LSU Health Sciences Center
NEW ORLEANS
School of Medicine
Department of Psychiatry

School of Medicine
School of Dentistry
School of Nursing
School of Allied Health Professions
School of Graduate Studies
School of Public Health

PerformCare, Behavioral Health Solutions
Dr. Richard Edley, President
Clover Hill Business Park
P.O. Box 6600
Harrisburg, PA 17112

August 4, 2011

Dear Dr. Edley:

On behalf of the LSU Department of Psychiatry, I am looking forward to working with PerformCare, if they are selected as the Statewide Management Organization (SMO) for the Louisiana Behavioral Health Partnership.

As you know, I have met with representatives from both PerformCare and its sister CCN company, LaCare, and truly appreciate the commitment to improving health outcomes in Louisiana, especially in behavioral health. PeformCare's origins in and commitment to the provider community distinguishes you in the area of managed behavioral healthcare. We envision a positive relationship between our two organizations that will positively benefit the State of Louisiana and those at-risk individuals.

Sincerely yours,

Howard J. Osofsky, MD, PhD

Howard J. Osofsky, M.D., Ph.D.
Kathleen and John Bricker Chair
Professor and Head
Department of Psychiatry

Catholic Charities

1000 Howard Avenue
New Orleans LA 70113-1916
phone (504) 523-3755
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www.ccano.org

July 27, 2011

Flora Castillo
AmeriHealth Mercy Family of Companies
Flora.Castillo@amerihealthmercyHP.com

Dear Ms. Castillo:

On behalf of Catholic Charities Archdiocese of New Orleans, I would appreciate the opportunity to work with PerformCare in Louisiana, if they are selected as the Statewide Management Organization (SMO) for the Louisiana Behavioral Health Partnership. I have been the medical director of various behavioral health programs in the greater New Orleans region and am aware of the needs of the chronic mentally ill and the constraints upon the public system in financing effective and equitable care.

In meeting with representatives from both PerformCare and LaCare, I was impressed with your organization's grasp of the issues and the plans you have for improving access and efficient quality behavioral health care to our clients. We at CCANO also value your interest on healthy communities and your willingness to invest in non-medical approaches that influence health outcomes.

We look forward to collaborating with you in developing a mental health delivery service that will benefit our clients and the State of Louisiana. We wish you success in your endeavors.

Sincerely yours,

Elmore F. Rigamer, MD, MPA
Medical Director
Catholic Charities Archdiocese

METROPOLITAN HUMAN SERVICES DISTRICT

400 Poydras Street, Suite 1800 • New Orleans, Louisiana 70130 • Tel: (504) 568-3130 • Fax: (504) 568-3134

July 25, 20111

PerformCare
8040 Carlson Road
PO Box 6600
Harrisburg, PA 17112

ATTN: Sheryl Swanson, VP Provider Network Operations

Dear Ms. Swanson:

On behalf of Metropolitan Human Service District (MHSD), I am excited about the opportunity to work with PerformCare in Louisiana, if they are selected as the Statewide Management Organization (SMO) for the Louisiana Behavioral Health Partnership.

We have met with representatives from both PerformCare and LaCare and applaud their commitment to improving health outcomes in Louisiana, especially in behavioral health. PerformCare's origins in and commitment to the provider community distinguishes them in the area of managed behavioral healthcare. We envision a meaningful collaboration between our two organizations that will positively benefit the State of Louisiana and those at-risk individuals.

Sincerely yours,

Judge Calvin Johnson (ret)
Executive Director

Since 1971 ...
A Voice for
Louisiana's Youth

LACCA

P.O. Box 9481
Metairie, LA 70055-9481

866.214.4916
866.214.9569 *fax*
LACCAvoice4youth@gmail.com

July 19, 2011

Joseph E. Comaty, Ph.D., M.P.
SMO RFP Coordinator
Chief Psychologist Medical Psychologist
Development Section
Office of Behavioral Health, LA DHH
628 N. 4th Street
Baton Rouge, LA 70821-4049

Dear Dr. Comaty:

The Louisiana Association of Child Care Agencies (LACCA) is excited about the opportunity to work with PerformCare if they are selected as the statewide qualified behavioral health managed care organization (SMO) for the Louisiana Coordinated System of Care (CSoC).

At our June membership meeting, we met with representatives from both PerformCare and LaCare and applaud their concern and commitment to improving health outcomes in Louisiana, especially in behavioral health. PeformCare's origins from the service provider network enable them to have an understanding of provider issues and concerns that distinguishes them from others in the area of managed behavioral healthcare.

We envision a meaningful collaboration between our two organizations that will positively benefit the State of Louisiana and those children and families at-risk.

Sincerely yours,

Laura A. Jensen

Laura A. Jensen
Executive Director

2. WORK PLAN / PROJECT EXECUTION

a. Member Services

i. Describe how member services will be organized. Provide an organizational chart that includes position titles, numbers of positions, and reporting relationships. Describe the qualifications of the member services staff and supervisors.

PerformCare's Call Center and Member Services department will be located in Baton Rouge, and will serve as the single point of entry for all children, adults, and their families/caregivers receiving services. The Call Center will operate 24 hours per day, 7 days per week, 365 days per year and will be answered by live voices of Member Service Representatives (MSR). The MSRs will ensure that demographic information is obtained, information gathered, and assistance is given to all callers, including filing grievances. PerformCare will hire multi-lingual staff to meet the needs of members for whom English is a second language, including Vietnamese and Spanish and any other language spoken by at least 5 percent of the eligible population. When multi-lingual staff is not available, we will utilize a Language Line service for interpretation and will have TTY/TDD/Louisiana Relay capacity to ensure that those individuals with hearing impairments have access to the call center. Additionally, PerformCare has the capacity to make warm transfers (both internal transfers and external transfers), especially when an individual is in crisis or needs medical or police assistance

Member Services Staff

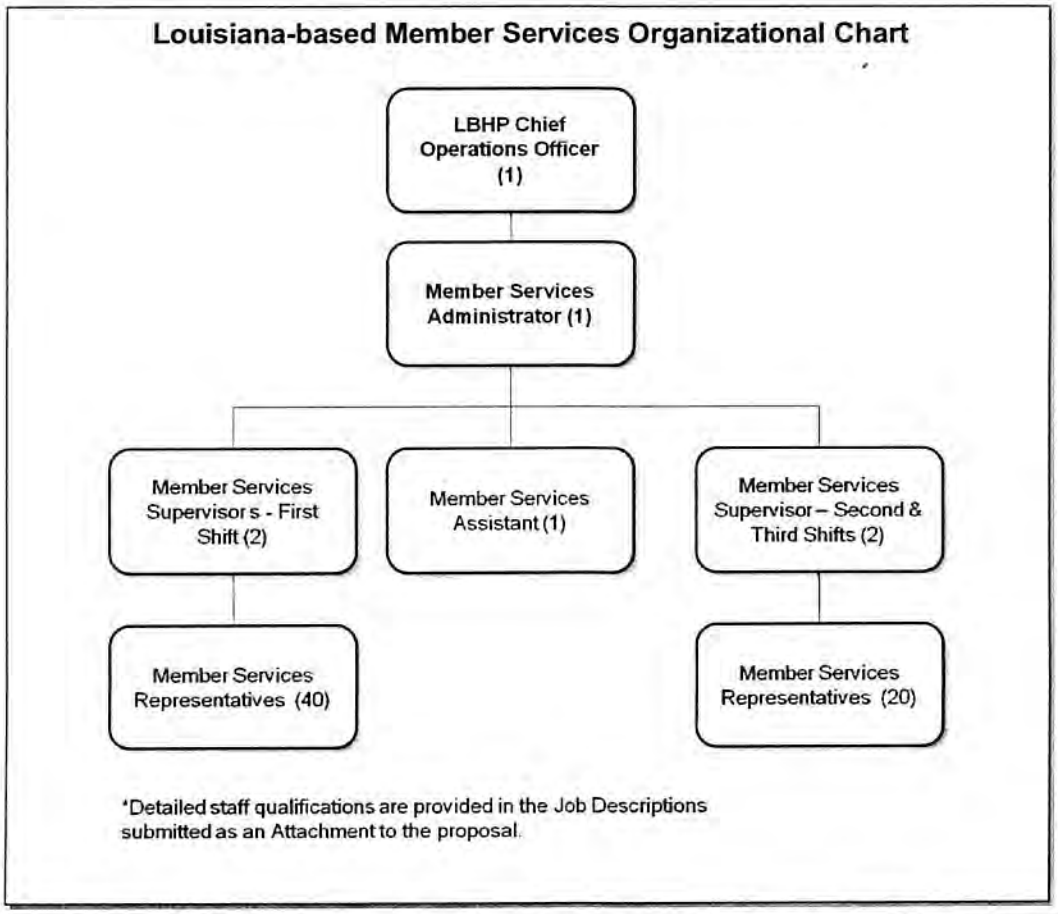
The Member Services Administrator has responsibility for oversight of the operational, reporting, and quality functions of the Call Center. This individual will also have experience with information inquiries, service requests, crisis calls, and grievances and appeals, and significant experience in the management of a Member Services department in compliance with state and federal laws and regulations, and state contracts. This position requires a bachelor's degree, three to five years of behavioral health experience, call center experience, and previous supervisory experience. The Member Services Administrator is responsible for the direct supervision of the Member Services Supervisors who hold primary responsibility for training and monitoring staff performance. The supervisor position requires a bachelor's degree, two to four years of behavioral health experience, and supervisory experience. The Member Services Representatives (MSR) are required to have a high school diploma and one to three years of experience in the human service field.

PerformCare is fully committed to ensuring that employees have initial and ongoing training that allows them to meet member needs in an effective and timely manner. Orientation consists of both Human Resources and department-specific activities that acclimate each employee to their job, co-workers, policies, procedures, benefits, System of Care services, managed care, and PerformCare as a whole. Timely and well planned orientation activities provide a strong foundation on which to build a rewarding and productive employment relationship. Initial training for Member Services Representatives includes, at a minimum, the following:

- PerformCare information
- Overview of the Louisiana Behavioral Health Partnership, including the program's mission, services provided, populations served, and any specific requirements
- Overview of the program's structure, including organizational and staffing infrastructure
- Terminology, definitions and acronyms related to managed care, mental health, and the Louisiana Behavioral Health Partnership
- Telephone and information technology system
- Member Services
- Diversity and cultural competence

- Lethality and Duty to Warn
- Interviewing skills
- Conflict management and handling difficult callers
- Customer service skills
- Managing warm transfers for clinical, crisis, and other services
- Eligibility process
- Registration process
- Care Management
- Understanding and communicating with special populations
- Information on community services and resources
- Role of system partners
- Confidentiality and HIPAA regulations
- Fraud, abuse, and corporate compliance
- Cultural diversity and sensitivity

LBHP Member Services Department Organizational Chart



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

PerformCare's member services will be located in Baton Rouge will have a toll-free 24/7 line, and will serve as the single point of entry for all individuals, including members (children, adolescents, and adults), family members, providers, community programs and services, WAA staff, FSO's, state and local agencies and staff (i.e. criminal and juvenile justice system representatives, DCFS case workers, etc.), primary care providers, peer support specialists, and any other individual seeking information regarding the program or requesting services.

The line will be staffed by highly trained and experienced Member Services Representatives (MSR) who will be responsible for responding to all caller inquiries and issues. The toll free line will be answered by a live person within 30 seconds and with a call abandonment rate not exceeding 3 percent. We will ensure that there are sufficient MSRs with multi-lingual capabilities to meet the needs of callers who speak Spanish, Vietnamese, and any other languages spoken by at least 5 percent of the eligible population. We will use the Language Line for any languages spoken by callers for which we do not have staff competency. Additionally, we will have a TTY/TDD and/or Louisiana Relay service available at all times for callers with hearing impairments.

PerformCare follows a first-call resolution approach, where we expect all MSR to address a caller's needs within the first phone call, minimizing the need for callers to follow up. As such, PerformCare MSRs are expected to address the caller's needs and conduct any follow-up needed on behalf of the caller.

MSRs will be responsible for:

- Responding to caller inquiries
- Assisting with complaints and grievance filings
- Providing information on the program, including member rights and responsibilities
- Checking member eligibility and assisting callers with information and the process for completing eligibility documentation and other requirements (including Title XIX and Title XXI eligibility requirements)
- Providing information on available services and referrals to providers
- Assisting providers with payments, training, or other provider-related inquiries
- Assisting providers with obtaining authorizations

At all times, the MSRs will have access to a CM for clinical issues, including assessing members for routine, urgent, and emergency services and referrals to services.

System Back-Up

The corporate design of our telephony network is a distributed model that affords the organization service availability in the event of a wide area connectivity failure or regional event. Service connectivity is maintained through two diverse carriers. The first carrier is the Avaya infrastructure. PerformCare's primary telephony infrastructure has a comprehensive back-up system with full redundancy capabilities to timely cover calls to the toll free line. We utilize the Avaya Single Image Switch architecture; a fully distributed IP-based phone system. This system provides feature transparency across the PerformCare infrastructure and also extends contact center and other telephony applications throughout the AmeriHealth Mercy Family of Companies. The main Avaya Communication Manager server resides in the Philadelphia, Pennsylvania corporate campus and supports all PerformCare locations including our

data center and all affiliates. The secondary standby server is located in a separate location to ensure continuity of service. Since PerformCare has migrated to the Avaya single image switch platform, all sites are fully capable of providing contact center call handling for any type of situation. This architectural design also takes into account survivability in the event of wide area network failures.

If any PerformCare site were to lose connectivity to the main Avaya server, the local Avaya gateway(s) at the affiliate site will register to the local Avaya Communication Manager standby server. In essence this site will function as a standalone PBX and would be fully capable of servicing calls.

In the event of a shutdown of any affiliate site, full phone system functionality can be achieved by the Philadelphia corporate site, or any other affiliate location. Calls will be redirected by our phone providers to such location so to provide seamless transition of call handling during any impactful event. This functionality is discussed in greater detail in Section M, Emergency Management Plan, where we walk through multiple emergency scenarios – including flooding and hurricanes – and how member services can continue to function uninterrupted.

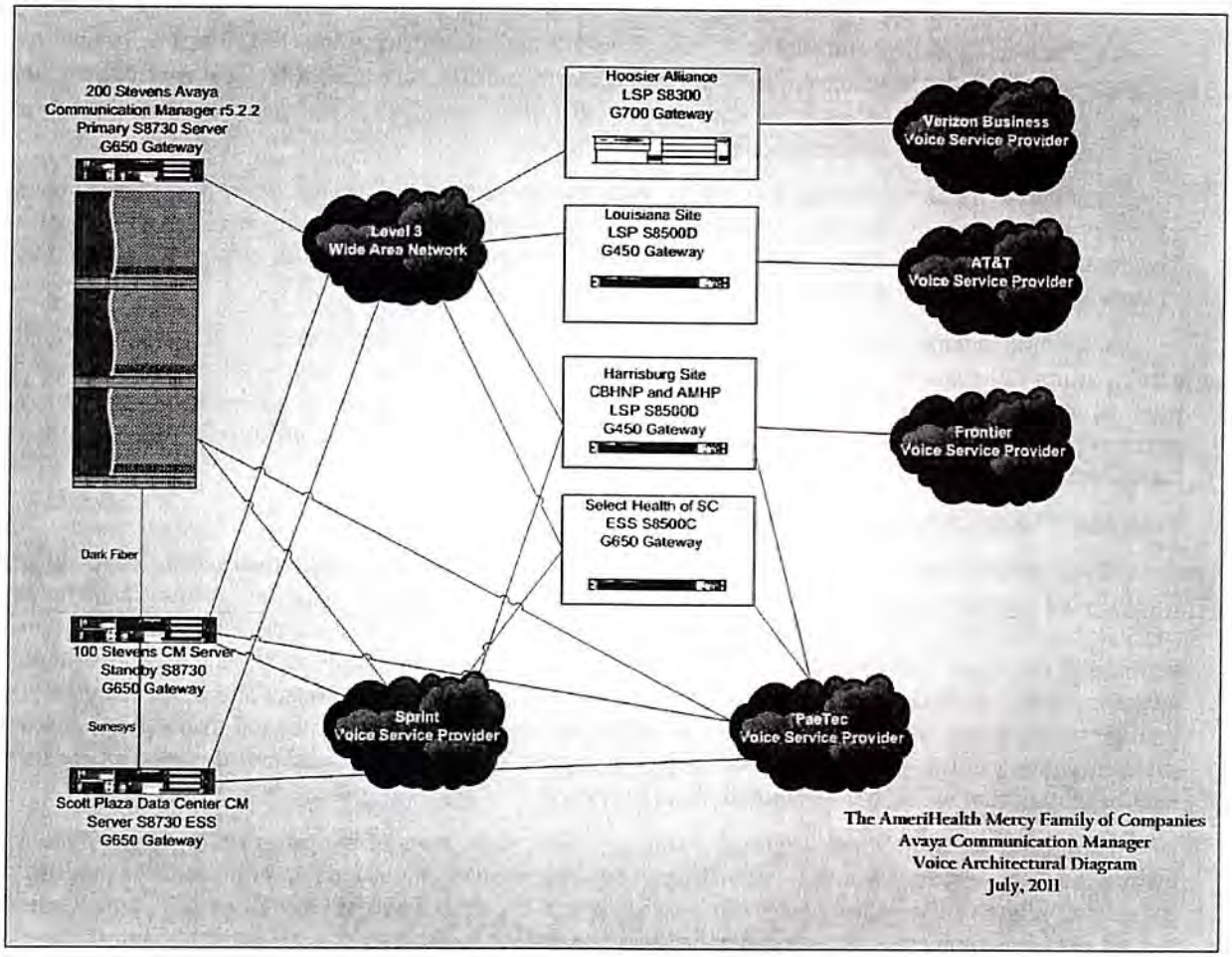
If connectivity to the enterprise hub is interrupted, the second diverse carrier will support the telephony requirements. The local passive PBX will engage and is fully capable to support the telephony requirements of the affected office. In the event of a regional event or power loss, phone and fax services utilized by the local office can be redirected to our Harrisburg, PA location or another affiliate with a seamless transition. Alternate back-up virtual PBX capabilities also allows for continued telephonic capabilities of the Louisiana staff in the case of local outages. This ensures the continued service of our members in the event of a crisis. In order to allow participation by Louisiana MSRs in the event of a system shutdown, and assuming that the enterprise hub cannot support the Louisiana office, PerformCare will initiate its own virtual PBX, which will allow local MSRs to remain available through alternative technologies, such as call-forwarding.

iii. Describe the capabilities of the telephone system with respect to warm line transfer, live call monitoring, and other relevant features.

PerformCare will utilize the Avaya Aura Contact Center and Verint Impact 360 Workforce Optimization Suites. These systems are configured with the Critical Reliability architecture to ensure optimum performance and up time of all telephony systems and services needed to support our 24/7/365 call center. The system includes immediate warm transfer capabilities and ability for supervisors and others to monitor live calls for quality and performance issues. In addition, our telephone system capabilities include the following:

- Interactive Voice Response (IVR) for self-service capabilities that include eligibility inquiry, form faxback, requests for identification cards, and provider directory requests
- 100 percent call logging of calls
- Simultaneous recording of call and desktop screen activity for quality auditing purposes
- Telephonic responses to provider claim status inquiries
- Provider selections based on multi-point geographic location, preferences for gender, languages spoken and affiliations
- Automatic Call Distribution (ACD) system:
  - Effective management of all calls received and assignment of incoming calls to available staff using a skill set hierarchy
  - Transfers of calls to other telephone lines or departments

- Detailed analysis for the reporting requirements, including the quantity, length and types of calls received, elapsed time before the calls are answered, the number of calls transferred or referred; abandonment rate; wait time; busy rate; response time; and call volume
- Messaging that notifies callers that the call may be monitored for quality control purposes
- Measurement of the number of calls in the queue at all times; the length of time callers are on hold; the total number of calls and average calls handled per day/week/month; the average hours of use per day
- Assessment of the busiest times and days by number of calls
- Messaging to inform the member to dial 911 if there is an emergency



iv. Describe the Proposer's plan to train member services staff. Suggested number of pages: 2

The values and principles of recovery, self-determination, person-centered, consumer and family driven access, planning, and services that provide the foundation for Louisiana's reform efforts will be incorporated into the training of all member services staff. A major initiative of our work in Louisiana will be to create systems, programs and services that integrate trauma-informed care (TIC). We know that a large population of residents of Louisiana has been impacted by two of the worst natural or human-caused disasters to impact the United States: Katrina and the Gulf Coast Oil Spill. These successive traumas naturally led to increased issues of vulnerability, insecurity, anxiety, depression, and post

traumatic stress disorder (PTSD.) Some key elements in fostering resilience and recovery are ensuring that members feel safe, respected, treated with dignity, and empowered through education, information, and involvement in their care.

The Wellness and Recovery Action Plan (WRAP), recognized by National Registry of Evidence-based Programs and Practices (NREPP) as a best practice, will be used as a model to educate and train member services staff. The five key concepts of this model are hope, personal responsibility, education, self-advocacy, and support. It is critical that member services staff receive education and training in trauma-informed care (TIC) and that Member Services promote an environment that is trauma-informed. This will be accomplished through leadership and staff development in WRAP and trauma-informed care values, principles, and approaches, organizational self-assessments, policies and procedures, and continuous quality improvement efforts.

Peer Specialists and representatives of the Family Support Organizations (FSO) will be invited to all training events in order to educate, train, and engage with member services staff. Hearing firsthand about the experiences, needs, and goals of consumers and family members will sensitize staff and promote recovery oriented, trauma-informed care of our members.

Louisiana is made up of many parishes and diverse population groups. It is not enough to train member staff on how to handle calls, promote calm, and help members make connections to services; they must also be culturally sensitive and informed. Indigenous trainers with expertise in the diverse cultures of Louisiana will be hired to provide this education and training.

All training events will utilize adult learning approaches in order to engage staff, promote active participation and increase knowledge and skill development. Training events will also utilize activities such as role playing to reinforce skills, techniques and tools. Ongoing supervision, unannounced observation of calls, and analysis of data collected on call outcomes will be used to identify the need for additional training or supervision.

Training Program for Member Services

New MSRs will receive three months of initial training, including instruction from existing, experienced PerformCare member services staff and supervisors from other programs throughout the country. During this time, the MSRs will be assigned to a mentor who will be available for support and as a training resource. For the first two weeks, the MSRs will be involved in an intense orientation program, including review of policies and procedures and mandatory trainings. The next two weeks will include trainings on working with the IT systems and other technologies needed to perform their jobs. The remaining period will include shadowing an experienced MSR followed by progressive experience handling live calls, which are monitored by a supervisor.

In addition to initial and ongoing training (orientation, mandatory program reviews, mandatory instruction, licensure requirements, certification and recertification, etc.) our training focuses primarily on issues that relate to the safety and welfare of members and their families as well as the clinical services we provide to members. Our secondary training priorities include issues affecting customer care and treatment.

The following is an example of the components of the initial training program that will be provided to LBHP MSRs and clinical staff:

- PerformCare information
  - Vision and mission/corporate and program objectives
  - Relationship to the LBHP program

- Overview of the Louisiana Behavioral Health Partnership, including the program's mission, services provided, populations served, and any specific requirements
  - Vision and mission/objectives and history
  - Populations served
  - Scope of services offered
  - Other collaborating state and local agencies
- Overview of the program's structure, including organizational and staffing infrastructure
- Terminology, definitions and acronyms related to managed care, mental health, and the Louisiana Behavioral Health Partnership
- Member Services
  - Objectives
  - Scope of member services
  - Member Services staff responsibilities and role within the member's treatment process
  - Role of other PerformCare staff in meeting member needs and working with Member Services Representatives
  - Performance standards and expectations
  - Responding to member calls and inquiries
  - Responding to grievances and appeals
  - Responding to calls regarding clinical issues (including those from members needing emergency services)
  - One-call resolution model and expectation
  - Educating and providing information to members on their rights and responsibilities
  - Using the CANS assessment tool
- Interviewing skills
- Conflict management and handling difficult callers
- Customer service skills
- Managing warm transfers for clinical, crisis, and other services
- Care Management
  - Objectives
  - Systems of Care approach
  - Care Management services
  - Care Management staff and responsibilities
  - Role of other clinical staff
  - Assessment, triage and referral process
  - Utilization management reviews

- Pre-authorization for services
- Discharge planning and follow-up services
- Denial of services

- Understanding and communicating with special populations
  - Children and adolescents with SED
  - Adults with SMI
  - IV drug users, pregnant women with drug addiction, and parents with drug addiction and young children
  - Elderly
  - Individuals involved with the criminal or juvenile justice systems
  - Persons with developmental disabilities
  - Ethnic minorities
  - Persons with addiction
  - Persons with co-occurring diagnosis
- Information on community services and resources
- Confidentiality and HIPAA regulations
- Cultural diversity and sensitivity

In addition to the above training, PerformCare ensures that staff who offer clinical services for members complete a comprehensive training curriculum that ensures that staff

- Remain current in the most recent evidence-based practices in behavioral health
- Provide timely and appropriate management of all emergency and urgent cases
- Provide appropriate and effective management of all utilization management services
- Understand and can respond to the needs of the special populations

Trainings will be augmented with routine and annual trainings focused on increasing MSR skills and understanding. The annual trainings will, in part, focus on reviewing pertinent information related to providing services to all callers. Basic program components, especially confidentiality of member information, member rights and responsibilities, first call resolution, grievance and appeals process, and customer service tenets will be reviewed. Additionally, any changes in policies and procedures made during the previous year that impacts the delivery of services will also be reviewed. Please refer to **Appendix 2** for sample member services training materials.

Additional regular trainings will include cultural sensitivity, responding to the needs of all callers, including those with special needs, understanding the CSoC, the role of the WAAs and the FSOs, as well as increasing their understanding of the WF model and any other issues that pertain to providing high quality and responsive member services. We will utilize any issues identified through program evaluation and a review of complaints and grievances as basis for routine training. Additionally, we will include MSRs in the clinical training that we will provide to the Care Management staff with the goal of increasing the MSR's understanding of the behavioral health issues and needs of our members.

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

Our MSRs will respond to all callers to ensure a common single point contact, and to meet the caller's needs by following a first call resolution approach. We assure that all callers are provided accurate information that fully address their needs through training described above, call reason, call functionality, performance monitoring and use of performance data, and workforce management. Other than the training strategy described above, each of these strategies are described below.

First Call Resolution Script

1. The MSR responds to the call: *"Good morning, thank you for calling the Louisiana Behavioral Health Partnership. This is Shana. How may I assist you?"*
2. The MSR responds to the caller's inquiries and resolves the issue.
3. The MSR ends the call by asking if she has responded to all of the caller's inquiries and if there are any other needs she could address. The MSR ends the call with *"Please feel free to contact us if you have any other questions or concerns."*

   OR
4. If additional follow up is needed, the MSR will provide the caller with that information. *"I will follow-up with XX department and will contact you with a final answer. What would be a good number and time for me to contact you?"*

PerformCare expects that all MSRs will address caller needs in that first phone call, eliminating the need for callers to follow up. Proven policies and procedures will be implemented to manage how calls must be answered and the role of MSRs in providing accurate and timely information. These policies and procedures will also define how MSRs will address member needs, transfer calls to appropriate persons within PerformCare, and ensure timely follow-up of any calls that require additional intervention. These policies and procedures are currently in place for all of our current contracts, have been tested to ensure their applicability and will be customized to meet the specific requirements of the LBHP.

To ensure that all staff members are meeting the expectations outlined in our policies and procedures and emphasized during our initial and regular trainings, we have in place procedures to measure the performance of both our call system and the services provided by our staff. We do so through the use of statistical data, workforce management processes, and performance monitoring.

Call Resolution

PerformCare utilizes the Call Reason Call Resolution functionality in our integrated technology platform, referred to as CLARIS, to track and report the reason for all incoming calls associated with a member and the outcome or resolution of that call. The full functionality of CLARIS is described in detail in Section *2.g. Technical Requirements*. Supervisors are able to easily review and monitor this information to assure accuracy and effectiveness through real time reporting and follow up to ensure all calls have been satisfactorily concluded. All calls received in Member Services are assigned a Call Resolution Reason Code by the staff person who completes the call. These disposition codes are used by management for tracking and reporting. Each MSR must complete each of the components listed below in the form. The supervisor can then audit the form to assure that the MSR is answering accurately and effectively. The forms are audited monthly and a formal report is completed. If any issues are detected with an audit they are addressed immediately with staff.

Definitions

Call Reason: Why the caller is calling

- **Access Issue:** Caller inquiring about eligibility of youth

- **Caller Providing Information:** Third party or provider relaying information to register a youth or supplement content in an existing record
- **Follow Up to Treatment Request:** Family, provider, or third party inquiring about an existing authorized service
- **Information Requested**: Requesting information about LBHP but not seeking actual services
- **Other** (we specify reason in Call Reason Comments Box)
- **Out of Home Treatment Request**: Caller requesting out of home (OOH) placement or status about OOH referral previously made
- **Service Request**: Seeking services for new youth or seeking new services for existing youth
- **Technology Question**: Calls pertaining to use of CLARIS or access of information in CLARIS
- **Treatment Plan Inquiry**: Caller inquiring about receipt, review or outcome of a treatment/service plan

Call Resolution: What action took place at the end of the call

- **Contacted Police:** Caller requires urgent police response due to emergency situation
- **Contacted Department of Social Services (for children and adults) or Elderly Protective Services:** Caller required warm transfer to DSS or EPS to report an abuse or /neglect concern
- **Information Documented**: Documented received information
- **Information Provided**: Provided information about the LBHP and CSoC
- **Other**: Information must be specified in Comment Box
- **Provided Service Information & Referral:** Provided information and referral for a service in the community which does not require authorization by the LBHP
- **Referred for Biopsychosocial Assessment:** Facilitated referral for and authorized Needs Assessment/Biopsychosocial
- **Referred to ACT, ICM, Mobile Crisis:** Facilitated referral for ACT, ICM, or mobile crisis services
- **Referred for Psychiatric Screening:** Referred for mental health screening to assess for hospitalization
- **Referred Internally for Resolution:** Referred to specific LBHP department such as QM, Service Desk
- **Referred to Current Provider:** Referred caller to current provider for information, access to services and service acquisition.
- **Contacted/Referred to Louisiana DSS:** Contacted or referred caller to Louisiana DSS to report possible abuse and/or neglect
- **Refused Services:** Caller declined offer for service authorization
- **Registration Completed:** Staff completed registration for new youth
- **Request Processed:** Request for service pertaining to new, modified or suspended authorizations

A Call Resolution Report from our New Jersey contract, which uses the same type of monitoring, is submitted as **Appendix 3**.

Performance Monitoring

A PerformCare quality management team monitors individual and department performance measures such as the following individual and departmental goals:

- Individual Goals
  - Adherence to call scripting and protocol
  - Total average call resolution time
  - Average hold time
  - Off the phone time
- Department Goals
  - Answer calls within 30 seconds
  - Meet abandoned rate of calls of not more than 3 percent
  - Service level
  - Trunk usage rate
  - Number of calls in queue

Our audit processes that measure the accuracy and effectiveness of MSRs in answering calls have contributed to consistent high performance in other markets, and will do the same in Louisiana. Our processes, technology and experience have given us the ability and agility to meet and exceed all contractual service level goals as is evidenced by our performance in other markets. For example, in our Pennsylvania HealthChoices program, over 99.9 percent of all calls were answered in 30 seconds with a total abandonment rate of less than 1 percent. These processes allow us to identify and quickly correct service performance issues using intraday performance reports (30 minute interval). For example, when call volume exceeds the forecast and available staff capacity, overflow calls are routed to additional call centers.

Use of Performance Data

In addition to the audits described above, our supervisors routinely monitor MSR responsiveness and performance, including random live call monitoring. PerformCare routinely keeps in-depth statistics for the call centers we operate. Statistics are available every Monday for the previous calendar week to all of our contracting entities. They include summaries by day, week, month, quarter, and year. In addition, monthly reports on individual call center staff are available for review and use by managers and administrators to ensure quality of services delivered. These reports highlight a staff member's strengths and weaknesses, enabling supervisors to provide additional training and education. Reports on both individuals and from the call centers are made available to PerformCare associates, their supervisors, and all interested external stakeholders.

Information routinely tracked includes:

- Total number of incoming calls
- Total number of outbound calls by logged-in staff
- Total number of internal calls by logged-in staff

The New Jersey Children's Systems of Care (CSoC) Experience

- *ensuring the accuracy of information given*
- *proper call transfer*
- *timely response to calls requiring follow up*
- *auditing of calls, supervision, training*
- *use of satisfaction surveys from families and providers*
- *meet or exceed all performance requirements*

- Total, average, and maximum ring times
- Total, average, and maximum talk times
- Percentage of calls answered in under 30 seconds
- Number of abandoned calls and the average time to abandon

In all PerformCare call centers, 99 percent of all calls are answered within 30 seconds and less than 1 percent of all calls are abandoned. We are confident and can assure DHH-OBH that we can meet and exceed the LBHP call hold and call abandonment rate standards. Our ability to do so is in part, due to the processes we have in place for answering calls coming into the call center.

We also report and review the following statistics:

- Number of calls received for intake or direct services for children
- Number of calls by type of caller
- Number of direct dial calls received by the operator
- Number of outbound calls made by the operator
- Number of staff available by time

Work Force Development

The quality of MSR responses are assessed through routine audits performed by the member services supervisor. The audits are designed to assess accuracy, timeliness, accessibility, legibility and completeness. The goal is to evaluate for quality assurance, coaching, training and operational improvements. Please refer to **Appendix 4** for a sample audit form.

Specific quotas for number of calls audited are established. For the first three months of employment for a new hire, three to five calls per week will be monitored. The numbers of calls audited are then reduced to three to five calls per month upon determination of consistent satisfactory performance. Satisfactory performance is determined based upon 90 percent compliance. If MS staff has less than satisfactory ratings the frequency of monitoring will remain or resume at three to five per week until such time the MSR has four consecutive weeks of satisfactory performance.

The MSR receives a monthly report about their individual performance. The MSR Administrator reviews audit findings with staff and addresses performance concerns through regularly scheduled supervision. If unsatisfactory performance persists, the MSR Administrator addresses performance concerns through the disciplinary process. At any time the supervisor may remove a staff person from handling calls due to performance concerns or initiate additional training such as one-to-one coaching conducted side by side, call monitoring by peers or policy procedure review.

The MSR Administrator regularly conducts audits as a method for supervision and monitoring staff performance. Additionally, members of the senior management team may monitor calls on an ad hoc basis. The MSR Administrator meets weekly with Member Services staff at a department level, during which time quality improvement findings are reviewed, changes or refined processes are presented and instructions are given. These meetings present an opportunity for open dialogue to receive feedback, foster discussion, and provide understanding. The MSR Supervisor meets with staff on a one-to-one basis for supervision to address strengths and areas for development. The supervisor is also located directly on the call center floor to directly observe call center performance activity and serve as an immediate resource for information or consultation when a MSR requires support.

vi. Describe the member experience when calling the member services line and the transition to care managers.

"I have been consistently impressed with the responsiveness and dedication on all levels of the staff at CBHNP [PerformCare]. They have been nothing but helpful over the four plus years that I have been dealing with them regarding my son's care, even to the point of contacting the provider on our behalf when they were not handling things appropriately. "

- TSD, Harrisburg

"Very simply, CBHNP makes it very easy to navigate the system... CBHNP helped me help a family find services for their children and helped them in a timely manner."

- D.W., Community Advocate

When a member calls the toll-free line, the call will be answered by a fully trained MSR who will introduce him or herself and inquire about the member's needs. If the member requires assistance in a language other than English, the MSR will either assist the member in that language (if they have that capability), will find an MSR who speaks that language, or utilize the Language Line in order to communicate with the member in their language.

At all times the MSR will treat a member with respect and reassurance, empowering the member to actively engage in service selection.

On each contact, the MSR will take the opportunity to review the member's contact information to ensure its accuracy. If updated information is not available, the MSR will obtain the following information from the member:

- Member's name and basic demographic information
- Insurance information (including Medicaid eligibility)
- Current services received, including provider name and type of service
- Emergency contact information

The MSR will then obtain further information about the member's needs and attempt to resolve the member's issue within that first call.

The MSR will conduct a brief crisis assessment with the caller to determine if there is an urgent or emergent issue requiring an immediate referral for crisis services or a warm-transfer to a Clinical Care Manager (CM). For adults, based on the results of the initial assessment, we will refer the adult to a culturally appropriate provider within the identified level of care.

For children and youth, we will use the CANS-Brief version to conduct a telephonic assessment to determine if the child/youth is eligible for the Coordinated System of Care (CSoC). If the child is eligible for the CSoC and the family/caregiver resides in a region that has a WAA, the MSR will refer the child/youth and his/her family/caregiver to the WAA and to an independent evaluator for completion of the CANS–Comprehensive assessment. The WAA is responsible for engaging the child and family teams, referring to the Family Support Organization (FSO), developing an individual plan of care (POC), and access to medically necessary services. The MSR will also refer the member and his/her family to the FSO, if a WAA is not available in the member's region, for family support during the process.

When a member presents with complex clinical needs, the MSR will warm transfer the member to the Care Manager (CM) who will assess the member as to their clinical condition or situation. Members who present with complex needs include those with special mental health care or substance abuse treatment conditions, such as individual who are IV drug users, pregnant substance abuse users, substance-using women with dependent children or with co-occurring disorders, children with behavioral health needs in

contact with other child serving systems who are not eligible for CSoC, children eligible for CSoC, and adults eligible for the 1915(i) HCBS services. More information about the care management process is provided in section *2.b. Care Management*.

> *"CBHNP has overseen the Behavioral Health services in my area since the first day my son was diagnosed on the Autism Spectrum, and we began receiving services. I have had multiple dealings with the staff over the last five years and they have always been willing to work with me, listen to my feedback, and most of all support me when my service provider was not delivering services as prescribed for my son. Whenever there have been problems, I have always been able to pick up the phone and receive help from a CBHNP employee as needed... CBHNP has always been there when my family has needed them and I truly appreciate all their efforts."*
>
> - *M.H., Mother of a 9 year old with PDD-NOS*

For members who call regarding a non-clinical issue, the MSR will take the following routes:

- For all eligibility questions, the MSR will assist the member by providing information, including documents needed to demonstrate eligibility for the services.
- For members seeking a routine provider referral, the MSR will assist the member in locating and referring the member to a provider who can meet the member's clinical and cultural needs.
- For all programmatic questions, the MSR will have detailed information about the program, services offered, how to access services, and other related matters that s/he will provide to the member. This could be provided as a telephone consultation, referral to the member website, mailing members additional information, or referring member to additional services.
- For any grievances and appeals, the MSR will gather and document the necessary information and provide the member with details on the grievance and appeals process. The MSR will be trained and able to provide the member with information on their rights and responsibilities, differentiate and assist members with grievance and appeals issues and will be able to warm transfer members to appropriate staff, should that be needed.
- For any other issues or questions, the MSR will attempt to respond to the question. If the MSR is unable to resolve the issue, the MSR will obtain the member's contact information and will follow-up with the member once s/he has obtained the necessary information.

Additionally, MSRs will be available to provide members with information about their rights and responsibilities, accessing services, scope of services, working with community programs and services, and availability of written materials.

At the conclusion of the call, the MSR will ensure that s/he has responded to the member's needs and will document the call and any actions taken in the member's record. The MSR will also ensure that the member has information on contacting the program in the future, if needed.

Please refer to the flow chart provided in response to the following question for a graphical depiction of this process.

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

Transitioning Adult Members

The first point of contact for a caller is through PerformCare's 24/7 Member Services department. When an adult caller contacts PerformCare, the MSR will communicate with the caller to determine the reason for the call and the urgency of the member's needs. Our MSRs are fully trained to complete a brief screening assessment which includes questions to ask the caller if they are having thoughts about harming

themselves or others. If the caller responds affirmatively, or if the MSR determines that there is a potential emergency situation, the MSR will manage the call as an emergency and immediately warm transfer the caller to a CM.

If the MSR determines that the caller's situation is not an emergency, the MSR will discuss with the member their reason for calling. If the member has previously been in or is currently in treatment, the MSR will access data about his treatment services through the shared electronic medical record and will review with the member existing demographic information in the system to ensure its accuracy. In addition, the MSR will obtain additional information about the member's support system, any treatment challenges, cultural and religious preferences, and other issues that should be considered. The next step for the MSR is to determine if the caller is currently involved in care management services. If the caller is active in care management, they will be warm transferred to his assigned CM. If the member is not receiving care management services, the MSR will warm transfer the member to the next available CM department contact for entry into the program.

Once the caller has been transitioned from the Member Services department to care management, the level of urgency determined by the MSR will dictate the process to be followed by the CM.

It should also be noted that PerformCare Member Services and Care Management staff play an important role in educating and ensuring that all members understand their rights and responsibilities. All staff will be trained and updated on these rights and their application. They will be expected to fully understand and be able to educate members about these rights, and to advocate for members. Member Services will be the first point of contact for most members and will be responsible for providing information to members on these rights and responsibilities.

Psychiatric Crisis

When a member contacts PerformCare regarding a psychiatric crisis, the primary role of the CM after the call is transferred from the MSR is to stabilize the member and obtain immediate services for the member. In talking with the member, the CM will attempt to gather as much information about the emergency while also querying and reviewing any information available on the member in the system. The CM will utilize this information to determine any community or natural supports that need to be notified, provider contact, and other related information. During this time, the CM will be supported by a back-up staff member who can assist by making phone calls, identifying community resources, and mobilizing needed crisis or medical services. This is especially important in cases where the member is suicidal or homicidal.

The CM will work with member to obtain needed services either through an emergency room or mobile crisis services. As needed, the CM will contact and request that emergency services such as an ambulance, police, or mobile crisis services be dispatched to the member's location to assist in transporting the member to an appropriate emergency facility. In addition, the CM will contact the emergency facility to notify them of the member's impending arrival, provide any available clinical information, and provide contact information for PerformCare. The CM will also contact the member's provider of record to update the provider and obtain direction on any specific services that the member may require.

