needs across the entire care continuum through our care planning process. We will designate coordinators who will focus on connecting eligible or potentially eligible Enrollees to the agency or agency's designee responsible for access to carved-out services, such as the Developmental Disabilities Individual Budgeting (iBudget) Home and Community-Based Services Waiver for people with intellectual and developmental disabilities. Care managers stay with the Enrollee throughout the process. Specialized coordinators may include a waiver coordinator, a foster care coordinator and others.

ENROLLEE ENGAGEMENT AND EDUCATION

Enrollee Handbook and Website --

All newly enrolled Enrollees will receive an AHCA-approved welcome kit that includes the Enrollee ID card and Enrollee Handbook that provides information about all covered services (including medical necessity definitions, prior authorization requirements, copayments, services limits, emergency guidelines, as examples). The handbook includes a benefit chart and additional sections to explain covered services that are more difficult to understand or apply primarily to special populations. The handbook will also inform Enrollees about other Medicaid-covered services available fee-for-service, such as prescribed pediatric extended care (PPEC) services, behavior analysis services, and services available through other Medicaid delivery systems, such as certain home and community-based waivers. In addition, the Lighthouse website will contain reader-friendly information about covered services and how to navigate the health plan and access covered services.

If and when a prepaid dental plan is enacted in Florida, all appropriate education about this service/benefit will be provided to Enrollees and all materials (handbook, website, etc.) will be updated.

Enrollee Open Houses --

Our Community Advocacy team will host a new Enrollee open house to educate Enrollees about our health plan. Topics include covered and non-covered benefits and how to effectively access services, work with your PCP, access NEMT, and use pharmacy benefits. Enrollee manuals will be made available.

Enrollee Call Center --

Because Enrollees may call us with questions about service authorizations, we train our Enrollee Services Representatives on state -specific program requirements including covered services and prior authorization requirements, including how to request services (through the PCP or treating provider). Enrollee Services Representatives will inform Enrollees about the services covered through Lighthouse; other Medicaid-covered services available fee-for-service, such as prescribed pediatric extended care (PPEC) services, behavior analysis services, and services available through other Medicaid delivery systems, such as certain home and community-based waivers (or a prepaid dental plan in the future). Call center materials will include contact information for common non-covered services, with phone numbers and websites, that staff can share as appropriate when Enrollees call in with related questions. We will update these materials regularly so that Enrollee Services staff have current information at all times.

Outreach and Care Planning Process --

The local care management team, including community health workers, nurse and behavioral health care managers will educate Enrollees about the differences in Lighthouse and carved-out benefits during outreach, assessment and the care planning process.

PROCESSES FOR ENSURING STAFF AND SUBCONTRACTORS PROVIDE ACCURATE INFORMATION ABOUT CARVED-OUT SERVICES

Our process for training and educating staff, providers and subcontractors will leverage successful models that the Lighthouse team has used in other states, and ensure that our Enrollees receive

accurate information about carved-out services and additional federal, state and local programs and community resources. We will follow most trainings with a survey to assess the impact of the training, knowledge gained, and identify and implement opportunities to improve the training. Training programs and written materials incorporating education about covered services and carved-out services and how to inform Enrollees about how to access them include the following:

Care Management Team Training –

Our program for new Care Management staff contains formal training including information on covered benefits and carved-out services provided through fee-for-service Medicaid, and other programs, basic eligibility criteria, contact information with care managers or appropriate staff at other agencies and programs to obtain more information and to discuss eligibility and the application process, and how to help Enrollees apply for these services. A written guide and a document uploaded to the patient records for care managers in Identifi Care will also contain key information about accessing carved-out services. Initial care management training is followed by four to six week of job shadowing with a seasoned team member who has the same role and responsibilities. Job shadowing continues until the manager and employee providing the training determine the new Care Manager is ready to work independently. When new coverage information is introduced (such as a new prepaid dental plan), Care Managers will receive updates and undergo re-trainings at regular intervals to ensure they have up-to-date information.

Enrollee Services/Call Center Training –

New Enrollee Services employees will attend a two- to three-week classroom style training program conducted by a dedicated Enrollee Services Trainer. Written guides will include scripts that answer potential Enrollee questions about covered and carved-out services, and how to contact other programs or care managers who can guide Enrollees in applying for other programs and services available in the community. Following the training, new employees will spend up to an additional 90 days answering calls under the close supervision of seasoned staff. We will continue to train our Enrollee Services staff with on-the-job experiences and at least quarterly retraining updates to ensure knowledge of changes in waivers, carved-out or new services (such as a new prepaid dental plan), and community resources.

Provider Services Call Center Training –

We will provide comprehensive training to our Provider Services Call Center staff, recognizing that they play an integral role in servicing and providing accurate information to our provider partners. New employees will participate in a two-week training program, followed by job shadowing a more experienced employee. When new coverage information is introduced and at regular intervals, Provider Services Call Center staff will undergo re-trainings to have up-to-date information.

Provider materials –

Our provider manuals, website and portal will also describe services covered through MMA, carved-out services and the types of additional services available through other agencies and programs. The manual will identify whom to contact at Lighthouse for additional information and

the help available to Enrollees and their families in accessing services through the call center and our local care management teams.

Subcontractor requirements and materials –

For subcontractors delegated to perform functions directly with Enrollees, information about carved-out services and guiding Enrollees to care managers for additional assistance will be included in the subcontractor's agreement. We will educate the subcontractors on these issues, and then conduct annual or more frequent evaluations to determine whether the delegated activities, including providing accurate information to Enrollees about carved-out services if relevant to the subcontractor's responsibilities, are being carried out according to our standards.

Evaluation Criteria:

1. The extent to which the respondent describes effective and efficient processes for reciprocal referral for needed services.

2. The adequacy of the respondent's approach to engage and educate enrollees in understanding the difference in benefits covered by the respondent and those that are available through other Medicaid delivery systems.

3. The extent to which the respondent's description includes a process for ensuring respondent's staff and subcontractors are aware of and effectively communicate the appropriate information on services available through other Medicaid delivery systems.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 18 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Jose is a 15-year old male. He is diagnosed with bipolar disorder and is currently hospitalized under the Baker Act; this is his third psychiatric admission under the Baker Act in the past year. Up until six (6) months ago, Jose lived with his mother and two younger siblings, but he moved in with his father after his behavior declined and his mother was unable to protect herself and his siblings from Jose's angry outbursts and verbal and physical aggression. His father is physically disabled from a work injury, and he is concerned about managing Jose upon release, as Jose's behavior at home and school has significantly declined. At school, Jose is currently failing and has a notable number of absences and office referrals for altercations. Jose was diagnosed two months ago, during his second psychiatric admission, with bipolar disorder. Jose has been prescribed a low dose of Seroquel daily, but he does not take it consistently because of the side effects. He experiences drowsiness, dry mouth, and nausea. In his current admission, his laboratory testing results showed evidence of thyroid dysfunction. The hospital social worker assisted the family in completing and submitting a referral for Statewide Inpatient Psychiatric Program (SIPP) services, but the SIPP provider informed the social worker that authorization was denied. Jose's father has called the plan's enrollee help line for assistance with completing an expedited appeal. Jose was involved in outpatient therapy for the past six weeks. There have not been any adjustments to his medications to date. Jose has been enrolled in Medicaid since he was 5-years old. He has been enrolled in his health plan since July 2014.*

The respondent shall describe its approach to coordinating care for an enrollee with Jose's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Lighthouse Health Plan (Lighthouse) learns of Jose's admission to a psychiatric inpatient unit from the Admit-Discharge-Transfer (ADT) feed that triggers a real-time alert in Identifi Care, our care management platform. The alert is received by the local, multidisciplinary care management team aligned with Jose's PCP. As soon as we learn of an enrollee's admission to an inpatient

setting, the care manager reviews the enrollee's risk score and, for enrollees identified as at risk or high risk for readmission, initiates development of the transition plan.

Jose's current inpatient admission and diagnosis of bipolar disorder, prior history of involuntary admissions, difficulty functioning at home and school, and social determinants (family's situation) make him high risk for readmission. The BH care manager implements the Transitions of Care program to coordinate his inpatient services and help transition Jose to his next level of care or setting. Jose's outpatient therapist and PCP also receive a notification from the BH care manager and he or she then completes a care note in Identifi. She contacts Access Health Care, the BH subcontractor, to alert them to coordinate Jose's BH needs including his BH services that include targeted case management (TCM).

The care note documents Jose's admission and enrollment in the Transitions of Care program and automatically populates the PCP's EHR. Since the outpatient therapist is not using an EHR, the note is emailed securely to the therapist.

Transition planning begins with enrollee assessment.

HEALTH RISK ASSESSMENT

Jose's BH care manager calls the inpatient unit to schedule a time to meet with Jose and his inpatient care team. While visiting Jose, she completes an assessment of Jose's needs and readiness for discharge. The assessment reviews all major domains including the enrollee's physical health, BH and social needs, functional status, proposed living situation, social supports, and access to caregiver supports. The BH care manager also reviews the inpatient clinical record and notes Jose's potential thyroid dysfunction. She speaks with the inpatient unit nurse to determine if a consult has been ordered and when the results will be available. The BH care manager calls Jose's father and then his mother to discuss Jose's current situation and their desired outcomes.

From a review of the records and discussion with Jose and his parents she learns:
• Jose was Baker Acted from school following an altercation with a teacher. The school notified Jose's parents of his planned involuntary admission to the inpatient unit.
• Jose's Seroquel dosage continues to be adjusted and he reports some reduction in side effects. When questioned, he says he doesn't know if the medication helps him.
• Since admission he has had intermittent outbursts of anger but is attending unit meetings and activities and met with the therapist. When asked what he does when he becomes angry, Jose says staff tell him to go to his room to calm down. The BH care manager asks if this helps and Jose says: "I guess so".
• Jose wants to go home. Hs parents state they cannot take him home.
• The BH care manager asks Jose about his outpatient therapy and whether it is helpful. He says he likes his therapist but doesn't know if it helps.
• Jose's parents say the therapist has helped them understand the importance of setting boundaries and being consistent but they have a hard time doing this when things are so stressful. Jose's mother says she won't have Jose at the house anymore because he gets out of control and she worries about his younger siblings.

CARE COORDINATION/CASE MANAGEMENT

All enrollees enrolled in the Transitions of Care program receive coordinated support from the local, multidisciplinary care management team working in collaboration with the enrollee and family/caregivers, enrollee's PCP, inpatient psychiatrist and other clinical staff, hospital social worker coordinating the enrollee's inpatient discharge, and outpatient providers, and others involved in supporting safe transition, such as an enrollee's targeted case manager. The local care management team makes sure Jose's physical health, behavioral health and social needs are addressed.

After Jose has been on the inpatient unit for two weeks, the inpatient team, working with Jose and Jose's parents, recommended a residential program through the local SIPP and the nurse obtained signed paperwork from the family and submitted this to the SIPP provider. Jose's BH care manager knows SIPP services must be authorized by Access Health Care (Access) as the health plan's BH subcontractor and she checks the UM module to see if a request was made to Access. Not seeing a request, she calls Access to confirm they have no open authorization request for SIPP admission for Jose and they confirm they do not. When she learns of the SIPP "denial" she calls the SIPP provider who says he declined to admit Jose because of his behavior and the needs of the other children at the SIPP facility. The provider notes he also does not have an available bed at present and states there has been a shortage of beds in the past three months, but does anticipate an opening within the next two weeks. A staffing has not been held as required and in order to ensure Jose will receive services in the most integrated setting that can meet his needs, the BH care manager schedules a staffing.

The BH care manager, Jose, his parents, the acute treatment team, the enrollee's targeted case manager, and a representative from the local SIPP facility meet on the inpatient unit to discuss Jose's needs and whether or not SIPP placement is the most appropriate residential option for Jose.

- Jose's targeted case manager states Jose would benefit from a structured, therapeutic residential setting to learn how to manage his bipolar disorder and improve his functional skills, at home and at school.
- The acute care staff note that after an initial adjustment period the first week, Jose is responding well to the structure the unit provides.
- Jose's targeted case manager notes that Jose was approved for in-home services prior to his most recent admission to help Jose and his father learn effective ways to manage Jose's behavior. However, Jose consistently delayed his return home after school ended, hanging out with other kids in the neighborhood, and refused to participate.
- Jose's father and mother state they believe Jose will benefit from a residential program and are committed to visiting Jose and supporting his participation and success in the program.
- The BH care manager asks Jose what he thinks and Jose says: "I don't care. I just want to get out of this place."
- The SIPP provider discusses his concerns about Jose's behavior and the safety of other children at the facility, and acknowledges there are no other residential options for Jose. He agrees to accept Jose if Jose commits to attending therapy sessions with a SIPP clinical social worker, follows the rules at the SIPP, participates in schooling and cooperates with his medication regimen adjustments. The SIPP provider also reviews the family's obligations, including:
  - Attending SIPP treatment team meetings
  - Visiting Jose while at the SIPP
  - Providing informed consent for Jose's medications

o Following Jose's treatment plan when he comes home for a visit

The team reaches agreement and recommends SIPP admission. Jose's recommended length of stay in the SIPP is 90 days, with a plan for increased home visits the last 30 days. The length of stay may vary based on Jose's progress.

The BH care manager, following the meeting, contacts the BH subcontractor to discuss the SIPP bed supply. The BH subcontractor states they will gather analyze the current bed supply, lengths of stay, admissions and discharges, contact SIPP providers to discuss bed supply and provide an update within 30 days to the health plan. Depending on the outcome of this analysis, Lighthouse and the BH subcontractor may meet with the Agency to discuss bed supply and determine the next steps to address this issue.

While Jose remains in the inpatient unit awaiting authorization for admission to the SIPP, Jose's BH care manager continues to work with the inpatient team to coordinate his inpatient treatment services. She collaborates with Access as needed to help obtain any information needed to complete the determination on the SIPP request.

SERVICE PLANNING

The BH care manager documents the SIPP authorization request in Jose's service plan in Identifi Care while onsite at the hospital and includes the agreed-to conditions. The team notes that the longer term plan is for Jose to return to live with one of his parents with wrap around services and to attend school. This longer-term plan is also included in the service plan.