Once the member has been evaluated in person (e.g., emergency room) and an intervention has been determined, the CM will assist the emergency facility, member, and family to implement the needed services and to move the member into the appropriate level of care for any needed services. As applicable, we will also conduct follow-up referrals to make sure an appointment is kept or will follow up with the member to determine if additional assistance is needed to maintain the appointment.

Non-Crisis

For routine referrals to care management, the CM will conduct a health risk assessment to determine the member's clinical status and needs. Based on the information obtained, the CM's assessment and the results of the health risk assessment, the CM will make a level of care determination, refer the member for additional needed evaluation services, and/or provide the member with a choice of culturally competent providers. As part of this process, the CM will educate the member about the results of the assessment and resulting recommendations. The CM will provide the member with information about member rights and the importance of being actively involved in treatment planning and decision making. The CM will spend as much time as needed to ensure that the member clearly understands that treatment is focused on him/her and that his/her voice must and should be heard throughout the treatment process.

The CM will provide a choice of providers who meet geographic, cultural, clinical, and other needs. The member or family member can either contact the provider for an appointment directly or can work with the CM to obtain an appointment. As part of this process, the CM will also obtain permission to share the member's information with the provider and to communicate with other provider(s) involved in the member's care, increasing the ability to effectively facilitate care. The CM will also provide the member with any other information and resources (e.g., peer support specialist contact, community programs, state agency information) that may be useful to the member.

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

Transitioning a Family Member/Parent of a Child/Youth

When a family member/parent of a child/youth contacts PerformCare for services, the MSR will ask for verification of the relationship of the caller by requiring three forms of identification, including the child/youth's social security number or Medicaid number, name, and date of birth. Upon verification, the MSR will then ask about the reason for the call and conduct a brief risk assessment of the member's current situation to determine if there is an urgent/emergent issue that needs to be addressed or if the call can be handled through the routine process.

As noted in the section above on transitioning adult callers, PerformCare Member Services and Care Management staff play an important role in educating and ensuring that all members and family members understand their rights and responsibilities.

Psychiatric Crisis

If a family member indicates that the need is emergent or urgent in nature, the MSR will manage the call as an emergency, as described above, and warm transfer it to a CM. If the caller reports that the youth reports active suicidal or homicidal thoughts, or the caller perceives the youth as being at risk of harming himself or others, the call will similarly be warm transferred to a CM who will assess the situation and support the family member or parent in stabilizing the situation and securing emergency services, if needed.

In such a situation, the CM will work to stabilize the child and obtain immediate services for the member and determine any community or natural supports that need to be notified, provider contact, and other related supports. During this time, the CM will be supported by a back-up staff member who can assist by making phone calls, identifying community resources, and mobilizing needed medical services.

The CM will work with family to assist them in obtaining needed services either through an emergency room or mobile crisis services. As needed, the CM will contact and request that emergency services such as an ambulance, police, or mobile crisis services be dispatched to the child/youth location

to assist in transporting the child/youth to an appropriate emergency facility. In addition, the CM will contact the emergency facility to notify them of the child/youth's impending arrival and offer assistance and available clinical information, including contact information for PerformCare. The CM will also contact the child/youth's provider of record to update the provider and obtain direction on any specific services that the member may require.

The CM will assist the emergency facility and family to implement the needed services and to move the member into the appropriate level of care for any needed services once the child/youth has been evaluated by the emergency room. As applicable, we will also conduct follow-up referrals to make sure an appointment is kept or we will follow up with the family members to determine if additional assistance is needed to maintain the appointment.

Non-Crisis

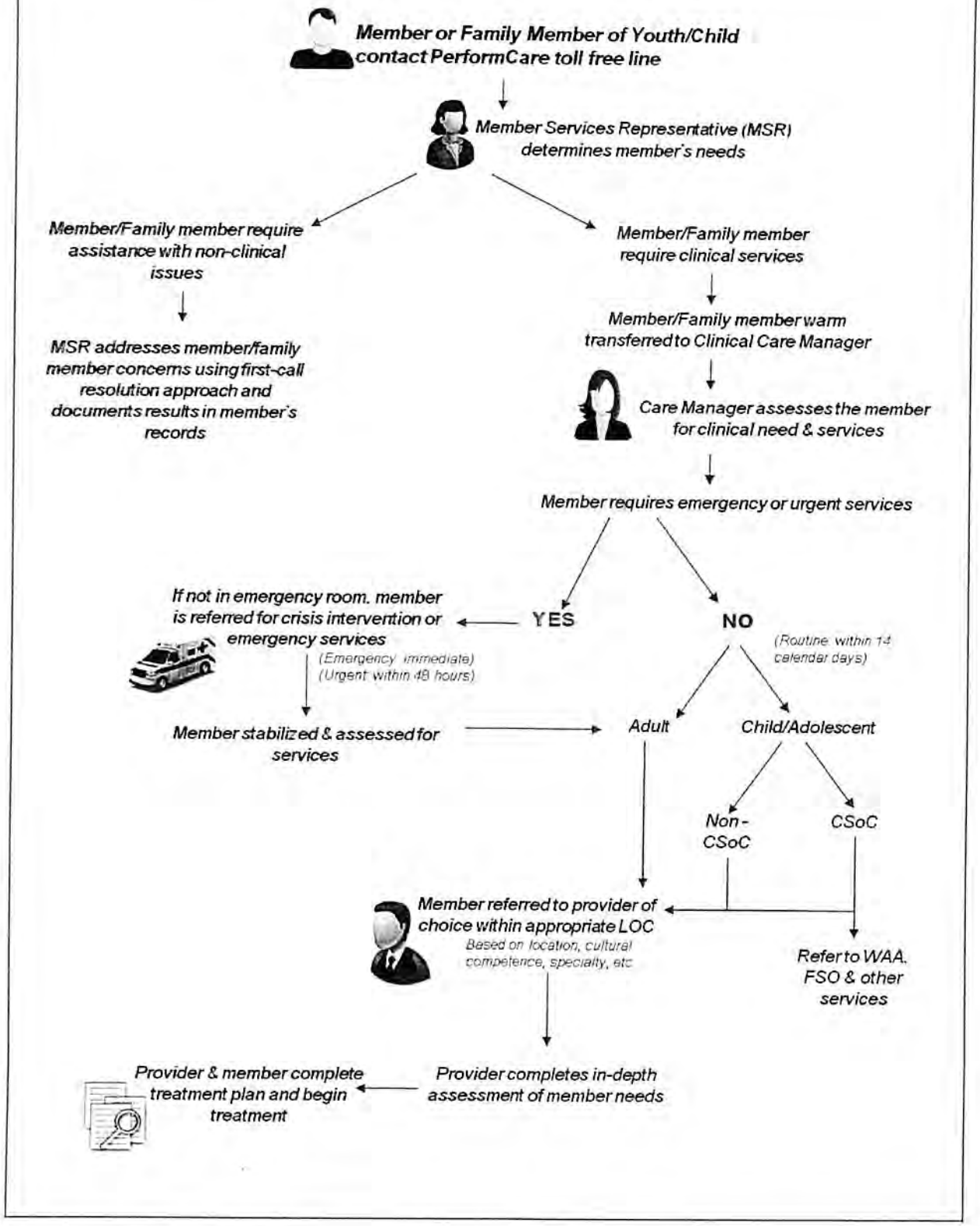
For non urgent calls regarding services for a child/youth, the MSR will complete a brief CANS (Child and Adolescent Needs and Strengths) screening assessment to determine the appropriateness for a referral to a WAA. The CANS is an assessment tool that is used to evaluate children and adolescents in numerous areas of functioning including problem presentation, risk behaviors, functioning, safety, caregiver needs and child strengths. It is used as a decision support tool to provide a structured assessment for treatment referral and planning.

PerformCare will monitor the treatment progress of children in the CSoC through review of the Plan of Care. If the youth does not meet the criteria for a referral to a WAA, the CM will ensure that the member is referred to and has access to services within the timelines defined for the member's current situation and that follow-up treatment plans are developed and monitored.

We will also consider the child/youth's school-based services, involvement with juvenile justice system, any prior out of home placements, the family's ability to address the child/youth's needs, physical health needs, and prior use of wraparound services and system of care services.

Please see the flowchart on the following page for a graphical depiction of the member services transition process.

Member Services Transition Flow Chart



vii. Describe the Proposer's plan to manage and respond to complaints, including the process for logging, tracking and trending complaints, call resolution, or transfer, and staff training.

The first thing PerformCare will do to manage and respond to complaints is to make sure members know they have the right to complain. Information regarding the member's rights to file a complaint, as well as the process for filing the complaint will be widely distributed to members through the following channels:

- Member Handbook (to be distributed at the time of enrollment and thereafter, upon request; redistribution will occur 30 days prior to the implementation of member impacting revisions)
- Member newsletters (at least annually)
- PerformCare's website and/or Member and Provider Portals
- Provider Manual
- Postings within public view in provider offices

Louisiana-based, PerformCare staff will be available 24/7/365 to receive any complaints from members through the toll-free telephone line, or to help members to file a complaint, to respond to any inquiry about the status of a complaint/grievance. Any PerformCare staff person to whom dissatisfaction is expressed, will log the contact, explain the process to the caller, and provide notification to the Quality Coordinator Specialist, specifically trained to handle such inquiries. PerformCare will make accommodations for the filing of a complaint/grievance in alternative formats which include TDD/TTY, use of Louisiana Relay, Braille, tape, computer disk, and others. Language interpreters will be provided at no cost to the member when necessary.

No members will be charged a fee for filing a complaint/grievance at any level of the process. Members will be verbally advised of this information by the PerformCare staff upon filing of any level complaint/grievance.

The Louisiana-based Grievance and Appeals Administrator will be responsible for the implementation and management of the Grievance and Appeals process with the support of a Louisiana-based Quality Coordinator Specialist (dedicated to member grievances). The local staff will be responsible for the day-to-day operation and administration of the process, including the provision of information and instructions to Members.

A log will be maintained by the Grievance and Appeals Unit to capture data required for reporting and tracking the status to assure that the necessary steps are taken within the required timeframes through resolution of each complaint.

Any complaint/grievance that is presented to PerformCare to express dissatisfaction with any matter including, but not limited to the quality of care or services provided, aspects of provider/employee interpersonal relationships, failure to respect member rights, denials or limitations in authorizations (including reduction, suspension or termination), payment denials will be handled in a highly professional manner. Every effort will be made to resolve the concern within a timely manner without the interference of unnecessary barriers.

The logging/tracking of complaints/grievances will be made available through CLARIS, with web-based access through the PerformCare website. Information will be organized in a fashion that will identify whether the concern is presented by a provider or a member, as well as the provider and level of care in question. At the inception, the main categories of concern noted above will be developed as grievance types. The system will allow for notation of filing dates, review dates, and due dates to allow for status reports to be given as needed. In each area, an "other" category will likely exist in order to allow for the filing of any concern which was not otherwise considered. The close review of the

processing of complaints/grievances and a detailed review of this "other" category will allow for the swift identification of additional standard measures to be incorporated, making the process more efficient over time. Another key factor for consideration in the documentation of complaints/grievances relates to the timeliness of resolution and the level of satisfaction for the member and the provider.

PerformCare routinely reviews data to evaluate trends of the grievances process, as part of its Quality Management and Performance Improvement process. Compliance with policy and regulatory and accreditation requirements is also monitored through internal reports and case file reviews.

Once grievance data is gathered, recommendations for improvements in operational performance and targeted training made to the Quality Committee as part of the Quality Management Program Evaluation. The committee will monitor the process for timeliness, evaluate trends, identify root causes, recommend actions, assign accountability for implementation of recommendations, and ensure follow through on approved changes.

Case Example

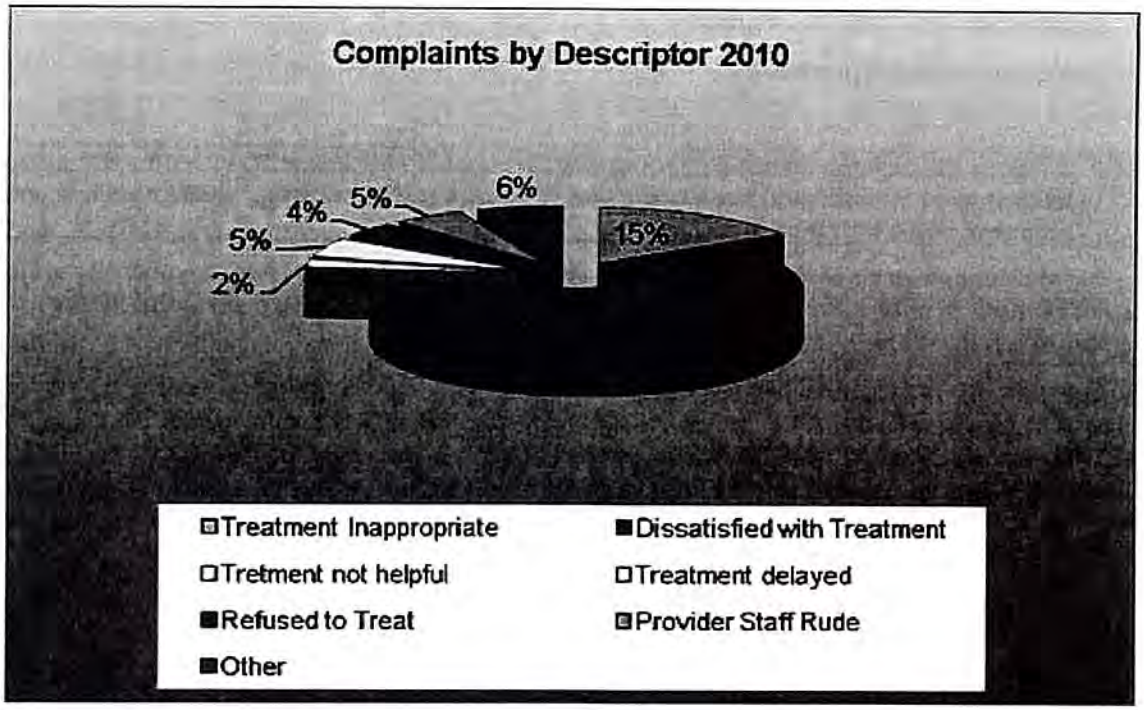
As a result of grievance monitoring, we were able to identify an inpatient facility that was abusing the grievance process. Upon admission, they would have members sign to give facility personnel "authorization for representation". Then, if the initial days authorized were expended and continuation of services was denied, the facility would file a grievance on behalf of the member to earn the benefit of continuation rights which was a standard 10 days for this programs. As attempts were made to schedule the grievance for resolution, facility staff did not make themselves available. When the member was discharged, they would withdraw the grievance. Over a six month period of time, this practice resulted in the filing of 80 grievances, 59 of which were withdrawn (74 percent) and allow the facility to bill for 270 additional inpatient days. In working with the customer, a change made was related to the administration of continuation rights. When a grievance is filed, facilities are now only entitled to an additional three days through continuation rights. This has reduced the number of grievances filed by that facility by more than 50 percent, with $40,000 savings from the facility in one quarter of business.

The information we receive assists us in improving our performance and provides topics for training for our clinical care managers, physicians and psychologist advisors. On a quarterly basis, grievance data is reviewed with the clinical CMs so that relevant topics can be incorporated into the clinical training schedule. In addition, monthly meetings are held with the Chief Medical Officer, behavioral health advisors, and Clinical Managers to review selected appeals to be used for staff training.

PerformCare used this analysis to improve its processes and care of the members. The information of the analysis was provided to key areas, such Utilization Management, Provider Relations and Quality Management to address on an individual resolution basis. Additionally, the analysis was provided to the Quality Management/Utilization Management (QM/UM) Committee to identify and respond to any trends.

The QM/UM committee is provided a series of quarterly trend reports for both grievances and appeals. These reports provide information regarding the number of complaints/grievances by level of care and complaint descriptor; a rolling 12-month trend of the number filed per month; and the top providers involved in the grievance or appeal. These trend reports will serve to identify the need for increased training to PerformCare staff (i.e. claims, authorizations, provider relations), as well as to identify specific providers, levels of care and/or regions of the state which may be in need of more focused training.

The graphic on the following page shows the type of analysis of the complaints received from members for our Pennsylvania HealthChoices contract.



Staff Training on Complaints/Grievances

PerformCare is fully committed to ensuring that employees have initial and ongoing training that allows them to meet member needs in an effective and timely manner. Training for Member Services Representatives includes comprehensive instructions on handling complaints/grievances to quickly and successfully resolve member issues. The Member Services department is the first point of contact for receiving member complaints.

In the event that a member chooses to seek resolution to a concern through the grievance process, the MSR is trained to assist the member to ensure that members fully understand the entire grievance process. MSR are available to assist members who may require help completing forms or need interpreter or TDD/TTY services. MSRs may also provide members with translated materials in the member's preferred language if they are identified as needing grievance information in an alternative format.

Grievance training is augmented with routine and annual trainings focused on increasing MSR skills and understanding the grievance process. The annual trainings will, in part, focus on reviewing pertinent information related to providing services to all callers. Basic program components, especially confidentiality of member information, member rights and responsibilities, first call resolution, grievance and appeals process, and customer service tenets will be reviewed. Additionally, any changes in policies and procedures made during the previous year that impacts the delivery of services will also be reviewed. Compliance with policies and procedures is monitored through routine audits and call monitoring.

Extensive training is given to PerformCare staff in the Quality Management department who are responsible for the processing of grievances.. This training and documentation includes a thorough review of all aspects of the process including:

- The format of grievance meetings with members
- Member and provider rights related to the filing of concerns
- Service eligibility requires and limitations

- Authorization processes and limitations
- Claims processes and limitations

viii. Describe the ongoing monitoring protocols for member services staff, including the nature and frequency of supervision, documentation of audits, call monitoring, quality review, and any other oversight activities.

PerformCare utilizes a variety of methods to monitor the protocols for member services staff. These methods include a random sampling of calls, work force management, aggregate performance analysis, and trend analysis. Each of the methods is discussed below.

Quality Call Observation is implemented to assist with measuring the performance of Member Services Representatives (MSR) to ensure that they are providing services according to established standards and to confirm MSR have the necessary skills to perform their job responsibilities and to identify any areas where additional training might be needed. Call Observation also exists to evaluate the overall quality of customer service being provided and to assist in identifying caller expectations and possible changes that are needed in policies and procedures.

It is important to note that two types of monitoring are conducted on an informal basis. "Side-by-Side" monitoring is conducted as a part of the training and mentoring process for all new MSR within the six-eight weeks training period. This process utilizes a splitter that permits a mentor to hear both sides of the conversation. The mentor and the staff being trained may also switch places allowing the staff being trained to learn by listening to the mentor. "Passive Monitoring" is also conducted on an ongoing basis as Supervisors walk through the MSR area listening to MSR while they are on the phone.

In addition to the live call monitoring process, monthly documentation audits are completed to assess MSR documentation in the areas of accuracy, timeliness, accessibility, legibility and completeness. The goal is to evaluate for quality assurance, coaching, training and operational improvements. Two records per month are audited for those MSR whose tenure with CBHNP is less than six months and continue until satisfactory completion of the Introductory Period. Staff under supervision for performance issues and those who received an overall "Needs Improvement" performance evaluation will also have two records audited per month for the duration of the corrective action plan. On an ongoing basis three records per quarter will be audited for those MSR whose tenure with PerformCare is more than six months and have demonstrated satisfactory or above performance.

An additional type of auditing is built into the daily workflow protocol to monitor MSR performance individually and collectively. The indictors measured include: total inbound calls, abandoned calls, abandonment rate, average time to abandon, calls answered under 30 seconds, calls answered over 30 seconds, maximum wait time, average wait time, and average talk time. This data is used by the supervisor and Administrator to assure that staffing levels are adequate to meet established metrics for responsiveness and quality.

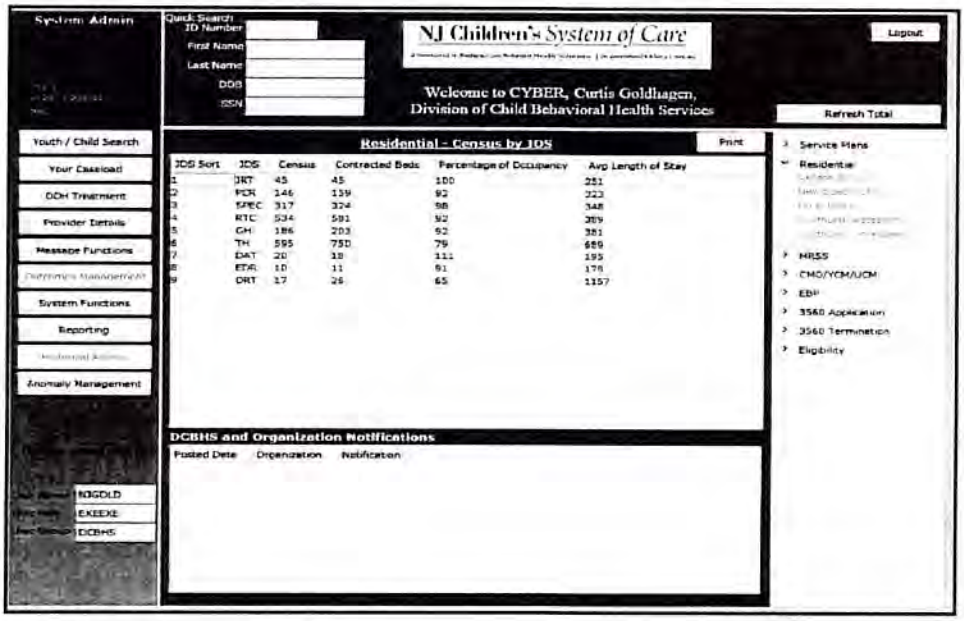
Audit findings are used to track, trend, and report monthly performance at both individual and organization-wide levels. The Quality Management department is responsible for the monitoring and reporting functions. The MSR receives a monthly report about their individual performance. The Supervisor reviews audit findings with staff and addresses performance concerns through regularly scheduled supervision. If unsatisfactory performance persists, the MS Administrator shall address performance concerns through the disciplinary process. At any time the Administrator may remove a staff person from handling calls due to performance concerns or initiate additional training such as one-to-one coaching conducted side by side, call monitoring of peers or policy procedure review. Monthly reports are aggregated and reported to the Quality Management Committee for oversight and assignment of any corrective actions when needed.

An aggregate report is also compiled summarizing the department's performance as a whole. The aggregate performance report is used to assess for opportunities for improvement and to assess effectiveness of improvement activities initiated. Examples for improvement activities may include staff training, policy and procedure refinement and communication, and process flow improvement to address accuracy of information given, use of standardized script, correct verification of callers, completeness of registration, and correct youth search in the database.

Please see **Appendix 5** for sample reports from our HealthChoices Program in Pennsylvania.

ix. Describe how the Proposer's information management system will support member management activities.

PerformCare's robust information management system supports member services activities in a variety of ways. Once a MSR receives a call from the member, the MSR can obtain information about the member in the form of a Welcome Page. An example of the Welcome Page used with the CSoC program in New Jersey is shown below. The Welcome Page consists of a variety of dashboards, and dynamically changes based on the user type. Member Services will have set of dashboards available to them (right hand side of the Welcome Page) that will present them with customized utilization information at a glance that will assist the MSR in helping the member.



Welcome Page

After signing on the MSR chooses which grid they want to view by highlighting any choice in the right side menu, every menu option has a series of dashboards associated with it. All the grids can be exported to various formats that include but are not limited to Excel, PDF, and RTF. The grid being shown is a State-Wide Census by Intensity of Service. These dashboards can be customized to meet Louisiana's specific requirements, which will include a series of utilization management data views and others for member services and other user types. All data presented to the user is limited to the individuals based on their assigned clearance/security level, including the assurance of HIPAA compliance. The example above is logged in a user with statewide access.

Another module in the application that Member Services will have access to is Anomaly Management. There are two access points for anomaly management, the Anomaly Management screen

PerformCare

Behavioral Health Solutions

An AmeriHealth Mercy Company

August 15, 2011

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Director – Quality Management Division
Development Section
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Dear Dr. Comaty:

The AmeriHealth Mercy of Family of Companies, through its companies AmeriHealth Mercy of Louisiana and PerformCare, welcome the opportunity to submit our proposal to the Louisiana Department of Health and Hospitals, Office of Behavioral Health (DHH-OBH) to serve as the Statewide Management Organization (SMO) for the Louisiana Behavioral Health Partnership (LBHP). This proposal is being submitted through AmeriHealth Mercy of Louisiana, Inc. (AML), as a Louisiana-licensed HMO.

AmeriHealth Mercy of Louisiana will be the contract holder with DHH-OBH, and will utilize the considerable behavioral health knowledge and expertise of PerformCare for the management and operations of this program. Unless required for specific legal reasons in answers to a specific question, we use "PerformCare" as collectively referring to AmeriHealth Mercy Family of Companies, AmeriHealth Mercy of Louisiana, and PerformCare of Louisiana in this RFP response. Notably, AmeriHealth Mercy of Louisiana (operating under the trade name "LaCare") was recently recommended for award of a contract by DHH to provide Prepaid Coordinated Care Network (CCN-P) Services in DHH's Geographic Service Areas A, B and C.

Our proposal to DHH-OBH presents a tested successful approach to meeting Louisiana's System Reform Goals as defined for the Louisiana Behavioral Health Partnership:

a) Foster individual, youth and family-driven behavioral health services,

b) Increase access to a fuller array of evidence-based home and community-based services that promote hope, recovery and resilience,

c) Improve quality by establishing and measuring outcomes,

d) Manage costs through the effective utilization of State, federal and local resources,

e) Foster reliance on natural supports that sustain individuals and families in homes and communities.

The proposed PerformCare program will not only meet DHH-OBH's goals and objectives, it will also bring the following capabilities to the SMO:

1. A customized information technology platform that is built on the platform successfully used in the PerformCare New Jersey Children's System of Care (CSoC), a program with many similar features to that of the design in Louisiana. This information system includes distributed technology capabilities that will support activities of Wraparound Agencies and Family Support Organizations, providers of service, as well the State's involved departments and other key program stakeholders.

2. Established relationships with some of Louisiana's largest behavioral health providers and advocates: e.g., LSU, Franciscan Missionaries of Our Lady (including Our Lady of the Lake Hospital), Catholic Charities, United Way, NHS Human Services, Youth Advocate Programs, Resources for Human Development, as well the various local health districts and authorities.

3. Access to the LaCare CCN provider network, which positions us to begin the process of physical and behavioral health integration and collaboration efforts.

4. Over ten (10) years experience managing underwriting risk for adult and children in behavioral health managed care programs in Pennsylvania, and substantial experience in managing adult and child behavioral health care in New Jersey, South Carolina and Indiana – all states that have challenges similar to the recipients covered by this proposal.

5. A commitment to quality as PerformCare (operating as CBHNP in Pennsylvania) holds ***full NCQA accreditation*** as a behavioral health managed care organization (BH-MCO) for Medicaid.

6. A proven track record for successful implementations in a number of states and in a variety of program designs.

PerformCare will operate in Baton Rouge, where we intend to co-locate with LaCare. Our management model emphasizes that decisions will be made locally, with input from stakeholders to support the growth and development of the program and the vision of the LBHP.

In addition to our reputation for delivering high quality, timely, and effective services, PerformCare is recognized for our use of a person-centered model that allows for cross-system collaboration, care coordination, and integrated service offerings. We are also proud of our ability to incorporate recovery and resiliency principles into all of our core offerings, and for our focus on the use of evidence-based practices and a system of care model to meet member needs.

Attestations

AmeriHealth Mercy of Louisiana and PerformCare are pleased to submit the following attestations in response to RFP requirements:

- AmeriHealth Mercy of Louisiana and PerformCare attest that we have no financial, contractual or employment relationship with any employee of the Louisiana Department of Health and Hospitals, or person who was employed at any time between January 1, 2010 and July 29, 2011 by the State of Louisiana and who during that period engaged in the drafting or discussion of this RFP. We also attest that we will not employ or contract with or have a financial relationship with any employee or, between February 1, 2011 and January 1, 2012 with any former employee, of the State of Louisiana who participated in discussions regarding or assisted in the drafting of this RFP.

- AmeriHealth Mercy of Louisiana and PerformCare warrant that we will comply with all state and federal regulations, as they exist at the time of the contract or as subsequently amended.

- AmeriHealth Mercy of Louisiana and PerformCare warrant that each of us, and our respective officers, and employees have no interest and shall not acquire any interest, direct or indirect, which conflicts in any manner or degree with the performance of services hereunder. We will disclose any dual relationships that pose any evident or potential conflicts of interest. We will periodically inquire of our officers and employees concerning such conflicts, and shall inform DHH-OBH promptly of any potential conflict. AmeriHealth Mercy of Louisiana and PerformCare warrant that we will remove any conflict of interest prior to signing the contract with DHH-OBH.

Finally, as an attachment to this letter we are providing a certification from AmeriHealth Mercy Health Plan, as the parent organization of AML, as to meeting the initial minimum necessary capitalization requirement under this RFP.

Thank you for the opportunity to submit this proposal. Please do not hesitate to contact me should you have any questions or require any additional information.

Sincerely,

Michael A. Rashid
President
AmeriHealth Mercy of Louisiana, Inc.
215-937-8400
Michael.Rashid@amerihealthmercy.com

Richard S. Edley, Ph.D.
President and Chief Executive Officer
PerformCare
717-671-6505
Redley@performcare.org

CERTIFICATION

OF

AMERIHEALTH MERCY HEALTH PLAN

The undersigned, Michael A. Rashid, as the President & Chief Executive Officer of AmeriHealth Mercy Health Plan, do hereby certify as follows:

As the parent organization of AmeriHealth Mercy of Louisiana, Inc. (AML), AmeriHealth Mercy Health Plan (AMHP) will provide the initial minimum capitalization necessary for AML to meet the requirements set forth in Louisiana Department of Health & Hospitals Office of Behavioral Health RFP #305PUR-DHHRFP-SMO-OBH. The amount of such funds will be equal to sixty (60) days of estimated payments to AML under the SMO contract, and such funds will be unencumbered, such as by loans subject to repayment.

This requirement will be met within thirty (30) days of the contract award date to AML.

Michael A. Rashid
President & CEO

8/4/11
Date

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Attachments

Appendices

1. INTRODUCTION / ADMINISTRATIVE DATA

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

This proposal is being submitted by AmeriHealth Mercy of Louisiana, Inc. (AML), as a Louisiana-licensed HMO, in conjunction with its sister company PerformCare of Louisiana (PerformCare). Both AML and PerformCare are members of the AmeriHealth Mercy Family of Companies (AmeriHealth Mercy). PerformCare is a behavioral health managed care organization, and provides behavioral health management services to members of organizations within the AmeriHealth Mercy Family of Companies, as well as governmental and private companies not affiliated with AmeriHealth Mercy.

AML will be the contract holder with DHH-OBH, and will utilize the considerable behavioral health knowledge and expertise of PerformCare through a management contract. Unless required for specific legal reasons in answers to a specific question, we will refer to PerformCare as collectively referring to AmeriHealth Mercy Family of Companies, AmeriHealth Mercy of Louisiana, and PerformCare.

Notably, AML was recently recommended for award of a contract with DHH to provide Prepaid Coordinated Care Network (CCN-P) services in DHH's Geographic Service Areas A, B and C.

PerformCare

PerformCare has over 14 years of experience providing behavioral health services to a wide range of populations including those covered under government/public sector funds. During this time, we have successfully implemented numerous programs and touched over 4 million lives, all within the highest standards of quality and timeliness. PerformCare has full accreditation as a BH-MCO for Medicaid with NCQA, and is the only PA based company to have earned this status.

Our success is based on our ability to effectively collaborate with our customers, such as DHH-OBH, to effectively meet program goals while continuously expanding the scope and quality of the services offered. Our success has also been based on our ability to connect members with appropriate providers and services, enabling provider access to evidence-based practice and needed resources, and joining with partners to enhance the availability of employment, housing, transportation, and other services for members and families. **Our mission and our success are about the connections we form and maintain with and on behalf of members.**

PerformCare's history dates back to 1995, when a group of behavioral health providers committed to meeting the needs of Medicaid members whom they had served for numerous years. The behavioral health providers combined their resources

"PerformCare supports the child-centered, strength-based and family focused values and principles of New Jersey's Children's System of Care. They utilize the Child and Adolescent Needs Assessment to determine eligibility into the System of Care and also assist DCBHS in establishing eligibility criteria for all service lines. Their quality indicators and feedback mechanism to the State provides us the information necessary to understand system utilization and service gaps. Furthermore, they work in partnership not only with DCBHS but also with Family Support Organizations, stakeholders, and service providers in the delivery of a coordinated system of care."

\- Jeffrey J. Guenzel, MA, LPC
Director, Division of Child Behavioral Health Services
State of New Jersey
Department of Children & Families

and talents to form an organization, originally called Community Behavioral Health Network of Providers (CBHNP). The organization's first public sector program was the HealthChoices Program in the Capital Area of Pennsylvania. CBHNP (now known as PerformCare) has held this contract for over 10 years. We have since responded to other programs within Pennsylvania and continue to be a strong and collaborative partner of the counties who hold the **HealthChoices** contract with the Commonwealth of Pennsylvania Department of Public Welfare. **PerformCare is the only HealthChoices Behavioral Health Managed Care Organization (BH-MCO) in Pennsylvania that holds full NCQA accreditation for Medicaid.**

Since then, PerformCare has been engaged under numerous other contracts managing the needs of Medicaid populations in **Indiana, South Carolina**, and other states. Most recently, in July 2009, PerformCare was selected as the Contract Systems Administrator for the **Children's System of Care by the New Jersey DCF Division of Child Behavioral Health Services**. Under this program, which is uniquely suited to similarly meet the needs of the Coordinated System of Care (CSoC) in the State of Louisiana, we are assisting New Jersey in enhancing its own children's systems of care program. Our responsibilities include:

- Providing 24-hour, seven-day-a-week customer service/call center support
- Providing utilization management, outlier management, and care coordination
- Coordinating access to services for all children, youth, and young adults
- Facilitating access to specialized services for children, youth, and young adults
- Providing quality and outcomes management and a system measurement program that supports DCBHS' goal to promote best practices and assists the State in assuring compliance with State and federal guidelines
- Implementing a complaints, reconsiderations, and appeals process
- Providing support for provider network development

PerformCare has a highly innovative and customized management information system that offers flexibility, system integration, comprehensive information management, and production of sophisticated and practical management reports. This integrated system is referred to as CLARIS and is described fully in *Section 2.g – Technical Requirements* of this proposal. This system will make the work of those delivering services more efficient and provide them more time to spend with youth and families in service, rather than on data entry. PerformCare is implementing its innovative outcomes management system to help clinicians and youth/families receiving services understand the effectiveness of treatment. The CLARIS system is built off of the base platform of CYBER, which is utilized in New Jersey for that successful program.

In addition to the above programs managed in collaboration with state and government entities, we have numerous contracts with various health plans throughout the United States to manage the needs of their members who are covered by Medicaid or Medicare. These programs demonstrate our ability to address the needs of members receiving services through diverse funding streams:

- **Gateway Medicare Advantage Plan** – In January 2006, PerformCare was selected to provide full behavioral health management for Gateway's Medicare Advantage Plan, Medicare Assured℠, a managed care program for dual eligibles in 27 counties in Pennsylvania. Services include: network development, care mangement, utilization management, provider relations, quality management, and member services.
- **Select Health of South Carolina, Inc.** – In May 2008, PerformCare began providing behavioral health care and case management services for Select Health of South Carolina's SCHIP members.

South Carolina later modified its program, and behavioral health services for SCHIP were combined with other Medicaid recipients. As of May, 2011, PerformCare provides behavioral health services to over 215,000 members in South Carolina. PerformCare provides the following BH- MCO functions (member services, utilization management,).

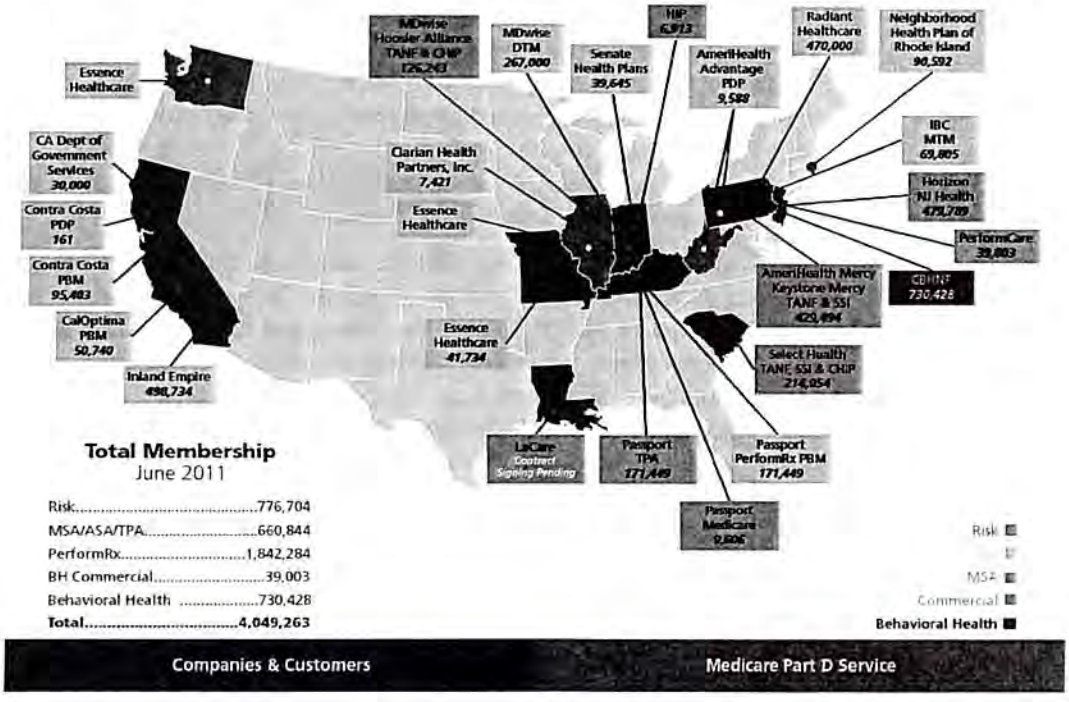
- **MDwise Hoosier Alliance of Indiana** – On January 1, 2009, PerformCare began managing the behavioral health benefits of Indiana's MDwise Hoosier Alliance, a statewide Medicaid Managed Care Organization serving TANF, CHIP, and uninsured adults. PerformCare provides case management, utilization management, and claims payment to over 135,000 members. We also participate in an integrated physical health/behavioral health CM Program.

The AmeriHealth Mercy Family of Companies

AmeriHealth Mercy Family of Companies wanted to strategically position itself to be able to provide integrated care to its members. An important step in providing integrated care was to obtain the expertise of an entity with premier behavioral health management experience. In 2008, PerformCare was acquired by AmeriHealth Mercy Health Plan. PerformCare's mission to serve the Medicaid and underserved populations, its provider member board, and the wide breath of experience of its management team, made PerformCare the perfect organization to add to the AmeriHealth Mercy family.

AmeriHealth Mercy is one of the largest Medicaid managed care organizations in the United States, employing over 2200 employees and touching more than 4 million Medicaid, SCHIP, Medicare and commercial lives nationwide through our managed care, behavioral health, and pharmacy programs. The AmeriHealth Mercy Family of Companies is one of the nation's experts and industry leaders in the delivery of quality health care to low-income populations covered by publicly-funded programs, especially Medicaid. Its mission and values are constructed from their history of connecting the most vulnerable citizens to primary care while providing health care through its network providers and its own health management programs.

AmeriHealth Mercy Family of Companies | *Current Markets*



Understanding Louisiana

The behavioral health service system in Louisiana is unique in valiantly meeting the needs of the hundreds of thousands of people who have lost their homes and livelihood in the face of recent natural disasters and who have come to depend on DHH and its providers for their daily health care needs.

In its wake, Hurricane Katrina alone left nearly 1,900 people dead and total property damages in excess of $81 billion dollars. The health care system in Louisiana was similarly damaged, with the sudden closure of hospitals, residential facilities, and behavioral health providers who did not have the resources or staff to address the needs of their regular and new members. Today, five years later, thousands of Louisianans continue to be displaced, living in temporary accommodations, attempting to live as normal a life as possible despite the havoc that has been caused in their lives. The health care system is also attempting to build upon its existing infrastructure and DHH should be commended for the vigilance and commitment with which it has addressed the needs of the diverse and ever-expanding populations it serves.

PerformCare corporate CEO (far left) and other AmeriHealth Mercy and PerformCare staff preparing to assist in renovations in St. Bernard Parish following Hurricane Katrina.

This Louisiana system, however, has been heavily reliant on a network of state managed and funded agencies along with an array of disconnected local, private providers delivering mental health, addictions, and rehabilitation services to adults and children. This service system can be described as traditional; relying heavily on costly emergency room, inpatient and residential levels of care, the juvenile justice system, crisis management, and rehabilitation services with little emphasis on family support and consumer involvement. The State's current plan is to "right size" the mental health system for children and youth with significant behavioral health challenges or co-occurring disorders at risk for out-of-home placement, other children and youth with serious emotional disorders (SED) and adults with serious mental illness (SMI) and addiction disorders by creating a system of "coordinated" care across the state. Key attributes of this system will be that it is person-centered, consumer and family focused and driven, supportive of resiliency and recovery models, and consistent with national models of care and Evidence Based Practices (EBPs).

In assessing the needs in Louisiana and in developing effective solutions, the PerformCare Louisiana team will benefit from the expertise and knowledge of Dr. Kenneth Thompson, who will serve as PerformCare's Interim Chief Medical Officer for the LBHP. Dr. Thompson, whose resume is submitted as **Appendix 35**, has long-standing experience providing services to children, youth, and adults with behavioral health problems. Dr. Thompson also served as Medical Advisor to Dr. Kathryn Power, Director of the Substance Abuse and Mental Health Services Administration (SAMHSA) Center for Mental Health Services (CMHS). In this capacity, he was responsible for consulting with and providing oversight of the Louisiana Spirit Crisis Counseling Response Program following the disasters of Katrina and Rita. His additional responsibilities included:

- Co-Chairing the Federal Workgroup on Primary Care Mental Health Integration.
- Conducting extensive national speaking tours and participating in national meetings on mental health policy.
- Consulting on the development of CMHS/SAMHSA policies and programs.
- Serving as a representative of SAMHSA on the Health and Human Services Multiple Co-morbidities Workgroup.
- Serving as a member of the clinical leads group of the International Initiative on Mental Health Leadership.
- Participating in SAMHSA's global health activities.

Dr. Thompson is pleased to bring this expertise and his passion for the State of Louisiana and its resident to the LBHP program.

> ***"While working in my capacity as the Medical Director for the Center for Mental Health Services within the Substance Abuse and Mental Health Administration, I had the pleasure to work with many people in Louisiana engaged in addressing the disasters of Katrina, Rita and the Deepwater Horizon oil spill during 2007-2010. I was able to visit Louisiana many times, maintaining close ties with community leadership. While there it became very clear to me that the citizens of Louisiana would be better served by having improvements in their publicly funded behavioral health care.***
>
> ***I am greatly looking forward to working with PerformCare in seeing these and other important initiatives progress and come to fruition in Louisiana."***
>
> - Kenneth S. Thompson, MD
> Interim Chief Medical Officer, PerformCare of LA,
> past-Associate Director for Medical Affairs,
> CMS/SAMHSA

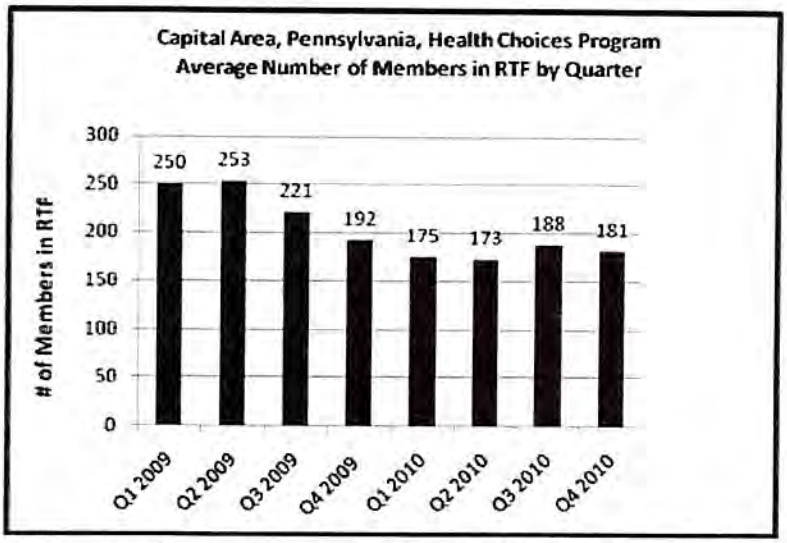
Program Goals

Understandably, in the aftermath of Hurricane Katrina, Louisiana has ranked poorly in national behavioral health comparisons. Despite the fact that fewer than 5 percent of children in Louisiana are uninsured, only 7 to 14 percent with behavioral health disorders are receiving the services they need. Yet, DHH has taken the lead in developing and implementing a system of care that will effectively address the needs of the child and youth population by implementing the CSoC and seeking a vendor who can assist them in formulating the plans and fully implementing this program for this vulnerable population.

The following are goals set forth for Louisiana in this proposal:

- *Coordinate system:* PerformCare can assist in developing a clear single vision for how the state serves children and adults with significant behavioral health challenges.
- *Improve financial investment:* PerformCare will assist the state in better leveraging and maximizing state tax dollars. For example, Louisiana has a history of spending more on institutional care per capita and continues to rely less on community based services than many other states in the nation. We applaud Louisiana's efforts to obtain federal and state waivers to develop and increase access to community-based services for its members. Given our successful history of developing such approaches in other programs, we look forward to working with DHH to expand this service category and have already identified numerous providers who have committed to work with us on these types of enhancements.
- *Expansion of Services:* PerformCare will work with the State of Louisiana to enhance the use of best practices, both within specific geographic regions and statewide. We will work with DHH-OBH to develop and provide access to the following services for members:
    - Youth in or at-risk of placement (CSoC) – Once approved by CMS, the following 1915(c) will be available to eligible youth and families: youth support and training, family support and training, individual living/skills building, short term respite, and crisis stabilization. This will enable the State of Louisiana to serve additional members.

- Medicaid and non-Medicaid eligible adults and children – DHH-OBH is making significant strides in helping Louisiana Medicaid recipients by making the following services available:
  - Assessment and diagnosis, treatment planning, mental health consultation, home based services, outpatient psychotherapy, Medicaid management, day treatment/partial hospitalization, crisis services, and behavioral health services.
  - Therapeutic group homes, residential treatment facilities (RTF), inpatient hospital services, transportation, and addictive disorder services. Note that the chart to the right shows the decrease in RTF use in our Capital Area (PA) HealthChoices program over time. The slight increase in recent years was due to a transformation in PA whereby Children and Youth services were rolled into the program, including Out-of-Home placements. This assisted the State in federal matching dollars while decreasing use of such placements. The fact that the RTF use was kept relatively flat during that period was a major accomplishment.



  - Expansion services offered by licensed Psychologists, Medical Psychologists, Clinical Social Workers, Professional Counselors, Marital and Family Therapists, Addiction Counselors, and Advanced Practice Registered nurses. These services include: individual psychotherapy, behavior modification, supportive counseling/therapy, interactive psychotherapy, including play therapy, when indicated.

- *Improved outcomes:* PerformCare will work with DHH-OBH to make sure individuals with behavioral health conditions have timely access to quality recovery and resiliency-based treatment and services, within their community and home settings. Our collaboration efforts are based on experience gleaned from the forward management of the skyrocketing number of members who were presenting for behavioral health rehabilitation services at our HealthChoices program in Pennsylvania. Over a three-year period, we experienced more than a 100 percent increase in the number of members presenting to receive these services. As illustrated below, we moved from 2,072 children in need of this service to 4,282 children in a two-year period. We were able to leverage this 107 percent increase in demand by working extensively to educate our practitioners to modify their prescribing practices, as well as to incorporate active care management strategies to address the needs of target populations such as children under three or over 18 and children within certain diagnostic ranges which are better served in other services. Provider expansion efforts focused on assistance to providers in developing evidence-based alternatives.

Totals	# Children Served	Change in Average # Children Served	#Units Authorized (TSS/MT/BSC)	Average Units Auth'd Per Member
2008 Average per Month	2,072	+252	755,094	287
2009 Average per Month	3,797	+1,726	980,491	258
2010 Average per Month	4,282	+485	1,211,275	246

What PerformCare Offers the State of Louisiana

PerformCare can satisfy and exceed all provisions and goals of Louisiana reform efforts. PerformCare will:

- Assist DHH-OBH in fully **implementing the CSoC** through our significant experience and technological infrastructure, CLARIS, which was specifically developed to support the CSoC effort in the State of Louisiana.
- **Enhance the consumer experience** by fostering reliance on natural supports that sustain individuals and families in homes and communities and providing individual, youth, and family-driven behavioral health services that are evidence-based, such as developing Multi-systemic Therapy (MST) and Functional Family Therapy (FFT).
- **Increase access** to a more complete and effective array of behavioral health services and supports by developing and providing training in evidence-based services and promising home- and community-based services that promote hope, recovery, and resilience.
- **Improve quality of care** through development of sustainable plans of care and outcomes by establishing and routinely measuring clinical and service outcomes.
- **Reduce inappropriate utilization** such as repeat emergency room visits, hospitalizations, out-of-home placements and institutionalizations by use of sophisticated care management and utilization management processes that are imbued with quality monitors. We will build upon our success and use lessons learned from our Pennsylvania HealthChoices program to achieve similar decreases in out-of-home placements for children in Louisiana.
- **Manage costs** through effective utilization of State, federal, and local resources by use of state-of-the-art information technology to track and manage care for multiple benefit packages to ensure services are matched to needs and cost contained as well as insure compliance with federal rules for Medicaid that require close attention to the member.

The Statewide Management Organization – A Partner to DHH-OBH

The State is presently working towards implementing a Coordinated System of Care for children, youth and their families/caregivers that will be managed by the Statewide Management Organization (SMO). This approach is family and youth driven and uses wraparound facilitation (WF) provided by Children and Family Teams (CFTs). WF is characterized by intensive, individualized care planning and management processes. Wraparound facilitation will be provided by wraparound agencies referred to as WAAs. Another key element is serving non-CSoC eligible children and youth within an effective and coordinated service system. The current plan recognizes the high prevalence of co-occurring mental and addictive disorders and calls for a true integration of mental health and addiction care.

1. INTRODUCTION / ADMINISTRATIVE DATA

Providers of behavioral health and addictions services are at varying levels of integrating these services. Some providers in Louisiana were the recipient of SAMHSA Co-occurring Disorders Integration Grants (COSIG) starting in 2002. These providers have made real progress toward the goal of integrating mental health and substance abuse care and may be used as model programs. Other clinic providers have moved each of these services (mental health and substance abuse) to the same location; this co-location approach does not necessarily result in integrated care. The service delivery system must and will be data driven to continually measure and improve outcomes, quality, and accountability.

> *"The Franciscan Missionaries of Our Lady Health System is in full support of the successful solution that AmeriHealth Mercy [PerformCare] is proposing to the Louisiana Department of Health and Hospitals for their program. Through numerous discussions with representatives of PerformCare and AmeriHealth Mercy, we have confirmed they are sensitive to regional and cultural issues of Louisiana residents and will provide a creative and proven approach to reforming our Medicaid services delivery system. The strategic goals and mission-driven culture of PerformCare and AmeriHealth Mercy are important perspectives our organizations share."*
>
> - John Finan
> President & CEO, FMOLLHS

The SMO plays a key role in the State's reform goals by creating and maintaining coordinated and effective community-based services. As a provider-founded organization, PerformCare is uniquely positioned to attain these goals through the creation of partnerships with both public and private providers in a multi-agency system of services. We have a long history of providing the resources and tools that providers require to deliver effective services. This includes extensive training with providers to operate within a managed and coordinated care system, regardless of the populations they must serve. PerformCare plans to build on the successes of earlier Louisiana initiatives to develop systems of care such as Louisiana Youth Enhanced Services (YES) and we embrace the same principles under which they operate:

- Access to comprehensive services
- Individualized services
- Least restrictive environments
- Family participants in all aspects of service planning and delivery that incorporate culturally competent practices
- Improved access to integrated services and systems of care
- Care management services for all children
- Early identification and intervention of children's problems
- Transitioning youth into adulthood
- Protecting the rights of service recipients
- Non-discriminatory services
- Continuous evaluation of the effectiveness of the system of care and its component services

PerformCare plans to join with community partners to work with families and youth addressing children's mental health. Critical collaboration partners include mental health, juvenile justice, child welfare, education, health, and human services (social services) areas. Service integration may start in family courts or in schools, or from a wide variety of other community portals. Services are characterized by coordination, multi-disciplinary teams, comprehensive array of services, community-based, culturally

and linguistically competent, evidence-based, and outcome oriented. This "wraparound" approach itself is an evidence-based model developed from national evaluations used for all federally funded systems of care. Family involvement is an integral component of our approach to services. This involvement refers to the identification, outreach efforts, and engagement of diverse families receiving system of care services so that their experiences and perspectives collectively drive the planning, implementation, and evaluation of the system of care.

We anticipate a close working relationship with the current array of service providers for individuals with a variety of mental illnesses and addictive disorders. These programs include crisis management, day and social rehabilitation, and family support services. In addition, we anticipate having all current OBH treatment facilities including mental health clinics, mental health rehab provider agencies, specialized inpatient facilities, residential treatment centers such as psychiatric residential treatment facilities (PRTF) and therapeutic group homes and acute units, as part of our provider network. Our network will also include current service delivery for addictive disorders including detoxification, inpatient and outpatient care; the full array of community-based programs such as halfway houses, recovery homes, and therapeutic community services; residential services, and services for women with dependent children. PerformCare will support the continued development of comprehensive health centers in Louisiana public schools through resources and training to foster integration of physical and behavioral health services in these settings.

The values and principles of recovery, self-determination, person-centered, consumer and family driven access, planning, and services provide the foundation for Louisiana's reform efforts. PerformCare will rely on SAMHSA's National Registry for Evidence Based Program's and Practices (NREPP) to appropriately match evidenced based practices (EBP's) to provider organizations, to consumer and family care, and to the service system. A major initiative of our work in LA will be to create systems, programs and services that integrate Trauma Informed Care. Trauma occurs as a result of violence, sexual or physical abuse, neglect, loss, disaster, war, and other emotionally harmful experiences. According to the Adverse Childhood Experiences Study (ACE), almost two-thirds of the study participants reported at least one adverse childhood experience of physical or sexual abuse, neglect, or family dysfunction, and more than one of five reported three or more such experiences.

We know that people who have engaged in the mental health, addictions, and juvenile and criminal justice systems are at higher risk of trauma due to the nature of their illnesses, living conditions, and even their systems of care. We also know that a large population of residents of Louisiana has been impacted by two of the worst natural or human-caused disasters to impact the US: Katrina and the Gulf Coast oil spill. These successive traumas naturally led to increased issues of vulnerability, insecurity, anxiety, depression, and PTSD. Some key elements in fostering resilience and recovery are ensuring that treatment environments feel safe (restraint and seclusion must be reduced or even eliminated), and that members are empowered through education, information, and involvement in their care. Wellness and Recovery Action Plan (WRAP) is recognized by NREPP as a best practice.

The following five key concepts will be used as a model throughout the service system:

- hope
- personal responsibility
- education
- self-advocacy
- support

. It is critical that staff, provider organizations and all involved in the LA systems of care receive education and training in trauma-informed care (TIC) and that care providers, including schools, juvenile justice programs and other child-serving agencies promote an environment that is trauma-informed. PerformCare will accomplish this through leadership and staff development in WRAP and trauma-informed care values, principles and approaches, organizational self-assessments, policies and procedures, and continuous quality improvement efforts.

Becoming a Transformational Partner with the State of Louisiana

PerformCare plans to satisfy the provisions of the RFP scope of work by becoming a transformational partner with the state of Louisiana. Through a partnership with the State, the Local Governing Entities (LGE's), and all other providers of services and care, we will create a shared vision, goals and objectives, design the infrastructure needed to establish effective statewide integration of mental health, addictions, and primary health care, and coordinate child and adult services, and networks.

> *"I have met with representatives from both PerformCare and its sister CCN company, LaCare, and truly appreciate the commitment to improving health outcomes in Louisiana, especially in behavioral health...We envision a positive relationship between our two organizations that will positively benefit the State of Louisiana and those at-risk individuals."*
>
> - Howard Osofsky, MD
> LSU health Sciences Center
> Department of Psychiatry

We will institute the use of credentialing, cross consultation, and positive incentives to reward progress towards goals within a quality improvement framework. The pace of movement toward these goals will be tempered by the need to bring all key players to the table to engage in a dialogue to develop this shared vision and a common set of expectations. As leaders in the community behavioral health system in Louisiana, it is hoped that the LGEs will assist in providing local leadership and partnership with the SMO. While the LGEs will be considered providers within the SMO network, the SMO will be expected to collaborate with the LGEs to explore the development of other community resources consistent with the direction of OBH.

In order to successfully engage key partners in delivering an effective and coordinated system of care, PerformCare will establish regional networking and coordination groups. These networking groups will be comprised of representatives from multiple adult and child-serving agencies and community leaders, families, stakeholders, and providers. The LGEs will be offered the opportunity to play a lead role in implementing these networking groups. PerformCare will support the regional Local Governing Entities by providing education, technical assistance and consultation to assist them with establishing local/regional stakeholder groups such as youth/adult planning boards, learning collaboratives, and crisis community collaboratives. LGEs can assist with the development of successful health home models in collaboration with FQHCs or other local primary health and specialty health providers. This approach has the dual potential for cost savings and improved health and behavioral health outcomes.

Facilitating service engagement and access to care will be another priority for PerformCare. Service engagement must be ensured for high-risk, high-cost individuals and families. LGEs are particularly well poised to provide outreach and connection to services, particularly for youth and adults with multiple disabilities and/or adults who are homeless, in and out of jails and/or emergency rooms and inpatient medical treatment, have no or poor family supports, and other risk factors.

Leadership and staff development will also be a major priority achieved through support, education, consultation, technical assistance, and credentialing. The LGEs can also partner with PerformCare to play a lead role in efforts that will target all service providers and organizations including the CSoC's, WAA's and Family Support Organizations (FSOs). The goal will be to integrate evidence-based practices and trauma-informed care into their organizational structures, treatment approaches and

delivery of services. Efforts will focus on providing training and support to providers of care on evidence-based practices (EBPs) and successfully engaging and serving youth and adults with multiple disabilities, cross-system service needs and risk for hospitalization.

A **sophisticated information technology platform,** with feedback mechanisms to providers, has been established to monitor and continuously improve outcomes and reduce costs. As a good-faith effort and in anticipation of being awarded the Louisiana Behavioral Health Partnership (LBHP) program, PerformCare has expended considerable resources and effort to design and architect a Louisiana-specific information systems solution. This system, called the Coordinated Louisiana Reporting Information System (CLARIS) uses a unique and innovative approach to providing a high-quality, cost-efficient, and person-centered spectrum of behavioral health services to children and adults requiring services through the LBHP. The CLARIS platform leverages the CYBER technology framework currently supporting PerformCare's operations for the New Jersey Children's System of Care to provide the State of Louisiana, DHH-OBH, provider and related care coordination agencies the same exclusive, industry-leading EHR web-based interface for data transfer and access to services. To meet DHH-OBH-specific requirements, the CLARIS platform also incorporates a robust and industry-leading claims-processing and provider network management engine based on the eCura technology platform, which has been in use at PerformCare for over 10 years. The CLARIS platform, seamlessly integrating and extending upon these two best-of-breed technology offerings, is an exclusive, best-in-class information technology solution that uniquely positions PerformCare to serve the individual needs of each stakeholder in the LBHP continuum of care.

Additionally, utilizing the SAMHSA National Outcome Measures (NOMs) will be a key component of our data strategy. The NOMs have a set of 10 measurable outcomes for three areas: mental health services, substance abuse treatment, and substance abuse prevention. SAMHSA's activities and data have determined which outcomes to measure for each NOMs domain. Louisiana data will be measured against these national data outcomes to inform and promote progress toward goals.

Large-scale systems changes require innovative approaches, ongoing support and education, guidance and intensive networking. PerformCare fully understands that achieving change will be a challenge given that many provider organizations have utilized established methods, services, and approaches for many years and that they too suffered setbacks and adversities as a result of the impact of the many natural and human-caused disasters that have impacted the Gulf Coast since 2005.

The metrics of success for systemic change will be defined by a number of measurable outcomes. Network development will be measured by the number of stakeholder groups established, which by the end of the first year should be at least five; by the end of the second year, this number should correlate with the number of regional offices across the state (10). Senior management-level staff of all provider organizations and other key stakeholders, especially families, will be identified in each region and their regular participation in monthly meetings will be expected. A baseline will be taken early in the implementation phase and an increase in the percentage of identified management staff in attendance at each of these meetings will be achieved in the first year; each networking group will establish its own measurable goals. Data on efforts to integrate EBPs and other national models of care, including trauma-informed care by all key providers of care and services, will be collected and analyzed.

These efforts will include staff training and education on identified models, delivered by subject matter experts, staff performance measures, credentialing of staff through defined core competencies related to recovery and resilience models, and trauma-informed care. The percentage of staff credentialed in trauma-informed care and other EBP's will increase from the established baseline by the first year and will further increase by the second year. Consumer and family satisfaction surveys will also be conducted to measure improvements in quality of services. This data will be used by PerformCare, each LGE and networking group to drive progress toward goals. Attainment of goals, such as integration of EBPs, will

prepare provider organizations for accreditation by the Commission on the Accreditation of Rehabilitation Facilities (CARF) and other relevant accrediting organizations. An increase in the numbers of accredited providers of care will demonstrate success and place them at an advantage to attract additional sources of funding.

Support for PerformCare as the Partner of Choice for DHH-OBH

We are confident that we will be a strong and effective partner for DHH-OBH, the State of Louisiana, providers, and the members we serve. We have demonstrated this commitment and our capabilities through the high quality management of our current public sector contracts. Additionally, we have communicated and met with numerous organizations, providers, and stakeholders in Louisiana. Letters of support from the following individuals, who include representation from our current programs, their stakeholders, and Louisiana stakeholders, are provided at the end of this section:

Letters from Current Program Stakeholders

- Jeffrey J. Guenzel, MA, LPC – Director, Division of Child Behavioral Health Services, State of New Jersey, Department of Children and Families (Trenton, NJ)
- Senator M. Joseph Rocks – Chairman & CEO, NHS Human Services (Lafayette Hill, PA and locations in LA)
- Madeline Lozowski – President, New Jersey Alliance of Family Support Organizations (Phillipsburg, NJ)
- Charles Goldstein, LCSW – Chief Executive Officer, CGS Family Partnerships, Inc. (Sewell, NJ)
- Elizabeth A. Manley – CEO, Caring Partners of Morris & Sussex (Mt. Arlington, NJ)
- Marie McCarville – Admissions Coordinator, The Children's Home (Mount Holly, NJ)

Letters from State of Louisiana Stakeholders

- Howard Osofsky, MD – LSU Health Sciences Center, Department of Psychiatry (New Orleans, LA)
- Elmore F. Rigamer, MD, MPA – Medical Director, Catholic Charities Archdiocese of New Orleans (New Orleans, LA)
- Judge Calvin Johnson (ret) – Executive Director, Metropolitan Human Services District (New Orleans, LA)
- Laura A. Jensen – Executive Director, Louisiana Association of Child Care Agencies (LACCA, Metairie, LA)

Milestones

The milestones for success discussed below overlap, to a considerable degree, all populations affected by the State's health care reform initiatives, including a special target population of children eligible for the Coordinated System of Care (CSoC), children in need of services not eligible for the CSoC and adults with serious mental illness (SMI) and addictive disorders. The challenge for all in achieving success is developing the network resources that will be required to provide necessary services. In our response to the Network Management section of the RFP, we describe development activities that will be critical to achieve the desired milestones.

The milestones noted in the narrative below have been developed to offer DHH-OBH a general summary of the activities we plan on implementing within the first two years. Within each of the proposal's subsequent sections, we have further detailed some of these activities and have fully detailed them in *Section 2.i. Implementation.* Examples of milestones in the first year are:

- Number of consumer/peer specialists hired or involved in service delivery;
- Percentage of providers using screening and assessment tools to explore trauma histories;
- Number of leaders and staff trained in trauma-informed care; and
- Increase in policies and procedures reflecting trauma-informed values, principles, and approaches.

By year two, we will expect to see an increase from the baseline in the number of treatment plans reflecting WRAP and trauma-informed principles.

As we implement these milestones, we commit to DHH-OBH that we will improve access to culturally competent, timely, evidence-based, and high quality services by assisting the State in enhancing its provider network and supporting multiple points of access to care. We further commit that we will improve the utilization and care management system to allow providers and PerformCare to offer services that are individualized, member-centric, provided within the least restrictive, most effective level of care and respect member rights and responsibilities. Being a performance-based organization and to show our commitment, we will work closely with DHH-OBH to develop performance incentives that demonstrate that we have achieved the milestones for years one and two.

General Milestones for Children and Youth (CSoC and non-CSoC)

For CSoC Children and Youth

Milestones for year one will include: increase in number of available HCBS, increase in numbers of youth/families utilizing family and peer support services, increase in number of peer specialists hired and engaged with members, decrease by end of year one of children/youth placed in restrictive settings. We will also measure the state's **cost of providing services** and will use the following milestones: increase in number of children/youth screened, identified as at risk, and wraparound plans developed per youth over baseline, decrease in cost per person served per month, decrease in utilization of emergency department and residential services. **Improving quality of care and overall outcomes** for children and their families will also be a metric of success by end of year one. This will be measured by: increase in numbers of children remaining in school, increase in utilization of in-home and community based services, decrease in numbers of children placed in alternative school placements, and increase in satisfaction by youth and families, via member satisfaction survey, with the quality of services provided.

PerformCare will have metrics that begin to focus on those service aspects for this population that are not available to other Medicaid youth. These include:

- Independent living/skill building
- Short-term respite
- Youth and parent support and training
- Crisis stabilization

It will be critical to measure the timely access to services as required for these entities and other service providers. This will be based on the service utilization and criteria parameters established in conjunction with DHH-OBH. In addition to access line data, PerformCare will trend call reason and resolution for all calls. We will monitor and analyze all service plan reviews by type and prescribed time frames. We expect 1,800 youth to receive wraparound facilitation in the first year. Additionally, we will also complete the business and technical specifications for provider outcomes. PerformCare will collaborate to select protocols, such as development and utilization of HCBS, utilization of youth/family support teams, and increase in number of available WAAs and FSOs to members that will be meaningful to stakeholders, including families, provider agencies and clinicians.

According to a recent press release, US Attorney General Eric Holder and Secretary of Education Arne Duncan announced the launch of the Supportive School Discipline Initiative, a collaborative project between the Departments of Justice and Education that will address the "school-to-prison pipeline" and the disciplinary policies and practices that can push students out of school and into the justice system. The initiative aims to support good discipline practices to foster safe and productive learning environments in every classroom. PerformCare, through regional collaboration and stakeholder groups will ensure that all necessary parties have access to needed data regarding these best practices and that these collaboration groups bring together the "right" people to bring about the change in policies and practices needed to improve outcomes.

Implementing Wrap-around principles

- *Family voice and choice*
- *Team-based*
- *Culturally competent*
- *Natural supports*
- *Collaboration*
- *Community-based*
- *Individualized*
- *Strengths based*
- *Persistent*
- *Outcomes-based*

PerformCare will complete all elements of our comprehensive Training Plan that addresses our employees and community providers. This will include an increase in the percentage of child serving staff trained and credentialed in evidence based and best practice models of care such as WF, MST, FFT, and Guiding Good Choices. At the end of the first year, we will conduct and trend family and service desk satisfaction survey results. The annual Network Development Plan will be completed and two performance improvement projects will be identified. We expect to have the Management of Care Plan reviewed and approved.

Based on feedback from Department of Children and Family Services (DCFS) and the level of care assessment conducted, PerformCare will develop a plan for an Out-of-Home network including performance-based contract expectations.

For Non-CSoC Children and Youth

PerformCare will manage the behavioral health services for children not eligible for the CSoC and will promote the utilization of EBP and best practice approaches, improve access to care and the delivery of efficient, high quality services. In order to more efficiently and effectively serve this population, LGE's will be asked to play a key role. Due to their knowledge and relationships with the provider network in each of their regions, they can facilitate collaboration with and connection to local providers of children/youth and family services.

We will expect to measure and improve outcomes that are very similar to those for CSoC children and youth. These will include: **timely access to services; reduction in costs; access to and enrollment in high quality/lower cost services.** Timely access will be measured by utilization criteria. By the end of year one we will expect to see a reduction in wait times for enrollment in services. We will also include non-CSoC provider organizations in all training and development activities and will measure provider and staff competency to deliver services that reflect EBP approaches. Through improvements in staff development and improved coordination of care, with assistance from the LGEs, we will expect to see an increase in the percentage of staff credentialed in EBP and best practice approaches, including trauma-informed care and an increase in the use of lower intensity services and a decrease in inpatient and residential care as compared with the baseline number at the beginning of the year. These outcomes will naturally result in a slight decrease in costs per child per month by the end of year one.

Year One

Our milestones for the first year for both CSoC and non-CSoC children and youth will include:

- Improving appointment access through processes such as increasing network capacity, decreasing wait times, and providing multiple points of access, among others.
- Increasing utilization of family and peer support services by educating members and families about the availability of such services and increasing availability of services.
- Increasing the use of evidence-based and culturally competent in-home and community-based services, such as those we have developed in the HealthChoices Program, such as the MST, FFT, high fidelity wraparound, and community residential rehabilitation services for children.
- Ensuring individualized person and family assessment, planning, and service delivery by incorporating these requirements into provider contracts, trainings, and record audits.
- Increasing improvement in member outcome by using clinician ratings (e.g., Child and Adolescent Needs and Strengths (CANS) assessment shows improved functioning in child risk behavior and child behavioral emotional needs).
- Decreasing emergency department utilization by increasing mobile crisis outreach services, early identification and intervention for at-risk children/adolescents, and increasing use of ICM services.
- Increasing crisis services utilization through the use of mobile crisis outreach services and educating hotline/helpline staff in delivering timely services. PerformCare has worked with multiple counties to consolidate and develop resources to decrease response time and can bring this experience to Louisiana parishes.
- Decreasing admissions to psychiatric inpatient services through facility discharge planning, follow up interventions, enhanced care management of at-risk children, increased family member involvement and use of family "voice and choice," and maximum use of community resources to support the member and family.

Year Two

In year two, PerformCare will support DHH-OBH's plans to complete the phase-in of at least two to three additional WAAs and regional FSOs. Also, in an effort to reduce out-of-home utilization, we will work with DHH-OBH to create community-based services in the developed WAAs. Wait times for residential facilities will be reduced and families/caregivers will be much more involved in placement decisions. We are committed to youth being in the least restrictive setting and reducing the trauma of the placement experience. There will be an emphasis on providing treatment to children and youth closer to their homes and families through an expanded array of evidenced-based in-home and community services that promote hope, recovery, resilience, and trauma-informed care. By year two, we will expect to see a reduction in the utilization of inpatient and residential beds; increases in the numbers of children and youth remaining in school and their family/caregivers home; and a reduction in the number of children/youth entering the juvenile justice system. Baselines will be established in these domains and annual comparisons will be conducted. We will also measure and expect to find an increase in the number of providers and staff credentialed and certified to deliver quality care through the use of EBP approaches.

By year two, we will also ensure that the intensity of service is congruent with the clinical assessments. This includes carefully matching members with Out-of-Home treatment settings. Utilization management for all child serving systems will be implemented.

We will develop data dashboards in conjunction with each of the service line elements and will discuss recommendations for the development of ad hoc reports with stakeholders. The system will allow users to create specific, customized queries for the extract data in real time and for the time needed. This will give providers the flexibility to format reports they choose and offer a wider array of data than what canned reports can offer.

Improving outcomes for children/youth and their families is a major priority of our service delivery model. The metrics of success will include credentialing and certification of providers and staff; satisfaction with services and outcomes via self-reporting and member satisfaction surveys; number of children utilizing high-cost inpatient and residential care rather than available community based services and supports. We will measure and expect to see increases over year one in the number of staff and providers trained and credentialed to provide services that reflect EBP. We will also expect to see higher rates of satisfaction with quality of and involvement in care, and higher rates of enrollment in community based programs and care, including children remaining in schools and reduction in numbers of children/youth residing in restrictive settings such as residential care and juvenile justice system. We expect these efforts and outcomes to further reduce (from year one) the per person cost per month of care.

Our milestones for year two for CSoC and non-CSoC children and youth will include:

- Decreasing use of restrictive settings outside the child's home by fully engaging the FSOs in providing treatment, increasing the use of in-home, mobile, and community based services.
- Decreasing contacts with juvenile justice system by developing processes for collaborating with juvenile justice system, providers, school systems, and other resources.
- Decreasing placements in alternative schools and contacts with foster care by improving methods that schools utilize to discipline children and access to resources that allow treatment within the school setting. We will implement processes and a tracking system for early identification of children in need of services and utilize family support organizations to assist parents who require additional support in managing the child/adolescent's needs within the home setting.
- Improving school attendance and conduct (decrease in school suspensions and expulsions) by providing access to school-based services and access to educational and other resources to support educators and school counselors.
- Maximizing use of natural supports by increasing the involvement of FSOs.
- Increasing the number of persons served in EBPs and promising practices that have been implemented to fidelity by monitoring EBP through provider profiling and quality management activities as well as ongoing provider training.
- Increasing the number of client surveys that indicate improved child/family satisfaction with quality, outcomes and involvement and choice in treatment planning.
- Improving functioning and acquisition of daily living and social skills in home, school and community by developing member-centric plans of care (POC) and ensuring member and family involvement in the treatment process.
- Increasing the number of FSO-based specialists engaged in service to clients by collaborating with the FSOs to offer training and increase workforce capacity.
- Increasing the number of wrap-around plans developed per youth population served by building and utilizing a tracking tool that monitors the availability and use of wraparound services per child/youth and population.

- Ensuring the development and quality of crisis plans included as part of the individual service plan by educating staff and providers about choice and crisis plan development, use of peer specialists in the education and planning process, and educating members and families regarding the use of crisis plans.
- Increasing, over year one, the number of at-risk youth screened and referred to wrap-around agencies by using CANS-brief, identifying high-risk members, and monitoring through the tracking tool.
- Increasing the number of children screened before age six, and, as clinically indicated, have an early intervention service plan in place by coordinating with LaCare and other MCO's EPSDT screening protocols.

General Milestones for Adults with SMI and Addictive Disorders

The integration of mental health and addictions services was started in Louisiana and elsewhere with SAMHSA's Co-occurring Systems Integration Grants (COSIG). These grants helped provide a framework for integration along with an evidence-based curriculum and training to a limited number of organizations. Statewide systems integration is still needed. Each point of contact, including primary care and behavioral health care settings must be prepared to deliver, or facilitate access to integrated care. This will require leadership and staff development in the area of co-occurring principles, values, and approaches. In year one, progress will be measured by the percentage of individuals screened using co-occurring tools and receiving treatment plans specific to co-occurring disorders, and percentage of staff trained by subject matter experts and credentialed through demonstrated competencies. LGE's will be trained and provided with technical assistance and consultation for their role in facilitating these processes. Billing and reimbursement will be designed for integrated services, and quality improvement plans will support and measure these efforts.

Adults with SMI and/or addictive disorders will be served in recovery-oriented, person-centered, consumer- and family-driven, and trauma-informed settings. Use of existing and development of additional Assertive Community Treatment (ACT), Case Management (CM) and Intensive Case Management (ICM) services will be integral to effective outcomes, improvements in quality of care and reductions in spending. Other measurable outcomes include an increase in the number of adults remaining in supportive or independent housing, reductions in level of intensity of services such as urgent care services; and reductions in inpatient and residential beds. By the end of year one, we will expect to see an increase in the number of ACT, ICM, and CM services with a decrease in utilization of high intensity services such as inpatient mental health and substance abuse care. We will also expect decreases in average lengths of stay (ALOS) in inpatient facilities which will translate into a decrease in costs/increase in savings.

Year One

Our goals for year one for adults with SMI will include:

- Implement and actively utilize an effective service utilization management system, inclusive of level-of-care system by introducing Coordinated Louisiana Reporting and Information System (CLARIS), described in *Section. G. Technical Requirements.*
- Ensure a process for easy access to services and providers of service by enhancing the provider network, decreasing wait times, use of the LBHP website, and PerformCare member services, among others.
- Ensure network of competent behavioral health providers credentialed to serve persons with mental, addictive, and co-occurring disorders by implementing the network development plan, detailed in *Section 2.e. Network Management.*

- Promote early identification and intervention of behavioral health needs, including co-occurring disorders, by implementing timely and evidence based assessment and referral processes.
- Reduce duplication of services among agencies through the use of CLARIS and care management processes.
- Improve appointment access by enhancing provider network and implementing effective care management processes, which includes pre-authorization of intensive services.
- Decrease in emergency department utilization by increasing mobile crisis outreach services, early identification and intervention for at-risk adults, and increasing use of ACT and ICM services.
- Decrease in admissions and re-admissions to MH/SA facilities through facility discharge planning, follow-up interventions, enhanced care management of at-risk adults, increased family member involvement and use of member "voice and choice," and maximum use of community resources and peer specialist involvement to support the member and family.
- Decrease in ALOS for intermediate inpatient care through utilization management services and consistent application of medical necessity criteria.
- Increase drug utilization review and identification of BH needs through drug therapy management specific to psychotropic medications and appropriate prescriber education.

Year Two

Throughout year two, the percentage of people screened using co-occurring tools will increase over the baseline as will the percentage of treatment plans reflecting co-occurring approaches to care. There will also be an increase in the percentage of staff credentialed in integrated care and other EBP models as compared with the baseline. In year two, we expect to see a greater increase in these percentages as compared to year one. By the end of year two, using standardized consumer and family self-report surveys, we will measure and expect to see improvements in functioning, reduced symptom severity, and improved quality of life. At this point in time, we will expect to see a measureable increase in the number of community services available such as ACT, ICM, CM and Peer Support. We therefore will expect an increase in the number of members enrolled in these services and a further decrease over year one in the utilization of high intensity/high-cost services, including inpatient mental health and substance abuse and emergency department care.

In order to effectively manage care for adults, PerformCare will ensure transparency and accountability of all functions within the SMO. Feedback mechanisms, both formal and informal, will be developed to assess the effectiveness of our leadership team in ensuring effective communication with all adult consumers, families, and community and government stakeholders. PerformCare will develop, implement and maintain structures that support best practices in treatment and system of care local structures.

Our goals for year two for adults with SMI will include:

- Increase use of lower intensity services, over time, through early and effective intervention by improving access to continuum of care, expanding availability of services, and monitoring under-utilization.
- Improve quality of care by training staff and providers to use EBP, establishing and measuring outcomes, providing staff and providers with feedback regarding services offered, access to peer specialist and an expanded array of services, and ensuring active member involvement in care planning and treatment process.

- Increase in use of claims paid services through provider education and training for such things as proper CPT-coding and working with DHH-OBH on defining Medicaid-eligible service descriptions with the goals of maximizing federal matching dollars.
- Reduce cost of person served, per month through the proper applications of UM and CM processes, high-risk member stratification, and the development of alternative services.
- Improve follow-up after discharge from MH/SA inpatient facility through use of ICM, collaborative discharge and follow-planning, and involving the member in the discharge and follow-up planning.
- Decrease in denied claims through provider education and training and offering updates and information on claims submission through the Provider Portal and direct contact with providers. We also work closely with providers who are submitting inaccurate claims.
- Implement standardized consumer and family self-report surveys demonstrating improved functioning, reduced symptom severity, daily living and social skills, and improved quality of life.

As part of this process, PerformCare proposes to work with DHH-OBH to develop processes for providing incentives to providers and community based services to increase access to services and to re-invest funds into Louisiana communities.

Network Development Milestones

Network Development Milestones for Children and Youth

Year One

- Improve the array of community based services by assuring at least one new service or service expansion in each LGE and parish in the first year with a specific focus on ACT and ICM to decrease admissions to psychiatric inpatient
- Increase availability of family and peer support services
- Provide training and technical support to existing providers to increase in use of evidence-based and culturally competent in-home and community-based services
- Provide training and technical support to existing providers to ensure individualized person and family assessment, planning and service delivery
- Demonstrate improved outcomes through the use of Child and Adolescent Needs and Strengths (CANS) and CANS-brief assessments
- Complete assessment of crisis intervention resources across the State and provide training and support to providers and the community, where necessary, to increase crisis services utilization

Year Two

- Implement services in each region per the regional plan to increase community based services by at least one new service offering or one significant expansion in each LGE and parish to decrease use of restrictive settings outside the child's home
- Provide training and technical support to providers to emphasize the importance of natural supports and maximize the use of such supports and community services (churches, community activities, YMCA)
- Increase the number of persons served in EBPs and promising practices that have been implemented to fidelity and monitor providers adherence to models

- Improve quality by establishing and measuring outcomes and providing regular feedback to providers on their performance and the performance of their peers
- Improve child/family satisfaction with service quality, outcomes and involvement in treatment planning, as demonstrated by member satisfaction surveys
- Increase the number of peer specialists engaged in service to clients served through training and/or coordinating scholarship options for persons interested in pursuing certification.
- Increase the number of wrap-around plans developed per youth served
- Provide training and technical support to providers to emphasize the importance of WRAP and of crisis plans developed and implemented as part of individual service plans and increase the number of such plans
- Increase the number of youth screened, identified as at-risk and referred to wrap-around agency
- Increase the number of children, under age six, assessed and with early intervention service plans developed

Network Development Milestones for Adults with SMI and Addictive Disorders

Year One

- Complete network gap analysis and, as needed, increase community based services with the goal of decreasing admissions and re-admissions to MH/SA facilities
- Ensure a process of easy access to services and providers of service and train providers accordingly
- Ensure network of competent behavioral health providers credentialed to serve persons with mental, addictive and co-occurring disorders
- Provide training and technical support to providers to promote early identification and intervention of behavioral health needs
- Improve appointment access through monitoring and provider relations staff visits

Year Two

- Continue expansion of community based services based on results of gap analysis
- Improve quality by establishing and measuring outcomes and providing regular feedback to providers on their performance and the performance of their peers
- Provide training and technical support to providers to improve follow-up after discharge from MH/SA inpatient facility

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

PerformCare's organizational structure and the work conducted by our staff are interwoven to ensure that members receive a fully integrated and individualized program. Every service that PerformCare

provides is developed and managed to enhance the member's treatment experience and outcomes by forming necessary connections between various departments, entities, and individuals providing services to the member.

Interdepartmental Communication and Collaboration

Clinical services such as assessment, referral, care coordination, and discharge planning are those that impact members most directly. The quality and timeliness of these services, provided under the leadership of our clinical team, is important in meeting member needs. However, the quality and accessibility of these services is not sufficient without the availability of a culturally competent and specialized provider network that uses practices that are recovery and resiliency oriented, evidence-based, and includes the appropriate treatment processes to address member needs. PerformCare's Provider Relations department works closely with our Clinical department to assure the availability of needed services for members and to fill gaps in the service delivery process. They also assume responsibility for credentialing and providing training to providers on practices that are recovery and resiliency-focused, system of care and evidence-based, and include the use of additional treatment modalities.