The SIPP is responsible for medical treatment and medication management and so will address Jose's possible hypothyroidism and medication adjustment if not resolved at the time of admission. Any medical issues that arise while Jose is at the SIPP will be coordinated with the BH care manager who will consult with the local care management team nurse, pharmacist and Medical Director as needed. The BH care manager will participate in the SIPP treatment team meetings. She obtains Jose's and his parents' signatures on the service plan indicating agreement with the service plan and conditions and provides a copy of the service plan to Jose and to his parents.

Prior to discharge from the SIPP, a discharge /transition meeting will be held to develop a transition plan to support Jose's transition home.

Jose is authorized for admission to the SIPP and moves to the SIPP facility the following week. The BH care manager documents his transition to SIPP in Identifi Care using a care note which populates his PCP's EMR and is emailed to the TCM case manager.

SIPP Stay --

The SIPP provider, Jose's targeted case manager and our BH care manager participate in SIPP team meetings. The targeted case manager provides support to Jose's family as they participate in SIPP meetings, and manages coordination of BH services Jose will need after discharge as well as coordination with the school. The targeted case manager visits Jose every two weeks to assess his progress with his SIPP treatment plan goals. Jose's BH care manager collaborates

with the SIPP provider as needed to ensure Jose's physical health needs are met, continued stay is authorized and any additional services requiring authorization are reviewed and authorized timely. She updates Jose's care plan so that it continually reflects integration of the SIPP provider's treatment plan and targeted case manager's service plan.

DISCHARGE/TRANSITION PLANNING

Thirty days before the planned date of discharge from the SIPP, Jose's BH care manager schedules a transition planning meeting to develop the transition plan that is part of the enrollee's care plan and that documents the enrollee's history, and current medical, BH, and social support needs, the enrollee's short-term, and long-term goals, post-discharge support needs, authorized services and follow-up schedule. The plan includes:
• All services and supports to meet Jose's community-living needs
• Relevant community resources
• The initial PCP and specialist appointments
• A safety plan
• Medications and the enrollee's chosen pharmacy

The team includes Jose, Jose's targeted case manager, the BH care manager, SIPP staff, and a school representative. They participate in-person at the SIPP or by teleconference to plan his transition home.

The team identifies the following needs:
• Resumption of outpatient therapy for Jose
• Psychiatric services including medication management
• Continued targeted case management
• Coordination with local school through IEP process
• A PCP appointment
• Therapeutic behavioral on-site services (at his father's home) – behavior management

The BH care manager will coordinate authorization of services needing prior authorization (the therapeutic behavioral on-site services) and the targeted case manager will help Jose and his family identify and select a network provider. The targeted case manager will ensure necessary BH services are ready or scheduled on or after Jose's date of discharge as specified in his service plan, including:
• Therapeutic behavioral on-site services scheduled to begin the day after discharge
• An outpatient BH provider and psychiatrist visit within 7 days of Jose's SIPP discharge
• An appointment with Jose's PCP for a check-up and to ensure his thyroid function has returned to normal or is being treated appropriately

The targeted case manager is ready to help Jose return to school and to participate in IEP meetings and will meet Jose's ongoing care coordination and BH care management needs, working with the local care management team as needed to address Jose's physical health care needs and access to providers and services. TCM service plans and Jose's care plan will be coordinated and shared during coordination meetings with the local care management team.

DISEASE MANAGEMENT

At present Jose is at high risk for inpatient readmission and is receiving targeted case management with support from the local multidisciplinary care management team to meet his complex BH needs. If Jose demonstrates improved functioning, at school and at home, with no inpatient admissions for six months, he may be a candidate for BH disease management that includes continued care coordination and self-management education, and care gap monitoring. The decision to transition to a less intense care management program will be made by the multidisciplinary team with Jose's and his family's concurrence.

UTILIZATION MANAGEMENT

Upon notification of a psychiatric inpatient admission, Access reviews the documentation related to involuntary admission and provides authorization of the inpatient stay within 24 hours. Access works with the admitting hospital and the Lighthouse BH care manager to determine and authorize a length of stay appropriate to Jose's needs.

Authorization of a SIPP admission requires completion of the staffing that confirms Jose's needs can be met by the SIPP provider, a determination that SIPP is the least restrictive residential alternative available that will meet his needs, and confirmation that Jose meets the level of care criteria for SIPP. Access authorizes the enrollee's stay providing the authorization to the SIPP provider and will review Jose's progress and continued need for this level of care when reviewing requests for additional days.

GRIEVANCE AND APPEALS

In Jose's situation, the provider determined he could not meet Jose's needs and therefore denied admission. However, this denial was not a Lighthouse or subcontractor service request denial. The BH subcontractor did not receive a request for SIPP authorization. Therefore, we classified the issue as a grievance.

Access acknowledged the receipt of the non-urgent grievance in writing immediately following receipt of the information about Jose's father's complaint, using an AHCA-approved grievance acknowledgment letter. The Access team member launched an investigation and learned that a request for SIPP had been received subsequent to the complaint and approved by Access. Access issued a subsequent letter noting SIPP services had been authorized and believed this resolved the father's grievance. Should Jose's father feel the grievance was not resolved or have any other questions about his concern he could contact the Access or Lighthouse by phone or in writing.

EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes that the plan has in place;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;
- **f.** Application of discharge and aftercare planning protocols that facilitate a successful transition;
- **g.** Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;
- **h.** Description of the assessment of provider capacity to meet the specific needs of enrollees;
- **i.** Identification of strategies that promote enrollee self-management and treatment adherence;
- **j.** Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and
- **k.** Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondent's workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoids unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 19 - Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

> *Jane is a 57-year old female with Type II diabetes mellitus and hypertension. Jane is compliant with her treatment plan, which consists of the following prescribed drugs: Insulin and Lisinopril. She is also compliant with her follow-up appointments with her specialists. She lives alone, but receives support from her eldest daughter who lives nearby. Jane thought she timed her follow-up visit with her endocrinologist adequately to allow sufficient time to receive a new prescription for all drugs; however, Jane realizes she only has enough insulin to last through the doses for tomorrow. Her appointment with Dr. Seem, her endocrinologist, is in two weeks. Jane calls her doctor's office who informs her that they have no availability to see her today or tomorrow and Dr. Seem will not write a new prescription without examining Jane since it has been four months since her last appointment. Jane decides to call her health plan's member hotline for assistance.*

The respondent shall describe the approach for handling Jane's call and how the respondent would help Jane obtain her medication.

Response:

Jane called our toll-free Enrollee Services call center and spoke to an Enrollee Services Representative who called Dr. Seem's office with Jane on the line to see if she could get a next-day an appointment for Jane. Because she was not able to, and Jane's issue is clinical (prescription refill needed), the Enrollee Services Representative escalated her call to the clinical team using a warm transfer.

A nurse spoke with Jane and confirmed Jane had projected she would not run out of insulin before her appointment but miscalculated her use, then documented Jane's need for an insulin prescription or appointment in Identifi. She advised Jane she would contact Dr. Seem's office to try and obtain a prescription for a temporary refill. Prior to calling Dr. Seem's office, the nurse contacted the Pharmacy Benefits Manager (PBM) to verify the last insulin dispensing date and amount dispensed to confirm Jane's need for a refill. After confirming this, the nurse contacted Dr. Seem's office to learn why the doctor was not willing to see Jane or write a prescription for a limited supply of insulin. In our scenario, Jane spoke to the office manager who stated in urgent situations like Jane's, Dr. Seem would issue a prescription to cover the period until Jane's office visit and she was not certain why this did not occur. The office manager confirmed they would send a prescription to Jane's pharmacy and apologized for the confusion. After the call, the office manager learned their new office staff person did not recognize Jane's situation as urgent and followed normal scheduling and refill protocols instead of the urgent refill process. The office manager trained the new staff person on how to appropriately handle urgent medication refill requests.

If Jane needed a prescription for any of the following reasons, the nurse would call the PBM with Jane on the line to resolve her need:
- Vacation Override
- Refill too soon or excessive quantity

• Lost medication
• Stolen medication
• Dropped the bottle and broke
• Medication lost in a fire

If Dr. Seem had been reluctant to provide the temporary prescription after learning of Jane's needs, the nurse would contact Jane's PCP to check appointment availability, share relevant clinical details from Jane's case record (including the last dispensing date for the insulin, dosage, and confirmation that she would have used all the insulin dispensed tomorrow), and ask if the PCP could write a temporary prescription or see Jane the next day to fill her prescription.
If Jane's PCP was unwilling to see Jane or write a temporary prescription, the nurse would contact the Lighthouse Medical Director.

The Medical Director would then contact Jane's endocrinologist and discuss the importance of seeing Jane on an emergency basis so she does not run out of insulin or issue a temporary refill. He would review the potential impact of Jane going without insulin for two weeks, note that Jane attends her scheduled appointments and she inadvertently lost track of her prescription refill date, and ask Dr. Seem to issue a temporary prescription for insulin that will cover Jane until her scheduled appointment. In our experience, a conversation with our Medical Director generally has a satisfactory outcome (the provider complies with the Medical Director's request).

If we learned that Dr. Seem was repeatedly unwilling to assist enrollees with urgent refills, including making appointments available in accordance with timely access standards, even after calls from the Lighthouse nurse or Medical Director, the Medical Director would notify our provider contracting/credentialing team to follow-up with Dr. Seem, providing education about urgent appointment timeliness requirements. If Dr. Seem continued to be non-compliant we would require a corrective action plan and confirmation of compliance. Continued and repeated non-compliance would result in Dr. Seem's termination from the network.

Enrollee Services Representatives' Training --

Our Enrollee Services Call Center training provides a comprehensive classroom training program followed by up to 90 days of answering enrollee calls under the supervision of experienced staff. Classroom training includes discussion and review of:
• Customer services skills, including use of approved call scripts
• Proper call documentation
• Appropriate instances for transferring an enrollee to another department for assistance
• How to identify and escalate prescribed drug issues
• Receiving, identifying, and making appropriate referrals to providers, clinical staff and/or the 24/7 Nurse Line, as applicable to help enrollees in resolving urgent or emergency issues
• Assisting enrollees in the selection of a PCP or specialist, making appointments and obtaining services, and arranging transportation for enrollees

Refresher courses and regular on-the-job training based on findings from supervisor review of recorded enrollee calls ensures quality and consistency.

Avoiding a Visit to Urgent Care or the Emergency Room for a Prescription --

The nurse documents Jane's outcome (temporary prescription) and completes an alert in Identifi for the local care management team to contact Jane before her scheduled visit with Dr. Seem to provide in-person enrollee education. If Jane was enrolled in care management, her assigned nurse care manager would contact Jane. Otherwise an available nurse care manager calls Jane, confirms her upcoming endocrinologist appointment, and assesses why Jane had insufficient insulin until her next appointment with Dr. Seem.

She assesses whether Jane has been using her insulin correctly, including whether she had changes to her insulin use, such as initiation of a sliding scale, that may have contributed to more rapid insulin use. She reviews Jane's dosing schedule and amount and how to determine when a refill will be needed. She also reviews the steps Jane can take if she is about to run out of medication, including:
• Calling her provider's office and reminding the staff there is an emergency procedure for refills
• Calling the local care management team or care coordinator for help
• Calling the enrollee services call center for help
• Speaking with her PCP to obtain a referral to a different endocrinologist

The nurse care manager also secures Jane's agreement to meet her at Dr. Seem's office to review her insulin management and, in discussion with Jane and Dr. Seem, develop a plan for future refills that will help avoid last minute appointments and unnecessary ER use. The nurse also coordinates a discussion with the local care management team pharmacist to make sure Jane has all the information she needs to manage her insulin and refills in the future.

The nurse care manager documents her discussion and outcomes in Identifi, and if Jane is enrolled in care management, updates her care plan and notifies Jane's PCP and Dr. Seem of the outcome via Identifi e-messaging.

If Jane needed ongoing help and education around self-management of her diabetes and related medications, the nurse care manager would refer her to our Diabetes Condition Care (DM) program.

Systems Supporting Seamless Resolution --

In addition to standard communication by phone or email, all departments, including care management, provider relations and enrollee services, use a single IT platform, Identifi, to document enrollee and staff interactions, record clinical information, and to generate alerts, and messaging. Identifi also provides visibility into paid claims for the authorized staff and delivers this information to providers through Identifi. Authorized staff can view enrollee-specific information across functional areas, limited to the information needed to perform their duties.

Communication with the local care management team pharmacist includes discussion using a three-way call with Jane during health education and e-mail updates from the nurse.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

(a) Training for call center staff that illustrates the ability to triage cases of this nature, including the internal escalation process available to call center staff.

(b) Description of the interventions and strategies that would assist Jane in avoiding a visit to urgent care or the emergency department to receive a new prescription.

(c) Evidence of the integration between and among all relevant departments, including subcontractors if applicable, to facilitate a seamless resolution.

Score: This section is worth a maximum of 15 raw points with each of the above components being worth a maximum of 5 points each.

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EXHIBIT A-4-b
MMA SUBMISSION REQUIREMENTS
AND EVALUATION CRITERIA (10-2-17)

MMA SRC# 20 – Vignette (Statewide):

The respondent shall review the below case vignette, which describes potential Florida Medicaid recipients. Note: The vignette included below is fictional.

Emma is four-years old. She currently lives in a pediatric nursing facility. At the age of two she was admitted to PICU following a respiratory arrest during an acute illness. A further complication of her condition led to her requiring a tracheostomy to support her breathing. Following an acute exacerbation of her condition, she is now unable to breathe without the support of her ventilator when she is tired, asleep, or unwell. She is fully ventilated overnight. Her difficulties are compounded by complex seizures. Emma's doctor says Emma needs to have nurses or health care assistants with her at all times to monitor her ventilation. Emma's most recent developmental screening indicates the presence of an intellectual disability. Emma's condition has stabilized, but her mother is concerned about agreeing to bring her home permanently. Her mother is the sole income for their home, which includes three older siblings and Emma's maternal grandmother. Emma's grandmother is retired, and her ability to help the family is limited by severe rheumatoid arthritis.

To be discharged to her home, Emma's physician has ordered a custom wheelchair that must be individually fabricated and assembled. Her physician also ordered an electronic tablet to provide cognition exercises for Emma. The tablet has a cognition exercise application that reduces the likelihood for any seizure activity that may occur with other similar tablets. Florida Medicaid does not cover the tablet nor the wheelchair, which includes a part that will make it easier for Emma to hold the tablet. Her mother is unable to bear the costs for these special service items. Further orders for Emma's transition to home care are:

- *Continuous pulse oximetry monitoring.*
- *Apnea monitor when she is not on the ventilator.*
- *A backup generator for the ventilator if the power goes out in the home.*

Emma is a new enrollee. Prior to her enrollment, all services were provided through the Medicaid FFS delivery system.

The respondent shall describe its approach to coordinating care for an enrollee with Emma's profile, including a detailed description and workflow demonstrating notable points in the system where the respondent's processes are implemented:

a. New Enrollee Identification;
b. Health Risk Assessment;
c. Care Coordination/Case Management;
d. Service Planning;
e. Discharge/Transition Planning;
f. Disease Management;
g. Utilization Management; and
h. Grievance and Appeals.

Where applicable, the respondent should include specific experiences the respondent has had in addressing these same needs in Florida or other states.

Response:

Evolent, with its partners, has been supporting Members with Special Health Care Needs for 20 years through their comprehensive care management programs. Lighthouse will leverage this experience meeting the needs of Medicaid enrollees with a wide range of special needs, including children and adults with disabilities who have long term services and supports (LTSS) needs.

The model of care is designed to meet enrollees' special needs across the entire care continuum through a care planning process that ensures coordination with relevant state and local agencies and community resources. We will designate a Lighthouse liaison who works with specific external programs and agencies to ensure close coordination and collaboration, alignment of policies and procedures, referral processes and work flows, shared care planning/service coordination and information exchange. For example, we intend to designate a waiver coordinator, who will focus on connecting eligible or potentially eligible enrollees to the agency responsible for access to waivers, such as the Agency for Persons with Disabilities (APD) and the iBudget Waiver for people with intellectual and developmental disabilities.

NEW ENROLLEE IDENTIFICATION

Upon receipt of the enrollment file and accompanying FFS historical data, we analyze the file to identify new enrollees, their age, identifiable diagnoses and service history.

From the file we identified Emma's age, historical nursing facility claims and nursing facility provider, and enroll Emma in the Care Management for Members with Special Health Care Needs (CM MSHCNs) assigning her to a local nurse care manager with pediatric experience. Our CM for MSHCNs program provides personalized support from a clinical team that includes an RN, medical social worker, dietitian, and pharmacist for enrollees who require intensive care and service coordination to meet enrollees' complex health care needs. The clinical team has access to therapists (speech, physical therapy and respiratory therapists), BH clinicians, a DME specialist, Community Health Workers and a waiver coordinator.

The clinical team works together to support nursing facility care with the facility that is in our network, and discharge and transition home or to another community-based setting, arranging in-home and other covered services and coordinating carved out services such as Prescribed Pediatric Extended Care (PPEC).

The nurse care manager notifies the nursing facility within one business day of identifying Emma's stay in a NF of her enrollment into the CM program, requests a copy of her NF care plan and most recent level of care documentation, and schedules an intake assessment within 72 hours. Prior to the initial assessment, the nurse care manager also contacts Emma's PCP for additional health information to help make sure Emma's intake assessment is accurate and complete.

From the enrollment file, she also locates Emma's mother's contact information. The nurse care manager calls Emma's mother to:

• Welcome Emma and her mother to our health plan
• Provide a brief description of the differences between managed care and fee-for-service Medicaid
• Introduce herself and her role as Emma's care manager
• Describe the objectives of the CM program for MSHCNs and benefits of participation
• Describe the care management process
• Obtain consent to proceed with CM activities, starting with an assessment of Emma's needs and related family needs
• Confirm previous completion of the "Freedom of Choice" Form, indicating the choice to transition Emma home and confirms this is still the mother's choice, (which she confirms)

The nurse care manager informs Emma's mother she will visit Emma by Friday (within 72 hours of Emma's identification) and complete an assessment of Emma's needs at the pediatric nursing facility with Emma's mother present if possible. Emma's mother states she can arrange time off to attend if she knows 24 hours in advance. The nurse care manager also will make a visit to Emma's home to assess the family situation, resources to support Emma's discharge, and transition-related needs following this visit.

The nurse care manager secures Emma's mother's agreement to proceed with care management and contacts the nursing facility to coordinate the date and time for Emma's assessment (and confirms this is acceptable to Emma's mother). The home visit will be scheduled following completion of Emma's assessment, which provides time for the nurse care manager to review her assessment findings and identify critical supports that will be needed at home.

ASSESSMENT

Our assessment tool is housed in Identifi and includes, but is not limited to, the following elements:
• Clinical history, including medications
• Health status, including medical and behavioral health condition-specific issues
• Current providers
• Activities of daily living and cognitive functions, needs, preferences and barriers
• Mental and social-economic health status needs, preferences and barriers
• Cultural and linguistic needs, preferences, or limitations
• Visual and hearing needs, preferences or limitations
• Health beliefs and behaviors including smoking, diet and exercise
• Available covered and non-covered services and community resources
• Personal safety
• Home/living situation

The nurse care manager completes the assessment in-person at the nursing facility, with Emma's mother and Emma's nurse's aide present to answer specific questions. She will also gather information from Emma's nurse, attending provider, or the charge nurse and NF social worker as needed. During the visit, the nurse care manager learns:

• Emma remains ventilator dependent at night
• Emma has been seizure free for the past five months following a change to her medication regimen
• Emma has a custom wheelchair that she has almost outgrown. The wheelchair allows her to go to therapy and activities.
• Emma responds to eye contact, speech and touch by smiling or nodding and has some favorite toys. She can walk short distances with total support.
• Emma has a picture board the staff have been using to try and enhance communication.
• Emma has a discharge order and an anticipated discharge date within 60 days (specific date to be determined)

The nurse care manager schedules a home visit three days later to assess the home environment, resources and needs.

Emma's family lives in a four-bedroom home with two bathrooms. The entrance to the home has a short ramp, which the nurse care manager learns was installed to help Emma's grandmother access the house without having to climb the steps. The nurse care manager sits with Emma's mother and grandmother and completes relevant questions in our Discharge Planning assessment tool. This tool is also housed in Identifi and includes the following domains:
• Review of discharge orders and knowledge related to discharge
• Medication management
• Living situation and support
• Mood screening (adults only)
• Anxiety screening (adults only)

The tool provides "rules" related to each question and response, indicating needed actions and referrals.

During the assessment, the nurse care manager also asks open ended questions about the family's plans and specific resources for Emma's return home. She learns:
• Emma's mother works during the day, Emma's siblings are at school and her grandmother is home.
• Emma's grandmother cannot help care for Emma because of her rheumatoid arthritis, although she does plan to spend time with Emma, reading to her and keeping an eye on her breathing.
• Emma's mother intends to use the family room for Emma when she comes home – it is big enough to accommodate a hospital bed, ventilator equipment and wheelchair.
• The family has two bathrooms but no walk-in or wheel-in shower. Since Emma is small this is not a problem right now but Emma's mother wonders how this will work as Emma grows.
• Emma's older sister, who is 16, has told her mother she will help take care of Emma evenings when she has no activities and during the weekend.
• Emma's mother says she wants Emma to come home but is afraid she will need more help than they can get.

The nurse care manager identifies the following needs:
• Additional support in the home. This includes day time and night time help.

• Help scheduling appointments. Follow-up appointments will be needed – Emma will need PCP and specialist visits scheduled for post-discharge assessment and treatment planning
• Needs DME (custom wheelchair – follow up on order)
• Needs communication device (electronic tablet – follow up on order)
• Potentially needs other home and community-based services not covered by Lighthouse
• Will need prescription refills
• May need help administering medication (assess)
• Family support – ongoing care coordination
• Family support – health education and health management support

Enrollee Incentives --

The nurse care manager also briefly reviews the enrollee incentive program highlighting the qualifying activities relevant to Emma, including periodic checkups and, if clinically appropriate for Emma as determined by her treating providers, immunizations. She notes that Emma may earn $25 per qualifying activity up to a maximum of $50 a year distributed on a reloadable card to her mother for completion of specific activities such as completion of well child visits and care gaps closure. She will review this information again when Emma is coming due for these visits, as family members may not recall this information shared during an initial visit.

Because CSHCNs often require extra time during a medical appointment from completion of the components of a Child Health Check Up, the nurse care manager will work closely with Emma's provider to make sure adequate time is scheduled, as well as coordinate other needed assistance such as scheduled transportation.

CARE COORDINATION/CASE MANAGEMENT

Emma's nurse care manager begins developing a personalized care plan. She uses the auto-populated preliminary care plan in Identifi that includes Emma's identified needs based on the results of the assessments:
• Monitoring during the day, including nursing oversight of her oxygen levels and medication regimen
• Nighttime ventilator management
• Coordination of DME and other items ordered by the physician including identification of which items will require prior authorization, are carved out (and available through fee-for-service Medicaid) or are non-covered and would be accessed through another program
• Family education and support
• Suggested referrals – social worker, dietitian, respiratory therapist, waiver liaison

The nurse care manager is responsible for scheduling care planning meetings and teleconferences, gathering relevant information to support development of the care plan, and guiding the enrollee and/or his or her parent or legally authorized representative and care planning participants through the person-centered planning process. Care management workflows guide care management activities to help ensure enrollee's needs are addressed comprehensively and consistently

A multidisciplinary care team (MDT) meeting is scheduled at a date and time convenient to Emma's mother and in addition to Emma's nurse care manager, and Emma's mother, includes

the other members of the care team (therapist, dietitian, medical social worker, pharmacist and waiver liaison) and other health care professionals involved in Emma's care, at present the NF representative and Emma's physician.

The nurse care manager ensures all participants receive notification of the meeting and the opportunity to participate by teleconference or in person. If a MDT invitee is unable to participate during the scheduled time, the nurse care manager is available by phone prior to the meeting to discuss Emma's needs and receive the participant's input and encourages submission of written, relevant information such as the treating provider's treatment plan. All of this content will be available within Identifi Care.

The NF social worker plans to join the teleconference.
The physician is not available and is not in-network but provides Emma's treatment plan that includes documentation of her need for the services he ordered.
Emma's mother will join by phone from her work.
The members of the local care team will assemble at the local office.

SERVICE PLANNING

The nurse care manager convenes the multidisciplinary team (MDT) meeting to comprehensively review Emma's services and supports needs, authorize Medicaid reimbursable health plan covered services and coordinate access to other needed services or supports to support discharge. Starting with the preliminary care plan, the nurse care manager working with the MDT members, walks through the key assessment finding and identified needs and discusses the services required to meet Emma's needs. The MDT first focuses on services covered by Lighthouse that Emma needs to transition home:

• PPEC is a carved-out service but available to eligible enrollees. PPEC would provide the monitoring Emma needs during the day, including nursing oversight of her oxygen levels and medication regimen and works with children who use ventilators. Some PPECs provide transportation to and from the facility. Otherwise Medicaid transportation must be arranged. PPECs also provide caregiver training in the use of special equipment such as ventilators. PPEC is authorized by the Medicaid Quality Improvement Organization (QIO) and the PPEC provider submits the authorization request. Emma's mother is interested in PPEC and agrees to visit PPECs in her area to choose one for Emma, then notify the nurse care manager who will provide needed documentation to the PPEC provider to support the request from the PPEC provider to the QIO. The CHW will give the mother a list of PPECs within a reasonable travel distance.
• Nighttime ventilator management requires nursing oversight and will be covered under the private duty nursing benefit.
• Coordination of DME and other items ordered by the physician:
• The wheelchair is covered. The NF social worker states the order was provided to a DME provider and an evaluation is scheduled this week. The nurse care manager takes the DME provider's information and will call the provider after the MDT to discuss the order and process for health plan reimbursement.
• The electronic tablet to provide cognition exercises will be covered under the state plan, if it is a dedicated augmentative and alternative communication (AAC) device or, if not, the plan determines it should be covered under EPSDT because of Emma's unique needs. The MDT

discusses whether the tablet is an AAC and the nurse care manager recommends a speech language pathologist assess Emma's use of this type of device visiting Emma at the NF and obtaining additional information from the prescribing physician. Additional information, including the therapist's assessment and recommendation will be provided to the Medical Director for a determination.

• The nurse care manager has a list of pediatric PCPs in Emma's service area. Emma's mother says she will research the PCPs and select one for Emma. Emma has also been seen by a pulmonologist in the past and the nurse care manager, using the historical claims, identified this physician as in network. Emma's mother agrees to call and notify the pulmonologist Emma will be coming home and she will get an appointment for Emma once her discharge date is determined.

• A ventilator, apnea monitor and pulse oximeter are all covered under the DME benefit. In addition, the nurse care manager recommends referral to a respiratory therapist who will visit Emma following discharge to assess her respiratory status and equipment use and ensure her needs are met. An action item to identify a network respiratory therapist is added to Emma's care plan.

• Generators are not covered under the Medicaid state plan and are specifically excluded. The waiver specialist believes the generator is not covered under EPSDT. Because Emma's recent developmental screening indicated the presence of an intellectual disability, the waiver specialist recommends a discussion with the Agency for Persons with Disabilities to determine if ventilators are typically authorized through EPSDT for children on the waiver or if the waiver covers this. She will also ask if Emma might be eligible for Developmental Services and enrollment in the iBudget Waiver on a priority basis because she will be leaving a NF to go home. The specialist will contact the APD area office following the meeting and report back to the MDT on her findings. The waiver specialist will help Emma's mother with the Developmental Services application process and if eligible, the waiver application process.

• Because arranging access to a generator could delay discharge, the MDT discusses possible rental of a generator until coverage is confirmed and recommends coverage. The nurse care manager will discuss rental as a cost-effective alternative to support home care with the Medical Director.

• The nurse care manager and medical social worker will provide family education and support during periodic telephonic and in-person contacts. The CHW will help connect Emma's mother to community resources including support groups as needed.

• The MDT discusses medication management and the need to refer Emma to a pediatric neurologist for ongoing management of her seizure medications. Emma's neurologist recently retired. The CHW will identify pediatric neurologists within the required travel distance accepting new patients and provide the list to Emma's mother for review and selection. A referral will be completed once the neurologist is identified and Emma's discharge date is known.

• The nurse care manager will finalize the transition plan within 30 days of Emma's discharge. The MDT will meet at that time to review and update the final transition plan.