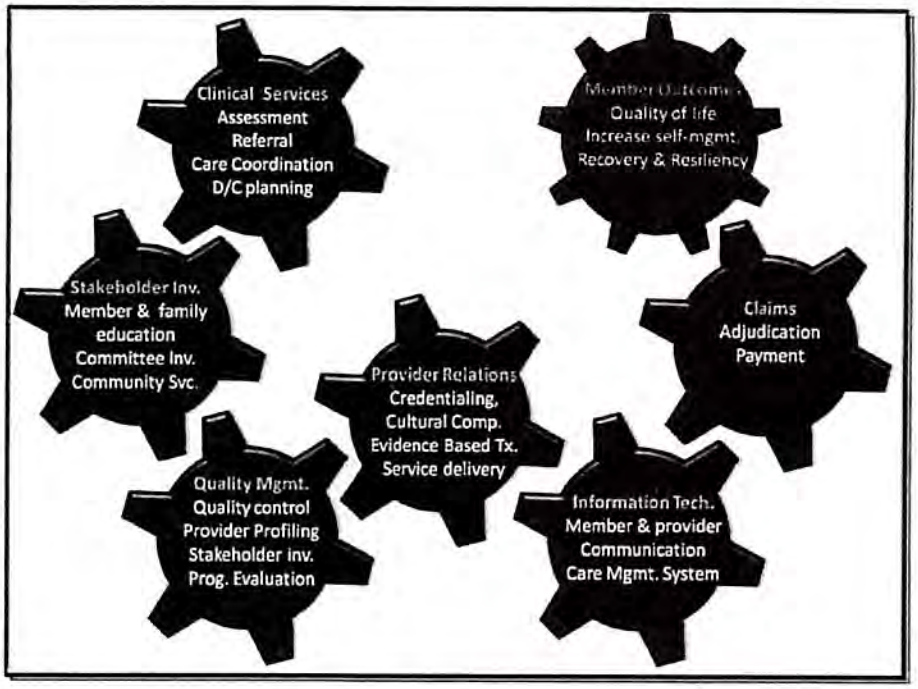
The active and meaningful participation of members, families, and stakeholders in program implementation, development, and quality improvement activity is imperative to achieving the successful implementation and ongoing goals of the program. Members, families, our clients, and other stakeholders offer an essential membership voice on the PerformCare Stakeholder Steering Committee and Quality Management Committees, allowing us to form the right connections with and on behalf of members. The Community Education Manager, who also works with the Network Management and Clinical departments, ensures active outreach to and engagement of members and families at the beginning and throughout the program.

The Quality Management (QM) department takes responsibility for the quality of services provided by PerformCare and works closely with other departments to ensure that PerformCare's high standards of quality and performance are mirrored in every aspect of our organization and service delivery process.

Connections with members, families, and providers involved in the member's care are not possible without a strong information technology infrastructure. PerformCare's CLARIS technology platform serves as the conduit for effective information sharing and is the connection to accommodate the diversity of information and services that we offer through our organization. This platform allows for accurate and timely reporting and claims processing, as well as supports activities that impact PerformCare and our clients' ability to ascertain the program's success and ensure provider satisfaction. As with any other component of our program, these services connect directly with the services that we provide to members and improve their ability to effectively participate in and benefit from treatment. The graphic above demonstrates the connectivity of PerformCare's departments within our organization. These connections are extended to our interface and relationship with our clients and other stakeholders.

Functional Capacity from the Top Down

PerformCare recognizes that local control is essential to any program's success. Though PerformCare's executive and corporate staff will be available to the PerformCare LBHP in a supportive capacity, they will not direct any decisions or operations at the local level. Decisions will be made locally with input from stakeholders to support the growth and development of the program and the vision of the LBHP. Local management will make all local decisions about program operations as they best understand the needs, culture, and history of the State, regions, and members we will be serving.



All decisions regarding the daily administration and overall operations of the LBHP will be made by the PerformCare Louisiana-based staff, under the direction of **Scott Daubert, Ph.D.**, PerformCare's Chief Operations Officer. Dr. Daubert will lead our Louisiana-based implementation and operations until the time when a Chief Executive Officer and team have been hired. Dr. Daubert and the Louisiana-based team will work closely with **Ms. Sonia Madison**, who has been named the Interim Executive Director of AmeriHealth Mercy of Louisiana / LaCare, which was recently recommended for award of a contract with DHH to provide Prepaid Coordinated Care Network (CCN-P) Services in DHH's Geographic Service Areas A, B and C.

PerformCare has worked closely with Ms. Madison over the last several years and has been close to the discussions that grew into the vision for Medicaid reform and CSoC. Ms. Madison is committed to working with PerformCare to ensure that the services offered to LBHP members are within the same high quality standards as those of LaCare.

PerformCare's Management Philosophy

PerformCare's management philosophy is grounded in our comprehensive approach to care and our overall mission and values. We help people:

Toward that end, we have built our services on these values:

- Advocacy
- Care of the poor
- Compassion
- Competence
- Dignity
- Diversity
- Hospitality
- Stewardship

PerformCare's programs include Medicaid risk and non-risk, Medicare Advantage, and varied commercial insurance programs totaling over 4 million covered lives. Our mission is the foundation upon which we build all of our programs and products and enables us to meet the special medical, pharmaceutical, and behavioral health needs of these vulnerable populations, while satisfying complex state and federal requirements. Our programs are sensitive to the multiplicity of needs in the diverse regions and populations we serve.

NCQA has awarded full behavioral health accreditation to PerformCare's Medicaid operations in Pennsylvania and we will ensure that the same level of operations will be implemented in Louisiana. In addition, AmeriHealth Family of Companies has a long history of achieving NCQA accreditation as demonstrated by accreditation for the following programs: Keystone Mercy Health Plan, AmeriHealth Mercy Health Plan and Select Health of South Carolina.

Quality Control

PerformCare's management philosophy is to embed a Continuous Quality Improvement approach into all operations. This approach looks both *outward* to the provider network and *inward* to the provision of services by PerformCare to members and providers. PerformCare is committed to providing the highest quality of behavioral health care services possible to its members by actively supporting each case and provider with appropriate medical decisions by dedicated professionals. PerformCare is committed to a philosophy of Continuous Quality Improvement (CQI) to develop an effective Quality Management (QM) program. This program coordinates activities designed to monitor and ensure high quality administrative and clinical services provided to members. To achieve this goal, the QM/UM program will implement CQI processes commonly used in health care and incorporate National Committee for Quality Assurance (NCQA) standards in its design and operation, as well as standards based upon state regulations, clinical best practices, and ethical guidelines. This philosophy is consistent with the broad objectives of the State of Louisiana to increase access, quality, and financial stability.

The global CQI process used by PerformCare is to first identify the key initiatives of quality care and performance, which then provide the framework for all QM activities of the organization using a balanced and well-integrated quality, cost, and risk perspective. Under each identified goal / objective (which are called Strategic CQI Initiatives), there are multiple indicators (Dimensions of Performance), which form the basis of the annual QM/UM Program

Description and Work Plan. In this way, a consistent structure and philosophy guides PerformCare's continuous quality improvement efforts and is apparent in all QM documentation.

PerformCare will systematically monitor and evaluate the quality and safety of clinical care and the quality of service by PerformCare and network providers with an emphasis on improving member safety. Quality of care is defined as the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The following 10 Strategic CQI Initiatives were developed and can be further customized if needed for the Louisiana programs to provide the focus for all QM activities:

PerformCare Strategic CQI Initiatives

- **Access** – The degree to which appropriate care and services are accessible and obtainable to meet the member's needs.
- **Appropriateness** – The degree to which the care and services provided are relevant to the member's clinical needs, given the current state of knowledge and available resources.
- **Competency** – The degree to which providers and PerformCare staff adhere to professional and/or organizational standards of care and practice.
- **Consumer and Family Involvement** – The degree to which members and families of members have an active role in SMO operations.
- **Continuity and Care Coordination** – The degree to which needed health care services for a member or specified population are coordinated across levels of care, across organizations, or across care of physical health and behavioral health.
- **Diversity and Cultural Competency** – The degree to which providers and PerformCare staff understand and demonstrate respect for differences among groups.
- **Outcomes and Efficacy** – The degree to which a treatment or service improves health status.
- **Prevention and Community Outreach** – The degree to which PerformCare services promote health, prevent deterioration of conditions, and educate the community.
- **Safety** – The degree to which risks of adverse outcome are reduced for the member and others, including the health care provider.
- **Service Excellence** – The degree to which PerformCare meets established service standards and produces provider and member satisfaction.

Professional Practices

The PerformCare management philosophy regarding professional practices by PerformCare, its provider network, and associated state agencies will be focused on three areas:

- Increased delivery of community-based and evidence-based services
- Adherence to Clinical Practice Guidelines
- Consistent application of Medical Necessity Criteria in determination of needed levels of care for members

Our management philosophy in this regard can be summarized as "the right service at the right time and in the right amount."

Supervision

PerformCare provides extensive management training to all managers and supervisors with the full support of local and corporate Human Resources. Our management philosophy is that continuous learning is essential for all employees and that learning is a lifelong commitment. Our goal is to support the mission and strategy of the AmeriHealth Mercy Family of Companies by helping associates excel. We provide development services that help develop the organization -- its people, its processes, and its business. Organizational development is long- term change achieved in a variety of ways, big and small. Our supervisory and development philosophy is summarized in the graphic on the right.

Distribution of Work

A related Human Resources function is that job titles and job descriptions are not an afterthought but are carefully evaluated on an ongoing basis. Ongoing performance evaluation and feedback is an important part of the process to maximize each associate's contribution to organizational goals. Performance LINC (Linking Individual Contributions) is a proprietary performance management process, through which we plan for, and manage, the performance of our business.

The Performance LINC is a four step process:

1. **PLAN**: During this part of the process, annual individual goals are developed and incorporated into the "All-in-One" Performance LINC Form.
2. **COACH**: This is continuous dialogue between the employee and their supervisor/manager regarding their performance relative to expectations outlined during the planning process (Step 1).
3. **EVALUATE**: During this part of the process the supervisor/manager will use the "All-in-One" Performance LINC Form from Step 1 ("Plan") to evaluate and rate employee introductory (initial) and annual performance.
4. **REWARD**: We have a "pay for performance" philosophy so that rewards are based on the rating employees received in Step 3 ("Evaluate"). Most associates are eligible for an annual merit increase and/or bonus based on their individual performance rating and the overall performance of the company. Certain associates may also receive monetary rewards through department and/or corporate recognition programs (such as "Key Contributor").

Communication Systems

PerformCare is able to leverage multiple corporate and local communication systems. First, it is important to note that we are proposing an extensive local office and presence within 10 miles of the DHH office in Baton Rouge. Despite all of our current communication technologies, there is no substitute for personal relationships and face-to-face discussions. The strong local presence will allow for strong communication channels with DHH, providers, state agencies and WAAs. That said, this office will be fully supported by all available AmeriHealth Mercy communication systems including an integrated phone and data network, email and intranet desktop solutions, tele- and video- and Web-conferencing capabilities, and a best-of-breed information system to support their daily work.

PerformCare Staffing and Structure

PerformCare's overall structure is composed of longstanding and highly expert executive staff members who work in tandem with our location-based staff to ensure the delivery of high quality and timely services to members. The staff benefits from advisory and quality management boards and councils that provide feedback on programmatic issues and areas of program enhancement. We have provided information about the executive management team that will be working with DHH-OBH and our Louisiana-based staff in *Section 4 – Personnel Qualifications*. An organizational chart depicting the staffing for the LBHP is submitted on the following page.

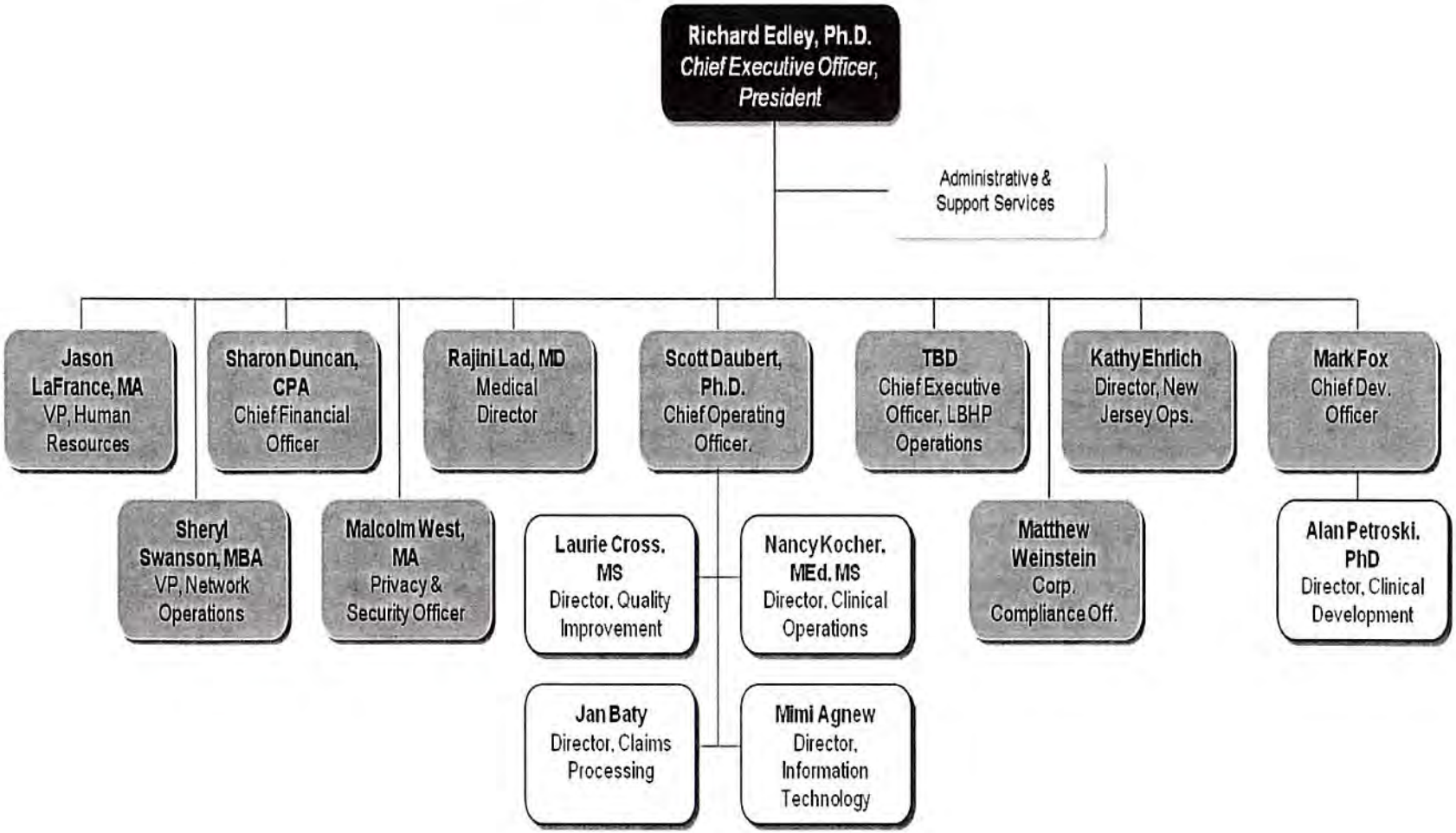
The following table provides a listing of the key, required, and support personnel who will be located in Baton Rouge to support the LBHP.

Key Staff	Required Staff	Support Staff
• Chief Executive Officer • Chief Financial Officer • Chief Medical Officer • Medical Administrator • Chief Operations Officer • Children's System Administrator	• Corporate Compliance Officer • CM/UR Administrator • Quality Management Administrator • Network Development Administrator • Network Management Administrator • Member Services Administrator • Information System Administrator • Claims/Encounter Administrator • Grievance and Appeals Administrator	• Care Managers • Behavioral Health Advisors • Quality Management Staff • Provider Services Staff • Member Services Staff • Grievance and Appeals Staff • Claims Processing Staff • Encounter Processing Staff • Reporting Staff • Data Analysts • Human Resources Staff • Program Liaisons

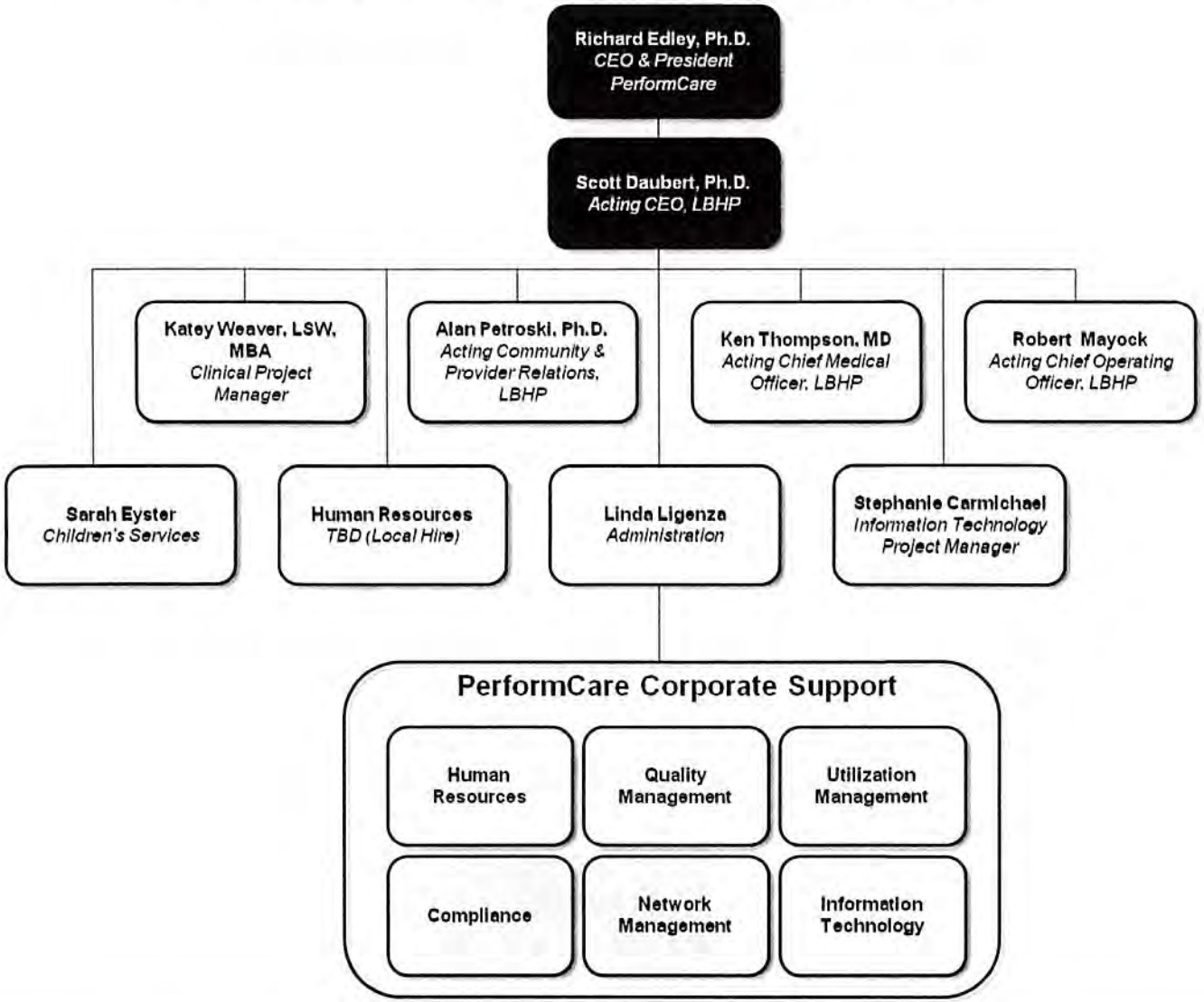
The following organizational charts are submitted on the next pages:

- PerformCare corporate organizational chart
- PerformCare LBHP Implementation Team organizational chart
- PerformCare Louisiana-based LBHP organizational chart

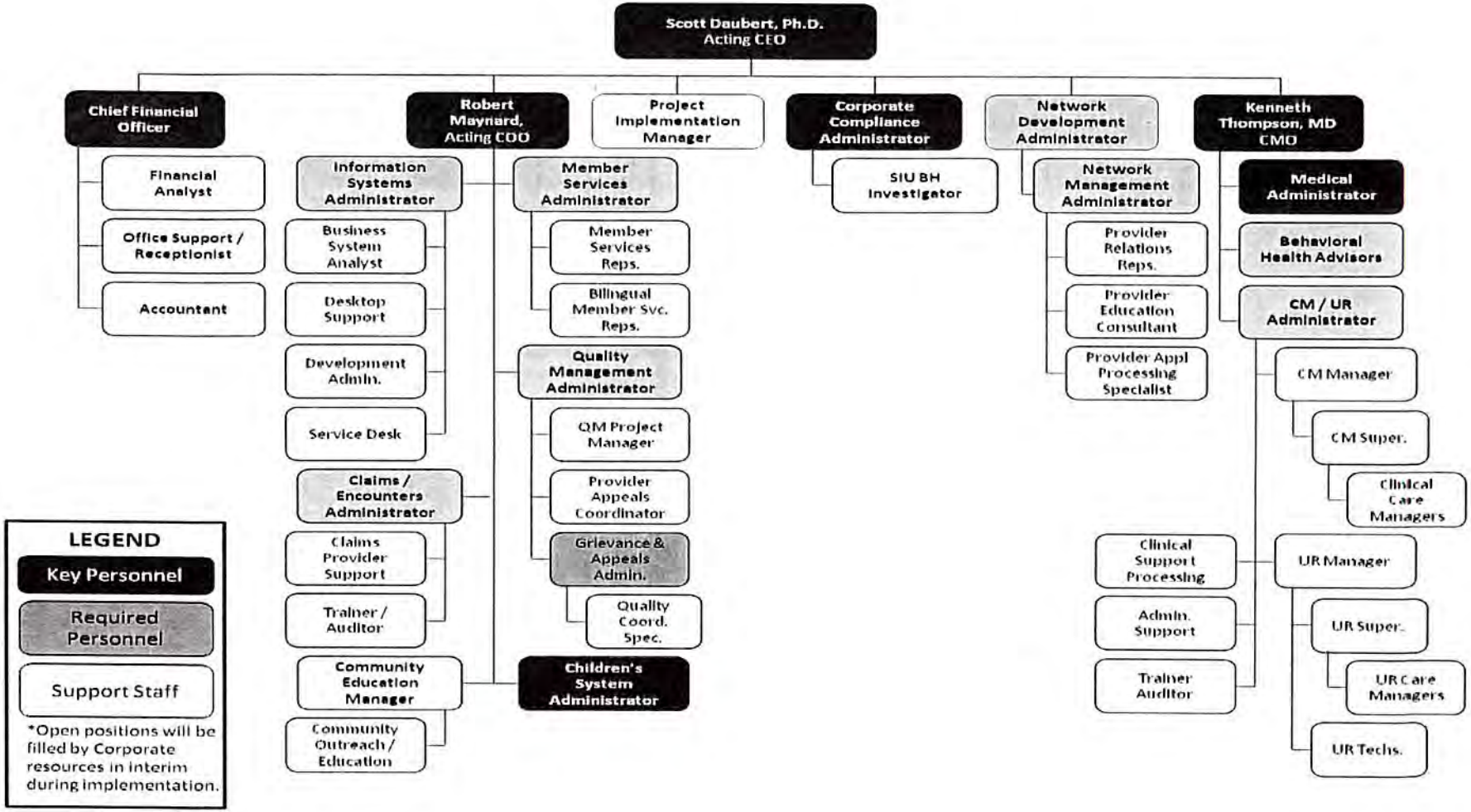
Organizational Chart for PerformCare Corporate



Organizational Chart for PerformCare LBHP Implementation Team

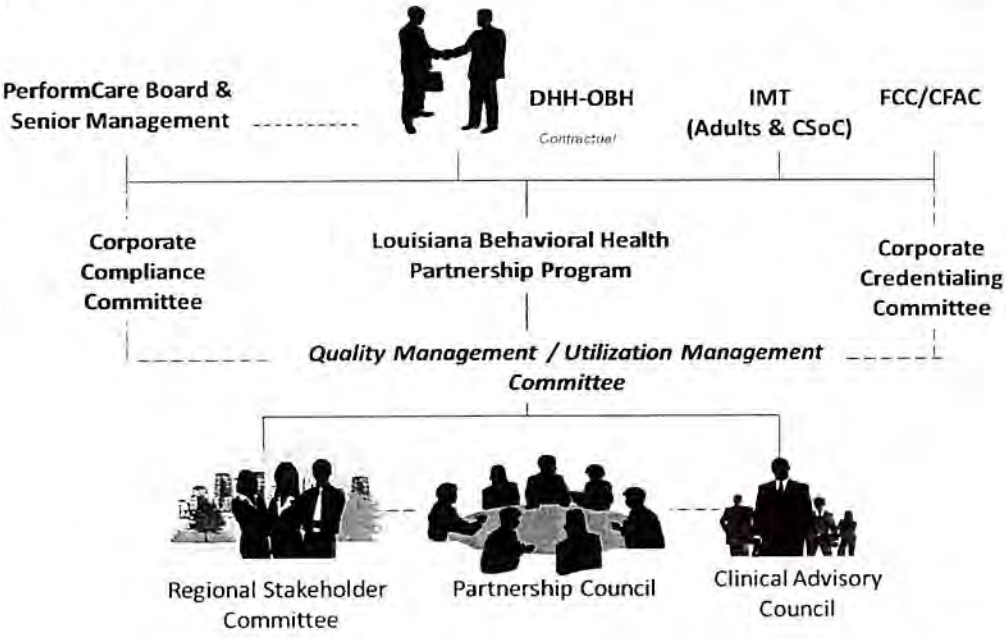


Organizational Chart for PerformCare Louisiana-Based LBHP Staff



PerformCare Committees

The following graphic depicts the proposed committee structure for the LBHP. Please refer to *Section d. Quality Management*, for more detailed information on these committees, their function, and membership.



c. This section should also include the following information:

i. Location of Active Office with Full-time Personnel, including all office locations (address) with full time personnel.

Office Location in Baton Rouge

PerformCare will locate its Louisiana office at a location within 10 miles of DHH-OBH offices. PerformCare intends to gain efficiencies and promote physical health-behavioral health collaboration by having these offices at the same site as AmeriHealth Mercy of Louisiana (AML). AML was recently recommended for award of a contract with DHH to provide Prepaid Coordinated Care Network (CCN-P) services in DHH's Geographic Service Areas A, B and C. AML is operating as LaCare, and already has executive offices located at 8550 United Plaza Blvd., in Baton Rouge (shown at right). PerformCare will be able to receive mail and locate implementation staff at the United Plaza address immediately upon contract award.

In addition to this space, we have already located additional operational space at 10000 Perkins Rowe in Baton Rouge, which has office space suitable to house PerformCare's LBHP staff and LaCare staff (building shown at right). This opportunity allows us to: 1) benefit from and build upon the existing resources and support available at LaCare to bring cost and process efficiencies for DHH, and 2) potentially allow us to effectively address the needs of the members with co-occurring physical and behavioral health services whom we will be jointly serving.

PerformCare's corporate headquarters and national operations center is located at 8040 Carlson Road in Harrisburg, PA.

ii. Name and address of principal officer

Richard S. Edley, Ph.D. serves as PerformCare's President and Chief Executive Officer. He is located at:

8040 Carlson Road
P.O. Box 6600
Harrisburg, PA 17112

iii. Name and address for purpose of issuing checks and/or drafts

Ms. Sharon Duncan, PerformCare's Chief Financial Officer serves as the contact for purpose of issuing checks and/or drafts. She is located at:

8040 Carlson Road
P.O. Box 6600
Harrisburg, PA 17112

iv. For corporations, a statement listing name(s) and address(es) of principal owners who hold five percent interest or more in the corporation

AmeriHealth Mercy of Louisiana, Inc. (AML) is responding to this request for proposal through its sister company PerformCare of Louisiana ("PerformCare").[1] Both PerformCare and AML are wholly-owned subsidiaries of AmeriHealth Mercy Health Plan (AMHP), and as such, they are both members of the AmeriHealth Mercy Family of Companies. AMHP owns 100 percent of both PerformCare and AML. No individual holds an ownership interest in either PerformCare or AML.

AMHP is a Pennsylvania general partnership; its corporate offices are located at:

[1] As explained in greater detail in Section 1.c.v of this response, PerformCare of Louisiana is the trade name under which Community Behavioral HealthCare Network of Pennsylvania, Inc. (CBHNP) will provide services in Louisiana.

200 Stevens Dr.
Philadelphia, PA 19113
Phone: (215) 937-8000

v. If out-of-state Proposer, give name and address of local representative; if none, state so

AmeriHealth Mercy of Louisiana, Inc. is a Louisiana corporation, with offices in Baton Rouge.

CBHNP is qualified in Louisiana, under Charter No. 40517156F, as non-Louisiana business corporation. (See **Appendix 1** for a printout from the Louisiana Secretary of State's office.) In this capacity, CBHNP's (and, by extension, PerformCare's) local representative is CT Corporation, with offices at 5615 Corporate Blvd., #400B, Baton Rouge, LA 70808-2536 [Ph.: (225) 922-4490]. CBHNP has registered the trade name PerformCare of Louisiana in the parish of east Baton Rouge.

vi. If any of the Proposer's personnel named is a current or former Louisiana state employee, indicate the Agency where employed, position, title, termination date, and social security number

None of PerformCare's current or proposed personnel are current or former Louisiana state employees.

vii. If the Proposer was engaged by DHH within the past twenty-four (24) months, indicate the contract number and/or any other information available to identify the engagement; if not state so

Neither AML nor PerformCare has been engaged by DHH within the past twenty-four (24) months.

viii. Proposed location and functions of the required Louisiana-based operations in the Baton Rouge area

PerformCare will locate its Louisiana office at a location within 10 miles of DHH-OBH offices. PerformCare intends to gain efficiencies and promote physical health-behavioral health collaboration by having these offices at the same site as AmeriHealth Mercy of Louisiana (AML). AML was recently recommended for award of a contract with DHH to provide Prepaid Coordinated Care Network (CCN-P) services in DHH's Geographic Service Areas A, B and C. AML is operating as LaCare, and already has executive offices located at 8550 United Plaza Blvd., in Baton Rouge (shown on previous page). PerformCare will be able to receive mail and locate implementation staff at the United Plaza address immediately upon contract award.

In addition to this space, we have already located additional operational space at 10000 Perkins Rowe in Baton Rouge, which has office space suitable to house PerformCare's LBHP staff and LaCare staff. This opportunity allows us to: 1) benefit from and build upon the existing resources and support available at LaCare to bring cost and process efficiencies for DHH, and 2) potentially allow us to effectively address the needs of the members with co-occurring physical and behavioral health services whom we will be jointly serving.

We propose to have a full service, local, behavioral health managed care operations center in Baton Rouge. Local functions in that office will include:

- Administration (CEO, CFO,COO)

- Compliance
- Finance (Accounting)
- Care Management/UR Management
- Member Services (24/7)
- Quality Management
- Provider Network (recruitment, contracting)
- Information Services (split functions with Harrisburg, PA corporate office)
- Claims Adjudication and Payment
- Community Education/Outreach
- Human Resources

ix. Proposer's state and federal tax identification numbers

AmeriHealth Mercy of Louisiana, Inc.'s federal tax ID number: [redacted]

AmeriHealth Mercy of Louisiana, Inc.'s Louisiana Revenue Account Number: [redacted]

d. The following information must be included in the proposal:

i. Certification Statement: The Proposer must sign and submit the attached Certification Statement (See Attachment I).

A signed copy of the Certification Statement is submitted as **Attachment A.**

State of New Jersey
DEPARTMENT OF CHILDREN AND FAMILIES

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

ALLISON BLAKE, PH.D., L.S.W.
Commissioner

July 22, 2011

Joseph E. Comaty, PhD, M.P.
Chief Psychologist/Medical Psychologist
Director-Quality Management Division
Development Section
Office of Behavioral Health
Louisiana Department of Health & Hospitals
PO Box 4049 (Bin12)
628 N. 4th Street
Baton Rouge, LA 70821-4049

Dear Dr. Comaty:

On behalf of the NJ Department of Children and Families (DCF) and the Division of Child Behavioral Health Services (DCBHS), the Department of the Treasury currently contracts with PerformCare as its Contracted System Administrator (CSA). Through this five year contract executed in 2009, PerformCare manages our statewide Children's System of Care. The CSA is the single point of access for all children, youth and young adults who are in need of behavioral health services including children involved in our child welfare system. DCBHS and PerformCare are committed to providing children the right service, to the right program at the right time. The Division's goal is to ensure that children remain at home, in school and out of trouble.

PerformCare provides a broad range of administrative and clinical functions including:

- A call center with 24/7 care coordination and customer service including Intensity of Service Determinations; this includes triage and dispatch of mobile response for crisis stabilization services statewide or police for emergency situations;
- Care Management including utilization management and outlier management;
- A dedicated Division of Youth and Family Services (DYFS) Unit to facilitate services for those children involved in the child welfare system;
- Effectively matching youth to Out of Home Treatment;
- Verify Medicaid status for all children and properly execute eligibility matching with Medicaid;

- Help NJ maximize federal matching funds used to serve children and families;
- Billing and claims processing;
- A complaints, reconsiderations and appeals process;
- Services accessible through a network of local service delivery providers;
- Enhanced service delivery technology via an electronic medical record;
- Data dashboards and aggregate reports per service line provider (i.e. CMO, Youth Case Management, Mobile Response) accessible through the medical record portal;
- A comprehensive training and support program for providers, stakeholders and state staff, and
- Flexibility to allow for changes per state policies

PerformCare supports the child-centered, strength-based and family focused values and principles of New Jersey's Children's System of Care. They utilize the Child and Adolescent Needs Assessment to determine eligibility into the System of care and also assist DCBHS in establishing eligibility criteria for all service lines. Their quality indicators and feedback mechanism to the State provides us the information necessary to understand system utilization and service gaps. Furthermore, they work in partnership not only with DCBHS but also with Family Support Organizations, stakeholders, and service providers in the delivery of a coordinated system of care.

I am pleased to provide this letter of support to PerformCare. Should you have any further questions, do not hesitate to contact me at 609-292-4741.

Sincerely,

Jeffrey J. Guenzel, MA, LPC
Director, Division of Child Behavioral Health Services

JJG

NHS
HUMAN SERVICES
NHS CORPORATE HEADQUARTERS
620 E. GERMANTOWN PIKE
LAFAYETTE HILL, PA 19444
610.260.4600
WWW.NHSONLINE.ORG

July 28, 2011

Richard S. Edley, PHD
President and CEO
Perform Care
Behavioral Health Solutions
8040 Carlson road
P.O. Box 6600
Harrisburg, PA 17122

Re: Letter of Support for Louisiana Children's System of Care Service Management Organization (SMO)

Dear Dr. Edley:

As Chairman and Chief Executive Officer of NHS Human Services, the largest not for profit, community- based human services provider in the country, I am pleased to offer my support to PerformCare Behavioral Health Solutions for your Louisiana Service Management Organization (SMO) application.

NHS Human Services has had a long and successful partnership with your organization since 1994. We appreciate and support your recovery focused, consumer oriented system of care which has allowed for the development of unique programs to wrap around individuals to help them meet their personal recovery goals. Your focus on quality care has created positive relationships with your members and their families. In addition, you have been able to forge positive partnerships and strong collaborative relationships which have resulted in additional opportunities for the people you serve.

As you know, NHS Human Services has a broad footprint in the Louisiana Behavioral Health System of Care, providing services in seven regions for approximately 1000 adults with chronic and persistent mental illness. Our experience in Louisiana has been, and continues to be, one of the most exciting ventures in NHS history.

The historical relationship between PerformCare and NHS has been built on trust and integrity and NHS has the utmost respect for you and your associates. We look for ongoing opportunities to work together.

Sincerely,

Senator M. Joseph Rocks
Chairman and CEO

NEW JERSEY ALLIANCE
OF
FAMILY SUPPORT ORGANIZATIONS

114 So. Second Street
Phillipsburg, NJ 08865
908-213-0932

July 27, 2011

Ms. Kathy Enerlich, Executive Director
PerformCare
300 Horizon Drive, Suite 306
Robbinsville, NJ 08691-1919

Dear Ms. Enerlich:

Please accept this letter in support of your proposal to become the System Administrator for the System of Care in the State of Louisiana.

Central to the System of Care in New Jersey is the role of the Contracted System Administrator (CSA). The CSA is the gatekeeper for families coming into the behavioral health system. A few years ago, the Division of Child Behavioral Health Services chose PerformCare to take over that role. The transition from the old system to the new CYBER system, while daunting, was accomplished with no loss of vital information on the families already enrolled. Since then, you and your staff have worked diligently to continually upgrade and improve the system and at the same time continue to be responsive to the needs of our families. You, personally, attend the monthly meetings of the Family Support Organizations to update us on CYBER and to get feedback on how the system works for families. PerformCare has established a Stakeholder Steering Committee with the goal of soliciting input from parents, youth and young adults on access to behavioral health services through the CSA which truly shows your commitment to Family Voice.

I wish you success in this endeavor

Sincerely,

Madeline Lozowski, President

CGS Family Partnership, Inc.

Serving Cumberland, Gloucester, and Salem Counties

July 15, 2011

To Whom It May Concern:

I am writing this letter in reference to my experience with PerformCare and CYBER for the past two years. My organization provides two levels of care: Care Management, which is for children with intense behavioral/emotional needs and Youth Case Management, which is for children with moderate behavioral/emotional needs. PerformCare is our Contracted Services Administrator and my agency works with them 24 hours a day, every day. This relationship necessitates open and clear communication between both agencies. Our combined goals are to meet the needs of children and youth and to maintain these children safely at home, in school, and in the community. PerformCare has been an excellent partner in meeting the needs of our children.

Contrary to common expectations PerformCare commenced providing services that were very clear in their direction and interactions with agencies. Throughout their tenure they have provided a calendar for expected updates and a dialogue of how to institute the changes in their system. CYBER has more than met the needs of my staff it has well served the children and families of New Jersey. As CYBER has grown it has added to our ability to track changes and to look at the viability of interventions performed with our children.

Most important has been the working relationship with PerformCare. My staff has found PerformCare to respond to their needs and to work in a positive manner that is focused on promoting our efforts. They respond quickly and clearly. I also had the personal opportunity to experience this lately when I had an administrative change and needed

Phone: 856-716-2100 Fax: 856-716-2109

445 Woodbury-Glassboro Road

Suite One

Sewell, New Jersey 08080

CGS Family Partnership, Inc.

Serving Cumberland, Gloucester, and Salem Counties

assistance. PerformCare's line staff dealt with my phone call, answered my questions, and addressed my needs. They easily and quickly satisfied my agency's needs.

I recognize that I have been speaking in superlatives throughout this communication and want to recognize that they are a human company that makes mistakes. They also readily admit mistakes and then quickly resolve them. This attitude has created an open communication where my staff and there staff work together in partnership and share accountability. We do not blame, together we seek to meet the needs of the children and find the best and most viable way to do this. I very strongly support their efforts.

Sincerely,

Charles Goldstein L.C.S.W.

Chief Executive Officer

CGS Family Partnership, Inc.

Phone: 856-716-2100 Fax: 856-716-2109

445 Woodbury-Glassboro Road

Suite One

Sewell, New Jersey 08080

CARING PARTNERS
OF MORRIS & SUSSEX

July 20, 2011

Kathy Enerlich
Executive Director
PerformCare – An AmeriHealth Mercy Company
300 Horizon Drive – Suite 306
Robbinsville, NJ 08691-1919

Dear Ms. Enerlich:

As the CEO of Caring Partners of Morris/Sussex, Inc, it is my honor and privilege to provide a letter of support for the PerformCare – An AmeriHealth Mercy Company as part of your response to a proposal to become the Statewide Management Organization (SMO) for the Louisiana Department of Health and Hospitals, Office of Behavioral Health.

As you are aware Caring Partners is a care management organization, tasked with managing the behavioral health care for youth with complex needs within Morris and Sussex counties in NJ. We utilize a child family team and wraparound services with the goal of keeping our youth at home, in school and out of trouble. PerformCare plays an integral part in our ability to achieve this mission.

Since PerformCare is the contracted systems administrator for NJ (CSA) all referrals for Caring Partners flow through the CSA. PerformCare has the difficult task of appropriately identifying the necessary level of care for each youth referred balanced against managing the capacity of each care management organization. In this role PerformCare has worked closely with all providers to find the right balance. The staff works diligently to ensure all youth are assigned the appropriate level of care. Once identified PerformCare works with all system of care providers to ensure that accurate and timely authorization for services is provided and that all services plans meet Medicaid eligibility.

The staff at PerformCare are accessible and willing to collaborate in an effort to ensure that the needs all of youth under their care are met in the most timely and professional manner. They have a strong commitment to the development and implementation of community partnerships and work to integrate feedback in all parts of their practice. The staff has a strong understanding of the NJ Children's System of Care practice model and works to ensure fidelity to this model at all levels. The service desk allows for the timely resolution of identified concerns.

The management of PerformCare elicits feedback from all possible resources and utilizes this feedback to inform practice on a ongoing basis. The management team is approachable and responsive to any and all identified needs. PerformCare works to communicate openly with all system partners, parents, and referrals sources.

In closing I would again like to reiterate my support PerformCare in their efforts to become the Statewide Management Organization. If you are in need of any further information, please don't hesitate to contact me direct at (973)770-5505 ext. 104 or via email at emanley@caringpartnerscmo.org.

Sincerely,

Elizabeth A. Manley
CEO

The Children's Home

A Private Nonprofit Organization

243 Pine Street • Mount Holly, NJ 08060 • (609) 267-1550 • Fax (609) 261-5672

Roy A. Leitstein
Executive Director

August 8, 2011

Ms. Kathy Enerlich
Executive Director
PerformCare
300 Horizon Drive
Suite 306
Robbinsville NJ 08691-1919

Dear Ms. Enerlich:

It is a pleasure for me to write this letter of recommendation for PerformCare. Since PerformCare became the contract system administrator for behavioral health services for youth in New Jersey, our Residential Treatment facility has experienced nothing but professional and efficient service from your organization. In particular, Cyber and Youth Link have proven to be valuable tools to me and have become an integral aspect of my everyday work routine as Admissions Coordinator for The Children's Home, which contracts with the state of New Jersey to provide residential treatment services to over 90 youth.