DISCHARGE/TRANSITION PLANNING

Emma's date of discharge is now 30 days away and the MDT meets again to finalize the transition plan. The nurse care manager, with the enrollee (when feasible), enrollee's family or legal guardian, convenes the MDT and together they develop the final, written transition plan that is part of the enrollee's care plan and that documents the enrollee's history, and current medical, BH, and social support needs; the enrollee's short-term, and long-term goals; post-

discharge support needs; authorized services and follow-up schedule. The MDT ensures the enrollee has adequate caregiver support and appropriate resources at home, and incorporates an enrollee/family self- management plan including when to contact the doctor. Emma's mother and various members of the team provide updates from the last meeting:

• PPECs: Emma's mother visited several PPECS in her area and has found one she likes and that agrees to enroll Emma. The PPEC provides transportation, which is something Emma's mother really wanted. The nurse care manager will call the PPEC to notify them of Emma's discharge date and provide any information that will help them complete the prior authorization request for QIO determination. Emma's mother has requested nine hours of PPEC daily Monday through Friday.
• The MDT authorized PDN for Emma for 10 hours a day seven days a week from 8 PM to 6 AM and 4 hours of personal care on the weekend (6 AM to 8 AM and 6 PM to 8 PM). Emma's mother and her older sister believe they can care for Emma the remaining hours.
• The wheelchair is almost finished and the DME provider will be completing the final fitting next week at the NF. The chair will be delivered to Emma's home prior to her discharge. The local care management team DME specialist will visit Emma after discharge to confirm the chair is satisfactory and functional.
• The Medical Director determines, after a review of the therapist's assessment and recommendation and prescribing physician's treatment plan, the tablet is medically necessary. The Medical Director authorizes purchase from a DME provider and training by the speech language pathologist – to start following Emma's transition home.
• Emma's mother selected a PCP and notified the pulmonologist Emma will be coming home in the next 30 days. She has scheduled appointments for Emma for the week following anticipated discharge.
• A ventilator, apnea monitor and pulse oximeter have been ordered and will be delivered to Emma's home by the DME provider several days before Emma's discharge. In addition, a respiratory therapist has been authorized to provide up to six visits to Emma's home following discharge to assess her respiratory status and equipment use and ensure her needs are met.
• The waiver specialist met with the Area Office of the Agency for Persons with Disabilities and learned generators have not been authorized under the state plan previously. APD was unable to state whether Emma would or would not be eligible for Developmental Services: the application must be completed in order to make this determination. If Emma is eligible for Developmental Services, the Area Office will review the application and enrollment process for the waiver. APD states they will review the application as quickly as possible and issue a written determination of Developmental Services eligibility to Emma's mother. The waiver specialist is helping Emma's mother with the Developmental Services application process which was completed last week.
• Because access to the waiver, assuming Emma was eligible, will not be completed before discharge and likely not for several months, the nurse care manager states rental of a generator has been approved as a cost-effective alternative by the Medical Director for 90 days pending the outcome of the Developmental Services application and possible waiver enrollment.
• The nurse care manager and medical social worker have scheduled a family education session at Emma's house two weeks prior to discharge to review Emma's care plan and transition plan and walk through a typical day. During this visit, they will also provide detailed medication education, education about Emma's specific conditions, and "what to watch for" after discharge.

• The CHW provided a list of pediatric neurologists to Emma's mother for review and Emma's mother identified the provider she prefers. The nurse care manager will complete a referral that includes Emma's discharge date and clinical information. The neurologist's office usually calls patients to schedule a visit.
• The nurse care manager will finalize the transition plan within 30 days of Emma's discharge. The MDT will meet at that time to review and update the final transition plan.

TRANSITION AND POST DISCHARGE

Four to seven days prior to Emma's discharge, the nurse care manager completes a medication reconciliation and determines if there are duplicative medications, issues with adherence or compliance. She consults with the pharmacist and works with the NF to resolve any issues. She also works with Emma's mother to ensure she has identified a pharmacy to supply Emma's medications upon her discharge. Within 10 business days of Emma's discharge from the NF, the care coordinator submits the Department of Children and Families (DCF) Client Discharge/Change Notice to DCF.

The nurse care manager also confirms all needed supports authorized in Emma's care plan as well as PPEC are ready upon Emma's discharge.

She schedules a home visit and within 48 hours of discharge to complete a post-discharge assessment. The post-discharge assessment focuses on medication review, confirming or scheduling follow-up appointments, self- management status and understanding of discharge instructions, and confirms receipt of the services and equipment ordered prior to discharge.

The nurse care manager makes telephonic follow-up calls weekly for a minimum of four weeks post-discharge supplemented by home visits and may meet Emma and her mother at the PPEC or PCP/specialist visit as needed. During calls and visits, the nurse care manager completes in-home medication reconciliation, reinforces the established discharge plan, and provides any needed care coordination and/or education. An enrollee of the local care management team confirms completion of scheduled PCP and specialist visits calling Emma's mother after the scheduled date to discuss the visit outcome or to help reschedule the visit in the event they missed this.

Throughout the transition period and post-discharge, the nurse care manager updates the enrollee's assessment and care plan including the enrollee's short-term and long-term goals, reviews and confirms access to needed services, and coordinates services and treatment planning across providers and specialties.

DISEASE MANAGEMENT

Enrollees enrolled in CM for MSHCNs receive team support. If the enrollee requires disease management interventions to address a chronic condition, the appropriate member of the team delivers these interventions to the enrollee and, as applicable parents/caregivers, that emphasize education about the enrollee's chronic condition(s), self-management support and treatment plan and medication adherence. For example, the nurse care manager working with the pharmacist and consulting with the Medical Director as needed, provides education to Emma's mother, grandmother and older sibling (as caregivers) about seizure management,

what to do if Emma has a seizure, avoiding known triggers and adherence to the prescribed medication regimen. If Emma were to develop diabetes at a future date, the nurse care manager would implement our diabetes Condition Care program in collaboration with our nurse health educators and local care team dietitian.

UTILIZATION MANAGEMENT

We will authorize NF and PDN services, and other services needed to meet a child's needs while in a NF or while living at home and receiving PDN, through our MDT care planning process. The child's nurse care manager will be responsible for leading the MDT meeting and for obtaining any necessary clinical information to support the request for a specific service. This includes obtaining assessments and recommendations from clinicians as appropriate to the service, such as a speech language pathologist for a requested AAC device. Where medical necessity cannot be determined during the MDT meeting, the nurse care manager will forward the service request and accompanying information to the Medical Director for a determination.

GRIEVANCE AND APPEALS

We implement an established and compliant grievance and appeals process that includes the appeal process whenever a service is denied or authorized in an amount less than requested (i.e., is an adverse benefit determination). Denials may only be made by the Medical Director.

If the MDT makes a preliminary determination that a requested service is not medically necessary, or should be authorized, but in a mount less than requested, the request and related documentation will be provided to the Medical Director for final review and determination. At the time, the MDT makes this determination, the nurse care manager will inform the enrollee and/or parent/legally authorized representative of the determination process and the enrollee's rights, or parent's/legal representative's rights, to appeal the adverse determination and if the appeal is not decided in the enrollee's favor, the right request a Medicaid Fair Hearing from the Agency. Denial of a service, in whole or in part, triggers written notification of the reason for denial and the enrollee's right to appeal and request a Medicaid Fair Hearing, and to be assisted in filing their request, in accordance with the contract.

Evaluation Criteria:

1. The adequacy of the respondent's approach in addressing the following:

- **a.** Identification processes for enrollees with complex health conditions or who are in need of care coordination;
- **b.** Description of the sources of data/information that would be utilized in the assessment process, including timeframes for completion;
- **c.** Application of the respondent's case management risk stratification protocol;
- **d.** Identification of service needs (covered and non-covered) and a description for service referral processes that the respondent has in place;
- **e.** Description of the interventions and strategies that would be used to facilitate compliance with the plan of care, including use of incentives, healthy behavior programs, etc.;

f. Application of discharge and aftercare planning protocols that facilitate a successful transition;

g. Application of coordination protocols utilized with other insurers (when applicable), primary care providers, specialists, other services providers, and community partners particularly when referrals are needed for non-covered services;

h. Description of the assessment of provider capacity to meet the specific needs of enrollees;

i. Identification of strategies that promote enrollee self-management and treatment adherence;

j. Application of utilization management protocols (i.e., identification of the criteria that will be utilized, processes to ensure continuity of care, etc.); and

k. Application of strategies to integrate information about the enrollee across the plan and various subcontractors when the respondent has delegated functions.

2. The extent to which the respondents' workflows/narrative descriptions include timeframes for completion of each step in the care planning process.

3. The extent to which the respondent demonstrates innovative processes that it has in place to enhance communication among all service providers and subcontractors (for delegated functions).

4. The extent to which the respondent describes an approach that supports care delivery in the most appropriate and cost-effective setting and avoid unnecessary institutionalization (i.e., hospital or nursing facility care) or emergency department use.

5. The extent to which the respondent demonstrates experience in providing services to enrollees with complex medical needs and provide evidence of strategies utilized that resulted in improved health outcomes.

6. The extent to which the respondent demonstrates a holistic system of coordinated health care interventions designed to achieve cost savings through the organized and timely delivery of high quality services.

7. The extent to which the respondent describes innovative strategies to integrate information across all systems/processes (e.g., prior authorization data synching up with the claims system) into its workflows.

Score: This section is worth a maximum of 85 raw points with each of the above components being worth a maximum of 5 points each.

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F. OVERSIGHT AND ACCOUNTABILITY

No SRCs in this Category for MMA.

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G. STATUTORY REQUIREMENTS

MMA SRC #21 – Provider Network Agreements/Contracts Statewide Essential Providers (Statewide)

The respondent shall submit **Exhibit A-4-b-3**, Provider Network Agreements/Contracts Statewide Essential Providers, to demonstrate its progress with executing agreements or contracts with Statewide Essential Providers by submitting **Exhibit A-4-b-3**:

Response:

Florida's Agency for Health Care Administration identifies twenty-three Statewide Essential Providers, listed in Attachment MMA SRC 21: Exhibit A-4-b-3. To meet AHCA's standards and adequately serve our enrollees, Lighthouse Health Plan, LLC has contracted with XX% of the twenty-three Statewide Essential Providers.

Evaluation Criteria:

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0% - 25%	10
25.1%- 50%	20
50.1%- 75%	30
75.1% or greater	40

Score: This section is worth a maximum of 40 raw points based on the above point scale.

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EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Enter Respondent Name Below
Lighthouse Health Plan, LLC

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

General Instructions:

Each Respondent shall complete the Managed Medical Assistance Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of individual providers with whom they have agreements/contracts per Provider Type by using column 'b' on the worksheet.

MMA Required Provider Types Workbook Explanation:

Service Provider Types to be Measured List
Endocrinology
Internal Medicine
Pediatrics, Cardiology
Pulmonary Diseases
Surgery, Cardiovascular
Pediatrics, Endocrinology
Cardiovascular Medicine
Psychiatry, Child
Psychiatry, Adult
OB-GYN

Statewide Essential Providers Scoring Template Fields		
Field	*Respondent Data Entry Required?*	*Description*
Service Provider Type	*No*	*See Service Provider Types to be Measured List above*
**Agreements/Contracts*	*Yes*	**Agreements/Contracts count to be entered by respondent*
Total Population	*No*	*Total Medicaid eligible in the region*
% of population	*No*	*% of total Medicaid eligible in the region AHCA utilizing for ratio Recipient Count*
Recipient Count	*No*	*Recipient count utilized for as part of calculation for Ratio Results*
Ratio	*No*	*Regional provider ratio*
Ratio Results	*No*	*Shows service provider type requirement count for region using Recipient Count as the dividend and Ratio as the divisor*
%	*No*	*The number of agreements/contracts Respondent entered in column 'b', divided by the total number of Statewide Essential providers and converted to a %*

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
191

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist	16	117,974	0.3	35392	1500
Board Certified or Board Eligible Child Psychiatrist	3	117,974	0.3	35392	7100
Cardiology	47	117,974	0.3	35392	3700
Cardiology (PEDS)	3	117,974	0.3	35392	16667
Cardiovascular Surgery	8	117,974	0.3	35392	10000
Endocrinology	8	117,974	0.3	35392	25000
Endocrinology (PEDS)	0	117,974	0.3	35392	20000
Internal Medicine	102	117,974	0.3	35392	3000
Obstetrics/Gynecology	27	117,974	0.3	35392	1500
Pulmonology	1	117,974	0.3	35392	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
23.00	69.6%	19
4.00	75.0%	19
9.00	100.0%	24
2.00	100.0%	24
4.00	100.0%	24
1.00	100.0%	24
2.00	0.0%	0
12.00	100.0%	24
23.00	100.0%	24
5.00	20.0%	9