The PerformCare Youth Link contains the information I need to be proactive and find youth who would benefit from the services our program has to offer. This process is quick and efficient. A quick glance at the spreadsheet reveals exactly what the needs are for each child. Along with the information pertaining to the youth, it also contains Case Management contact information to enable me to have immediate access to individuals that I need to reach out to schedule interviews and admissions.

It also provides Case Management Organizations throughout New Jersey with vital information pertaining to providers such as location, availability of beds, program descriptions, level of care, types of youth served, etc. With a few clicks of the mouse, Case Management can see the real time status of every provider in the state.

Many of the functions that were very time consuming with the previous program have been completely automated in PerformCare. Admission, Medicaid authorizations, adding new users, changing passwords, etc. are done with one click of the mouse.

The customer service options for PerformCare are excellent. I have never called or e-mailed with problems that was not corrected within 24 hours with courteous and competent personnel.

I believe this program has contributed immensely to the successful and timely placement and treatment of "at risk" youth in the state of New Jersey. It has empowered providers to be proactive and enabling them to make the initial contact with Case Management and advocate for youths who are in need of intensive mental health and behavioral services.

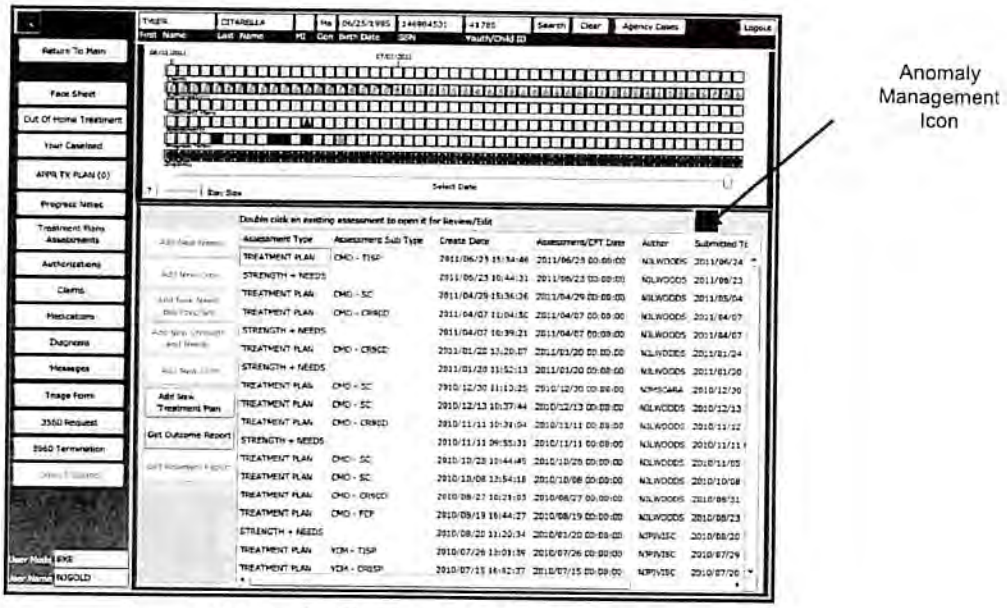
I believe the PerformCare System is an asset to the State of New Jersey and is continually improving its services and is always looking for suggestions from users on how to improve their services even more.

Respectfully,

Marie McCarville

Marie McCarville
Admissions Coordinator

which looks at outliers from a state or agency level, or by clicking on the Anomaly icon available in various screens in the application. For Utilization Management for a specific person in the system a user goes to the Treatment Plan and Assessment window.



Anomaly Management Screen

When the user navigates to this screen and clicks on the Anomaly Management icon a series of choices is presented to the user to select. One of those choices is Utilization Management, where the system will identify if a person has overutilization and/or underutilization of services. Once the icon is clicked by the user a pop-up box will appear with the services that are being over or under utilized. The criterion for determining over- or under-utilization is configurable. As an example, the criterion used in the New Jersey System of Care to determine over- or under-utilization of services are submitted as **Appendix 6**.

x. Member Services Website

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

PerformCare will utilize our experience in developing member-centric websites to develop the website for the Louisiana Behavioral Health Partnership.

Plan for Implementing the Website

PerformCare will customize a website for the Louisiana members that will provide the online access to member services information, including all of the elements of *II.B.3.C.i.* As a template, PerformCare will modify its successful New Jersey System of Care website as a model for developing the CSoC website. This website (http://www.performcarenj.org) is currently in use in New Jersey and is the central access point for the System of Care user community.

The plan for implementing the CSoC website is as follows:

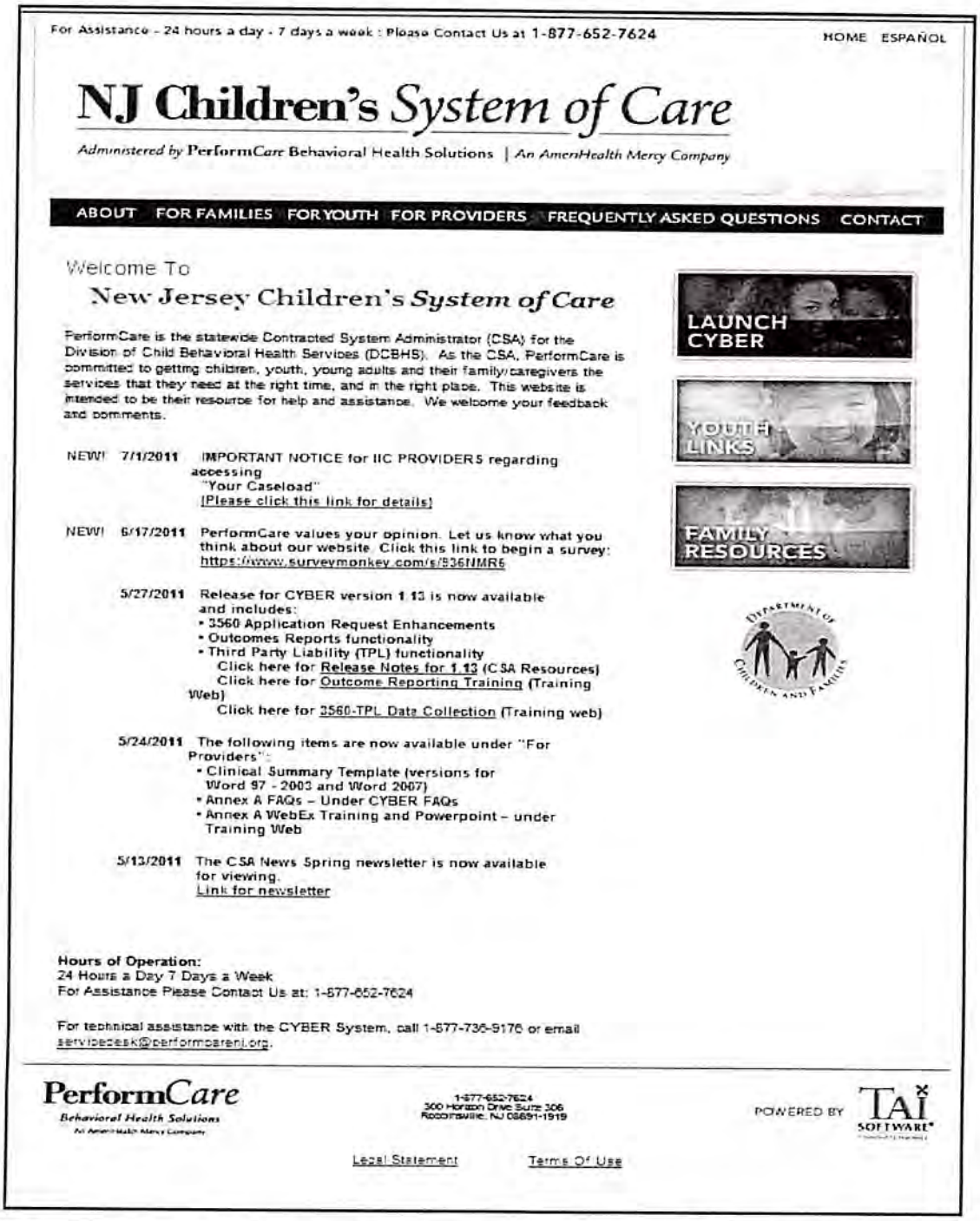
- Business Analysis
  - Fit Analysis using the New Jersey System of Care website as a baseline.
    - Document modifications to the baseline website
    - Document the CSoC content
    - Finalize and document CSoC functional design
      - Graphical User Interface (look and feel, navigation, etc.)
      - Security Protocols
- Development
  - Secure administrative components (URL, link points etc)
  - Develop website
    - GUI
    - Security
  - Load content, including all elements required in RFP Section *II.B.3.C.i.*
  - Develop training
    - Test Group Training Material
    - User Community Functional Training
- Testing
  - Systems test all components of the website
    - User Acceptance Testing (supported by technical project team)
      - Train test groups
        - Stakeholder testing
        - Provider testing
        - Family member testing
        - Member testing
- Deploy website

The Louisiana website is currently in production and will be delivered with a majority of the functionality required by the Louisiana RFP already in place. The majority of the modifications to the existing site will include adding Louisiana specific content to the site, making minor changes, and adding required functionality documented during the Business Analysis phase of the website development plan.

Similar to the New Jersey website, Louisiana's website will have multiple purposes and user types. Users can access CSoC information (i.e. Youth and Family Guide, Resources, etc.), technical information (Functional Release Notes, links to application training), communications (announcements, new process, etc.), and launch points into the CSoC technical applications. Users can also submit service desk requests.

PerformCare will maintain the website and ensure that the content is up to date. Most of the functional points on the website (menus, buttons, and links) are configurable and expandable. The

architecture used on the back end of the website minimizes the level of effort and expertise required to maintain the site, including but not limited to adding or modifying content, links, buttons, menus, and menu items. These changes can be made in a timely manner with little impact to the user community. This is essential to the success of CSoC, as it is our experience that modifications and additional functionality will often be required throughout the project. Success requires that changes and additional functionality be made quickly and accurately. This timely response and implementation enhances the user experience and builds credibility in the user community, which results in more proactive system use and user involvement and greater penetration into the user community.



For Assistance - 24 hours a day - 7 days a week : Please Contact Us at 1-877-652-7624 HOME ESPAÑOL

NJ Children's System of Care

Administered by PerformCare Behavioral Health Solutions | An AmeriHealth Mercy Company

ABOUT FOR FAMILIES FOR YOUTH FOR PROVIDERS FREQUENTLY ASKED QUESTIONS CONTACT

Welcome To
New Jersey Children's System of Care

PerformCare is the statewide Contracted System Administrator (CSA) for the Division of Child Behavioral Health Services (DCBHS). As the CSA, PerformCare is committed to getting children, youth, young adults and their family/caregivers the services that they need at the right time, and in the right place. This website is intended to be their resource for help and assistance. We welcome your feedback and comments.

NEW! 7/1/2011 IMPORTANT NOTICE for IIC PROVIDERS regarding accessing "Your Caseload" (Please click this link for details)

NEW! 6/17/2011 PerformCare values your opinion. Let us know what you think about our website. Click this link to begin a survey: https://www.surveymonkey.com/s/536NMR6

5/27/2011 Release for CYBER version 1.13 is now available and includes:
- 3560 Application Request Enhancements
- Outcomes Reports functionality
- Third Party Liability (TPL) functionality

Click here for Release Notes for 1.13 (CSA Resources)
Click here for Outcome Reporting Training (Training Web)
Click here for 3560-TPL Data Collection (Training web)

5/24/2011 The following items are now available under "For Providers":
- Clinical Summary Template (versions for Word 97 - 2003 and Word 2007)
- Annex A FAQs – Under CYBER FAQs
- Annex A WebEx Training and Powerpoint – under Training Web

5/13/2011 The CSA News Spring newsletter is now available for viewing.
Link for newsletter

LAUNCH CYBER

YOUTH LINKS

FAMILY RESOURCES

Hours of Operation:
24 Hours a Day 7 Days a Week
For Assistance Please Contact Us at: 1-877-652-7624

For technical assistance with the CYBER System, call 1-877-736-9176 or email servicedesk@performcarenj.org.

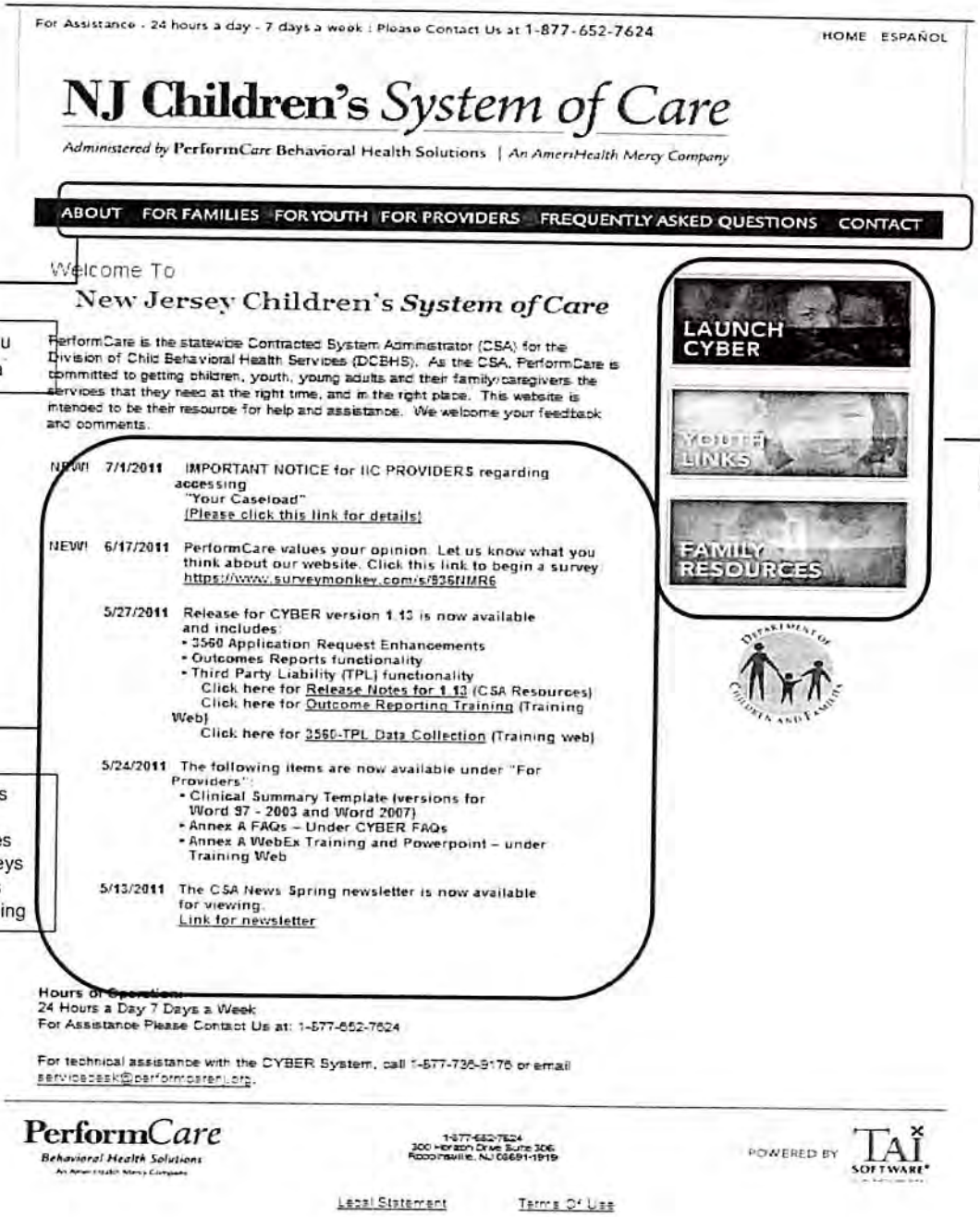
PerformCare
Behavioral Health Solutions

1-877-652-7624
300 Horizon Drive Suite 306
Robbinsville, NJ 08691-1919

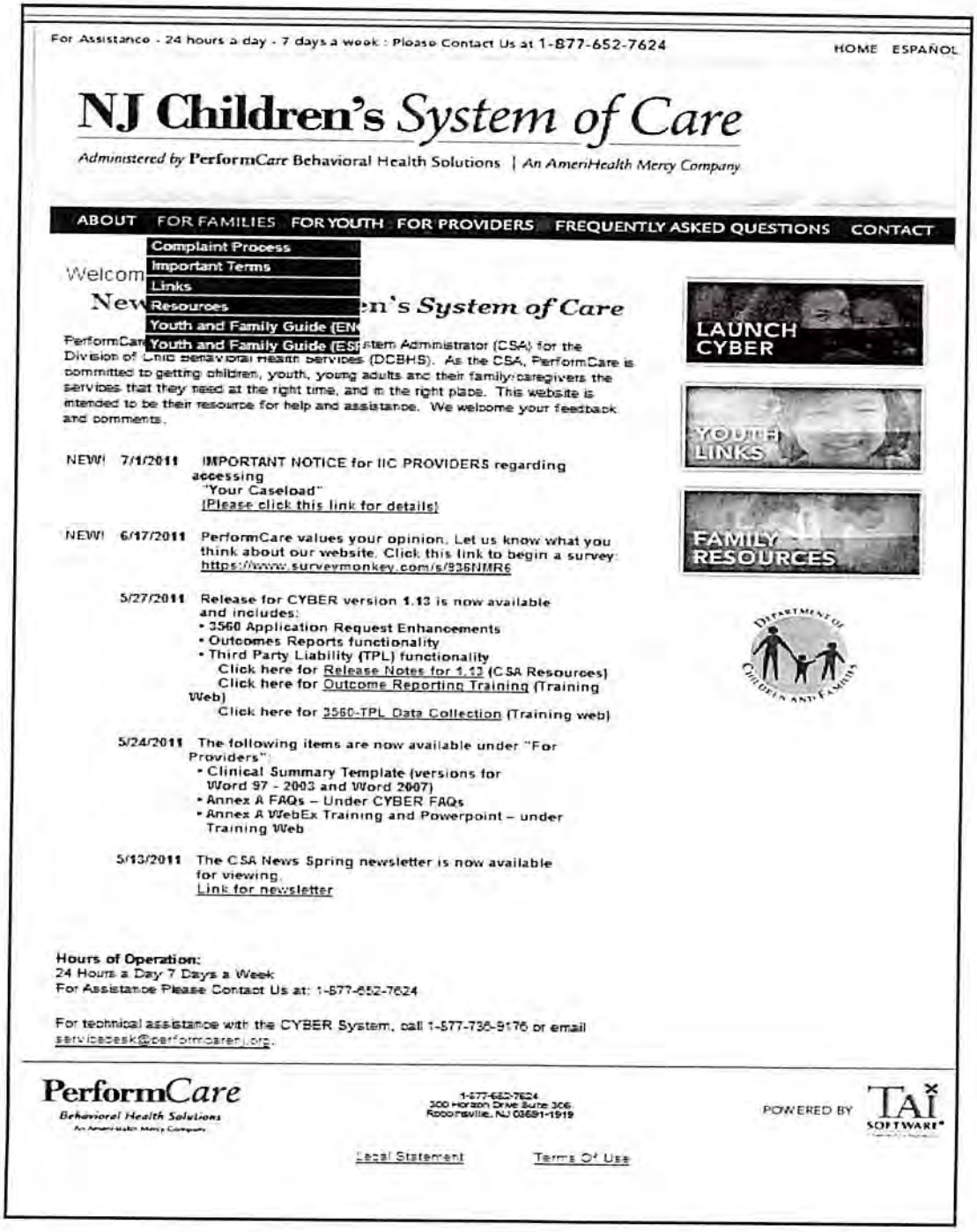
POWERED BY TAI SOFTWARE

Legal Statement Terms Of Use

Description of Existing Website



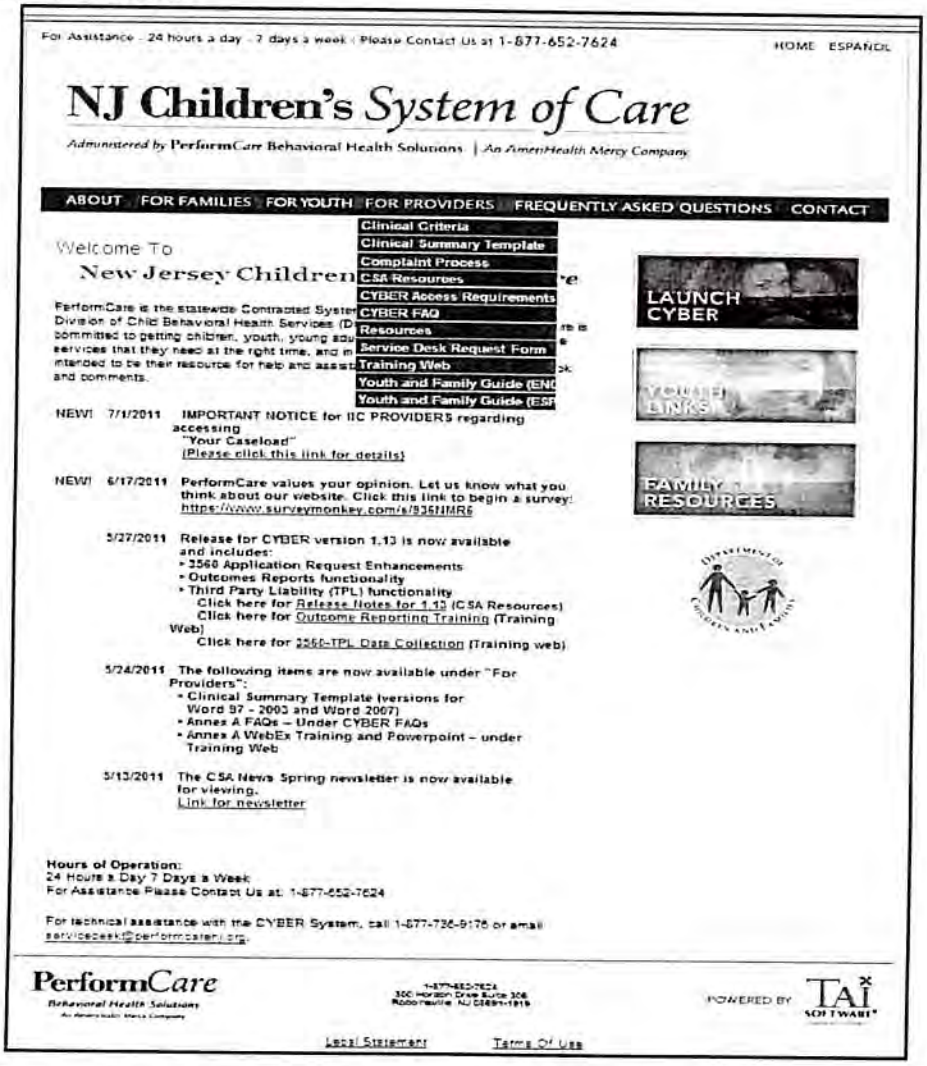
Members and families are able to get information on providers, obtain information about how to submit a grievance or appeal, access links to educational and support organizations, and download critical information that the CSoC wants to disseminate, such as the Youth and Family Guide in New Jersey. This information is accessible to the general public so there is no security password required to access this part of the website.



Provider Access

Providers have their own component of the website, and portions of this information require user IDs and passwords. This is where providers can go for easy access for items such as:

- Clinical Criteria
- Templates
- CSoC Resources
- Service Request Form (Automated Help Desk Ticket Submission)
- Application Standards
- Frequently Asked Questions
- Links to Training (Web-Ex recorded trainings, and other training material)
- Application Functional Release Notes
- Other Required Information or Links
- Application Launch Point



Proposed Content of the Website

The website's content will include information that enables members and family members to understand and effectively use the program. It will also include content that provides information on behavioral health conditions, common co-morbid physical health conditions, and wellness that will enable members and family members to better address their diverse needs. The following is a listing of the content that PerformCare has identified for inclusion on the website:

- Program Information
  - Basic information on the LBHP including requirements, benefits, and covered services
  - Call center contact information (phone, fax, and TTY/TDD number)
  - Member Services contact information (phone, fax, and TTY/TDD number and email address)
  - 24/7/365 Hours of operation (including weekends and holiday hours)
  - Program eligibility information (including links to appropriate state and local agencies for further information or document/form retrieval)
  - Accessing behavioral health services
    - Including routine, urgent, and emergency services
    - Including crisis response information and toll-free crisis telephone numbers and related website links
  - Filing a grievance or appeal (including information on process, any required forms, and contact information)
  - Role of members and family members in the program (including involvement on program committees and workgroups)
  - Member rights and responsibilities (Member Bill of Rights)
  - Links to information on the program as maintained by DHH-OBH and other state or local agencies
- Service Delivery
  - Accessing behavioral health services
    - Including routine, urgent, and emergency services
    - Including crisis response information and toll-free crisis telephone numbers and related website links
  - Recovery and resiliency approach and services
  - System of care approach and services
  - Services available through the program
  - The role of the clinical staff in managing a member's needs
  - The role of members and family members in the treatment process
  - The role of the provider in the treatment process
  - Working with community and wrap-around programs to meet member needs
  - Mental health diagnosis and services

    - Issues related to children and youth
    - Issues related to adults
    - Links to various sites providing additional information, such as the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration
  - Provider listing and Web search tool
  - Reporting provider fraud and abuse, including how to access DHH's toll free number
  - Informational brochures on recovery oriented and trauma informed care
  - Member Bill of Rights
- Community-Related Information
  - Hyper link to DHH-OBH/CSoC websites
  - Listing and links to available community-based programs and services
  - Listing and links to community forums, volunteer activities, committees, and workgroups
  - Listing and links to WAAs and FSOs
  - Listing of upcoming community training, education, and outreach events for members and family members
  - Emergency preparedness and response information
    - Including updates on current emergency situations that can impact the public
    - Links to state and federal preparedness websites
    - Information will be available in English, Spanish, and Vietnamese
  - Listing, links to, and role of various advocacy organizations for adults and children/youth and how to access and utilize them
  - Information on area support groups and services
  - Educational brochures on behavioral health care services
- Health and Wellness Information
  - Basic health and wellness information
  - Overview of basic mental health issues for adults and children/youth
    - Links to various sites providing additional information, such as the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration
    - Information on Wellness Recovery and Action Plan, Trauma-Informed Care
    - Overview of evidence based practices
  - Overview of prevalent physical health issues and link to physical health managed care entity
  - Co-occurring disorders and the impact on behavioral health services and treatment
  - Preventive services and programs
  - Role of and information on nutritional issues
  - School based health care services

- Information and links on accessing physical health services
- Holistic and alternative (non-traditional) health care
- Links to various state, federal, and local organizations, such as the National Institutes of Health

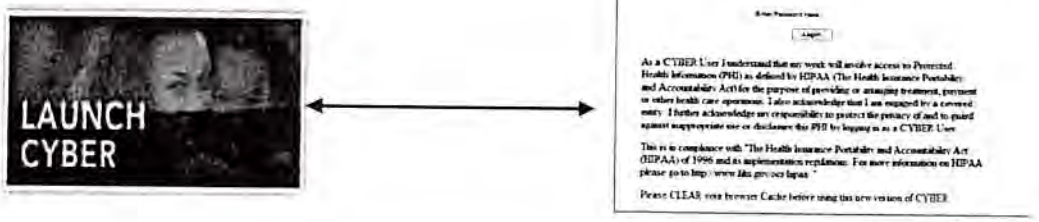
- Forms and Links to Other Documents
  - Including documents required by the CSoC Governance or DHH-OBH
  - Links to DHH-OBH and other state and local agencies offering services to members and family members
- Information for Child/Youth Members
- Information for Adult Members
- Information for Parents, Family Members, and Caregivers

The website's content will comply with Section 508 of the US Rehabilitation Act. All content will be written in a level no higher than fifth grade, in a manner that is easily understood by members and family members, and in a print that is no smaller than 12 point font. All vital and non-vital materials on the website will be translated into Spanish and Vietnamese, and any language spoken by more than 5 percent of the population. We will seek approval for all content that will be posted on the website from DHH-OBH.

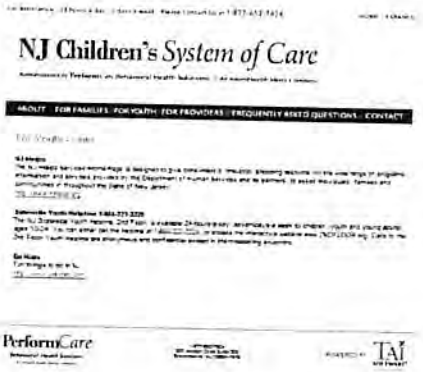
We will notify members and family members of the website through the Member Handbook as well as through other written materials, posters, flyers, and at community forums and trainings. Information about the website will also be made available at provider offices and state and local agencies serving members and family members.

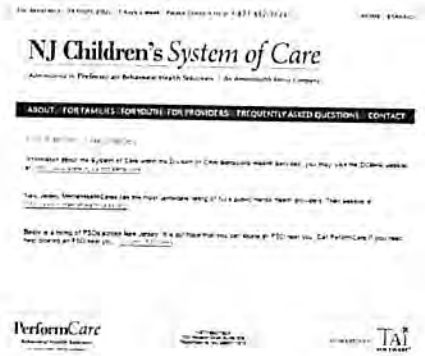
Secure Access

When security is required to access information on the website, the user is prompted for a user ID and password. For example, when a user launches the application, the system controls whether security is required as with the CYBER Application in New Jersey:



When security is not required, the website navigates directly to the website being accessed or to a list of available websites.





xi. Member Handbook

Describe the Proposer's experience demonstrating compliance with annual notification to members of member rights and other required information given confidentiality concerns and the transient lifestyle of some members.

Annual Notification of Members

PerformCare has extensive experience with annual notification of members of their rights and responsibilities as well as information on how to access services because we currently comply with this requirement for all of our contracts. Notifications are critical for all members, but especially those who have a transient lifestyle, live in homeless shelters or rural areas.

For example, in Pennsylvania in the HealthChoices program, we provide information to members about their rights and responsibilities, services, and programs through a number of modalities including, but not limited to:

- **Member Handbook** – Each member is provided with a Member Handbook that includes information on the program, member benefits, accessing services, and the grievance and appeals process. A section of the Handbook is dedicated to information on the member's rights and how these rights should be respected by PerformCare employees and providers. The rights are described in detail and the member is provided with information on how to contact PerformCare if they feel that their rights have not been observed. A sample Member Handbook is submitted as **Appendix 7**.
- **Member Orientation** – Member rights and responsibilities are reviewed during regularly-held member orientations, which are offered to both new and current members.

- **Member Website** – The entire Bill of Rights as well as its application will also be displayed prominently on the member website. We have included a screenshot of the Member Rights and Responsibilities page of our Pennsylvania HealthChoices program on the following page.
- **Provider Manual and Trainings** – PerformCare providers and their staff are expected to fully understand the Member Bill of Rights and its application. Providers are reviewed during the Record Reviews to ensure that the Bill of Rights are mentioned and reviewed with the member. A sample Provider Manual and a provider training that includes member rights and responsibilities are submitted as **Appendix 8** and **Appendix 9**, respectively.
- **Member Newsletter** – We review member rights and responsibilities routinely in the Member Newsletter, focusing on how these rights apply to the member and their participation in the treatment process. **Appendix 10** includes sample member newsletters from our HealthChoices program.
- **Public Posting** – Member Rights and Responsibilities are printed and prominently displayed in public places frequented by members, such as state and local agencies, provider offices, community programs, emergency rooms and crisis centers, treatment centers, and libraries.
- **PerformCare Staff** – PerformCare MSRs and CMs are trained and able to educate members about these rights and advocate for them.

For the HealthChoices program, all member publications are provided at the fourth grade level. Technical terminology and acronyms are avoided whenever possible, with a concentration on wording that is understandable to members. If difficult terms must be used for technical clarity or legal purposes, a layperson's explanation will always be included. Additionally, the materials are developed in several languages, and can be produced in versions for any non-English language speaking group that accounts for 5 percent or greater of the population. Selected materials, such as the Member Handbook, are available in Spanish. In addition, visually handicapped members have their choice of Braille or audiotapes and the Pennsylvania Relay Service is used by Member Services to assist the hearing impaired with their questions and service access.

We commit to providing LBHP members with information on their rights and responsibilities through similar processes meeting the requirements noted in the Louisiana RFP.

Screenshot of Pennsylvania HealthChoices Program Member Rights & Responsibilities Page

Members Rights and Responsibilities

As Members of CBHNP you have rights and responsibilities. They are listed below and we invite you to call us if you need help understanding your rights and responsibilities.

Use this link to find the Member Services toll-free number for your county or area.

KNOW YOUR RIGHTS!

- **Receive Information.** Each Member has the right to receive information about CBHNP, our policies and procedures, our services, our practitioners and Providers, and your rights and responsibilities
- **Dignity and Privacy.** Each Member is guaranteed the right to be treated with respect and with due consideration for his or her dignity, right to privacy, and right to confidentiality
- **Receive information on available treatment options.** Each Member is guaranteed the right to receive information on medically necessary available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand, regardless of cost or benefit coverage
- **Participate in Decisions.** Each Member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment. You can be a part of your treatment team by asking questions and getting answers before and during your treatment and involving family Members and other important people in your treatment
- **Refuse Treatment.** Each Member, as part of making decisions regarding their care, can refuse treatment. You have the right, under these circumstances, to get an explanation of what may happen if you don't get treatment
- **Voice Complaints or Appeals.** Each Member has the right to voice complaints or appeals about CBHNP or the care provided to them. Let us know if you are unhappy about any decision made by us or one of our Providers
- **Make Recommendations.** Each Member has the right to make recommendations regarding CBHNP's Members rights and responsibilities policies
- **Free from Restraint or Seclusion.** Each Member is guaranteed the right to be free of any restraint or seclusion used as a means of coercion, discipline, convenience or retaliation
- **Copy of medical records.** Each Member is guaranteed the right to request and receive a copy of his or her medical records, and to request they be amended or corrected.
- **Free Exercise of Rights.** Each Member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Member is treated by CBHNP and the Provider

In addition to the rights listed above, Members of CBHNP also have the following rights:

- **To choose your Provider**
- **To ask for a therapist who understands your language and culture**
- **To receive needed services at convenient times and places**
- **To receive emergency care within 1 hour**
- **To receive urgent care within 24 hours**
- **To receive care within 7 days of your request for routine care requests**

KNOW YOUR RESPONSIBILITIES!

KNOW YOUR RESPONSIBILITIES!

CBHNP Members also have certain responsibilities:

- **To Supply Information.** Each Member has the responsibility to supply information (to the extent possible) that CBHNP and our practitioners and Providers need in order to provide care
- **To Follow Instructions.** Each Member has the responsibility to follow plans and instructions for care that they have agreed on with practitioners. .
- **To Understand.** Each Member has a responsibility to understand their health problems and participate in mutually agreed-upon treatment goals to the degree possible

In addition to these responsibilities, Members of CBHNP also have the following responsibilities:

- **To treat others with consideration and respect**
- **To be at appointments on time**
- **To call if you must cancel**
- **To be part of the treatment team by telling your doctor or therapist about symptoms and to ask questions**
- **To tell your doctor or therapist if you do not agree with recommendations**
- **To tell your doctor or therapist when/if you want to end treatment**
- **To take medication as prescribed and to tell your doctor if there is a problem**
- **To carry your insurance cards with you**
- **To tell us if you have other insurance**

SECOND OPINION

Another important right CBHNP Members need to know about is the right to request a **second opinion**. Members can request a second opinion from a qualified health care professional within CBHNP's network. CBHNP will provide for a second opinion from an appropriate behavioral health care professional within the network or arrange for the Member to get one outside the network at **no cost to the Member**.

Call CBHNP for more information about this right and benefit.

If you feel that your rights have been violated or if you want more information about these and other rights, please call CBHNP and let us know. We will work to make sure your rights are respected.

Providing Information to a Transient Population

Working with the transient and homeless population is clearly a nationwide issue, and one that needs to be carefully addressed in Louisiana. Persons with severe mental illness represent about 26 percent of all sheltered homeless persons, according to the National Coalition for the Homeless 2008 Annual Homeless Assessment report to Congress. HOPE for the Homeless, the northwest Louisiana continuum of care collaborative, reports that approximately 30 percent of the homeless self reporting in the annual Point-in-Time count suffer from some form of mental illness (http://www.hud.gov/local/la/library/2009-10-02.cfm). Further, it has been reported that Louisiana has the highest rate of child homelessness of the 50 states, according to a report released by the National Center

for Family Homelessness based in Newton, Mass. The report warned: "The effects of our nation's economic downturn -- including increasing numbers of foreclosures, job layoffs, rising food and fuel prices, and inadequate supplies of low-cost housing -- will surely add to the legions of children who are homeless." (The Times-Picayune Tuesday, March 10, 2009).

Our extensive experience with the Medicaid population has taught us the importance of engaging members where they live and in a way that fosters respect and trust. The transient population poses a special challenge to engage in services. We understand that the key to influencing a member's behavior is building a trusting relationship between the member and the health plan. By partnering with community leaders, faith-based organizations and agencies already serving the transient population, we are in a position to identify and outreach to these individuals and to establish connections with members that result in improved health outcomes. In addition we sponsor and participate in local health related events annually to bring health care directly into the communities we serve. As an example, we will be participating in the 2011 LA State Homeless Conference to be held October 5-7, 2011 in Shreveport, LA.

In addition to our experience, we have also carefully researched material relative to this difficult situation, such as the data and information published by the US Department of Housing and Urban Development, including their Annual Homeless Assessment Report to Congress. It is clear that for outreach to be successful, it is important to understand where the homeless and transient persons are living. PerformCare material on available services has to be brought to emergency or transitional shelters, commercial spaces, transportation depots, soup kitchens, food banks, and other similar venues.

When we do have direct contact with a member, PerformCare staff verifies all demographics in the integrated information system. Any updates are entered into the system so all PerformCare staff have access to this information. PerformCare staff asks each member their preferred manner of contact, including a home phone, cell phone, texting, email or social media. Additionally, if the member reports no manner of direct communication available (i.e. they do not have a phone), staff will explore with the member alternative methods, such as leaving messages with a family member, friend or neighbor of the member. When a member is difficult to reach, PerformCare staff utilize a variety of creative interventions to make the connection. Staff will, for example and with prior member consent, reach out to the member's current providers, including the PCP and pharmacy to see if they have updated contact information for the member. If they do not, staff will ask the provider to relay a message to the member the next time they come in. We commit to finding ways to better serve these members in need.

xii. Member Communications

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

PerformCare will implement a communication program that ensures that members, family members, providers have comprehensive information about the program and services available. The communication plan and all deliverables will be submitted to DHH-OBH for approval prior to use.

Developing and Implementing a Comprehensive Communication Plan

The goals of the communication program are to increase member, family member and provider understanding of the program and its components, while decreasing confusion about accessing services and the member's role in the treatment process. An additional goal is to provide members and family members with information that will aid them in better managing their behavioral and physical health needs and be an active part of the treatment and recovery process.

PerformCare's communication plan will be implemented during program implementation and will continue for the duration of the contract. At a minimum, communication materials will include information on the program and services offered, member rights and responsibilities, available culturally diverse network providers, and educational materials related to a member's specific needs. Materials will be available in alternate formats such as Braille and in other languages used in the service area. Welcome Letters, Member Handbook, and Newsletters are sent to all members regardless of whether or not they are receiving services. The communication resources will include, but not be limited to the following:

- Notices of Action and Notices of Decision
- Welcome letters and packets
- Member Handbook
- Member website
- Community forums and training sessions
- Posters, brochures, and flyers
- Presentations and signage
- Department of Education, schools, day care centers, etc.
- Newsletters, policy advice, and other similar materials
- Indirect marketing (attendance at health fairs, sponsoring community forums, radio spots, etc.)
- Presentations and community meetings held with PerformCare staff
- Brochures available in PCP offices

All communication materials will be developed in at a fifth grade reading level, will use visuals to emphasize specific points, and will be written using language that is not technical and jargon-free. The materials will be available to the entire area, including the general public. Certain notices and updates, as agreed upon with DHH-OBH will also be distributed to community stakeholder, DHH, DCFS, DOE, and OJJ.

Our MSR and CMs also play an important role in the communication process as they provide information and educate members, family members, and providers during their interface with them.

The proposed timeline for the distribution of materials is as follows:

- Implementation and transition period
    - Basic information regarding the program, eligibility requirements, PerformCare's role, and contact information
- Upon program eligibility
    - Welcome letter
    - Member Handbook
    - Other information specific to the member's health care needs
- Throughout treatment
    - Notices regarding changes in treatment plan or level of care
    - Information specific to the member's needs, diagnosis, and level of care

- Written notice of termination when a contract or provider agreement is suspended or terminated

- Through the course of contract
  - Annual updated Member Handbook
  - Notices of Action and Notices of Decision
  - Newsletters, policy advice and other materials as agreed upon with DHH-OBH

Materials Included in the Communication Program

The following table provides a summary of some of the communication materials that PerformCare will provide for members, family members, providers, and the community. All the items noted below will be provided by PerformCare in its role as the SMO, at no additional cost to the State. Items in **bold** are those specifically required by the State.

Members/Family Members	Providers	Community
• **Basic information about the program, accessing services, benefits, and eligibility** • **Welcome letter** • **Notices of Action & Notices of Decision** • **Member Handbook** • Disease / Condition-specific educational materials • Information on member rights and responsibilities • Notices of upcoming community-based trainings and forums • **Information required for distribution by DHH-OBH** • Newsletters • Flyers, posters, and information cards • **Grievances and Appeals notices** • Family involvement in the treatment process	• **Basic information about the program, accessing services, benefits, and eligibility** • **Welcome Letter** • **Provider Manual** • **Notices of Action & Notices of Decision** • **Information required for distribution by DHH-OBH** • Notices of upcoming provider training & continuing education opportunities • Changes to/updates on policies and procedures • **Grievances and Appeals notices** • **Evidence Based Practice Protocols**	• Basic information about the program, accessing services, benefits, and eligibility • Notices of upcoming community-based forums and educational opportunities • **Information required for distribution by DHH-OBH** • Changes and updates to program and services • Educational brochures and information on behavioral health • Press Releases that describe new programs and services

(b) Illustrate an example of the Proposer's most successful member communication effort that embodies the system principles outlined in the RFP.

PerformCare has managed a successful member communication effort for our HealthChoices program since 2001, which embodies the system principles outlined in the RFP. Many of the components of this communication effort will be used for the LBHP program.

The HealthChoices Program Member Communication Effort

PerformCare conducts a two-pronged member communication and education effort. We routinely communicate with all HealthChoices members regardless of whether they are receiving services. The goal of this outreach and education is to increase understanding of the HealthChoices program, PerformCare's role, and the services available through the program. We outreach to these members by:

- Communicating program information to state and local agencies, emergency rooms, local health care clinics, mobile crisis services, hospitals, and other inpatient facilities
- Conducting member/family forums and town hall meetings to provide information on the program, its goals, eligibility criteria, program benefits, and how to refer members
- Holding forums and town hall meetings as well as using culturally competent (in Spanish and other languages as necessary) brochures and flyers outlining the program and how to refer/obtain services
- Posting flyers and informational posters at locations where potential clients congregate
- Promoting the program in newsletters and Web pages maintained by community organizations
- Using public service announcements to promote the use of the program

For members who are in treatment, we utilize additional member outreach and education. We send a welcome letter to these members with additional materials based on their diagnosis and treatment plan. We follow this initial outreach with targeted mailings and additional materials that will assist them in utilizing the program effectively.

An important component of our outreach strategy is obtaining stakeholder feedback and opinions. We have done so at the commencement of every contract and on an ongoing basis, thereafter, to identify any new trends and determine program enhancements. To do so, we routinely hold focus groups, forums and town hall meetings within different service areas and targeting the diverse population that we serve. During these meetings we identify any issues or obstacles related to stakeholder (consumer/family) involvement and voice and determine the means of addressing these issues. We also identify other ways we can work with member and families, as well as other volunteers, to assist with educational/outreach efforts. From these meetings, PerformCare develops a plan to address specific issues, including timelines, persons involved, and deliverables. Once the plan has been formulated, it is implemented with collaboration from all those identified.

We also seek and participate in opportunities where PerformCare and members can collaborate with program oversight entities, county MH/MR, advocacy organizations, NAMI, adult and family support groups, and others to ensure a wide range of input. In addition to being identified through the processes noted above, potential members can be referred for enrollment by their behavioral or physical health provider. They can also be referred to the program by a community-based caseworker or program, or they can self-refer into the program.

An example of the significance we place in our communication efforts is demonstrated in the efforts conducted by Mr. Tony House, PerformCare's Manager of Consumer and Family Affairs who was recently nominated and recognized by Central Penn Parents Journal as a 2011 HealthCare Hero. Excerpts from Mr. House's nomination are provided in the narrative in the following box.

Tony is an advocate at CBHNP [PerformCare], assisting consumers and families who are in need of mental health and substance abuse services. He also serves as an important link between CBHNP and the larger Central Pa community. People accessing behavioral health care, especially within the Medicaid population, are often at the most difficult and vulnerable times in their lives. They are dealing with the many effects of illness and disability and may have no one to turn to. Tony is there for them. He assists families in finding services, navigating the myriad of systems and paperwork, and ultimately in getting the help and answers they need.

Tony also reaches out proactively to the community through outreach and education. An important part of his position is increasing awareness of mental illness and how people can receive information and care. There is a true commitment to the larger Central PA community. Clearly, this is not an easy position. We all know that Tony is competent and knowledgeable. But he also performs this varied role with empathy, compassion, grace, and a smile. He is genuine and cares. Internally to our organization, Tony serves as our conscience. He reminds us of our mission, that people have needs, and why we are here. To serve. Tony focuses our efforts on those who are receiving services and in need of help. In sum, Tony House is a rare individual. Unassuming, often reserved, he has a wealth of information and provides hope for consumers and families in need in Central PA. He is a worthy recipient of the Central Penn Parents Journal HealthCare Heroes Award for 2011.

We continuously refine and enhance our outreach processes. We do so by:

- Developing lists of groups, people, committees, advisory boards, PCPs, clubhouses, drop-in centers, support groups, Children Adolescent Service System Program (CASSP) committees, human services boards, and other stakeholder groups that will accommodate outreach efforts.
- Designing presentations for various groups to educate and solicit input about service delivery and program design.
- Working with Stakeholder Steering Committees to identify individual or community groups that need information or have questions about HealthChoices or PerformCare.

Member orientation is one of the primary and most essential components of our service delivery model and communication effort. We believe that educated members are empowered members. To facilitate this, we provide initial and ongoing orientation and information to members. Our goal is to

assist members, families, and communities in navigating the system of care. Our staff members meet with individuals, parents/families, support groups, educators, community leaders, advocates – essentially anyone interested in the HealthChoices program. During the initial orientation, we provide members and their families with information on:

- The HealthChoices program and services offered
- Roles and rights of members and their families
- The recovery and resiliency model and the role members play in meeting their treatment objectives
- Types of services offered
- How to access services and PerformCare's role in meeting member needs
- Enhanced Care Manager's (ECM) role in meeting member needs
- Working with state and local agencies and other providers of services
- Complaints and grievance process
- Client satisfaction surveys
- Contact information

Staff members are available to address specific member questions and provide clarification on issue of concern. Once member demographic data is available, we distribute the PerformCare Member Handbooks to every new HealthChoices member. We also include articles and other materials that might be useful for members as they obtain services through the HealthChoices program. Additional member orientation is provided by the MSRs and CMs as part of the initial assessment and ongoing care management process.

Troubleshooting

The Service Desk troubleshoots technical issues with the currently developed system, including system issues such as computers, printers, internet service providers, network connectivity, browsers, and software interference.

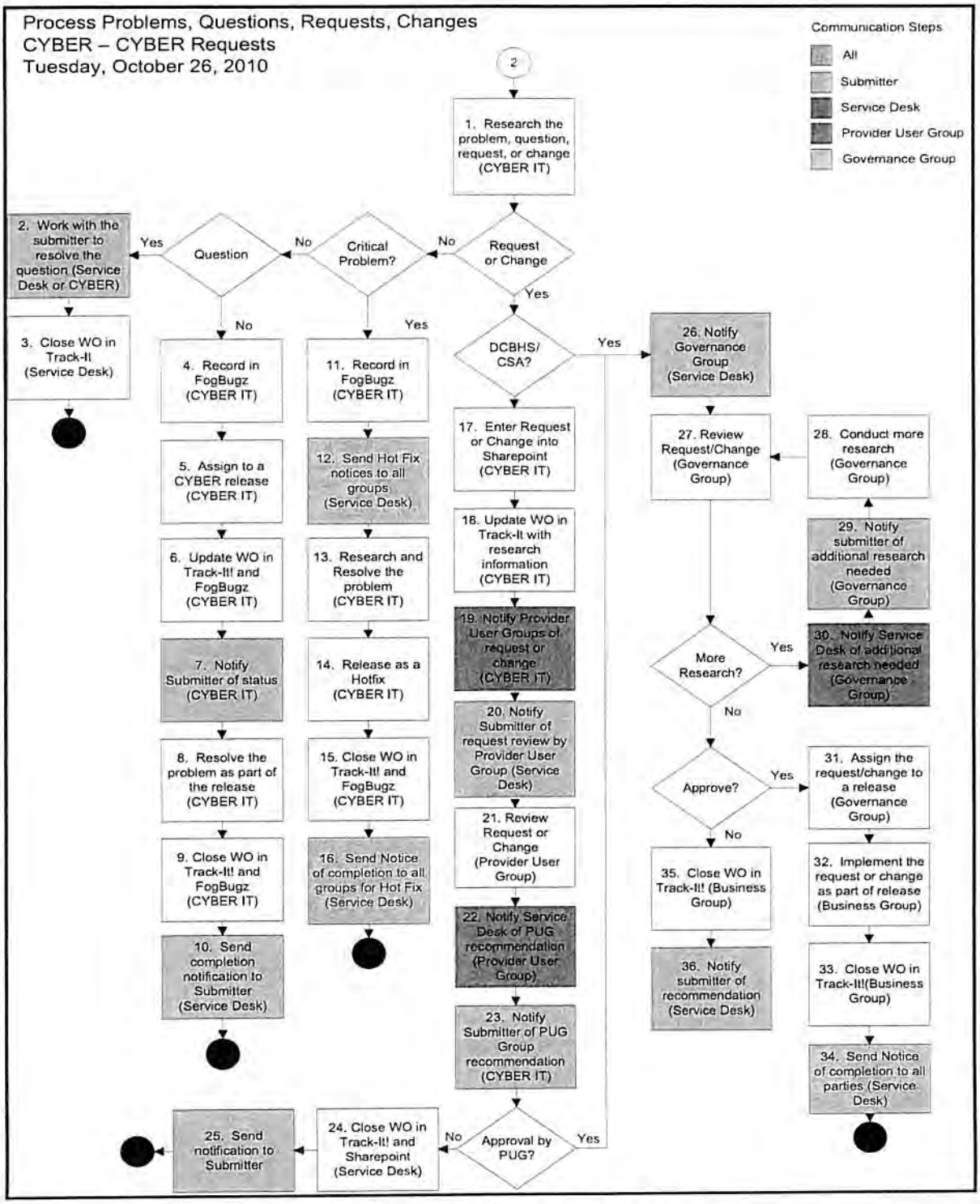
Issue investigation (pre-testing)

The Service Desk investigates issues identified by users of the system. Technicians document all aspects of identified issues, attempt verification or duplication of the issue, document findings, and pass work orders to the testing group in preparation for future development or enhancement.

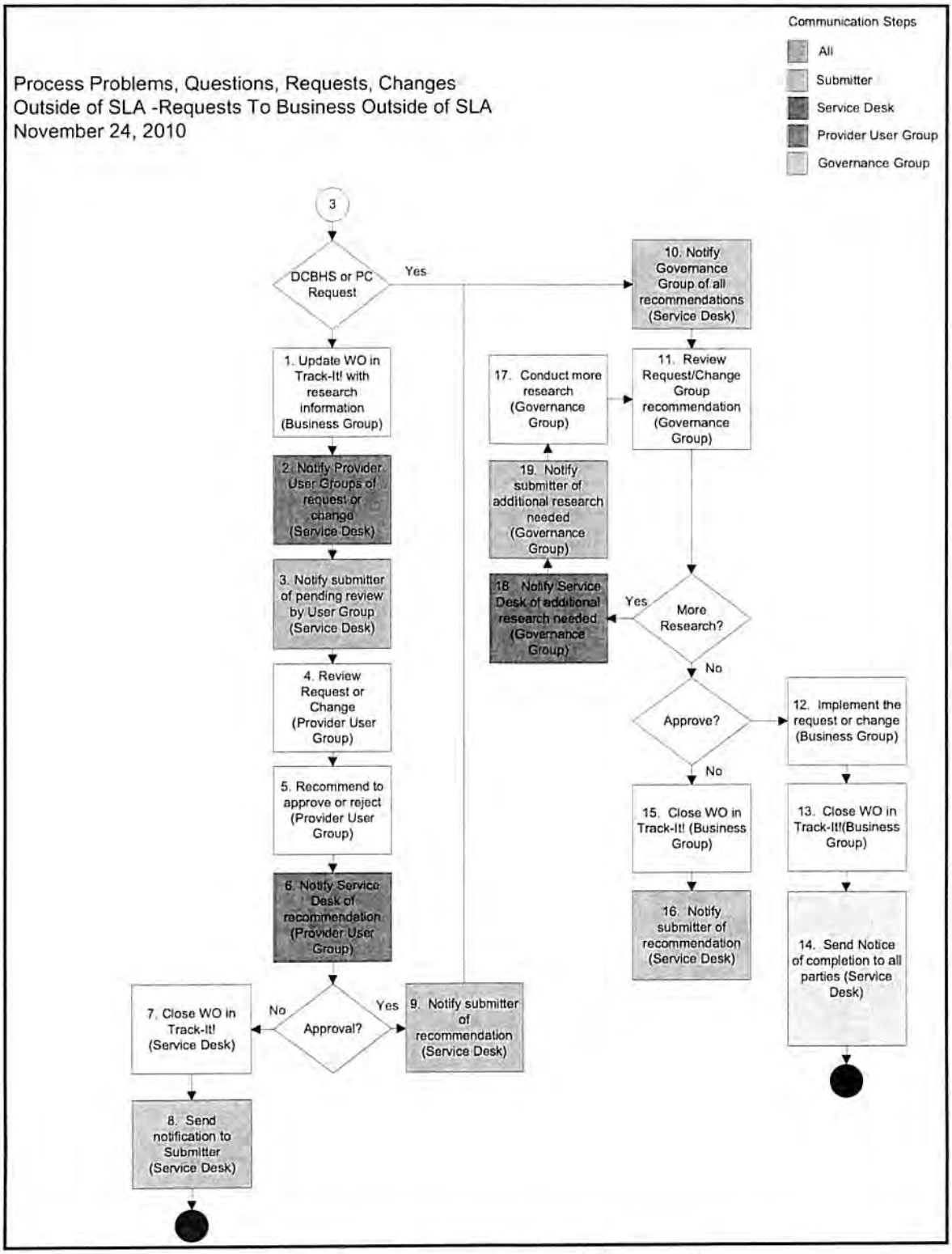
Enhancements

In New Jersey, the Service Desk gathers data on enhancement requests to the current system. Requests are documented and discussed at Provider User Group meetings. Agency-approved enhancements are then proposed to the State level. State-approved enhancements are implemented into the development schedule.

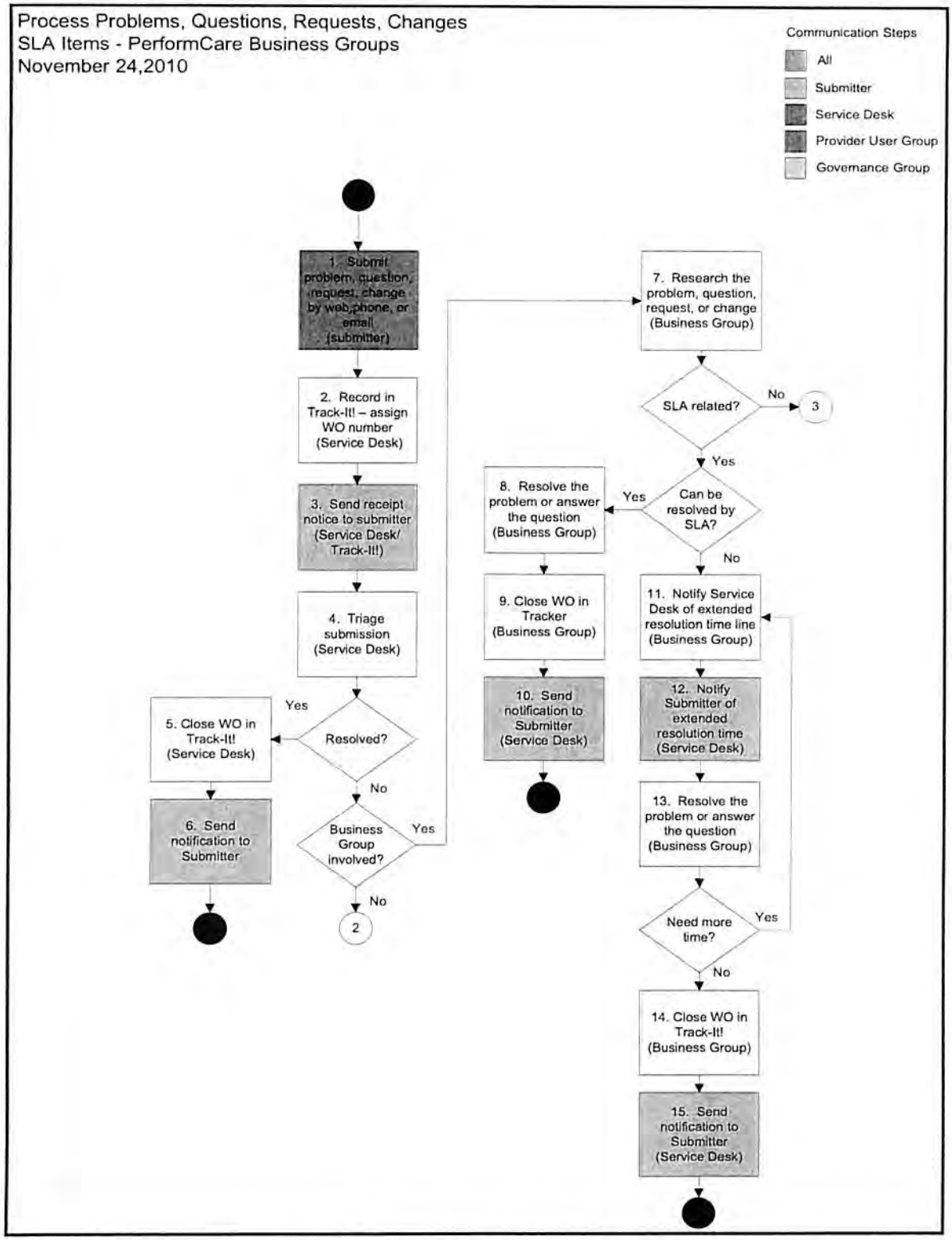
See the change management process depicted in the diagrams on the following pages:



Change Management Process (Diagram 1)



Change Management Process (Diagram 2)



Change Management Process (Diagram 3)

Communication Hub

The Service Desk has the capacity to act as a communications hub among the user community, the SMO staff, the IT team, and the State to ensure that documented issues and resolutions can be shared among groups in a timely manner.

FAQs

The Service Desk gathers, edits, and distributes FAQ information through the organization's website.

Contacting the Service Desk

The Service Desk may be accessed by calling the 800 number provided. Technicians are available during standard office hours (8:00 am to 7:00 pm), and a technician is available on-call every night (7:00 pm to 8:00 am) and on all weekends and holidays. Calls are answered promptly, and a script is followed to collect identifying information and gather data pertaining to the issue or question.

The Service Desk may also be contacted via a web form that is submitted to the problem tracking software. This is constantly monitored by technicians during office hours. The form is customized to fit the needs of the organization with all the areas of support that the Service Desk covers.

Every work order that is resolved has a survey link attached for the user to respond about the quality of services provided by the Service Desk. A quarterly report is produced from the results of the survey for the client.

On the following pages, we have provided samples of our informatics (interfaces and reporting products) presenting help-desk results:

Service Desk Satisfaction Survey (Report)

PerformCare provides reporting designs to permit users the ability to clearly evaluate important performance measures in an easily understandable format.

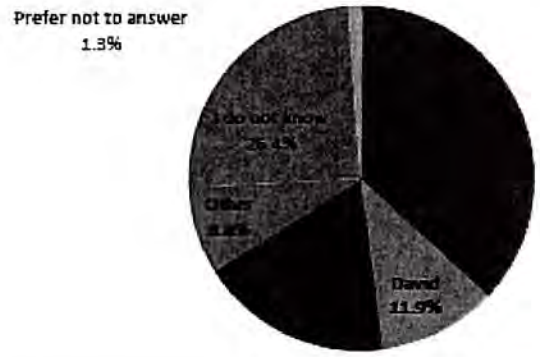
Excerpts from Service Desk Survey Comments

Respondents were also invited to write in comments and 77 respondents commented on Perform Care Service Desk Staff.

- Earl is consistently helpful and polite.
- Terrific...the matter was resolved in 15 minutes. Thanks!
- I was so impressed with how quickly my email was responded to and Chuck was very knowledgeable and helpful! Not only did he help, but has a wonderful sense of humor which made it fun as well....I can say I have never said that about a help desk!! Thanks
- The quality of support was excellent and does not need improvement
- Always enjoy working with Earl and Chuck, now I can add David to my list of very helpful people
- I like that I can send an e-mail and it's taken care of and I don't necessarily have to call someone
- The customer service staff and technicians are very pleasant and knowledgeable
- Solution focused
- I have spoken to several support staff and each one is really wonderful: very helpful, very respectful. I can't think of a thing to improve. Thanks for the help
- I always am received with courtesy & respect & answers are available
- The staff is patient, informative and professional. They always take the time to research the situation, and will follow up and call back when warranted.

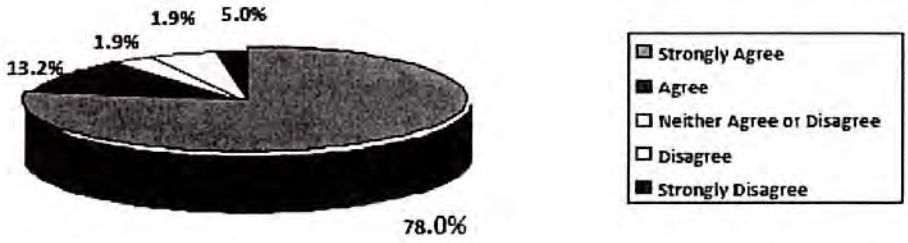
PerformCare
Behavioral Health Solutions

What PerformCare technician was assigned to your case?



30% of the cases were assigned to Chuck, 26% of the respondents did not know which technician was assigned to their case, nearly 9% were assigned to other technician, and 19.5% were assigned to Earl.

I was satisfied with the amount of time it took to resolve my issue:

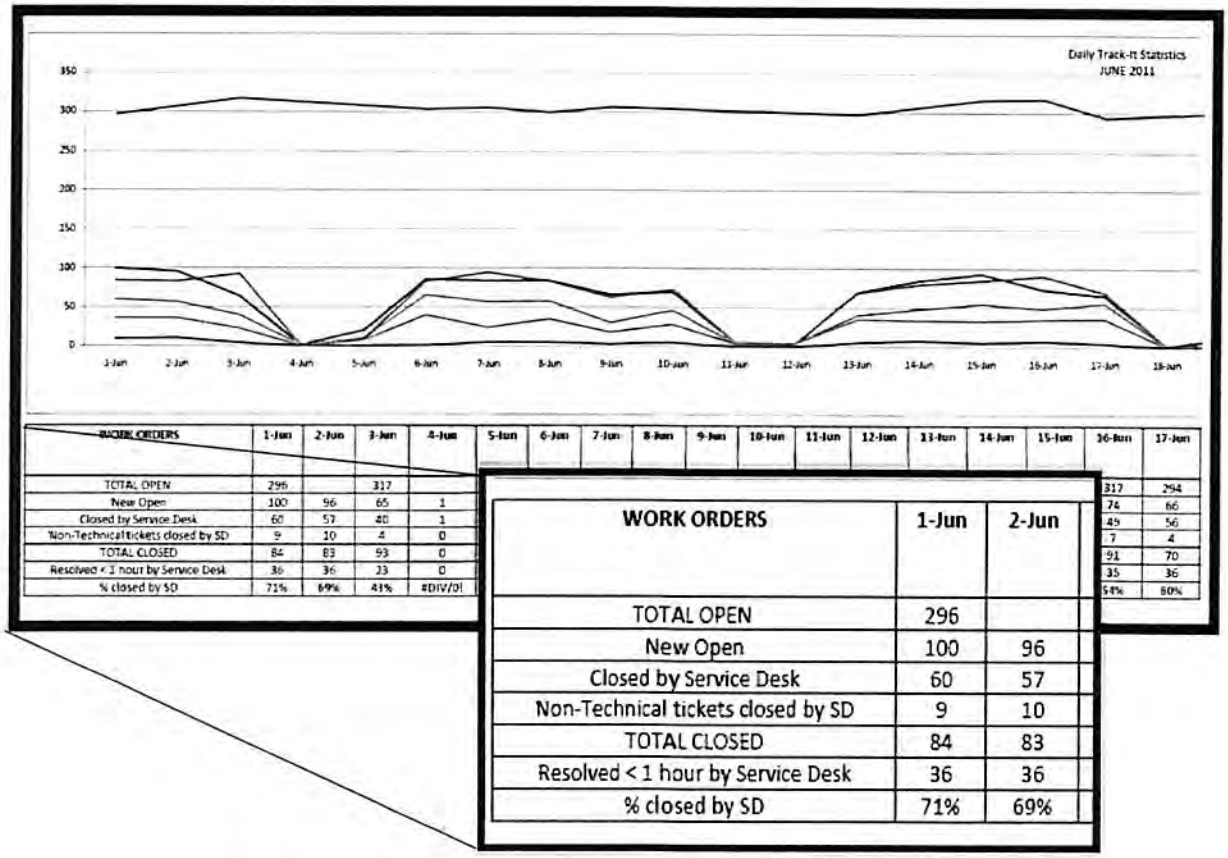


More than three-fourths of the respondents were very satisfied with the amount of time it took to resolve their issues.

Sample Help Desk Satisfaction Survey Results

Service Desk Satisfaction Survey (Metrics)

In addition, periodic reports about work orders processed by the Service Desk are produced for internal auditing, and customized reports are available for the client. Work orders are tracked in an array of measurement cohorts, on a month by month basis. The reporting criteria will be as specified by the State of Louisiana.



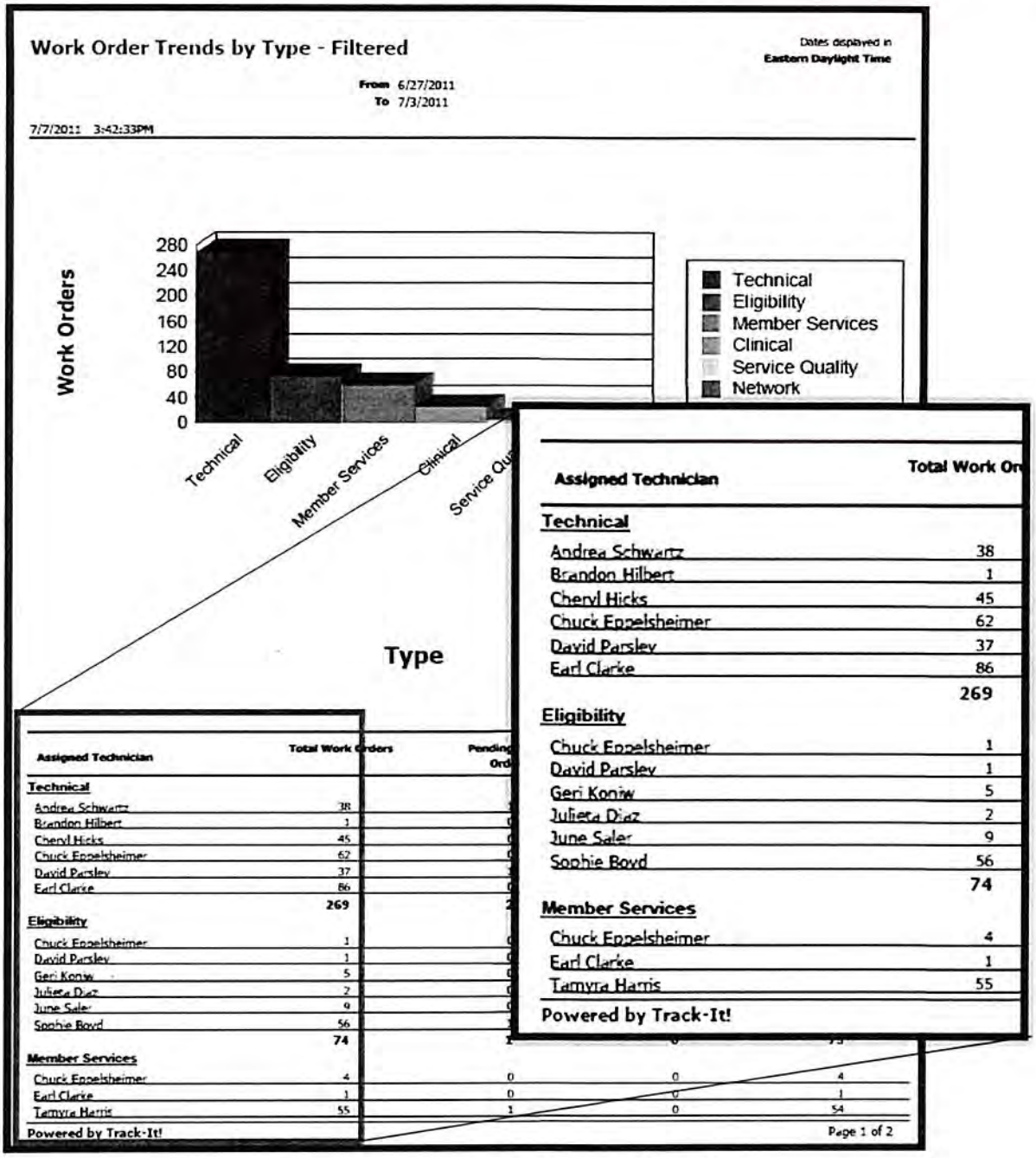
WORK ORDERS	1-Jun	2-Jun	3-Jun	4-Jun	5-Jun	6-Jun	7-Jun	8-Jun	9-Jun	10-Jun	11-Jun	12-Jun	13-Jun	14-Jun	15-Jun	16-Jun	17-Jun
TOTAL OPEN	296		317													317	294
New Open	100	96	65	1												74	66
Closed by Service Desk	60	57	40	1												49	56
Non-Technical tickets closed by SD	9	10	4	0												7	4
TOTAL CLOSED	84	83	93	0												91	70
Resolved < 1 hour by Service Desk	36	36	33	0												35	36
% closed by SD	71%	69%	43%	#DIV/0!												54%	80%

WORK ORDERS	1-Jun	2-Jun
TOTAL OPEN	296	
New Open	100	96
Closed by Service Desk	60	57
Non-Technical tickets closed by SD	9	10
TOTAL CLOSED	84	83
Resolved < 1 hour by Service Desk	36	36
% closed by SD	71%	69%

Sample Help Desk Satisfaction Survey Metric Results

Work Order Trends (Report)

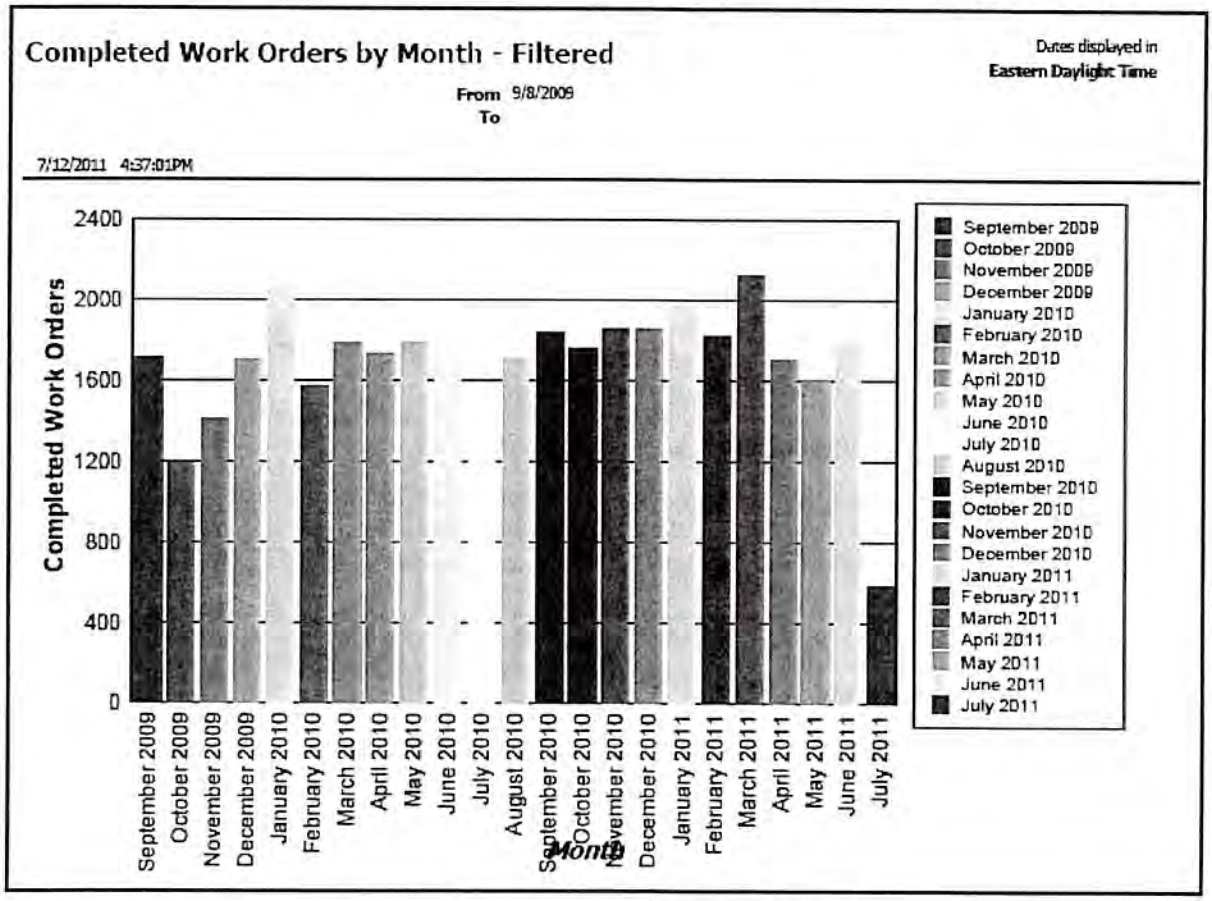
Customized Service Desk reports are provided and can be used to identify Service Desk productivity in terms of total work orders presented, pending work orders (queued for disposition), overdue work orders, and closed work orders by Service Desk Technician. Additional aggregate Service Desk formats will be provided as specified by the State of Louisiana.



Work Order Trends Report – Sample 1

Work Order Trends (Report)

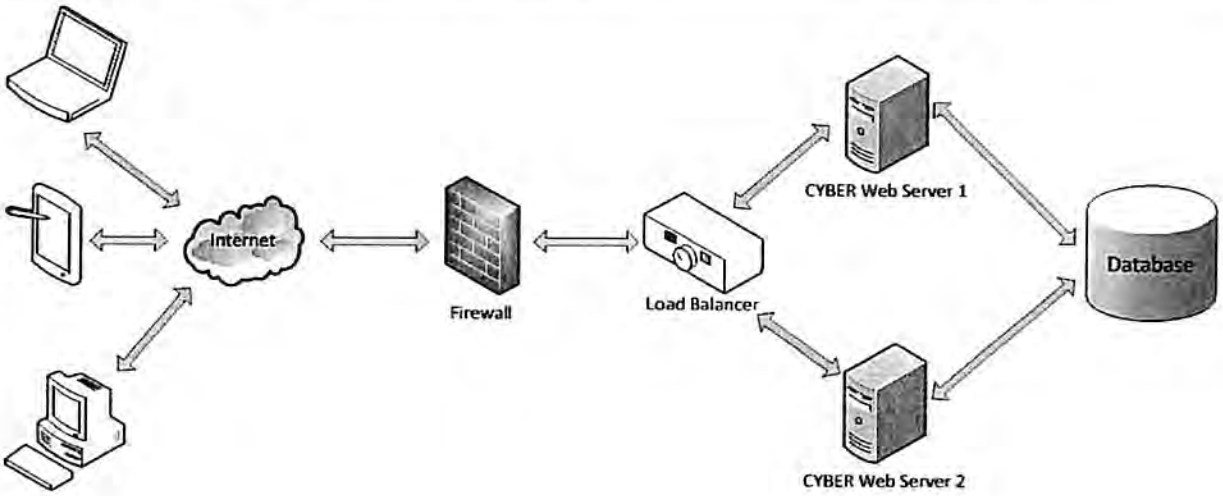
Work Order Trend reporting is provided to quickly observe the trending of Service Desk requests. Depicted below is a 23 month trend report measuring the work order volume on an aggregate level.



Work Order Trends Report – Sample 2

xvi. Describe the Proposer's ability to access the system for end users not working in the office.

The CYBER component of the CLARIS platform is a web-based application and is completely accessible to the end-users outside of the office, accessed via a common internet browser. The application is protected by a strong username and password (utilizing letters, by case; characters, and number values) that the user must enter before accessing the system. CLARIS delivers the user interface entirely via a web browser. Therefore, all interactions with records or processes from the community at large are conducted through CLARIS. The proposed architecture assures the secure transfer of HIPAA-compliant information that is easily accessed and users can tailor their user experience by selecting different menu options. The below diagram represents the PerformCare New Jersey basic configuration for end users and will be replicated in Louisiana.



The end-user and network infrastructure is outlined below:

- End users are required to run a system with at least Windows Vista but Windows 7 is preferred. Mac Leopard 10.5 or better is also supported. We recommend that the screen resolution be 1280x1024 or greater, but this not required. Lower resolutions force the end-user to use the scroll bars to navigate around the screen.

  End-User Hardware

  - 1.5 GHz processor or better
  - 2 GB of system memory or greater
  - Recommended 1280x1024 display for best viewing experience but lesser resolutions are supported.

  End-User Software

  - Windows Vista (32 or 64 bit), Windows 7, or newer, Mac Leopard 10.5 or better.
  - Microsoft Silverlight 4
  - Internet Explorer 8.x or newer
  - Firefox 4.x or newer
- The firewall blocks ports other than HTTPS from being exploited by a potential attacker who may be looking for another means into a system. The idea is to decrease the surface area exposure to reduce risk.
- There is a load balancer between the firewall and the web servers to ensure that both web servers are using an equal amount or resources. For example, without a load balancer, traffic may be directed to only one server which will bear the demand weight of processing. A load balancer monitors both web servers and makes a decision as to which web server is using fewer resources. When the load balancer determines which server is using fewer resources, traffic is routed to that server. This configuration also allows for many more web servers be put in place if/when the need arises.

- The web servers process data to a dedicated database server. All transactions are replicated in real-time between the two or more databases. Communication between the user device and the web servers is transmitted using industry standard secure HTTPS communication protocols.
- All CLARIS data is stored in the CLARIS intermediate database. – enabling easy access to the underlying data for any additional interfaces that may need to be developed going forward.

xvii. Describe the Proposer's experience with 270/271 Eligibility Request / Response transactions as well as submitting and receiving 834 Enrollment/Disenrollment transaction sets.

PerformCare has received eligibility in the 834 ANSI X12N since its inception in 2003. PerformCare has utilized outside vendors and its corporate operations EDI unit to parse and validate the file and transform it into a flat file for loading into its application systems. PerformCare takes much pride in having a solid process for managing intake of eligibility and processing eligibility discrepancies. While PerformCare has less direct experience in the 270/271 Eligibility transaction, its vendor, TAI and its corporate office in Philadelphia have extensive experience. This includes the processing of the 270/271 transaction in New Jersey by the CYBER system utilized by PerformCare.

270 / 271 Eligibility Status Requests and Response Illustration

Our corporate systems in Philadelphia process the 270/271 transactions by reading in the 270 request file and returning the 271 payer response file to the provider. A 270 transaction is received, parsed and the eligibility is verified. Based on the verification the response file is returned, i.e. the 271 transaction. The EDI system also provides the ability to import files in the 270 format and export files in 271 format containing eligibility status requests for a subscriber or dependent. The payer's response indicates whether the subscriber or dependent receives insurance benefits from the payer and is eligible to receive the service. The response is exported through the EDI Engine in a 271 file format. System support technology has been a standard contract requirement for the various eligibility mechanisms presented in the X12 transaction set. Typically, even "standard" X12 transaction sets require State specific customization as would be defined in a companion guide utilized by many States to define variations to the standard.

CLARIS is capable of processing the 270/271 in the opposite direction also. CLARIS can generate a X12 270 eligibility verification file for when a claim is submitted to validate a person's eligibility at the time of billing. Normally such determinations are made from the periodic eligibility feed of 834s from the overseeing entity—the State of Louisiana in this case. Problems often arise in the day to day or in some cases hour to hour fluctuations in this picture. Given that eligibility is often a moving target, many of our clients hold the standard that a bill/claim will pass the eligibility determination test when proof of eligibility can be provided that coincides with the submission of said bill/claim. In these situations the system can generate an X12 270 request and send that request off to the eligibility system. The system then awaits the X12 271 response; an affirmative response is stored along with the bill/claim as proof.

834 Enrollment

The Commonwealth of Pennsylvania transmits a series of 834 format enrollment files on a daily basis for the service population. The 834 data files reflect the result of the statewide eligibility system maintained by the Commonwealth's subcontracted enrollment data vendor - Electronic Data Systems (EDS) in their data warehouse. The daily eligibility data files contain changes to an individual's eligibility records from the prior day's record. Moreover, the daily files might contain multiple changes to the various elements of the record spread across a single or multiple records.

PerformCare receives and processes eligibility data files in the form of 834 Enrollment Transaction files on a daily basis. The 834 data files reflect the result of a statewide eligibility system The daily

eligibility data files contain changes to an individual's eligibility records from the prior day's record. Moreover, the daily files might contain multiple changes to the various elements of the record spread across a single or multiple records. These files are logged, processed, and archived daily. The files go through an initial staging process which includes parsing the 834 files, apply algorithms to appropriately interpret the data in the 834 file and identify exceptions. Exceptions are given to enrollment specialists who research the discrepancy with appropriate systems. The 'scrubbed' data is transformed into a daily eligibility file for use by PerformCare to import into the CLARIS application system. During the parsing of the daily eligibility file, it is read and identified for changes in the member's demographics, member's category of aid or member's plan eligibility. If such changes are identified, the entire member history is included in the daily upload file for the PerformCare Information System. The 820 capitation files are also parsed and reconciled with the 834 eligibility files. Discrepancies are researched and the eligibility information is updated accordingly and included in the next daily eligibility file supplied to PerformCare.

PerformCare receives and loads the daily eligibility files into its information systems on the same day as receipt of the 834 eligibility file. CLARIS has a Membership Upload Tool for mapping and importing eligibility data. PerformCare uses this tool developed as a standard feature of the application. All inserts and updates are tracked in audit tables. The membership Upload Tool has a Filter Configuration module which allows member and eligibility information to be automatically uploaded from various file formats. Using the Filter Configuration Module, one can configure the fields and default values for each file to be imported. The Upload Module then allows one to create a batch that imports the actual file. Selection criteria are used to filter out duplicate member information that exists in a file being uploaded.