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		125,460	0.3	37638	1500
Board Certified or Board Eligible Child Psychiatrist		125,460	0.3	37638	7100
Cardiology		125,460	0.3	37638	3700
Cardiology (PEDS)		125,460	0.3	37638	16667
Cardiovascular Surgery		125,460	0.3	37638	10000
Endocrinology		125,460	0.3	37638	25000
Endocrinology (PEDS)		125,460	0.3	37638	20000
Internal Medicine		125,460	0.3	37638	3000
Obstetrics/Gynecology		125,460	0.3	37638	1500
Pulmonology		125,460	0.3	37638	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
25.00	0.0%	0
5.00	0.0%	0
10.00	0.0%	0
2.00	0.0%	0
4.00	0.0%	0
2.00	0.0%	0
2.00	0.0%	0
13.00	0.0%	0
25.00	0.0%	0
5.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		285,422	0.2	57084	1500
Board Certified or Board Eligible Child Psychiatrist		285,422	0.2	57084	7100
Cardiology		285,422	0.2	57084	3700
Cardiology (PEDS)		285,422	0.2	57084	16667
Cardiovascular Surgery		285,422	0.2	57084	10000
Endocrinology		285,422	0.2	57084	25000
Endocrinology (PEDS)		285,422	0.2	57084	20000
Internal Medicine		285,422	0.2	57084	3000
Obstetrics/Gynecology		285,422	0.2	57084	1500
Pulmonology		285,422	0.2	57084	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
38.00	0.0%	0
8.00	0.0%	0
15.00	0.0%	0
3.00	0.0%	0
6.00	0.0%	0
2.00	0.0%	0
3.00	0.0%	0
19.00	0.0%	0
38.00	0.0%	0
8.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		346,257	0.2	69251	1500
Board Certified or Board Eligible Child Psychiatrist		346,257	0.2	69251	7100
Cardiology		346,257	0.2	69251	3700
Cardiology (PEDS)		346,257	0.2	69251	16667
Cardiovascular Surgery		346,257	0.2	69251	10000
Endocrinology		346,257	0.2	69251	25000
Endocrinology (PEDS)		346,257	0.2	69251	20000
Internal Medicine		346,257	0.2	69251	3000
Obstetrics/Gynecology		346,257	0.2	69251	1500
Pulmonology		346,257	0.2	69251	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
46.00	0.0%	0
9.00	0.0%	0
18.00	0.0%	0
4.00	0.0%	0
7.00	0.0%	0
3.00	0.0%	0
3.00	0.0%	0
23.00	0.0%	0
46.00	0.0%	0
9.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		203,089	0.2	40618	1500
Board Certified or Board Eligible Child Psychiatrist		203,089	0.2	40618	7100
Cardiology		203,089	0.2	40618	3700
Cardiology (PEDS)		203,089	0.2	40618	16667
Cardiovascular Surgery		203,089	0.2	40618	10000
Endocrinology		203,089	0.2	40618	25000
Endocrinology (PEDS)		203,089	0.2	40618	20000
Internal Medicine		203,089	0.2	40618	3000
Obstetrics/Gynecology		203,089	0.2	40618	1500
Pulmonology		203,089	0.2	40618	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
27.00	0.0%	0
5.00	0.0%	0
10.00	0.0%	0
2.00	0.0%	0
4.00	0.0%	0
2.00	0.0%	0
2.00	0.0%	0
14.00	0.0%	0
27.00	0.0%	0
5.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	7
25.1%	12
50.1%	17
75.1%	22

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		460,305	0.2	92061	1500
Board Certified or Board Eligible Child Psychiatrist		460,305	0.2	92061	7100
Cardiology		460,305	0.2	92061	3700
Cardiology (PEDS)		460,305	0.2	92061	16667
Cardiovascular Surgery		460,305	0.2	92061	10000
Endocrinology		460,305	0.2	92061	25000
Endocrinology (PEDS)		460,305	0.2	92061	20000
Internal Medicine		460,305	0.2	92061	3000
Obstetrics/Gynecology		460,305	0.2	92061	1500
Pulmonology		460,305	0.2	92061	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
61.00	0.0%	0
12.00	0.0%	0
24.00	0.0%	0
6.00	0.0%	0
9.00	0.0%	0
4.00	0.0%	0
5.00	0.0%	0
31.00	0.0%	0
61.00	0.0%	0
12.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		442,511	0.2	88502	1500
Board Certified or Board Eligible Child Psychiatrist		442,511	0.2	88502	7100
Cardiology		442,511	0.2	88502	3700
Cardiology (PEDS)		442,511	0.2	88502	16667
Cardiovascular Surgery		442,511	0.2	88502	10000
Endocrinology		442,511	0.2	88502	25000
Endocrinology (PEDS)		442,511	0.2	88502	20000
Internal Medicine		442,511	0.2	88502	3000
Obstetrics/Gynecology		442,511	0.2	88502	1500
Pulmonology		442,511	0.2	88502	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
59.00	0.0%	0
12.00	0.0%	0
23.00	0.0%	0
5.00	0.0%	0
9.00	0.0%	0
4.00	0.0%	0
4.00	0.0%	0
30.00	0.0%	0
59.00	0.0%	0
12.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		231,055	0.2	46211	1500
Board Certified or Board Eligible Child Psychiatrist		231,055	0.2	46211	7100
Cardiology		231,055	0.2	46211	3700
Cardiology (PEDS)		231,055	0.2	46211	16667
Cardiovascular Surgery		231,055	0.2	46211	10000
Endocrinology		231,055	0.2	46211	25000
Endocrinology (PEDS)		231,055	0.2	46211	20000
Internal Medicine		231,055	0.2	46211	3000
Obstetrics/Gynecology		231,055	0.2	46211	1500
Pulmonology		231,055	0.2	46211	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
30.00	0.0%	0
6.00	0.0%	0
12.00	0.0%	0
3.00	0.0%	0
5.00	0.0%	0
2.00	0.0%	0
2.00	0.0%	0
15.00	0.0%	0
30.00	0.0%	0
6.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		311,282	0.2	62256	1500
Board Certified or Board Eligible Child Psychiatrist		311,282	0.2	62256	7100
Cardiology		311,282	0.2	62256	3700
Cardiology (PEDS)		311,282	0.2	62256	16667
Cardiovascular Surgery		311,282	0.2	62256	10000
Endocrinology		311,282	0.2	62256	25000
Endocrinology (PEDS)		311,282	0.2	62256	20000
Internal Medicine		311,282	0.2	62256	3000
Obstetrics/Gynecology		311,282	0.2	62256	1500
Pulmonology		311,282	0.2	62256	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
41.00	0.0%	0
8.00	0.0%	0
16.00	0.0%	0
4.00	0.0%	0
6.00	0.0%	0
2.00	0.0%	0
3.00	0.0%	0
21.00	0.0%	0
41.00	0.0%	0
8.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		302,576	0.2	60515	1500
Board Certified or Board Eligible Child Psychiatrist		302,576	0.2	60515	7100
Cardiology		302,576	0.2	60515	3700
Cardiology (PEDS)		302,576	0.2	60515	16667
Cardiovascular Surgery		302,576	0.2	60515	10000
Endocrinology		302,576	0.2	60515	25000
Endocrinology (PEDS)		302,576	0.2	60515	20000
Internal Medicine		302,576	0.2	60515	3000
Obstetrics/Gynecology		302,576	0.2	60515	1500
Pulmonology		302,576	0.2	60515	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
40.00	0.0%	0
8.00	0.0%	0
16.00	0.0%	0
4.00	0.0%	0
6.00	0.0%	0
2.00	0.0%	0
3.00	0.0%	0
20.00	0.0%	0
40.00	0.0%	0
8.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	9
25.1%	14
50.1%	19
75.1%	24

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

SRC SCORE
0

Service Provider Type	Agreements/Contracts	Total Population	% of Population	Recipient Count	Ratio
Board Certified or Board Eligible Adult Psychiatrist		587,996	0.2	117599	1500
Board Certified or Board Eligible Child Psychiatrist		587,996	0.2	117599	7100
Cardiology		587,996	0.2	117599	3700
Cardiology (PEDS)		587,996	0.2	117599	16667
Cardiovascular Surgery		587,996	0.2	117599	10000
Endocrinology		587,996	0.2	117599	25000
Endocrinology (PEDS)		587,996	0.2	117599	20000
Internal Medicine		587,996	0.2	117599	3000
Obstetrics/Gynecology		587,996	0.2	117599	1500
Pulmonology		587,996	0.2	117599	7600

EXHIBIT A-4-b-1
MMA SRC# 6 - PROVIDER NETWORK AGREEMENTS/CONTRACTS (REGIONAL) (10-2-2017)

Ratio Results	%	Score
78.00	0.0%	0
16.00	0.0%	0
31.00	0.0%	0
7.00	0.0%	0
12.00	0.0%	0
5.00	0.0%	0
6.00	0.0%	0
39.00	0.0%	0
78.00	0.0%	0
15.00	0.0%	0

Percentage of agreements/contracts for each service provider type	Points
0.0%	0
1.0%	7
25.1%	12
50.1%	17
75.1%	22

TRANSITION PLAN – KEY TRANSITION ACTIVITY SUMMARY

Enrollee X is a 42-year-old man hospitalized for severe depression (PHQ9 of 21) and suicidal ideations. He does not have a PCP and would like assistance in locating a new BH provider stating the current provider is not meeting his needs. The Transition Care Manager (referred to as the Care Advisor in his care plan) receives the referral for the enrollee's admission and connects with the enrollee while he is still hospitalized. (The Transition Care Manager AKA Care Advisor is a local BH Care Manager.)

1. COLLABORATION WITH THE HOSPITAL TEAM

- Local Care Manager (Care Advisor) meets with the hospital Care Manger, Social Worker and Hospitalist to review enrollee's history and current status. Transition planning begins and potential needs identified.
- PCP notified of the enrollee's admission date and reason for admission
- Documented the outcomes of the hospital team collaboration

2. CONSENT TO DISCUSS TRANSITION PROGRAM WITH ENROLLEE RECEIVED FROM THE ENROLLEE

- Enrollee agreed to participate in the Transition Care Program.

3. TRANSITION DISCHARGE PLANNING ASSESSMENT COMPLETED. BARRIERS INCLUDED:

- Transportation to and from appointments
- Knowledge deficit regarding the purpose and side effects of medications
- Lack of understanding of available community resources
- Lack of social support at home and in the community
- A desire to select a new BH provider
- No PCP
- Lack of afterhours contact/Crisis center
- Lack of having a formal Symptom Management Plan
- A need for outpatient support with a Social Worker (SW)
- Documented the outcomes of the hospital visit

4. TRANSITION PLANNING CARE CONFERENCE

- Held with the inpatient team the day prior to transition
- Outcomes documented

5. TRANSITION ACTIVITIES PRIOR TO DISCHARGE

- BH provider selected by the enrollee after being provided a list of in-network providers
- PCP selected by the enrollee after being provided a list of in-network providers
- Assisted enrollee with scheduling an appointment with the enrollee's PCP within 5 business days of discharge date
- Assisted enrollee with scheduling an appointment with the enrollee's BH Provider within 5 business days of discharge date
- After review of enrollee's benefits, enrollee provided with a list of free local community resources for transportation
- Authorization for transportation obtained from the health plan

- Assisted enrollee with scheduling transportation for PCP and BH provider
- Transition plan including discharge instructions, medication updates, appointment dates and Crisis Center contact information reviewed with enrollee and questions answered
- Ensured enrollee received education on new and existing medications including purpose, side effects and risks of discontinuing medications
- Referrals arranged for outpatient (local care management team) SW support after obtaining enrollee's permission
- Enrollee provided consent to a post-transition follow-up call within 24 hours of transition and a home visit by the CHW within 3 business days
- PCP and BH Provider notified of enrollee's discharge date, discharge diagnosis and medications
- Documented the outcomes of the hospital visit

6. POST TRANSITION FOLLOW UP CALL
   - Post transition follow up call occurred within 24 hours of transition to home. Provided credentials, purpose of call and notification of call potentially being recorded. Verified enrollee identity by requesting enrollee's date of birth and address.
   - Reviewed the enrollee's transition plan received from the hospital and questions answered
   - Performed a medication reconciliation with the enrollee reviewing each medication bottle. Ensured enrollee filled his new prescription
   - Reinforced education on new and existing medications
   - Confirmed enrollee is aware of scheduled upcoming appointments with the PCP and BH provider
   - Confirmed with enrollee the transportation arrangements
   - Home visit scheduled with enrollee for 2 business days post transition. Communicated scheduled date/time with the CHW
   - Documented the outcomes of the transition call

7. SW PERFORMS A HOME VISIT
   - SW performs a home safety visit on the scheduled date and time
   - Reinforces the enrollee's scheduled appointments and transportation plan
   - Identifies any barriers to the enrollee not attending the appointments
   - Discusses enrollee's current support system and willingness to accept additional support and community resources
   - Provided enrollee with a list of local community resources
   - Ensured enrollee had the contacts for the local Crisis Center and provided enrollee with an on-line depression support network
   - Documented the outcomes of the home visit

8. WEEKLY AND PRN FOLLOW UP
   - Weekly and as needed follow-up from BH care manager and SW
   - Problems, Goals and Interventions addressed as well as barriers to reaching goals. At the beginning of every contact credentials were presented, the purpose of call and notification of call potentially being recorded were shared with the enrollee. Verified enrollee identity by requesting enrollee's date of birth and address.

PROBLEM LIST, GOALS AND INTERVENTIONS

PROBLEM IDENTIFIED: DEPRESSION - POSITIVE SCREEN

GOAL: Depression Management/Enrollee Has No Readmissions in 30 Days

INTERVENTIONS/OUTCOMES:

- Social Work Referral: Provided education and suggestions below. Worked with the enrollee to establish willingness to attend community support groups at the local church and library which are both in walking distance.
- Provide Education and Materials on Depression and Do Teach Back: Materials provided to the enrollee regarding depression and ways other than medications to possibly assist. Discussed self-soothing activities, importance of diet and exercise, yoga, meditation, and possibly volunteering with a youth organization. Enrollee appeared engaged in the conversation and willing to try. Plan to discuss whether any of the activities were tried and successful on the next call.
- Coordinate Psychiatric/Physiological Consultation: Enrollee's initial appointment with the BH Provider is scheduled for 10/5 at 10 am. Plan to f/u with enrollee after the appointments to answer questions and provide needed clarification.
- Develop Plan for Depression Management: Worked with the enrollee and the BH Provider and SW to develop a plan for depression management. Enrollee verbalizes understanding of the plan and treatments.
- Repeat PHQ2/PHQ9: Plan to re-assess enrollee utilizing the PHQ2 and PHQ9.
- Identify Alternatives to Hospital Admissions: Enrollee provided contact information for both the PCP and BH after hour's line as well as the nearest Urgent Care Center. The enrollee understands his Symptom Response Plan and the specific reasons to outreach for assistance.

PROBLEM IDENTIFIED: LIMITED TRANSPORTATION

(Note – this example is real. The specific program in which this enrollee is enrolled places a cap on transportation, unlike Florida MMA).

GOAL: Transportation

INTERVENTIONS/OUTCOME:

- Review Available Enrollee Benefits: Completed a three-way call with Enrollee Services and the Enrollee. Determined enrollee has no resources left for transportation assistance.
- Social Work Referral: CA notified SW of need to obtain enrollee benefits and transportation assistance to enrollee's appointments. Verified with the enrollee that contact has been made with the SW and enrollee stated he is receiving assistance with transportation and community resources.
- Identify Non-Emergent Medical Transportation Services: Writer researched free transportation services in the enrollee's community and provided to enrollee. Completed a three-way call with the Transportation Company and enrollee and secured transportation to and from his PCP and BH provider appointments next week. Will f/u with the enrollee after the appointments to ensure the transportation was sufficient. F/U occurred and transportation was sufficient. Enrollee successfully demonstrated the process to schedule future transportation.

PROBLEM IDENTIFIED: CONDITION KNOWLEDGE/UNDERSTANDING DEFICIT

GOAL: Enrollee Understands and Has a Plan for Managing Symptoms and Knows When to Contact the Physician
INTERVENTIONS/OUTCOME:

- Coordinate Care with the Provider: Message sent to the provider via EMR to review the Symptom Response Plan included on the Care Plan with the enrollee at his appointment on 10/5 at 10 am. Verified with the enrollee and provider that the Symptom Response Plan was verified.
- Provide Plan for Managing and Responding to Symptoms: Enrollee provided a Symptom Response Plan (see Care Plan). Verbalized understanding. Enrollee aware of the plan for him to teach back the plan to writer on 10/10.
- Patient Teach-Back of Symptom Response Plan: Enrollee successfully verbalized the purpose and contents of the plan.

PROBLEM IDENTIFIED: MEDICATION MANAGEMENT CONCERN
GOAL: Enrollee is Adherent to Prescribed Medication Regimen
INTERVENTIONS/OUTCOME:

- Complete Medication Reconciliation: Medication reconciliation completed with enrollee viewing medication bottles. No discrepancies identified.
- Identify Methods to Increase Medication Adherence: Provided enrollee with information on the purpose and side effects of Xanax and Effexor. Followed up to ensure enrollee received the information and questions answered. Reinforced the importance of not completely stopping medications. Enrollee already has a list of his medications on the fridge and an alarm on his phone as reminders.

PROBLEM IDENTIFIED: Follow Up Services Need
GOAL: Enrollee Has Completed All Necessary Post-Discharge Follow Up Appointments and Testing
INTERVENTIONS/OUTCOME:

- Assist with Drafting Questions/Concerns for Provider: Enrollee shared that he felt uncomfortable with asking the providers certain questions. Outlined and role-played questions and potential responses. Enrollee verbalized increase confidence in communicating with his providers.

After 30 days in the Transition Care Program Mr. X is assessed for additional needs. He qualifies for the Behavioral Health Care Management Program, which is a longer-term program designed for enrollees with high behavioral health needs. The Care Manager discussed program with enrollee. Enrollee agreed to participate. Enrollee transferred to Behavioral Health Care Management program for ongoing support.

Should Mr. X have transferred to another facility during his initial hospital stay, or transferred to another confinement at discharge the following activities would have occurred within 3 business days of notification of the transition:

- Care Plan sent to accepting facility with confirmation
- PCP/BH Provider notified of transfer/discharge
- Enrollee/Caregiver outreach

If Mr. X accessed the ED or had an Observation stay, was not admitted, and was deemed to be a high risk to return, the following activities would have occurred within 3 business days of notification of the transition:

- PCP/BH Provider notified of transition
- Enrollee/Caregiver outreach/ assessment/barrier resolution and interventions completed to ensure compliance with Treatment Plan

Care Plan for ****

Last Updated: **** Reason for Update: Transition Care Plan

MY GENERAL INFORMATION

DOB
****

Address
****

Preferred Method of Contact
Home Phone: ****

IMPORTANT CONTACTS

PCP
Not Available

Other Provider
Dr. XXX (BH For You): (141) ****

After Hours Contact
24 Hour Hot Line: (888) ****

Care Advisor
Suzanne: (888) ****

Pharmacy
CVS: (141) ****

MY ACTIVE CONCERNS

Concerns
Other: Condition Knowledge/Understanding Deficit
Other: Depression: Positive Screen
Other: Follow-Up Services Need
Other: Limited Transportation
Other: Medication Management Concern

MY GOALS

In Progress Goals	Target Completion Date	Priority
Transportation	10/02/2017	High
Patient has completed all necessary post-discharge follow-up appointments and testing	10/11/2017	High
Patient understands and has a plan for managing symptoms and knows when to contact physician	10/16/2017	Moderate
Depression Management	10/18/2017	High
Patient is adherent to prescribed medication regimen	10/19/2017	High
Patient had no readmissions in 30 days	10/29/2017	Moderate

Care Plan for ****

ACTIONS TAKEN TO ACHIEVE GOALS

In Progress Actions	Perform by Date
Social Work Referral Comments: CA notified SW of need to obtain member benefits and transportation assistance to member's appointments. - Seiders, Suzanne 09/30/2017 12:25 AM EDT Verified with the member that contact has been made with the SW and member stated he is receiving assistance with transportation and community resources. - Seiders, Suzanne 09/30/2017 12:27 AM EDT	09/30/2017
Complete Medication Reconciliation Comments: Medication reconciliation completed with member viewing medication bottles. No discrepancies identified. - Seiders, Suzanne 09/29/2017 11:44 PM EDT	09/30/2017
Review Available Member Benefits Comments: Completed a three-way call with Member Services and the Member. Determined member has no resources left for transportation assistance. - Seiders, Suzanne 09/30/2017 12:23 AM EDT	10/02/2017
Identify Non-Emergent Medical Transportation Services Comments: Writer researched free transportation services in the member's community and provided to member. Completed a three-way call with the transportation company and member and secured transportation to and from his PCP and BH provider appointments next week. Will f/u with the member after the appointments to ensure the transportation was sufficient. - Seiders, Suzanne 09/30/2017 12:40 AM EDT Member successfully demonstrated the process to schedule future transportation. - Seiders, Suzanne 09/30/2017 12:48 AM EDT	10/02/2017
Assist with Drafting Questions/Concerns for Provider Comments: Member shared that he felt uncomfortable with asking the providers certain questions. Outlined and role played questions and potential responses. Member verbalized increase confidence in communicating with his providers. - Seiders, Suzanne 09/29/2017 11:56 PM EDT	10/02/2017
Provide Plan for Managing and Responding to Symptoms Comments: Member provided a Symptom Response Plan (see Care Plan). Verbalized understanding. Member aware of the plan for him to teach back the plan to writer on 10/10. - Seiders, Suzanne 09/30/2017 12:12 AM EDT	10/02/2017
Provide Education and Materials on Depression	

Care Plan for ****

In Progress Actions	Perform by Date
Comments: Materials provided to the member regarding depression and ways other than medications to possibly assist. Discussed self-soothing activities, importance of diet and exercise, yoga, meditation, and possibly volunteering with a youth organization. Member appeared engaged in the conversation and willing to try. Plan to discuss whether any of the activities were tried and successful on the next call. - Seiders, Suzanne 09/30/2017 1:17 AM EDT	10/03/2017
Coordinate Care with Provider Comments: Message sent to the provider via EMR to review the Symptom Response Plan included on the Care Plan with the member at his appointment on 10/5 at 10 am. - Seiders, Suzanne 09/30/2017 12:12 AM EDT Verified with the member and provider that the Symptom Response Plan was verified. - Seiders, Suzanne 09/30/2017 12:13 AM EDT	10/03/2017
Coordinate Psychiatric/Psychological Consultation Comments: Member's initial appointment with the BH Provider is scheduled for 10/5 at 10 am. Plan to f/u with member after the appointments to answer questions and provide needed clarification. - Seiders, Suzanne 09/30/2017 1:32 AM EDT	10/04/2017
Identify Methods to Increase Medication Adherence Comments: Provide member with information on the purpose and side effects of Xanax and Effexor. - Seiders, Suzanne 09/29/2017 11:44 PM EDT Reviewed the materials provided with the member and questions answered. Reinforced the importance of not completely stopping medications. Member already has a list of his medications on the fridge and an alarm on his phone as reminders. - Seiders, Suzanne 09/30/2017 12:46 AM EDT	10/04/2017
Assist with Community Resource Referral(s) Comments: Writer researched free transportation services in the member's community and provided to member. Completed a three-way call with the transportation company and member and secured transportation to and from his PCP and BH provider appointments next week. Will f/u with the member after the appointments to ensure the transportation was sufficient. - Seiders, Suzanne 09/30/2017 12:31 AM EDT Worked with the member to establish willingness to attend community support groups at the local church and library which are both in walking distance. - Seiders, Suzanne 09/30/2017 1:30 AM EDT	10/06/2017
Identify Alternatives to Hospital Admission Comments: Member provided contact information for both the PCP and BH after hours line as well as the nearest Urgent Care Center. The member has an understanding of his Symptom Response Plan and the specific reasons to outreach for assistance.	10/06/2017

Care Plan for ****

In Progress Actions	Perform by Date
- Seiders, Suzanne 09/30/2017 12:58 AM EDT	
Develop Plan for Depression Management Comments: Worked with the member and and the BH Provider and SW to develop a plan for depression management. Member verbalizes understanding of the plan and treatments. - Seiders, Suzanne 09/30/2017 1:23 AM EDT	10/09/2017
Patient Teach-Back of Symptom Response Plan Comments: Member successfully verbalized the purpose and contents of the plan. - Seiders, Suzanne 09/30/2017 12:15 AM EDT	10/10/2017
Patient Teach-Back of Depression Treatment Plan	10/13/2017
Repeat PHQ2/PHQ9 Screen for Depression Comments: Plan to re-assess member utilizing the PHQ2 andPHQ9 . - Seiders, Suzanne 09/30/2017 1:12 AM EDT	10/18/2017

SYMPTOM RESPONSE PLAN

If you experience this...	Do this...
Increased feelings of sadness, anxiety, hopelessness	Meditate, call a friend or the support hot line, take a walk
Feelings of harming self or others	Call 911 and then the Crisis Center
Dizziness, sweating, headache, ringing in the ears	Contact Dr. but do not stop taking medications unless directed by your physician

UPCOMING APPOINTMENTS

- **10/03/2017 11:00 AM EDT**: Dr. XXX
- **10/04/2017 10:00 AM EDT**: Dr. XXX

TOPICS TO DISCUSS WITH DOCTOR

- Symptom Management Plan

ALLERGIES

Patient has no known allergies as of 09/29/2017

ADVANCE DIRECTIVES

- Member has an Advanced Directive on file at his PCP office.

Care Plan for ****

MEDICATIONS

Disclaimer: Medication list is taken from various sources that may not be current or complete. This information is not a substitute for your primary care provider's records or medical advice. Consult your primary care provider to ensure medication list is accurate and up-to-date and to seek medical care.

Drug Name, Strength and Form	Directions	Reason for Use	Medication Nickname	Prescriber
EFFEXOR 75 MG TABLET	Take 1 tablet by mouth every 8 hours; Take with food	Depression	Mood pill	
XANAX 1 MG TABLET	Take 1 and 1/2 tablets by mouth 2 times daily	Anxiety	Nerve pill	

Disclaimer: This Care Plan is not intended to serve as a substitution for your primary care provider's advice and/or treatment.

EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

INSTRUCTIONS:

Respondents should submit calendar year 2015/HEDIS 2016 and calendar year 2016/ HEDIS 2017 performance measure data for the selected HEDIS measures for the respondent's three (3) largest Medicaid contracts (measured by number of enrollees).

If the respondent does not have HEDIS results for at least three (3) Medicaid Contracts, the respondent shall provide commercial HEDIS measures for the respondent's largest Contracts. If the Respondent has Florida Medicaid HEDIS results, it shall include the Florida Medicaid experience as one (1) of three (3) states for the last two (2) years.

The performance measures that respondents are required to report on can be found on the Performance Measure Group B tab.

Use the drop-down box to select the state for which you are reporting and enter the performance measure rates (to the hundredths place, or XX.XX) for that state's Medicaid population for the appropriate calendar year.

EXHIBIT A-4-b-2
MMA SRC# 14 - MMA PERFORMANCE MEASUREMENT TOOL (10-2-2017)

RESPONDENT NAME:	Lighthouse Health Plan, LLC					
	Group B					
	State #1:	Kentucky	State #2:	Maryland	State #3:	Illinois
HEDIS Performance Measure	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate	CY 2015 Rate	CY 2016 Rate
Adolescent Well-Care Visits	45.18	44.46	64.03	58.78		50.12
Childhood Immunization Status - Combination 3	79.81	75.93	83.21	74.94		69.34
Frequency of Ongoing Prenatal Care - ≥ 81% of expected visits	74.48	69.46	71.84	57.66		46.23
Immunizations for Adolescents - Combination 1	87.41	85.15	80.00	83.21		79.08
Timeliness of Prenatal Care	86.83	81.00	84.47	80.78		68.13
Well-Child Visits in the First 15 Months of Life - 6 or more visits	66.32	59.25	66.76	65.01		44.04
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	71.57	70.00	85.51	75.74		75.67

Total Points	62

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

General Instructions:

Each Respondent shall complete the Managed Medical Assistance Agreements/Contracts scoring template worksheet. The respondent is required to submit the total number of agreements/contracts with Statewide Essential Providers by using column 'b' on the worksheet.

MMA Statewide Essential Providers Scoring Workbook Explanation:

Statewide Essential Providers List
Tampa General Hospital
Shands Teaching Hospital
Shands-Jacksonville
Jackson Memorial Hospital, Jackson Health System
Sacred Heart Hospital
Winnie Palmer Hospital at Arnold Palmer Medical Center, Orlando Health
NEO: All Children's Hospital
OB: Bayfront Medical Center
St. Mary's Medical Center
Broward General Medical Center
Memorial Regional Medical Center-
Lee Memorial Health System
University of Florida College of Medicine
University of Miami School of Medicine
University of South Florida College of Medicine
University of Central Florida College of Medicine
Nova Southeastern University College of Osteopathic Medicine
Florida State University College of Medicine
Florida International University College of Medicine
All Children's Hospital
Miami Children's Hospital
Nemours
Shriners Hospitals for Children

Statewide Essential Providers Scoring Template Fields		
Field	*Respondent Data Entry Required?*	*Description*
Service Provider Type	*No*	*Statewide Essential Provider*
**Agreements/Contracts*	*Yes*	*Agreements/Contracts count shall be entered by Respondent*
Statewide Essential Count	*No*	*Total number of available statewide essential providers (see Statewide Essential Providers list above)*
%	*No*	*The number of agreements/contracts Respondent entered in column 'b', divided by the total number of Statewide Essential Providers and converted to a %*
Score	*No*	*Specific statewide essential provider type score*

**notates only field to be completed by the respondent*

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

Enter Respondent Name Below
Lighthouse Health Plan, LLC

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

SRC Score
20

Service Provider Type	Agreements/Contracts	Statewide Essential Count	%	Score
Statewide Essential	7	23	30.4%	20

EXHIBIT A-4-b-3
MMA SRC# 21 - PROVIDER NETWORK/CONTRACTS STATEWIDE ESSENTIAL PROVIDERS (STATEWIDE) (10-2-2017)

Percentage of Agreements/Contracts	Points
0.0%	0
1.0%	10
25.1%	20
50.1%	30
75.1%	40

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to capture commitments made by the respondent in response to this solicitation.