This allows Intake and Clinical staff to verify insurance information directly in the member's electronic record rather than connecting to another system.

The 820 capitation files are also parsed and reconciled with the 834 eligibility files by ACA. PerformCare also receives copies of the 820 capitation files and parses and loads them into the reporting warehouse. The detail segments are loaded and then summary tables are also created. These tables can be accessed by the finance department to query and reconcile with the membership eligibility information in CLARIS. This allows for additional reconciliation routines to be performed.

It should be noted that since PerformCare's parent company also processes 834 Enrollment data, PerformCare does utilize and leverage these like processes that exist in house for some of its current contracts and may take advantage of the strong EDI tools for initial parsing and staging of the 834 enrollment data.

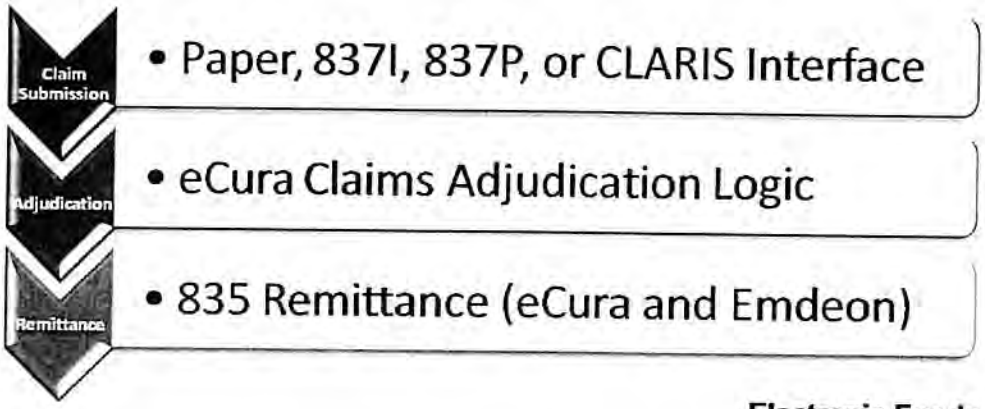
xviii. Describe the Proposer's experience with the HIPAA 835 and electronic funds transfer.

PerformCare offers a full 835 and EFT solution for all if its providers and has experience providing 835 since 2003 and EFT for any provider who requests since July of 2008. PerformCare has recently expanded the interface available to providers by contracting with Emdeon for ePayment Manager services.

835 Remittance Advice

PerformCare values the administration efforts of our providers, and we provide a HIPAA-compliant 835 to any provider who requests and is able to process the 835. We have been compliant with the HIPAA 835 since 2003 when it was required. PerformCare uses Edifecs to validate 835 compliance to SNIP level three (3). PerformCare has always been on the cutting edge of electronic remittance advice submissions to our providers. We are in the process of converting to the HIPAA 5010 835 and fully expect to provide HIPAA-compliant 5010 version 835s with no disruption of service to our providers.

As part of the weekly check run process for payment of claims, the 835 remittance advice is generated. The HIPAA Transaction Engine in our claims processing system provides the ability to export a file in the 835 format. An 835 file exported through the HIPAA Transaction Engine consists of claim payment information, including Remittance Advice. A Remittance Advice shows the checks or EFT paid to providers, reimbursing them for services rendered. For each check, it shows claim information for the members whose treatments the check covers. After generation of the 835, the in house processing parses each file and performs a second balancing routine and verification of the file. Once the file is balanced and passes edits, the file is then released for posting. The 835 files are transferred to Emdeon along with remittance advice files. Emdeon performs another level of compliance checking to verify the 835 is HIPAA compliant and the 835 file balances to the print image of the remittance advice. Emdeon will post the 835 ERA file at no additional charge on their Emdeon Payment Manager - ePayment Edition website service.



Electronic Funds Transfer

PerformCare understands the importance of providers receiving their funds due as quickly as possible. Therefore, PerformCare offers electronic payments to all of their providers and has experience in managing an Electronic Funds Transfer (EFT) enrollment program for providers, storing and validating Automated Clearing House (ACH) debit payment information for providers and generating the NACHA -*The Electronic Payments Association* file required by the banking industry for execution of the electronic funds transfer for claims payments.

As an additional option, PerformCare has recently contracted with Emdeon for an Emdeon Payment Manager- ePayment Edition. This makes it even easier for provider to sign up and receive payments via EFT. The ePayment Manager provides enrollment for EFT transactions, submit banking information in a secure manner and manage bank account changes. PerformCare sends a remittance advice file with payment information to Emdeon as part of claims payment processing. In turn Emdeon either prints a paper check or initiates an ACH Debit transaction to pay the provider.

Through Emdeon, EFT and remittance services are offered at no additional cost to the Provider for participating Payers. Emdeon manages the enrollment of providers for EFT through their Payment Manager - ePayment Edition service, which is offered as a complimentary service with EFT enrollment. On Emdeon Payment Manager - ePayment Edition, providers can electronically view the print image of the remittance advice. With Payment Manager, providers can quickly search, view or print each remittance as needed.

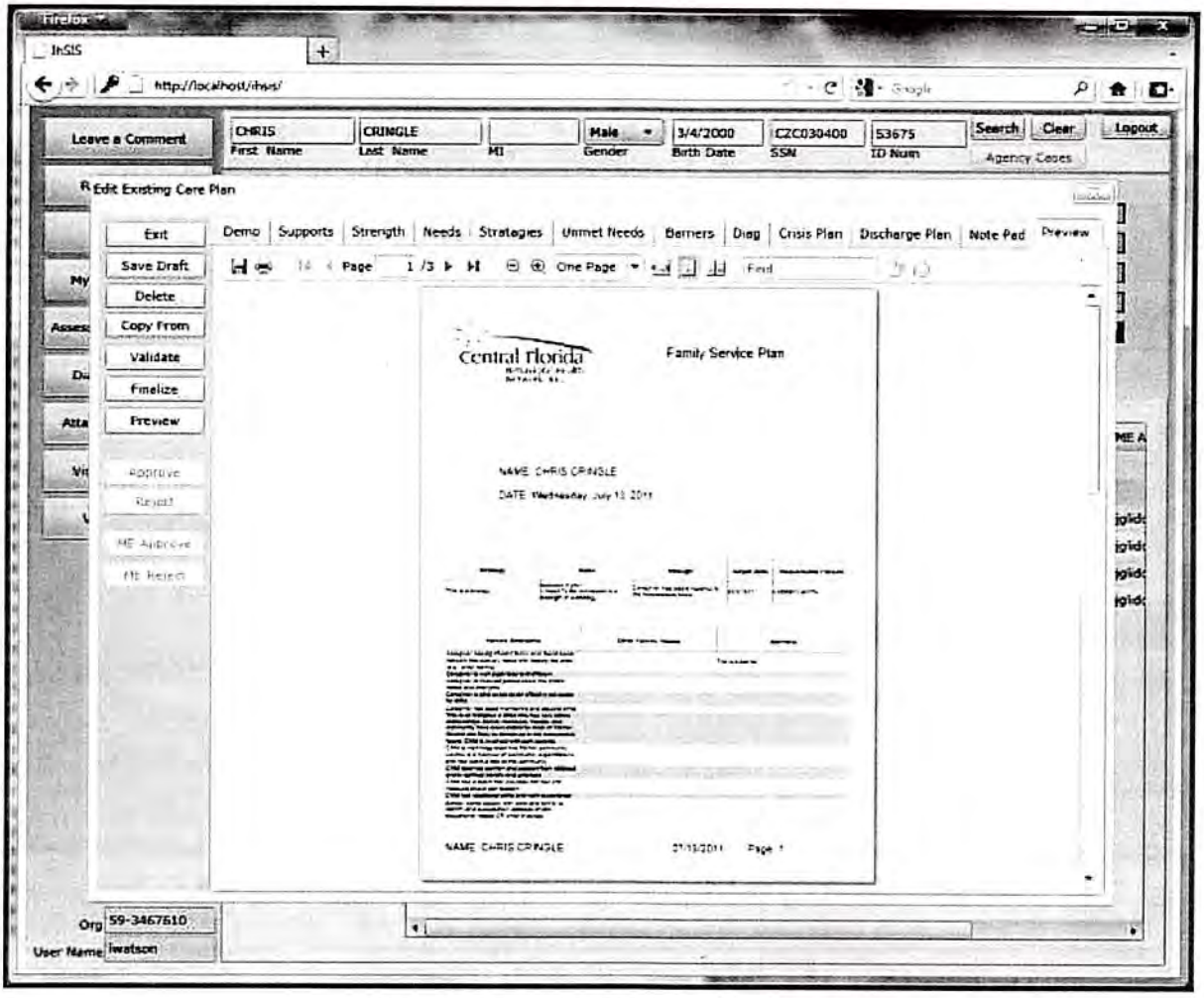
xix. Describe the Proposer's system ability to send and receive data from other agencies such as eligibility (HIPAA 834) and member's plan of care data consistent with the collaboration requirement in the Scope of Work.

CLARIS contains the capability to bring together the disparate departments and functional entities to facilitate smooth collaboration across agencies, families, and youth for the purpose of improving access and expanding coordinated community-based services and supports for children and youth with serious BH disorders and their families. We realize a core strategy for the improvement of children's MH systems of care is a collaborative partnership between families and service providers, the WAAs and with the SMO. CLARIS provides the answer to providing comprehensive care because all related stakeholders in the service delivery system have role-based access to the information made available in real time, fostering information-based service delivery at every point in the service continuum, and the accountability to monitor wraparound fidelity, service quality, and effective outcomes.

As a provider of user defined customized software solutions, all of our clients, to varying degrees, have asked for the ability to send and receive information in a multitude of interfaces, many of which are file based. In recent times the files received by the client and the files the client submitted to other parties have loosely adhered to various published specification standards (i.e. various X12 formats 834,820,837,835,270,271, etc.) as well as other loose standards like HL7 for data sets that do not fit into one of the X12 formats. There are, however, numerous occasions where created interfaces did not adhere to any published standard. What follows is a brief list of some of the other instances, as we believe Louisiana might have use for these types of interfaces.

Care Plan/Service Plan Data Feed from Providers into the System

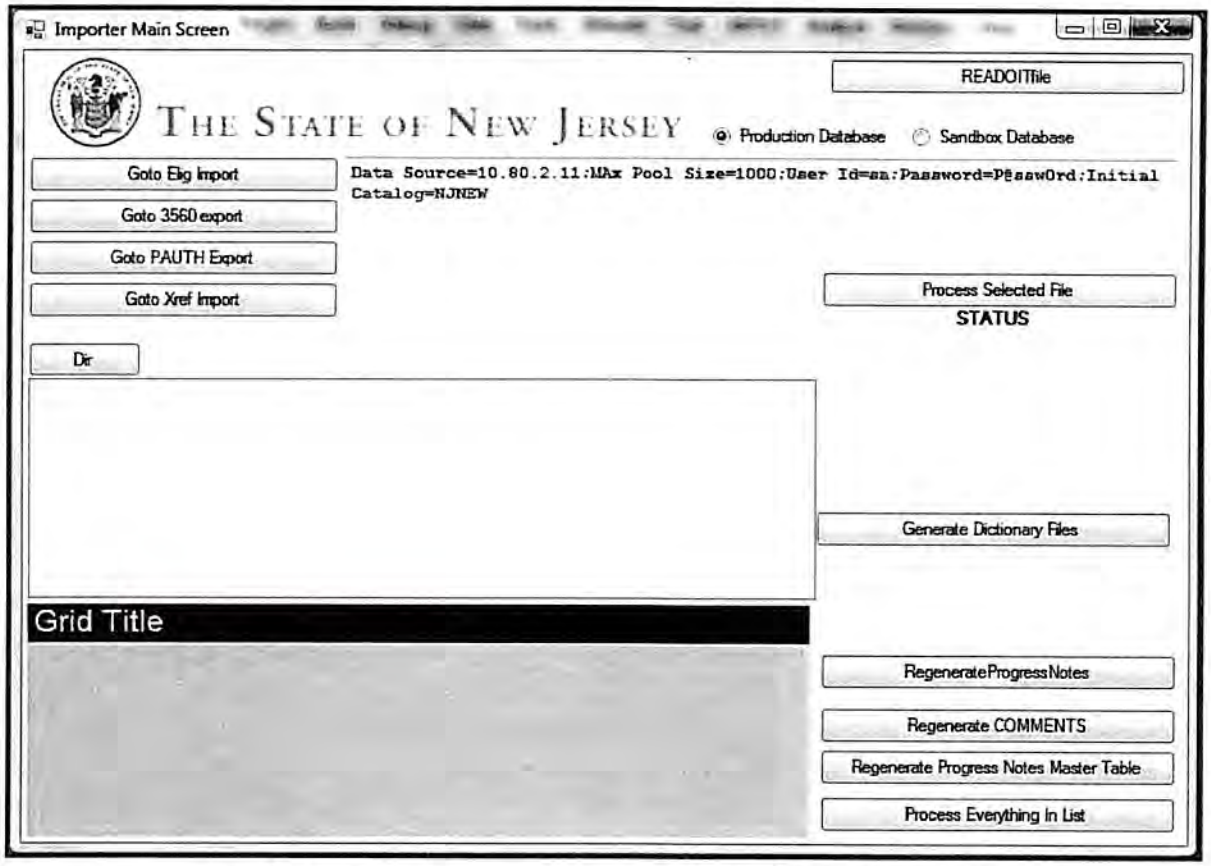
The custom file submission system allows several large providers to record their care plans electronically. The providers generate this report, which extracts the data from plan documents, and submit the file via the user interface. The system then extracts the relevant bits of information and inserts a care plan into the designated persons EHR. The plan is then available for review and printing in the system just as if that plan's content had been keyed into the system directly.



Sample Assessment Import results

Assessment Data Imports

When the PerformCare NJ system was being developed, there was a need to import several years' worth of assessment data accumulated prior to implementation in New Jersey. These files were all generated using the prior system and consisted of flat ASCII text files with various delimiter rules depending on context. We implemented a custom importer for this assessment data.



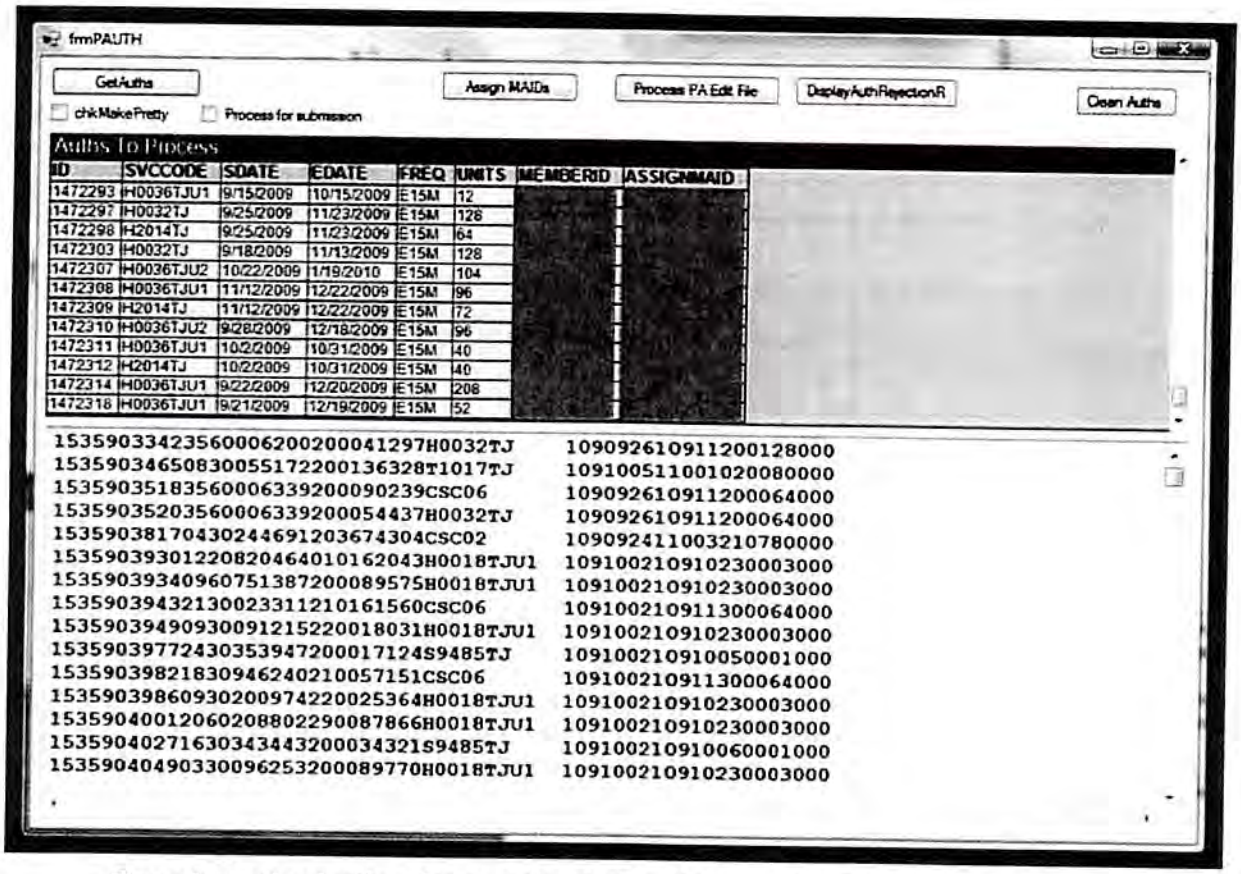
Sample Importer Exporter screen from the NJ implementation

Custom File Importer for 834 Medicaid Eligibility Feed from New Jersey Office of Information Technology

This is another example of a file based importer written to read the NJ OIT eligibility records from a file transmission that PerformCare picks up on a regular basis (daily and monthly). Unlike a normal set of 834 transactions, however, these files are in EBCDIC (Extended Binary Coded Decimal Interchange Code (EBCDIC) format, a format that was supplied in a series of COBOL (Common Business- Oriented Language (COBOL) copy books. The content of the transactions in the files is different depending on the first few characters of each line in the files. Importing these files requires that they first be converted from the EBCDIC format to ASCII before the transaction interpretation can continue.

Authorization Files Export to NJ OIT

One of the primary functions of CLARIS is to manage the generation of authorizations, so the providers in the community can submit claims and get paid. The authorization interface specified for the implementation team in New Jersey was a flat ASCII transactional specification that was completely customized. The files needed to be generated and submitted to the NJ MMIS (New Jersey Medicaid) web portal periodically (currently on Tuesday and Thursday evenings). A key aspect of this file's content is the specific member's Medicaid ID number gathered from the eligibility import process mentioned above.



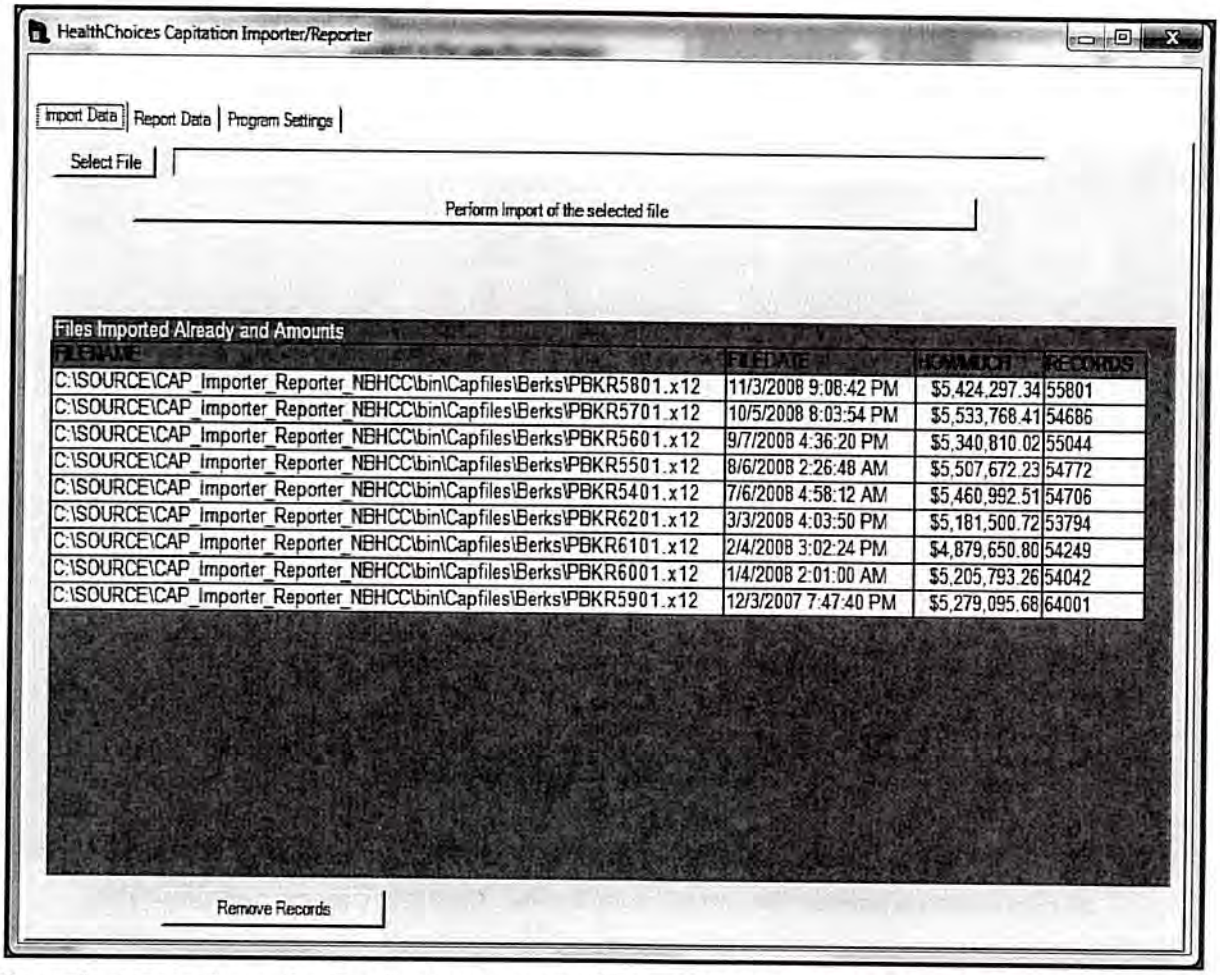
Sample Authorization file creation in the NJ Importer/Exporter application

3560 Eligibility Exporter – PerformCare NJ

While the CYBER system relies on an import of the NJ Medicaid systems eligibility data using a custom importer (mentioned above), CYBER is also used to generate eligibility records for the "Stop Gap" style of program that NJ employs. NJ specific Medicaid IDs always start with the digits 3560; hence the name of the process. In this process various forms are filed in CYBER and various determinations are made by PerformCare and the State, ultimately resulting in a set of transaction records appearing in a custom ASCII file format that is then transmitted to NJ OIT for processing.

Capitation Importer/Reporter Tool Set – Pennsylvania Clients

Our PA HealthChoices clients who manage the finances of their programs need to be able to read the capitation payment that were sent to them each month by the state of Pennsylvania. These files contain records of case rate payments made to the county for each eligible member in the county's HealthChoices program. Initially these files were in a custom text format. In 2005 the state transitioned to the X12 820 form for these files. At that point the tools were refitted to accommodate the change in format. This is one example of a single tool/application acting as both an importer of data and a dashboard application used for extracting and reporting information.



Sample screen from the Capitation Importer/Exporter tool created for PA Healthchoices

Various other file interfaces developed and supported

- LAG Tools
  - Allows claims analysts to perform LAGs on claim runs for determining run out. Specific output for this tool required a set of specially formatted excel documents that the tool produces automatically.
- FRR (Financial Reporting Requirements) Health Choices Programs for State of PA Clients
  - This process generates a set of transactions contained in a single ASCII file representing program status (e.g., people served by category, money spent in various cohorts, etc.) in multiple specially formatted lines of textual information.
- File Process Robotics
  - This category of importers and exporters exists to not only handle file based data transmissions into and out of systems that we have developed, but also to automate tasks that formerly required human intervention. Each item contains a selection of customized file readers and writers and

interface scripting/software robotics to mimic the operations of the human interaction. For example, the robot:

- Accesses the designated state website
- Logs in as a particular user
- Navigates via links to a specific area within the site
- Selects a series of extracts to be downloaded (with date parameter entry, and other selections)
- If the extracts are not available immediately, logs off and comes back after a pre-determined amount of time has passed
- Downloads extracts (Access Databases in this case)
- Opens the extracts and pushes their content into a more suitable format for consumption by other processes and users (SQL server data warehouse for example)

834 Enrollment

PerformCare receives eligibility data files in the form of 834 Enrollment Transaction files. These files are logged, processed, and archived daily. The files go through an initial staging process which includes parsing the 834 files, apply algorithms to appropriately interpret the data in the 834 file and identify exceptions. Exceptions are given to enrollment specialists who research the discrepancy with appropriate systems. The 'scrubbed' data is transformed into a daily eligibility file for use by PerformCare to import into the system. During the parsing of the daily eligibility file, it is read and identified for changes in the member's demographics, member's category of aid or member's plan eligibility. If such changes are identified, the entire member history is included in the daily upload file for the PerformCare Information System. The 820 capitation files are also parsed and reconciled with the 834 eligibility files. Discrepancies are researched and the eligibility information is updated accordingly and included in the next daily eligibility file supplied to PerformCare.

PerformCare receives and loads the daily eligibility files into its information systems on the same day as receipt of the 834 eligibility file. The system has a Membership Upload Tool for mapping and importing eligibility data. PerformCare uses this tool developed as a standard feature of the application. All inserts and updates are tracked in audit tables. The membership Upload Tool has a Filter Configuration module which allows the member and eligibility information to be automatically uploaded from various file formats. Using the Filter Configuration Module, one can configure the fields and default values for each file to be imported. The Upload Module then allows one to create a batch that imports the actual file. Selection criteria are used to filter out duplicate member information that exists in a file being uploaded.

- This allows Intake and Clinical staff to verify insurance information directly in the member's electronic record rather than connecting to another system.
- The 820 capitation files are also parsed and reconciled with the 834 eligibility files. PerformCare also receives copies of the 820 capitation files and parses and loads them into the reporting warehouse. The detail segments are loaded and then summary tables are also created. These tables can be accessed by the finance department to query and reconcile with the membership eligibility information. This allows for additional reconciliation routines to be performed.
- It should be noted that PerformCare's parent company, AmeriHealth Mercy, also routinely processes 834 Enrollment data. PerformCare does utilize and leverage these like processes that exist at a corporate level for some of its current contracts and may take advantage of the strong EDI tools for initial parsing and staging of the 834 enrollment data. Given that AmeriHealth Mercy of Louisiana

will be concurrently implementing a Coordinated Care Network in Louisiana, we will evaluate and pursue such joint efficiencies.

xx. Describe the Proposer's current status of implementing the HIPAA ANSI 5010 formats and preparation for the ICD-10 implementation.

Current Status of 5010 Formats

PerformCare began working on being ready for the HIPAA ANSI 5010 formats in 2010 by first preparing a full gap analysis and working with vendor to design a solution. PerformCare is preparing to accept the inbound 5010 transactions and produce the outbound 5010 transactions.

PerformCare is currently testing intake of 837 to validate in the 5010 format. PerformCare is working to upgrade our current claims system to be fully 5010 compliant by January 1, 2012. In the interim, PerformCare is using Emdeon to manage 4010 to 5010 translation where necessary. We are working closely with our provider community to assist them in being ready. We are currently in testing with multiple providers via Emdeon.

Preparation of ICD-10 Implementation

The Centers for Medicare and Medicaid (CMS) have mandated that all health organizations be compliant with ICD-10 (Internal Classification of Diseases) regulations by October 1, 2013. PerformCare began assessing the impact in 2009 and has participated with parent company AmeriHealth Mercy to complete our impact assessment earlier this year. Plans are to be able accept ICD-9 or ICD-10 at the same time within the same system and manage clinical and claims transactions in either format. For informatics purposes, a crosswalk will be established. By allowing this crosswalk, proprietary reporting to other agencies can be done in the format they require at the time they require it as well as better manage reporting needs during the cutover phase.

Our approach is as follows:

- Seek to achieve revenue neutrality in the shift to ICD-10
- Utilize a dual-processing approach so that we can process both ICD-9 and ICD-10 through our core systems without the use of a cross walk map
- Ensure that our informatics capabilities are insulated from the change to ICD-10 in the short term and leverage the increased granularity of ICD-10 in the long term.
- The Claims module is being configured to accommodate both ICD-9 and ICD-10 codes simultaneously. The diagnosis code will match to the one submitted and the system will know if it is ICD-9 or ICD-10 and store it.
- A key factor in the ICD-10 initiative is effective planning and communication with the provider networks. This approach, which will also be used for Louisiana, is expected to reduce the potential negative impacts of ICD-10, not just for that particular provider, but the network overall.

PerformCare has chosen not to use a crosswalk for processing claims for several reasons. First, the use of crosswalks is likely to confuse and alienate providers who are already concerned about the potential negative impact on their reimbursement with ICD-10. Second, while CMS has released general equivalence maps for ICD-9 to ICD-10, these were never intended to be used for determining reimbursement. Finally, a crosswalk is only a temporary solution at best that will need to eventually be replaced by a system that is fully ICD-10 capable.

PerformCare will be able to accommodate both ICD-9 and ICD-10 codes simultaneously and our ICD Translation Manager application allows our systems to define ICD codes, establish source code sets and establish mappings for translating ICD-9 and ICD-10 procedure and diagnosis codes. Additional features include:

- Ability to accept an ICD-9 or ICD-10 code and translate that code to its equivalent value for processing.
- Facilitates code translation from ICD-9 to ICD-10 code sets and vice versa.
- Extensiblity to products and processes outside of Facets.
- Ability to load, store and maintain ICD-9 and ICD-10 diagnosis and procedure code sets, along with their English language descriptions and effective dates (start/end dates) within a common repository within our claims processing system.
- Translation mapping will be based on 3M or other standardized translation services available as well as being customized for our particular requirements where needed.

A key factor in the ICD-10 initiative is effective planning and communication with the provider networks. AmeriHealth Mercy's other affiliates are working with key providers to understand how they are preparing for ICD-10, share plan experiences, identify common touch points and highlight potential risks that need to be considered as we jointly move forward. This approach, which will also be used for Louisiana, is expected to reduce the potential negative impacts of ICD-10, not just for that particular provider, but the network overall.

xxi. Provide claim submission statistics as directed below for the most recently completed month overall for your current clients, for electronic and paper submission. All formats, including proprietary formats, should be included.

Claims Submission Statistics – June 2011

Claim Type	Format	Claims Received
Professional	837	91,155
Professional	Paper or ePaper	29,396
Institutional	837	2,529
Institutional	Paper or ePaper	766

xxii. Describe the Proposer's process for receipt, storage, and data entry of provider paper format billings.

As part of the AmeriHealth Mercy Family of Companies, PerformCare leverages a strategic alliance with the imaging vendor Affiliated Computer Services (ACS) to primarily scan and key our paper claim and supporting claim documents. ACS performs image management for thousands of customers across America. This wide range of customers has given ACS a unique capability to apply knowledge gained from multiple industries (and form/document types) to the managed Medicaid business. ACS uses the latest technology in image scanning and Optical Character Recognition (OCR). When documents are prepared in an OCR format, ACS uses this technology to limit errors and lower manual intervention. This

is done for Professional claims submitted on the CMS-1500 as well as Institutional claims submitted on the UB-04. Furthermore, each paper claim is stamped with the date received at ACS and receives a document control number.

ACS validates provider and member information on the claim and transforms the claims data from the paper claims into 837 Professional and 837 Institutional claim files. Each EDI claim file is bundled along with the original claim images and any other attachments. The electronic version of the paper claim is now dubbed 'ePaper' claim. PerformCare receives the daily 837 claim files and the electronic images and performs the following steps:

- Validates the structural compliance of the file and returns a file level acknowledgement
- Uploads the claim images into CNG-SAFE and indexes according to the member and the document control number.
- Uploads the 837 files into the Claims Module and uses the received date of ACS to acknowledge receipt.
- Performs the claims processing

This allows for very simple, easy access to the original claim as submitted by the provider for the Provider Claims Hotline as well as auditing activities and general claims processing.

Should PerformCare receive the paper claims directly, the process is as follows:

Paper Claims Receipt & Entry

In order to establish document control and organization of paper claims received as well as easy retrieval, the following procedure has been established:

- All claims are stamped with the date received and scanned using digital imaging technology application.
- These claims are then sorted according to the adjudicator responsibility. Claims processors are trained to adjudicate claims by all types. In addition, each provider or claim type has been assigned a specific claims adjudicator who is responsible to assure timely and correct claims processing.
- Claims are batched in bundles of not more than 200 claims.
- Each batch is assigned a batch number that is recorded in an electronic log file, along with the number of claims in the batch, date received and assigned adjudicator.
- The batches are scanned into our electronic filing system and then distributed to the assigned adjudicator.
- Adjudicator then works each batch in date received order.
- Upon completion, the batch cover sheet is completed, recording date completed, number of claims processed, number of duplicates, number of claims returned to provider and any miscellaneous reasons for not processing.
- The information from the batch cover sheet is recorded in the Claims Log File.
- Batches are then filed in batch number sequence.

Claims processors enter a claim into the PerformCare Information System using screens that look like the CMS 1500 and UB04 claim forms submitted by providers. Further, some basic pieces of data will be automatically completed by the Information System (i.e., demographics and provider information). The

claims processor will enter only additional required information that the providers have submitted on the paper claim. As the screen looks identical to the form in front of them, and is populated with information that already resides in the Information System, the claims entry process becomes much easier and more accurate using the form screens.

xxiii. Describe the Proposer's internal claims audit including percent of claims audited. Provide a sample of the reports used in this process.

PerformCare Claims Director or designee on a daily basis performs audit of random claims for oversight and reporting purposes as well as for supervision purposes. This includes professional and institutional claims. The auditor will review a sampling of both paper claims received electronically from ACS (ePaper) and electronic claims received in the ANSI X12N standard from Emdeon via the 837 Professional or 837 Institutional. This sampling will be randomly selected and will be at least 2% of daily claims received by PerformCare.

The auditor will pull an Excel spreadsheet report of random claims that has all of the claim detail information as exists in the system. The report is configured to pull a selection of claims for the time period supplied. The auditor will assess the accuracy of the claims receipt in the system as compared to the original paper claim received by ACS or the 837 EDI parser and enter the audit results on the spreadsheet and also compile a summary report. The audit is designed to validate accurate receipt and entry, accurate payment amount, accurate coordination of benefits with other payers and accurate adjudication adjustment reason, if exist. Detailed analysis of all claims with errors will be gathered and documented that includes explanation of all errors.

Professional Claims

Data Elements reviewed, at a minimum include:

- Claim_Number
- Member_Name
- Patient Account Number
- PrincipleDiagnosis
- From_Date
- To_Date
- Received_Date
- CPT/HCPCS Code
- Modifiers
- Units
- Service Description
- Place of Service
- Billing_Provider
- Pay To NPI
- Rendering_Provider
- Rendering NPI
- Claimed_Amt
- Adjustment Reason
- COB_Paid_Amt
- Paid Amt

Institutional Claims

- Claim_Number
- Member_Name
- PatientAccountNumber
- Principal Diagnosis
- Admitting Diagnosis
- Additional Diagnosis
- POA Indicators
- From_Date
- To_Date

- Admission Date
- Admission Type
- Received_Date
- Revenue Code
- CPT Code
- Modifiers
- Units
- Service Description
- Facility Name
- Facility NPI
- Attending NPI
- Attending License
- Claimed_Amt
- COB_Paid_Amt
- Paid Amt
- Adjustment Reason

Each audit will be totaled by the (1) number of claims audited, (2) number of primary and secondary errors and a total error rate, (3) along with what the error rate (see below for standards). The summary report will contain:

- Audit Date (day claims were reviewed)
- Sampling ID #
- Sampling date (dates of processing)
- Number of Claims in audit
- Individual claims Audited
- Correct Claims
- Primary Claim Errors (Financial errors)[(includes missed claims and any errors that have an effect on the payment)]
- Secondary Claim Errors (Procedural errors) [(any error that does not affect the payment, i.e.; diagnosis, patient account number, etc.)]
- Error Rate (number of Primary or Secondary Claim Errors versus the number of Claims Audited).
- Claim Number
- Type of Error and Provider/Claim Type

Claims Accuracy Standards

Delivery System Name:
Reporting Period:

Quarterly Report	UB-04 (Institutional) Claims Accuracy			CMS 1500 (Professional) Claims Accuracy	
	Accuracy Rate	Sample Size		Accuracy Rate	Sample Size
Claims Processing Accuracy Rate for the Quarter					
Financial Accuracy Rate For the Quarter					

Monthly Report	UB-04 (Institutional) Claims Accuracy			CMS 1500 (Professional) Claims Accuracy	
	Accuracy Rate	Sample Size		Accuracy Rate	Sample Size
Claims Processing Accuracy Rate for the Month 1					
Financial Accuracy Rate For the Month 1					
Claims Processing Accuracy Rate for the Month 2					
Financial Accuracy Rate For the Month 2					
Claims Processing Accuracy Rate for the Month 3					
Financial Accuracy Rate For the Month 3					

Sample Claims Audit Format

xxiv. Explain the Proposer's high-level testing process to fulfill the claims testing processes requirements.

PerformCare maintains system testing and user acceptance testing (UAT) instances of its applications. All new implementations and system changes are first installed into a system test environment that was recently refreshed and is a replica of the production environment. In this environment, business systems analysts execute test scripts based on the business operational requirements. These test scripts will be based upon the specifics for claims processing and the covered services in Louisiana.

- Test scripts with sample claims will be developed to cover all the processing requirements
- System test environment will be configured for Louisiana including member enrollment, providers, benefit plan of covered services, rate schedules and system configurations.
- Test scripts will be entered into the system testing environment
- Results will be analyzed and adjustments made to system configurations as required until all test scripts pass successfully
- After system testing passes quality controls, the system will be configured in a user acceptance testing environment.

- Users and stakeholders will have opportunity to directly test or observe tests
- All system testing and UAT evidence will be preserved
- Training materials will be updated as needed
- Documentation of system will be updated as needed
- Upon approval, the system configurations required will be deployed to production

xxv. Describe the Proposer's process of paying claims and ensuring prior authorization has been obtained. Include the process or system functions that ensure only the number of services authorized are paid.

Life Cycle of a Claim

All claims received, whether electronic or on paper, have controlled processes to assure that all claims are accounted for, are either electronically or manually entered into the Claims Module, are processed in a timely manner and that only qualified claims are adjudicated. The life cycle of a claim consists primarily of these processes:

- Submission of the Claim by the provider
- Receipt of the Claim by PerformCare
- Processing of the Claim
- Checkrun and claims payment

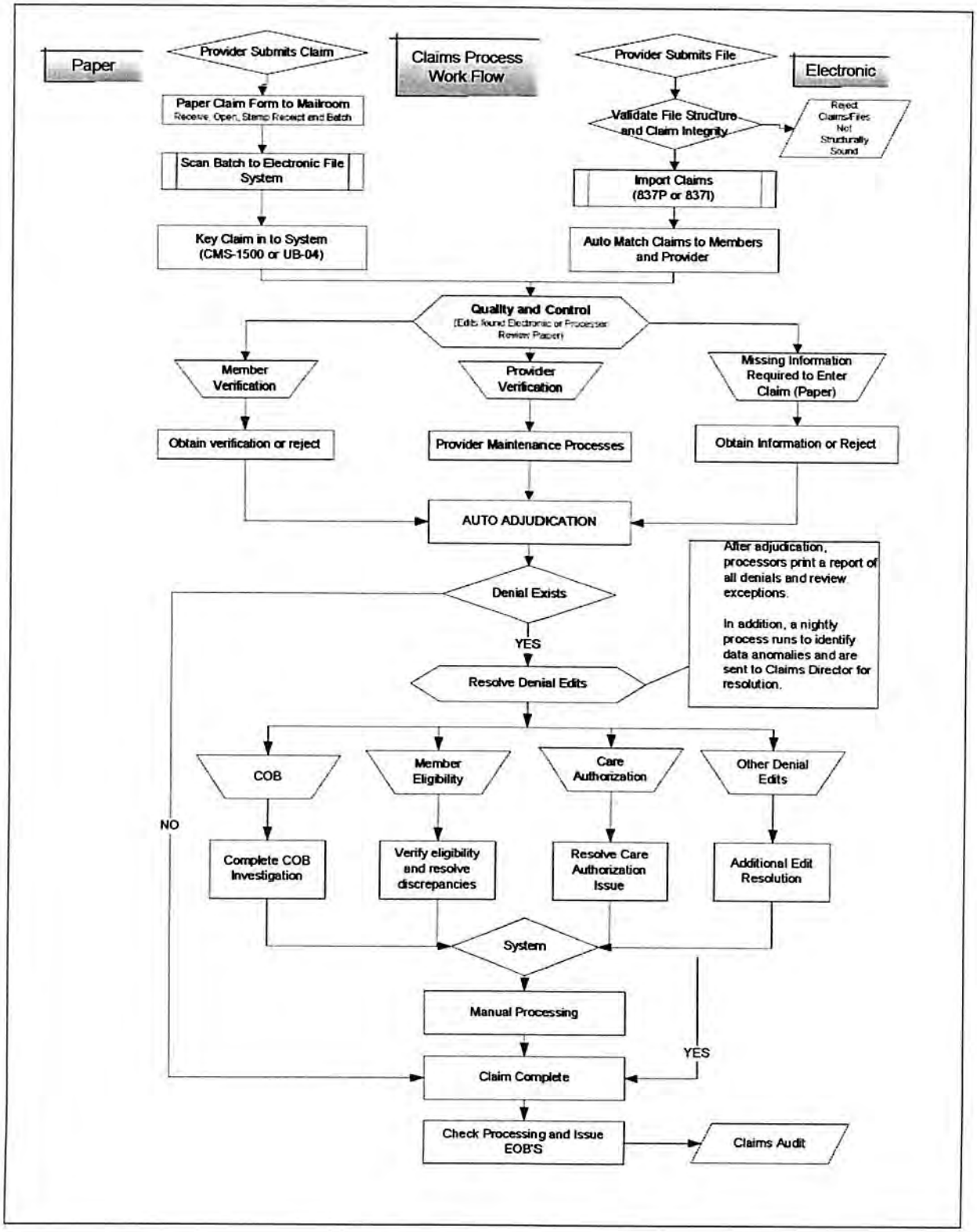
The flow chart on the following page provides a graphical depiction of the claims.