INSTRUCTIONS: The respondent shall identify each commitment made/proposed in the solicitation. Commitments include, but are not limited to: innovations that assist in achieving the Agency goals, improvements in service delivery coordination and quality outcomes for enrollees, improving the enrollee experience, commitments made in the respondent's provider engagement approach which result in an improved provider experience, and commitments reducing overall costs to the Medicaid program. The respondent shall identify the solicitation section/sub-section (Attachment X, Exhibit Y, Subsection Z), as applicable where the commitment can be found.

Category	Commitment (Brief Summary/Description)	Solicitation Section Reference
Example: Agency Goals	(Respondent to complete)	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals	Telehealth will be a large part of our plan to reach this vulnerable population, ultimately bringing care to those that need it most. Within the medicaid segment we have learned that telehealth improves barriers to care that exist today (ie lack of transportation, lack of access to specialists, physicians with limited medicaid panel size). As a PSN we can address all of those concerns, however our telehealth strategy is extensive and far reaching. We also plan to implement a telehealth steering committee that will include representation from clinical operations, care management, and provider network development. This committee will review access to care gaps and build strategies to eliminate those gaps. Gaps such as the large gap in behavioral health today. We plan to leverage telemedicine to connect enrollees to behavioral health providers, other specialists, and even their care team. Our telehealth subcontractor will be integrated into ourfull suite of modules within our Identifi platform. Our telehealth subcontractor will bring an expanded primary care network, licensed mental health counselors, Psychiatrists, Cardiologists, Pulmonologists, and Endocrinologists.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 4 - Telemedicine (Regional)
Agency Goals	Creation of a multi-provider shared risk program, similar to an Accountable Care Organization, where payment is tied to performance on quality measures including measures that impact potentially preventable events.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals	Encourage healthy behaviors by allowing enrollees to earn incentives for engaging in activities that improve their health and reduce their risk of potentially preventable events.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals	Utilize a care management model that includes local, multidisciplinary care management teams aligned with specific PCPs and their patients, and embedded in high volume practices, that support the PCP/member relationship and implementation of the PCP's treatment plan.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)

Agency Goals, Improvements in Service Delivery Coordination and Quality Outcomes for Enrollees	Our Care Management team will utilize Identifi. The Identifi data platform continuously analyzes all available sources of data, including claims and pharmacy data, electronic medical record (EMR) data, socioeconomic data, data from the member enrollment file including existing authorizations when available, and results of health risk screenings and health risk assessments, to accurately stratify the entire membership into three risk levels: low risk, moderate risk, and high risk groups. Our statistical models focus on predicting highly specific events, based on the population type. For Medicaid, these events include preterm deliveries, infants born with neonatal abstinence syndrome and behavioral health related ER visits and inpatient admissions. We have also developed a New Enrollee Model to identify and triage new high-risk Medicaid members moving between health plans within 60 days of enrollment using data that is more readily available. Identifi offers a pre-loaded, clinical program workflow that focuses care managers on the highest risk members and the most effective interventions. Evidence-based clinical content drives the creation of structured and understandable person centered care plans, and the application supports cross-functional collaboration with the entire care team. We have a team of dedicated staff that focus exclusively on building clinical programs and clinical content (assessments and problems, goals and interventions) incorporating the latest evidence-base.	Exhibit A-4-a, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals, Improvements in Service Delivery Coordination and Quality Outcomes for Enrollees	We will implement in-hospital interventions in high-volume hospitals, placing social workers and care managers in select emergency rooms or on inpatient units to collaborate with hospital staff and the local care management team in addressing and reducing the drivers of avoidable hospital use.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals, Improvements in Service Delivery Coordination and Quality Outcomes for Enrollees	We will offer providers access to Identifi Practice, a provider portal through which providers can gain access to the PCP's member roster, member assessments, service authorizations, care plans, member admissions, discharges and transfers, and service utilization data including prescribed drug utilization. Identifi Practice offers full interoperability with EMRs, connecting provider practices to our member-centered data warehouse to support real-time communication and coordination of care. Using Identifi Practice, providers can see their patients with active conditions, and their patients' diagnoses and risk stratification score, in a single view. Identifi Practice can be used to guide providers' patient assessments and documentation. We also give providers critical data they need to help close patient care gaps. Any member of the care management team can communicate with the provider through EMR messaging with updates on member status and progress on care plan goals, barrier resolution, clinical needs, care coordination needs, and questions for the provider. Importantly, the Identify Practice application can also be used to support communication between providers. When a provider accesses a enrollee record on Identifi Practice they can see records of the enrollee's recent utilization with other providers as well as any notes that those other providers have added to the Member's care plan.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Improved Provider Experience	We will have a Physician Advisory Committee (PAC): Chaired by board selected physician leader and include representation from local providers, the PAC is responsible for approving the Quality and Access Scorecard and ensuring fair and reasonable scoring thresholds. The PAC identifies potential operational challenges to be addressed through local plan or provider plan sponsor activities. This committee will also recommend local initiatives to address quality or cost opportunities. We will also have several provider lead workstreams that will report to the PAC. All workstreams include a multi-disciplinary represenation to ensure engagement and alignment with clinicians.	Exhibit A-4-a, Section D., Provider Experience, SRC# 15 - Provider Engagement Model (Statewide)

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

Improved Provider Experience	We will have a credentialing quality assurance program. This program will provide a vehicle for measuring the quality and consistency of service delivery, identifying trends, service issues and training opportunities to improve enrollment and credentialing staff performance and productivity. This programwill also monitor and evaluate how well staff are adhering to credentialing policies and procedures as well as regulatory requirements, including Credentialing Requirement, Profile Review, CMO/Committee Sign-off and 60-day notification to providers.	Exhibit A-4-b, Section D., Provider Experience, MMA SRC# 12 - Provider Credentialing (Statewide)
Improvements in Delivery Coordination and Quality Outcomes for Enrollees	We will make outbound welcome calls to all new enrollees, welcoming them to the plan, educating them on available services, and validating or requesting their PCP selection.	Exhibit A-4-b, Section C., Recipient Experience, MMA SRC# 8 - Primary Care Providers (PCP) Assignment (Statewide)
Improvements in Delivery Coordination and Quality Outcomes for Enrollees	We will provide disease management programs beyond those listed in the proposal. Conditions within our DM program include CHF, CAD, HTN, Oncology, COPD, Asthma, Diabetes, Depression, Anxiety. We also will provide a Complex Care Management intervention beyond single disease state management based on predictive analytics and risk profiling. Both models will be supported by an RN led care team. It is important to manage dyad conditions such as Asthma and HTN, or CAD and Diabetes as co-existing as known to be high cost dyads, managing in a model with a focus on self management helps coordinate care between specialties and also enhances adherence to treatment plans, reducing unnecessary ED visits, and improves physician satisfaction.	Exhibit A-4-a, Section A., Agency Goals, SRC # 5 - Disease Management (DM) Program (Statewide)
Improvements in Delivery Coordination and Quality Outcomes for Enrollees	Identifi UM is an SLA - driven workflow management module which integrates nationally recognized guideline support and medical policy administration to reduce inappropriate utilization and improve quality medical services. Identifi UM maximizes UM resources by providing UM resources complete and real time clinical and financial information allowing our model to scale resources in the most fiscally lucrative way. Ultimately reducing operational costs for the medicaid program. Identifi UM pairs with Identifi Care to truly bring an integrated medical management model (integrates with Identifi Practice, Identifi Engage, Identifi Pharmacy, et, as well). This integration maximizes staff efficiency and reduces unnecessary utilization.	Exhibit A-4-a, Section E., Delivery System Coordination, SRC # 18 - Utilization Management (Statewide)
Improved Provider Experience	Physician level reporting for program enrollement and opportunities, care gaps, assessment opportunities, utilization and cost reports. This is important in reducing costs to the medicaid program, as it allows physicians insight into their own data, trends within their own practice, and see where they specifically can make improvements to processes or care practices. Without this level of specificity it is oftentimes harder to implement change with in a practice or acute setting.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 1 - Potentially Preventable Events (Regional)
Agency Goals	Maternity Care Management for all levels of risk (high, moderate, and low) based on predictive analytics and proven interventions to match each level of risk to impact birth outcomes. With interventions focused on all levels of risk we are able to reach members that may not be deemed high risk in a traditional manner. We have seen a reduction in low birth weight babies and preterm deliveries, yielding healthier moms and babies, and reducing overall costs associated with pregnancy.	Exhibit A-4-b, Section B., Agency Goals, MMA SRC# 2 - Birth Outcomes (Statewide)
Improving the Enrollee Experience	Social media - ways to connect with enrollees outside of traditional social media campaigns - We will be offering Facebook Live events with our enrollees to educate and promote awareness each month. Campaigns will range from healthy eating, car seat safety, how to deal with a new asthma diagnosis, to best practices while pregnant and tips to easily adhere to your medication regimen. MIAMI ONLY	Exhibit A-4-a, Section C., Recipient Experience, SRC# 13 - Social Media (Statewide)

EXHIBIT A-5
SUMMARY OF RESPONDENT COMMITMENTS

Improving the Enrollee Experience	Identifi Engage is a patient facing app that will allow enrollees to live chat with their care team during busines hours and leave direct, non- emergent messages for their care team after hours. Finding different ways to connect with enrollees is critical to improve engagement effectiveness and overall increase enrollees actively learning to self manage. If enrollees can actively manage their own care outside of clinical programs it will help improve health, decrease costs.	SRC #13- Social Media (Statewide)
Improving the Enrollee Experience; Improvement in Delivery Coordination and Quality Outcomes for Enrollees	Healthify - is a community resource tool that will allow our care team easy access to find community resources that match the enrollees needs based on their assessment and care plan. This will allow the care team more time to be focused on interacting with the enrollee directly than researching resources that best meet the enrollees needs. Allowing the clinical team to spend more time with enrollees directly allows us to scale resources in a more cost effective manner and eliminate wasteful cost to the Medicaid program.	SRC #13- Social Media (Statewide)

Lighthouse Health Plan, LLC

Respondent Name

Michael E. [illegible]

Authorized Official Signature

10/31/17

Date

Mike Gleason

Authorized Official Printed Name

President

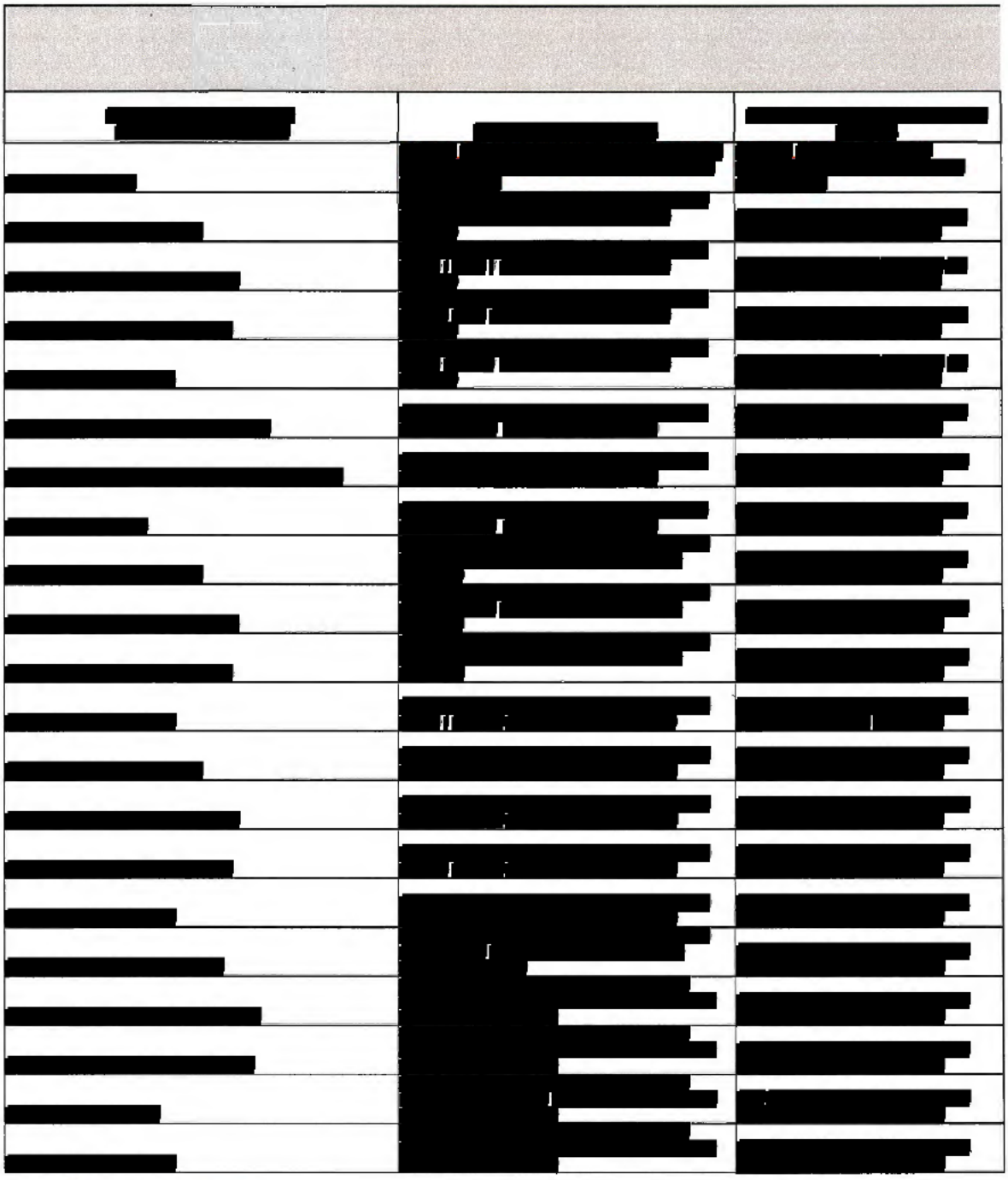
Authorized Official Title

EXHIBIT A-6
SUMMARY OF MANAGED CARE SAVINGS

PURPOSE: The Agency will review and utilize this Exhibit during the negotiation process, for respondents who are invited to negotiations, to identify managed care savings included by the respondent in response to this solicitation.

THE AGENCY RESERVES THE RIGHT TO INCLUDE ANY OR ALL MANAGED CARE SAVINGS LISTED HEREIN, OR AS NEGOTIATED, AS PART OF THE RESULTING CONTRACT.

INSTRUCTIONS: THE RESPONDENT SHALL IDENTIFY EACH MANAGED CARE SAVINGS PROPOSED IN ITS RESPONSE TO THIS SOLICITATION AND IDENTIFY BOTH THE SOLICITATION SECTION(S)/SUBSECTION(S)/ITEM(S), AND THE SECTION/COLUMN OF THE COST PROPOSAL TEMPLATE (ATTACHMENT C) IN WHICH THE MANAGED CARE SAVINGS IS PROPOSED. (SEE EXAMPLE BELOW) ADDITIONAL PAGES MAY BE INCLUDED AS NEEDED.



Lighthouse Health Plan, LLC
Respondent Name

Authorized Official Signature

10/31/19
Date

Mike Gleason
Authorized Official Printed Name

President
Authorized Official Title

Historical Delivery System:
MMA & FFS Express Enrollment

Managed Care Initiative:
Complex Care Program (non-maternity and maternity members)

[redacted]

Historical Delivery System:
MMA & FFS Express Enrollment

Managed Care Initiative:
Transition Care Program

Description of Initiative:

[redacted]

Historical Delivery System:
MMA & FFS Express Enrollment

Managed Care Initiative:
Care Coordination Program

[redacted]

EXHIBIT A-7
CERTIFICATION OF DRUG-FREE WORKPLACE PROGRAM

In the event of Identical or Tie Bids/Proposals: Preference shall be given to businesses with drug-free workplace programs. Whenever two or more bids which are equal with respect to price, quality, and service are received by the State or by any political subdivision for the procurement of commodities or contractual services, a bid received from a business that certifies that it has implemented a drug-free work place program shall be given preference in the award process. Established procedures for processing tied awards will be followed if none of the tied vendors have a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1) Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession, or use of a controlled substance is prohibited in the workplace and specifying the actions that will be taken against employees for violations of such prohibition.

2) Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.

3) Give each employee engaged in providing the commodities or contractual services that are under bid a copy of the statement specified in subsection (1).

4) In the statement specified in subsection (1), notify the employees that, as a condition of working on the commodities or contractual services that are under bid, the employee will abide by the terms of the statement and will notify the employer of any conviction of, or plea of guilty or nolo contendere to, any violation of chapter 893 or of any controlled substance law of the United States or any state, for a violation occurring in the workplace no later than five (5) days after such conviction.

5) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program if such is available in the employee's community by, any employee who is so convicted.

6) Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign the statement, I certify that this firm complies fully with the above requirements.

Lighthouse Health Plan, LLC
Respondent Name

Michael E. Gleason
Authorized Official Signature

10/31/17
Date

Mike Gleason
Authorized Official Printed Name

President
Authorized Official Title

EXHIBIT A-9
REGIONAL PREFERENCE HIERARCHY

RESPONDENT NAME: Lighthouse Health Plan, LLC

The Agency shall award one (1) additional Contract in a region to each successful respondent who receives a Region 1 or 2 Contract award. The Agency shall award the additional Contract in the respondent's highest desired region of preference in which the respondent submitted a responsive reply and negotiates a rate acceptable to the Agency.

Respondents shall complete the Regional Preference Hierarchy Table below, to indicate its preference for receipt of additional Contract awards.

If the Regional Preference Hierarchy Table is left blank, the respondent indicates that it does not desire any additional region awards.

Respondents shall indicate the region(s) in hierarchy order (highest desire being 1 and lowest desire being 10).

REGIONAL PREFERENCE HIEARCHY	
Order Requested for Additional Award	**By Region**
1.	
2.	
3.	
4.	
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Lighthouse Health Plan, LLC
Respondent Name

Michael E. Gleason
Authorized Official Signature

10/31/17
Date

Mike Gleason
Authorized Official Printed Name

President
Authorized Official Title

State of Florida Agency for Health Care Administration Statewide Medicaid Managed Care Invitation to Negotiate Actuarial Memorandum and Certification

Lighthouse Health Plan, LLC

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Lighthouse Health Plan
October 25, 2017

Exhibit C-1: Capitated Plan Cost Proposal Template
Statewide Medicaid Managed Care (SMMC) Invitation to Negotiate (ITN)
Cost Proposal Template Basic Instructions & General Inputs
Region 1 Cost Proposal

General Inputs:

Respondent Organization Name: Lighthouse Health Plan, LLC
Region: 1

Basic Instructions:

1. The purpose of this capitated plan cost proposal template, as part of the SMMC ITN, is to provide Respondents with a means for completing the SMMC Cost Proposal ("cost proposal") required in Attachment A of the SMMC ITN. This template is intended only for Respondents proposing to become a capitated plan in the SMMC program. Respondents proposing to become a Fee-for-Service (FFS) Provider Service Network (PSN) should fill out a different template.

2. **Respondents must follow the instructions presented in the SMMC ITN document "Attachment C: Cost Proposal Instructions and Rate Methodology Narrative."** That document includes both strict instructions for completing the cost proposal, as well as other information about the cost proposal and rate negotiation process that Respondents may find useful when completing their cost proposals. Please refer to that document for comprehensive instructions for completing the capitated plan cost proposal template.

3. **Under the "General Inputs" section above, Respondents should enter their organization name, as well as the region to which this cost proposal template applies.** Respondents must submit a separate capitated plan cost proposal template (with each of the necessary components completed) for each individual rate region in which they are proposing to participate in the SMMC program. The Respondent organization name and region entered on this tab will cause values in other tabs of the capitated plan cost proposal template to populate accordingly.

4. This single capitated plan cost proposal template Excel file includes tabs for three distinct components (the MMA cost proposal template, the LTC cost proposal template, and the non-benefit expense cost proposal template) that are required for different SMMC plan types. Please see the "Tab Structure" section below for details on the tabs included in this file, as well as a listing of which tabs should be completed by Respondents depending on their chosen SMMC plan type. Complete definitions for the SMMC plan types and additional instructions can be found in the SMMC ITN document "Attachment C: Cost Proposal Instructions and Rate Methodology Narrative."

5. In tabs that are not required for the Respondent's chosen SMMC plan type, Respondents should leave all inputs blank.

6. The capitated plan cost proposal template is password protected to allow Respondents to enter information only in cells shaded peach. Respondents must not change any formulas in the capitated plan cost proposal template and must submit the capitated plan cost proposal template with the original sheet and workbook protection intact. A formatting key is shown below and is also shown on each tab throughout the template for reference.

7. Respondents must enter a numeric value into each and every peach cell on all required tabs for their chosen SMMC plan type (except for the Respondent Organization Name input, the Proposed Specialty Population input in Worksheet M.11, and the adjustment factor name inputs on the various tabs, which can be input as text). If numeric values are not entered into each and every required peach cell, the cost proposal template will not appropriately calculate a proposed capitation rate from the Respondent's input base data and adjustments. If a particular adjustment factor, per member per month (PMPM) amount, or per delivery amount does not apply for a given region, rate group, or service category, Respondents should enter a 1.000 multiplicative adjustment factor or a $0.00 additive cost in the required input cells to allow the cost proposal template to appropriately calculate a proposed capitation rate.

8. Do not insert rows or columns in the template, or use the "cut" command on any cells within the template. If the Respondent requires more columns for adjustments than provided, please combine adjustments so that they can be entered into the number of columns in the template and include a description of each adjustment and its value in the Actuarial Memorandum that accompanies the cost proposal template (along with Excel numerical support as needed).

9. Respondents should complete the applicable MMA cost proposal template and LTC cost proposal template worksheets before completing the non-benefit expense cost proposal template worksheet. The non-benefit expense cost proposal template for capitated plans uses conditional formatting to apply dark shading to the rows for the rate groups that do not include a calculated projected service cost in the MMA or LTC worksheets. As a result, after a Respondent completes the appropriate MMA and LTC worksheets (depending on the Respondent's chosen SMMC plan type), Respondents only need to complete the rows for the rate groups that are not shaded. Respondents should enter 0 member months, 0 deliveries, $0.00 PMPM, or $0.00 per delivery in the peach cells in the rows that are shaded.

10. The final proposed capitation rates are shown in cells X23 through X42 of the 'N.1 Admin, Gain, Loss' tab.

11. Respondents should use the following file naming convention when submitting their cost proposal templates:
    a. Respondents should replace the "Region XX" portion of the cost proposal template Excel file name with the region to which the particular cost proposal template applies (e.g., "Region 1").
    b. Respondents should replace the "Respondent Name" portion of the cost proposal template Excel file name with their own organization's name.
    c. Aside from the file name changes described in items 11.a and 11.b, Respondents should not change the name of the cost proposal template Excel file.

Formatting key:

Peach shading indicates information to be input by Respondents.
White and other shading indicates information that Respondents are not permitted to change.
Yellow highlighting indicates formula-driven total projected cost or final capitation rate.

Blue font indicates values input by Respondents, or hard-coded inputs in the starting template.
Black font indicates formula-driven results automatically populated in the cost proposal template.

Tab Structure:

The capitated plan cost proposal template is set up to include the following tabs:

MMA Cost Proposal Template tabs
- M.1 through M.10, Section A: One tab for each existing MMA rate group (excluding the Maternity Kick Payment) where Respondents should enter their proposed base data and various adjustments as part of their cost proposals.
- M.1 through M.10, Section B: One tab for each existing MMA rate group (excluding the Maternity Kick Payment) which includes a condensed summary of the information in Section A for each rate group. No input by Respondents is needed on the Section B tabs.
- M.11, Section A: One tab where Respondents proposing to become a Specialty plan covering a new customized specialty population should, to the best of their ability, enter their proposed base data and various adjustments as part of their cost proposals.
- M.11, Section B: One tab for a proposed new customized specialty population that includes a condensed summary of the information in Worksheet M.11, Section A. No input by Respondents is needed on this tab.
- M.12: One tab for the Maternity Kick Payment where Respondents should enter their proposed base data and various adjustments as part of their cost proposals.

LTC Cost Proposal Template tab - L.1: One tab where Respondents should enter their proposed base data and various adjustments as part of their cost proposals for both the HCBS and Non-HCBS rate groups.
Non-Benefit Expense Cost Proposal Template tab - N.1: One tab where Respondents should enter their proposed administrative allowance and gain/loss margin for the relevant rate groups.

The following table illustrates which tabs in the capitated plan cost proposal template should be completed by Respondents for each SMMC plan type (please refer to the SMMC ITN document "Attachment C: Cost Proposal Instructions and Rate Methodology Narrative" for complete details):

SMMC Cost Proposal Submission Requirements for Each SMMC Plan Type ("Yes" = Required, "No" = Not Required, "N/A" = No Respondent Inputs)

Tab Name	Comprehensive Plan	LTC Plus Plan	MMA Plan	HIV/AIDS Specialty Plan	Child Welfare Specialty Plan	SMI Specialty Plan	Other Customized Specialty Plan[1]
M.1 Sec A - TANF NonSMI	Yes	No	Yes	No	No	No	No
M.1 Sec B - TANF NonSMI	N/A	No	N/A	No	No	No	No
M.2 Sec A - TANF SMI	Yes	No	Yes	No	No	Yes	No
M.2 Sec B - TANF SMI	N/A	No	N/A	No	No	N/A	No
M.3 Sec A - SSI Med Only NonSMI	Yes	No	Yes	No	No	No	No
M.3 Sec B - SSI Med Only NonSMI	N/A	No	N/A	No	No	No	No
M.4 Sec A - SSI Med Only SMI	Yes	No	Yes	No	No	Yes	No
M.4 Sec B - SSI Med Only SMI	N/A	No	N/A	No	No	N/A	No
M.5 Sec A - SSI Dual Elig	Yes	No	Yes	No	No	Yes	No
M.5 Sec B - SSI Dual Elig	N/A	No	N/A	No	No	N/A	No
M.6 Sec A - Child Welfare	Yes	No	Yes	No	Yes	Yes	No
M.6 Sec B - Child Welfare	N/A	No	N/A	No	N/A	N/A	No
M.7 Sec A - HIVAIDS Med Only	Yes	No	Yes	Yes	No	Yes	No
M.7 Sec B - HIVAIDS Med Only	N/A	No	N/A	N/A	No	N/A	No
M.8 Sec A - HIVAIDS Dual Elig	Yes	No	Yes	Yes	No	Yes	No
M.8 Sec B - HIVAIDS Dual Elig	N/A	No	N/A	N/A	No	N/A	No
M.9 Sec A - LTC Med Only	Yes	Yes	No	No	No	No	No
M.9 Sec B - LTC Med Only	N/A	N/A	No	No	No	No	No
M.10 Sec A - LTC Dual Elig	Yes	Yes	No	No	No	No	No
M.10 Sec B - LTC Dual Elig	N/A	N/A	No	No	No	No	No
M.11 Sec A - New Specialty	No	No	No	No	No	No	Yes
M.11 Sec B - New Specialty	No	No	No	No	No	No	N/A
M.12 - Maternity Kick Payment	Yes	Yes	Yes	Yes	Yes	Yes	Yes
L.1 - LTC	Yes	Yes	No	No	No	No	No
N.1 Admin, Gain, Loss	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Work Area[2]	Optional	Optional	Optional	Optional	Optional	Optional	Optional

[1] Respondents proposing to become a new customized type of Specialty plan should submit a full MMA cost proposal to the best of their ability.
[2] The 'Work Area' tab is an unprotected work space that is optional for Respondents to use when completing the cost proposal template.