Submission Options for Claims

Providers have three methods to submit claims. Individual claims can be directly entered in CLARIS as described above. Batch 837s can be submitted electronically via our AmeriHealth Mercy Family of Companies Emdeon relationship, and alternately on paper via ACS. Paper claims can be submitted using the CMS-1500 form for professional claims or the UB-04 form for institutional claims by mailing them to PerformCare's designated address. During the start-up of any new business, training for claims submission is provided and PerformCare maintains a claims hotline for any claim submission questions.

Paper Claim Submission

PerformCare leverages a strategic alliance with the imaging vendor Affiliated Computer Services (ACS) to primarily scan and key our paper claim and supporting claim documents. ACS validates provider and member information on the claim and transforms the claims data from the paper claims into 837 Professional and 837 Institutional claim files. Each EDI claim file is bundled along with the original claim images and any other attachments. The electronic version of the paper claim is now dubbed 'ePaper' claim. Daily, PerformCare receives the 837 claim files and the electronic images from ACS and processes the files nearly the same as the 837 files from Emdeon except that the original paper images are also loaded into our electronic filing cabinet, CNG-SAFe.


Paper
Provider Submits Claim
Claims Process Work Flow
Provider Submits File
Electronic
Paper Claim Form to Mailroom
Receive, Open, Stamp Receipt and Batch
Validate File Structure and Claim Integrity
Reject Claims Files Not Structurally Sound
Scan Batch to Electronic File System
Import Claims (837P or 837I)
Key Claim in to System (CMS-1500 or UB-04)
Auto Match Claims to Members and Provider
Quality and Control
(Edits found Electronic or Processor Review Paper)
Member Verification
Provider Verification
Missing Information Required to Enter Claim (Paper)
Obtain verification or reject
Provider Maintenance Processes
Obtain Information or Reject
AUTO ADJUDICATION
After adjudication, processors print a report of all denials and review exceptions.
In addition, a nightly process runs to identify data anomalies and are sent to Claims Director for resolution.
Denial Exists
YES
NO
Resolve Denial Edits
COB
Member Eligibility
Care Authorization
Other Denial Edits
Complete COB Investigation
Verify eligibility and resolve discrepancies
Resolve Care Authorization Issue
Additional Edit Resolution
System
Manual Processing
YES
Claim Complete
Check Processing and Issue EOB'S
Claims Audit

Electronic Claims Submission

837 (Professional, Institutional Claim)

PerformCare will establish an additional payer ID with Emdeon for Louisiana Behavioral Health Claims. Emdeon sends claims to PerformCare on a daily basis. The claims are then processed in the Claims Module. The HIPAA Transaction Engine has received Claredi certification for HIPAA Health Care Claims and can be used to successfully import and export electronic files in the 837 Professional and Institutional formats. PerformCare accepts electronic billing using the 837 EDI file and currently receives over 75 percent of their claims electronically. PerformCare analyzes each 837 submission prior to uploading into the system to perform reconciliation of the final claim results.

Claim Matching and Authorization

The Claims Module requires all submitted claims, whether paper or electronic, to be matched to a member and a provider. If an authorization exists on the claim, it is also matched to the specifically authorized treatment. Each payer can determine which services, if any, do not require a prior authorization. The matching of claims assures that a provider who submitted a claim will receive notification of the adjudication results on their remittance advice. Because of the interface between the clinical authorizations with claims payment, and the benefit plan setup that establishes which services require authorization, all claims adjudications are inherently centered around the authorization. Claims adjudication requires that the units billed do not exceed the total units authorized or the permitted frequency of units.

Processing of Claims

Timely Entry of Claims/Claims Processing Deadlines

PerformCare understands the importance of timely entry and payment of claims. PerformCare requests that providers submit claims within the timely standards listed on their contract, but are willing to work with them to improve the timeliness and accuracy of submissions. Claims are processed daily and batch adjudicated each night. PerformCare is committed to paying 90 percent of all clean claims within 30 days and 100 percent within 90 days. Payments are made weekly, and we have been fully compliant with similar claims processing timeliness standards in our other Medicaid lines of business. Check runs are overseen by the Claims Director with the assistance of Finance Department. All checks are electronically signed with the CEO signature, and if over $100,000 a second signature is required by either COO or CFO.

PerformCare contracts with Emdeon to manage payments to providers. When check runs are executed, the remittance information is sent to Emdeon in a data file. The file is then processed. Providers who signed up for EFT will have funds electronically transferred and others receive paper checks. All providers are able to receive paper remittance advices electronically.

xxvi. Describe the fields utilized in the exact duplicate match.

Duplicated Record Identification and Member Records Matching

The claims processing system was designed to allow customized validations of what constitutes a duplicate claim. Different lines of business for PerformCare require different data elements and we are able to configure the differences based on the insurer or payer. The following fields are considered for duplicate claims:

- Billing provider
- Procedure code or Revenue code

- Modifier codes
- Date of Service
- Member
- Place of Service (optional)
- Customization elements and algorithms as needed

The CLARIS Match Scoring program identifies duplicate records. Each member record is "Match Scored" against other member records using the first name, last name, date of birth, and social security number of the person. The program compares two different health records and determines whether the records are for the same person (a match), not for the same person (no match), or similar but in need of a manual review (near match). Records that score as a "match" are considered duplicate records and are reported to the Member Services Department for possible merging.

The CLARIS Match scoring program also finds Medicaid numbers in the Eligibility Data Feed received from the State eligibility System. It automatically identifies Medicaid Numbers for all records that "match." The "near match" records may be reviewed manually to identify Medicaid numbers especially for a member with no Medicaid number currently identified. Since there is a risk of identifying seeming matches such as siblings with similar first names, especially multiple birth siblings, the program has an exceptions table where these types of exceptions can be entered when they are identified. This will ensure that the identified exceptions are not automatically matched in the future.

In New Jersey, this program is also used for identifying children currently enrolled in DYFS (State Child Protection Agency). This information is automatically added to the child's electronic mental health record.

The four fields from each data file are compared to each other in order to calculate a total combined match score ranging from 0 to 101. The better the match between the same two fields from each file, the higher the match score and thus the greater the likelihood that the two separate are the same consumer. The match scoring is in a scale of 0 -101:

- Score of 100 – 101 Perfect Match.
- Score of 71 – 99 Close Match. Most people would consider the two records a match.
- Score of 60 – 71 Near Match. A person needs to manually review the records.
- Score of 0 – 59 Not a match. A person would consider these as not matched.

Calculating the Match Score

Each of the four fields is given a weighted match score depending on how closely they match. Since hyphenated names are common, we check to see if the last name is contained in the other record in a different position. Often typos or misspellings make a text match fail. The SQL Server function Soundex is used to compare the phonetic pronunciation of the first and last name.

Field	Score
Last Name	
First 12 characters	25
First 5 characters	20
First 3 characters	05

Field	Score
In a different position	10
First Name	
First 7 characters	20
First 5 characters	15
First 3 characters	5
Exists in a different position	7
Date of Birth	
Year, Month, Day	25 (an Exact match)
Year	10 (Not an Exact match)
Month	10 (Not an Exact match)
Day	05 (Not an Exact match
Social Security Number	
All 9 digits (exact match)	30
8 digits	16 (2 pts. each digit)
7 digits or less	0 (Most typos are only 1 digit)
One record has no SSN	10 (a 20 point penalty for missing SSN)

"Sounds Like" Functionality

The CLARIS Match scoring program takes advantage of this SQL Server Soundex functionality for the first name and last name fields. It scores the last and first names based on how similar they sound. For example, the SQL Server will return a score of 4 when comparing "Smithers" with "Smothers" because of how similar they sound. When the Soundex gives a high score, this score is weighted by the matching of the other fields. If two other fields score high, a bonus is added to the matching score.

xxvii. Describe the process for determining covered service payments that may not require an authorization.

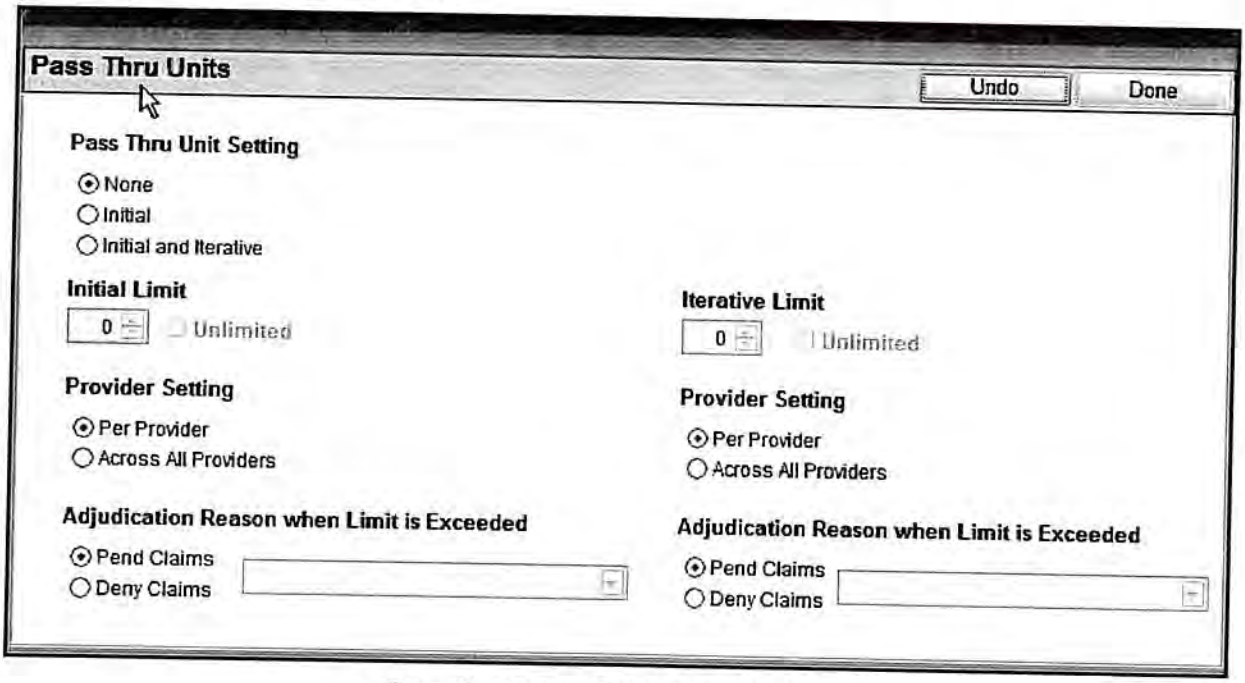
The CLARIS system allows each insurer to build unlimited number of benefit plans, should members be able to enroll into different plans. Each benefit plan declares the services that are covered. Within each benefit plan, each covered service may have its own rules as to authorization requirements. PerformCare would work with Louisiana to determine which services do not require authorization.

Based upon authorization requirements and limits, the system can be configured to allow a claim to 'Pass Thru' without an authorization. These settings determine whether a rule for prior authorizations exists and if so, the type of rule that applies.

- **None** - No prior authorization is required
- **Initial** – A defined number of claims do not require an authorization. This number can be any integer. For example, the first ten outpatient therapy sessions may not require an authorization, but more than ten would require an authorization to be obtained.

- **Iterative** – A defined number of claims that do not require an authorization before the number can be reset. Usually a clinician or other authorized person reviews the plan rule in the member's screen.
- If both the Initial and Iterative buttons are selected, the system allows claims to pay without an authorization for the number in the Initial Limit field. Then, the system pends or denies additional claims until a clinician or other authorized person reviews the rule in the Membership Subsystem.
- **All** - If an authorization is always required, such as Mental Health Inpatient, then the rule is set to allow zero in the Initial limit, meaning no claims can 'Pass-Thru'.

The accumulation of claims without an authorization requirement can be per billing provider or across all providers. If a threshold is reached, the claim adjudication process can either pend the claim for manual review or deny the claim. The adjustment reasons communicated to the provider can be set differently for each service, if desired.



Sample Claims Pass-Thru Screen

xxviii. Describe the process for ensuring that paid claims are for providers that are credentialed to perform the specific service rendered.

The CLARIS system allows a provider profile to be built and each provider has only those services in their profile for which they have been credentialed. If a provider bills for a service not in their profile, the claim adjudication will result in issuing a reason that the provider is not authorized to perform the service.

Described in more detail is the process and controls for building the provider profile along with the contracted rates. This assures that only those providers credentialed to perform the service are paid AND that they are paid at the agreed upon rate.

Process of entering provider information

PerformCare's management information system (specifically, the Provider Relations module) and the eChoMC credentialing application are the repositories for comprehensive information on the provider

network. Within the Provider Network Department a provider maintenance team is designated which falls under the credentialing department. The provider maintenance team is responsible to enter provider information and maintain provider contracting and rate data. Provider system maintenance is managed by use of a change form. Every form must have appropriate signatures. Changes to services of existing providers require an additional validation from the IT department to assure current authorizations and claims payment are not affected.

Each provider has an identified primary contact and is setup to include, at a minimum, provider NPI, Medicaid enrollment numbers, provider address and program details, the type of agreement (in network or out of network) billing terms, payment terms, services contracted to perform within their licensure and specific provider negotiated rates, if exist. A series of nightly quality checks are performed against the provider information entered in the system and exceptions are reported to the provider maintenance team for resolution. In this manner PerformCare is able to accurately and in a timely manner enter provider information and rates for only approved services.

During the implementation phase data will be collected and prior to start-up, the provider data fields and rate schedules in the PerformCare Information System will be populated using the information received from Louisiana. PerformCare has the capacity to accept multiple file formats to enable a smooth and efficient transition and population of the new provider network data warehouse.

At a minimum, the provider network data will include:

- Name of agency and parent corporation
- Name, address, and phone number for each subsidiary or service site
- The NPI number for the provider, each location or service type
- Provider type
- Practice type
- Population served (adult, children/adolescents, geriatric, and men/women)
- Special needs and priority population capability
- Capacity (in beds or units of service per day)
- Licensure/Approval Date
- Provider Contracts/Agreements, Services and Rates

While the process for handling special needs and requests using out-of-network providers is different, the typical process is as follows for adding a new provider to the network:

- A provider contacts PerformCare, or vice versa if PerformCare or the State identified the need. Upon concurrence from the State regarding inclusion of the provider, PerformCare mails a contract and, if applicable, the PerformCare fee schedule. If the provider is agreeable to contract terms and rates, he or she is invited to submit an application for network participation.
- PerformCare is NCQA accredited for the Medicaid line of business and follows NCQA standards for the process for credentialing and re-credentialing and quality monitoring of all participating providers.
- Individual clinicians complete an Individual Credentialing Application. PerformCare contracts with an NCQA-certified Credentials Verification Organization (CVO), MedAdvantage, for primary source verification and application management services. MedAdvantage mails the application to the

provider within three days of receipt of the request from PerformCare. The CVO can provide partially completed Credentialing Applications for subsequent re-credentials, reducing burden to providers.

- Organizational providers such as licensed mental health and substance abuse outpatient clinics, partial hospital programs, children's wrap-around services, methadone maintenance clinics and essentially every organization that holds a license, submits a Facility Credentialing Application. PerformCare mails that application directly to the provider once contract terms are deemed acceptable. Any provider that lacks accreditation or is potentially high volume will receive a quality on site review (site visit).
- Providers and practitioners are surveyed for special training and experience employing different treatment modalities and serving special needs. Also of interest is the provider/practitioners ability to serve people who are handicapped, speak foreign languages, use sign language proficiently or otherwise accommodate deaf, hard of hearing, or non-English speaking members.
- The Credentialing database, EchoMC, holds extremely detailed information about providers, including clinical interests, specialties, populations, languages spoken, site visit information, co-occurring competency and ability to meet special needs. PerformCare is able to tailor the application to meet additional state requirements. The data from the credentialing applications will subsequently be populated into the web-based CLARIS system for end user access.

Approvals and Documentation

All provider applications, once thoroughly reviewed, receive approval from the Credentialing Committee, chaired by the PerformCare Medical Director. In the event the Credentialing Committee does not approve a provider, PerformCare notifies the provider immediately. The Credentialing Committee occurs monthly however; PerformCare routinely circulates clean credentialing rosters with no adverse issues for approval mid-month as needed. Upon Credentialing Committee approval, PerformCare data enters the provider so the provider information is available for authorization and claims payment.

Maintaining the rate schedule and contract information

Rate schedule functionality

Rate schedules are maintained by the Provider Maintenance team. CLARIS will maintain rate schedules for each payer and rate schedules for individual service providers if they have negotiated special rates. The system also allows for negotiated rates outside of a rate schedule that can be entered down to the specific service and site level. This is typically used for specific inpatient or residential services. Each service in each provider's profile can point to the payer or state fee schedule, the provider schedule or the specific negotiated rate. The system then assigns the specific rate or rate schedule associated with the service as it is assigned to the particular provider.

Inpatient services are paid using a negotiated rate. PerformCare uses the existing Medicaid fee schedule when possible. If there is not an existing rate, the provider submits a budget along with the service description in order to set an initial rate with PerformCare.

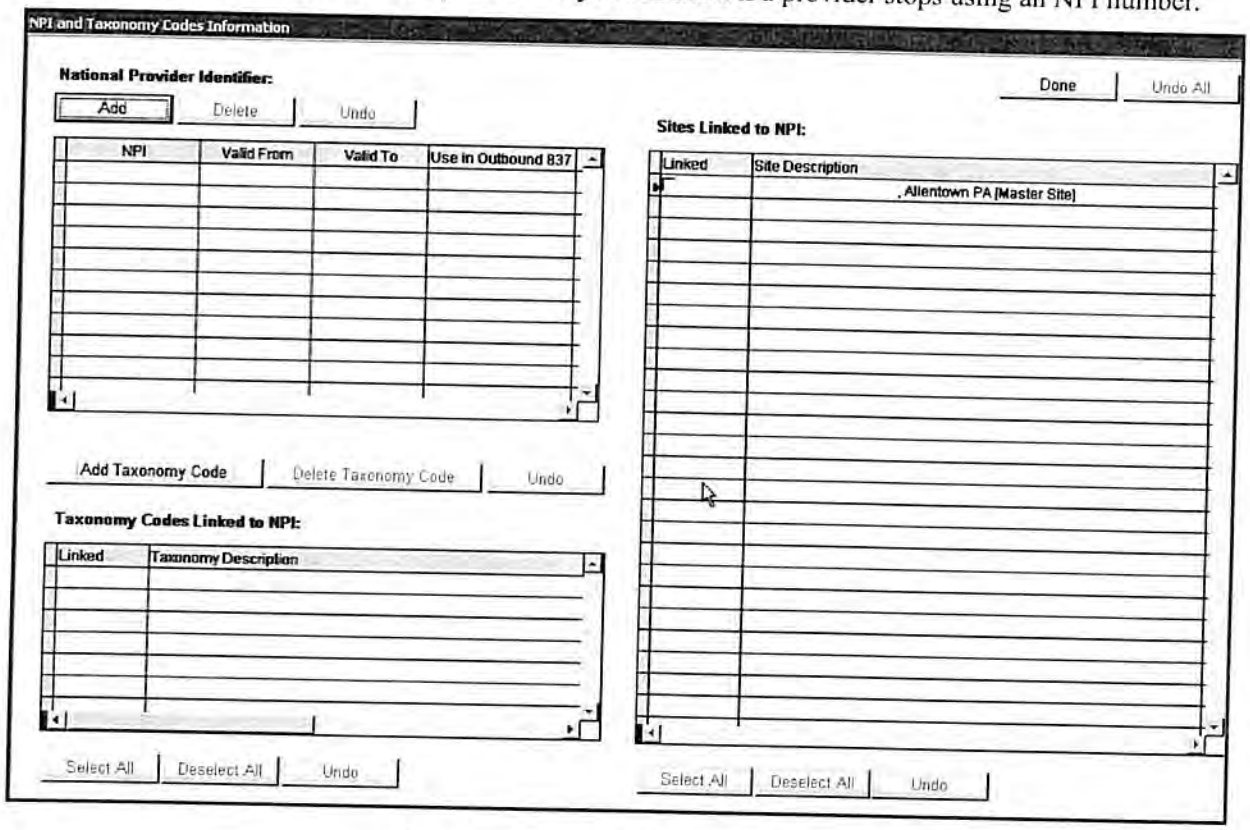
Loading Rate and Contract Information

The provider maintenance team enters payer specific and provider specific rate schedules in the Information System. A series of Rate schedule quality reports are then generated and used to validate or correct the rate information. Once the rate schedule is deemed accurate, the rates are then submitted to the Vice President of Provider Network for final approval.

Each provider is loaded with contract information and the services that are within the scope of their practice license are linked to the contract and pointed to the correct rate schedule. Rate quality reports are then generated to validate the provider setup correctly points to a rate for each service and identifies setup and rate irregularities.

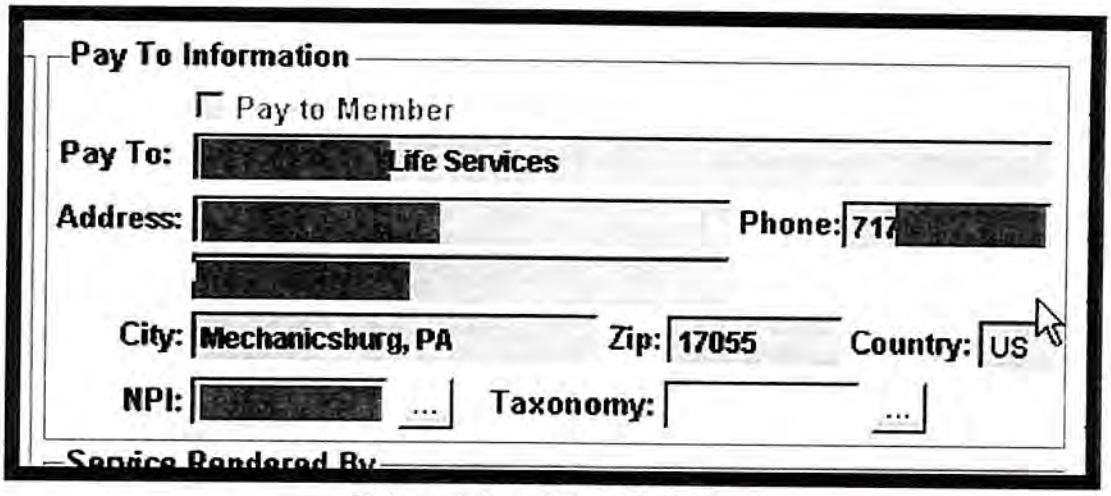
xxix. Describe the Proposer's storage of and use of national provider identification (NPI) numbers.

National Provider Identifier (NPI) is integral to PerformCare's claims processing system. PerformCare has fully implemented the NPI HIPAA rule and uses solely the provider's NPI number to identify the provider on electronic claims submissions. Each provider is configured with their NPI numbers and associated taxonomy codes. NPI numbers are stored in the application at the Provider/Site level. If a provider has only one NPI number, it can be loaded and associated to all the sites where the provider practices. If a provider has more than one NPI number, all NPI's associated with the provider can be loaded into their record and associated to the site(s) they are applicable for. Each NPI has an effective and expiration date for the provider so you can track if a provider stops using an NPI number.



System Storage of Provider NPI

Every claim received uses the NPI to identify the provider. Every claim must have either a pay-to NPI and rendering NPI, if different. The electronic claims process matches the NPI on the claim to the NPI in the provider's profile to identify the provider. If a claim is received that has an NPI not pre-registered in the provider's profile, the claim NPI is captured and maintained in the system. If the user has appropriate security, they can add the NPI to the provider profile pending verification by provider maintenance.



Claims Entry of Provider NPI

All claims go through NPI validations to assure that the NPI is valid and accurate with other information such as the Tax Identification Number (TIN) submitted on the claim.

- Billing Provider NPI exists
- NPI is not valid for billing provider on the claim
- Rendering NPI exists
- Rendering NPI is Not Valid for Rendering Provider on Claim
- Pay to Provider on the claim does not matches the NPI Submitted on 837 files
- The submitted tax Id is not for the pay to provider identified using the NPI

Subsequent 835 Remittance Advice, encounter reporting and any other data transaction where appropriately utilizes the NPI to identify the provider. The NPI is used to crosswalk to the provider's Medicaid enrollment number.

xxx. Describe the process for capturing DOE data as encounters.

CLARIS provides user interface functionality that can be made available to support related DOE interactions at the school level. It is clear that the DOE target population for the CSoC includes children and youth with BH challenges who are in, or at risk for, alternative school placement or homelessness, as defined by DOE. CLARIS will provide easily accessible data by related school officials and practitioners within the school setting to help facilitate a strong comprehensive system of learning supports that addresses barriers to learning and teaching, and help to eliminate many barriers due to inaccessible data or poor coordination for these children. CLARIS' framework for assessments, care plans, and notes can also support the specific forms of documentation required by the DOE, such as integrated IEP's, and educational assessments. CLARIS' Anomalyzer functionality and internal work-flow management logic provides a process to enable the efficient delivery of services through the schools to ensure that services authorized were delivered as approved, and to notify the school, DOE, and Medicaid if services are not rendered consistent with the individualized IEP.

Users permitted to access a child's record from within CLARIS will have the mechanism to be fully integrated in real-time with the required data elements as prescribed by the DOE (as would be accessed via an individual child's record within CLARIS, and / or as to establish systematic data transmissions (to and from DOE) relating to individual child data such as: All required data elements, for individuals or in aggregated summaries, as contained in the CLARIS CSoC EHR, including, but not limited to:

- Services provided and dates of service
- Provider information
- Assessments, Treatment Plans and Progress Notes
- Authorizations and Claims Encounters
- IEP's and related information
- All students referred by the School District, or the State
- Child demographics (name, data of birth, ethnicity, gender, disability)
- School Name
- CSoC services authorized
- List of Providers (by region)
    - Name of WAA facilitator assigned to case
    - Name of family service coordinator assigned to case
    - Dates of WAA team and Family team meetings
    - Child specific outcome data
    - Progress monitoring reports
    - Reimbursement reports in the form and frequency required by the DHH and DOE

Behavioral Imaging

CLARIS can also provide, using a product developed by Behavioral Imaging, Behavior Capture™ and Behavior Connect™ capabilities – the ability to have annotated video content as a part of the individual child's electronic health record. Behavior Capture™ and Behavior Connect™ allow users to document, annotate and tag events such as behaviors, treatments, academic interventions and other video or static images. This capability, available at an additional cost, allows for multiple uses across a broad range of professional interactions. The Behavior Imaging™ Suite allows for additional uses while maintaining the ease of a single system for the user.

The ability of professionals to communicate issues related to individual clients via video enhances the ***documentation process***. Attaching annotated video clips to the record allows treatment plans to have greater clarity and improved auditing capacity. The improvement in specific behaviors and in certain situations can be readily viewed and evaluated by multiple users in a HIPAA compliant fashion. With improved documentation of behavioral issues in the multiple environments of the clients organizations are better able to plan and execute interventions across a wide range of locations in which the client may interact. An example of this is the ability to understand the behaviors of children in academic, social and family

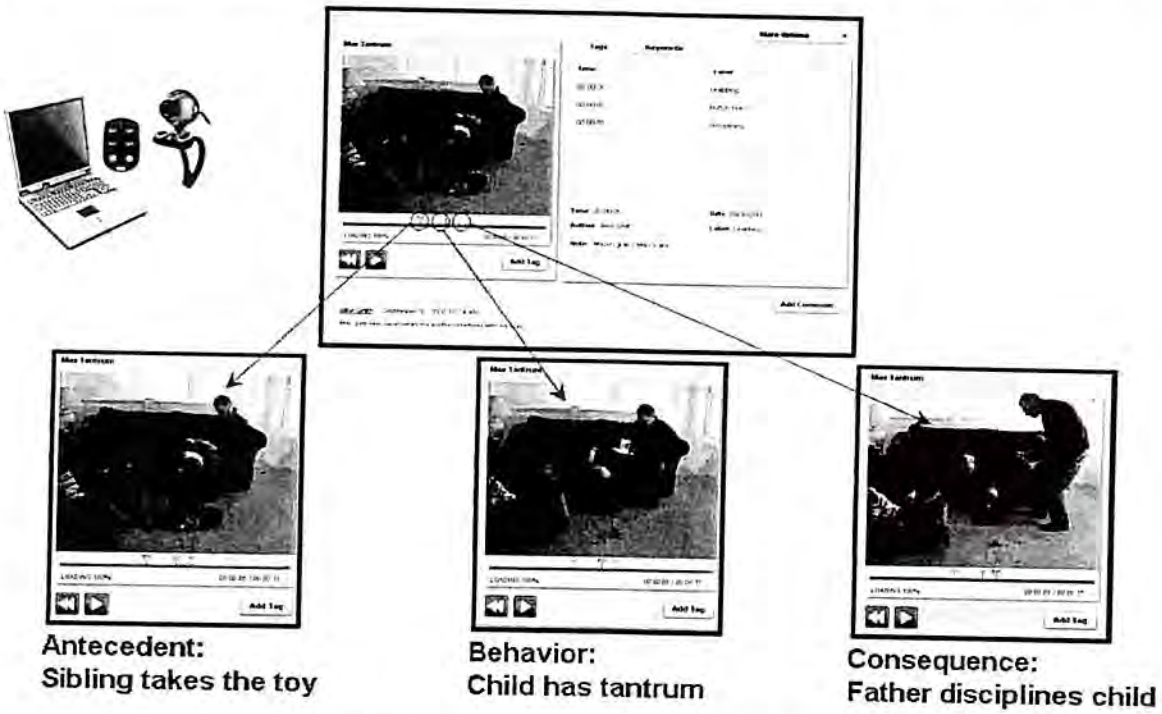
The annotation and tagging allows more experienced service providers to remotely evaluate and ***supervise*** less experienced providers and thereby expand the ability of the organization to provide service

in more rural areas. Behavior Imaging™ solution also allows for specialty providers to reach distant areas increasing availability and decreasing travel time for the client and the organization. Store and forward video evaluations with annotation and tagging provide important elements of the record. For example a speech therapist in one location can remotely view sessions in another location annotate and tag the video for suggestions for changes in therapy in the more rural location. The solution allows for multiple users in a team model to evaluate and comment in near real time related to specific video data.

Store and forward can allow professionals to deliver ***therapeutic consultations*** in to remote areas of the state improving access and compliance. The ability of the system to facilitate this access can help ameliorate disparities in provider distribution allowing improved diagnostics and treatment for clients.

The Behavior Imaging™ solution components of Behavior Capture™ and Behavior Connect™ are described below. The Behavior Capture™ technology can be used to capture video records, however the Behavior Connect™ software allows for data from any source to be uploaded and then tagged and annotated for uses as described above. Video from flip-like cameras, phones, tablets and fixed video feeds can be input into the system for use by the organization.

Behavior Capture™: This system was developed at the Georgia Institute of Technology's College of Computing. It consists of a novel video capture technology which can be used in a home or institutional environment and features a unique video buffering capability that documents relevant events that occur before, during, and after a behavior. This "going back in time" feature can provide insight into causes or triggers of certain behaviors.



Behavioral Imaging Screen Shots

With software applied to any personal computer, Behavior Capture™ enables a caregiver in a natural environment to capture a video clip of what happens before (antecedent), during (behavior), or after (consequence) with a small remote control device. That resultant video clip can tag aspects along the video

clip that either the caregiver or the health professional can annotate for collaboration or data mining purposes.

Behavior Connect™: This is a data and records management platform which allows users to organize, analyze, and share videos as well as other types of images such as x-rays and pertinent documents, among and between patients, caregivers, health providers, therapists, etc. It is a secure, HIPAA-compliant web-based application and complies with the healthcare industry's current health record technical standards. It facilitates the non-disruptive integration with other database systems. The product also provides a proprietary fax transmission tool, special file uploader which can securely transmit large files even from low-bandwidth connections (as in rural areas), and a secure messaging system to enable electronic consultations. Field applications have shown that the technology is simple to use and can provide caregivers with important support during times of crisis or when asked to provide more contextual information.

Behavior Connect

Behavior Connect™ allows clinicians to search file data of their patients (left), as well as uniquely tag and collaborate on any video or other data file (right).

xxxi. Provide a list of the system edits and their description to be used when processing the medical claims.

System Edits and Descriptions

Claim Adjudication Edits

All claim validations agree with the billing standards as outlined in the National Uniform Billing Committee (NUBC) for institutional claims and the National Uniform Claim Committee (NUCC) for professional claims. Before a claim is approved for payment it must pass through a series of more than 50 validations. In addition to auto adjudication rules, the claims pass through a series of edits each night to validate additional elements to make sure the claim is clean for encounter reporting. These edits are defined for each program and grant the flexibility to enforce or not certain idiosyncratic rules. For example, the nightly edits may report approved claims for members whose eligibility was retroactively revoked. Below are the primary validations:

- The member must be eligible on the date of service.

- The claimed service is not a future date of service.
- The claim has valid modifiers as defined by the system setup for the CPT code claimed.
- The provider is permitted to perform the service.
- The provider identifier (NPI) is valid for the provider.
- Diagnosis is effective and valid for age, sex and type of care.
- Sub-capitation checks for service submitted if applicable.
- Authorization requirements as established by benefit plan. If authorization required, checks authorization exists and dates on claim are within authorized timeframe.
- For Institutional claims submitted on the UB04 form in the Claims Subsystem or transmitted electronically in an 837I file, checks are made on the bill type and discharge status.
- Claim submitted within filing limits.
- System makes TPL and COB validations. If CPT code requires coordination of benefits and COB exists and EOB not submitted, denies for EOB missing.
- System checks for duplicate claim.

When a claim is adjudicated, the Claims Module compares claim information to the number of service units approved and the contracted rate for that service. This information allows automatic approval, pending, or denial of claims. This information is also used to authorize payment of approved claims. When the claim is adjudicated, the Claims Module also compares the claimed information provided by the provider to:

- Members eligibility
- Benefit plans
- Provider's contract
  - Status
  - Licenses
  - Contracted services
  - Contracted rate
  - Agreement limits
- Authorization
  - Units
  - Period
  - Frequency of authorization
  - Procedure code / modifiers
  - Diagnosis
- Coordination of benefits (COB)

This information allows for the automatic approval, pending or denial of claims. This information is also used to authorize payment of approved claims. Claims are adjudicated in the Information System starting with the gross billed amount and can be reduced by the following:

- The amount over the contract limit
- Deductible (if applicable as defined in member's benefit plan)
- Co-pay (if applicable as defined in member's benefit plan)
- Withhold Amount (if applicable, determined by provider's contract)

The net amount is what is paid to the provider, and the details are included in the Remittance Advice, either paper or HIPAA 835 electronic form, whichever is desired.

Claim Adjustment Reasons

These are the reasons and descriptions issued on claims and existing on the remittance advice. Depending on the rules for the payer, some of the reasons may not apply and are turned off. The following table provides information on some of these rules.

Reason for Denial	Explanation of Reason for Denial
Attending Physician ID/NPI Missing or Invalid	For inpatient claims, the attending physician must be identified
Bill Type Missing	Institutional claims must have a bill type
Billed with Invalid Bill Type	Institutional claims must have a valid bill type
Claim is duplicate of previous submission for member	A claim is identified as duplicate if the same procedure code, member, provider and date of service.
Claim submitted after plan filing limit	A claim must be submitted timely as agreed upon in the provider contract
Code not payable for provider specialty type	The provider must have appropriate credentials to perform the service. If the service is not within the provider's profile, i.e. the services permitted by their enrollment license, the claim would be caught with this edit.
Date of Service cannot be greater than received	Claims billed for future dates of service
Dates and/or Service Outside Referral/Authorization	Claims with dates of service before or after the authorized period
Diagnosis Invalid or Not Effective for DOS	The diagnosis submitted must be in effect for the date of service on the claim as declared by the ICD-9 and in the future ICD-10.
DOS not between treatment admission and discharge	The date of service on the claim is outside of the clinical admit and discharge date recorded by the care manager.

Reason for Denial	Explanation of Reason for Denial
EOB indicates primary insurer did not authorize	For coordination of benefits, the EOB attached to the claim indicates the primary insurer did not authorize the service
Incorrect Tax Identification Number Submitted	The tax ID is not valid for the provider identified using the NPI
Invalid or Missing Place of Service	The place of service must exist and be HIPAA compliant code
Invalid or Zero Units Submitted	Per the NUCC or NUBC rules, the units submitted if a date range must be appropriate and units may not be zero
Invalid Patient Status for Bill Type	The discharge status on a claim must be in agreement with what the bill type communicates about the treatment status
Invalid Procedure/Modifier/POS combination	The procedure code billed has modifiers or place of service not permitted
Like service billed on same DOS	A duplication of services were billed by the same provider
Member's Age not valid for diagnosis code	Certain diagnosis codes are specific to ages. If the diagnosis billed is not valid for age of member according to ICD-9 and in the future ICD-10
Member's Sex Not Valid for Diagnosis Code	Certain diagnosis codes are specific to gender. If the diagnosis billed is not valid for age of member according to ICD-9 and in the future ICD-10
Missing Discharge Hour for Discharge Bill Type	If bill type indicates final bill then discharge hour must be supplied
Missing HCPCS Code for Bill Type	Certain bill types require a HCPCS code
Missing Revenue Code for Bill Type	If bill type indicates accommodation, then an accommodation code must be provided
Missing/Illegible Procedure/Revenue Code	Claim must have procedure or revenue code
Not Enrolled on Date of Service	Member was not eligible on date claimed
Observation billed as inpatient	As noted
• Observation less than 24 hours	As noted

Reason for Denial	Explanation of Reason for Denial
Over Maximum Procedure/Benefit Limit	if limits exist in benefit plan, indicates limit was reached
Payment covered under Inpatient per diem	Used if ancillary services billed and the inpatient stay is paid as a per diem
Payment included in DRG	Used if ancillary services billed and the inpatient stay is paid under a DRG rate
Payment reflects COB, if $0, max liability met	For claims with other payer and no dollars due
Please submit the primary diagnosis	No primary diagnosis existed on the claim
Primary/Secondary Diagnosis POA Error	Present On Admission indicator not submitted or invalid
Prior Authorization Required	Service requires prior authorization and was not obtained
Provider Billed in Error	Corrected claim from provider to show re-adjudication
Rendering Provider not registered or enrolled	Rendering provider not qualified per agreement
Resubmit w/ Registered Billing Provider	Billing provider not registered
Resubmit with a DRG	Claim required DRG and none supplied
Resubmit with EOB from primary carrier	TPL exists and claim did not have EOB information
Service not covered when performed for reported Dx	Diagnosis claimed does not permit service provided
Service will be processed on a separate claim	Used when claim is required to be split
This service is not covered under plan	The service claim is not covered under the payer's benefit plan
Units exceed a utilization management auth	More units claimed than were authorized

xxxii. Provide the policy and procedure for fraud detection in claims submission.

PerformCare policies and procedures for fraud detection in claims submission are submitted as **Appendix 23**.

Recovering Fraudulent, Unsubstantiated or Inaccurate Claims

The result of claims audits, investigations, self-reports and findings from government entities such as the Pennsylvania Bureau of Program Integrity, Attorney General and Office of Inspector General will

often demonstrate that PerformCare has recovered payments for the following:

- Services not delivered
- Services not supported by required documentation
- Services incorrectly coded
- Services that should have been part of an inclusive rate
- Services not authorized
- Services provided by an unqualified or unlicensed provider

In these instances restitution must typically be made and reported to the State. The amount is determined by audit whenever possible and the amount to be recouped assigned to specific claims. In some cases PerformCare will confer with the State to determine an amount based on a survey of claims or a proration. This is most likely when there has been a continuous pattern for a number of years, and a calculated amount is acceptable to all parties.

The Fraud and Abuse Coordinator will send a letter outlining corrective actions to the provider, including the amount required for repayment. The provider will be given a specific time period to agree or dispute the amount. PerformCare has not yet required legal recourse to recover such payments. Once there is mutual agreement, terms for recovery will be negotiated. Usually the amount will be deducted immediately from the claims paid to the provider. However, there are exceptions. If immediate repayment would cause severe harm to the provider, payment terms lasting a year may be established. In other cases, providers have successfully requested lump sum payment back to PerformCare in order put the transaction on their accounts during the current fiscal year.

In addition to the above mentioned attachment, PerformCare has submitted the following attachments for review as Pennsylvania Medicaid examples of fraud, waste, and abuse:

- **Appendix 23** – PerformCare Policy QI-013 Reporting Suspected/Substantiated Provider Fraud and Abuse
- **Appendix 24** - Policy QI-034 Reporting Recipient Fraud and Abuse
- **Appendix 25** - Departmental trigger lists for fraud, waste, and abuse tips

xxxiii. Describe the Proposer's coordination of benefits (COB) experience for determining payment.

PerformCare has performed coordination of benefits processes and cost avoidance since inception. For example, PerformCare Pennsylvania Medicaid Program involves COB and some level of cost avoidance for over 15% of claims. In the most recent quarter, TPL cost avoidance for the Program totaled over $3.3 million across 17,066 claims.

The capture of third party resources is critical to ensuring that Medicaid remains available to those who need it most and that Medicaid is the payer of last resort. As such, PerformCare's system is capable to store unlimited third party liability (TPL) data from other carriers, agencies and relevant sources.

PerformCare has experience in the following areas:

- Cost-Containment – Execution of a cost containment strategy which identifies recovery-related projects (over- and under-payments) ranging in scope from small to large.

- Third Party Liability (TPL) – Responsible for maintaining and identifying our members' additional insurance carrier information. This includes identifying and flagging records for dual eligible (Medicaid/Medicare) and commercial carriers.

PerformCare trains all associates working with member or providers in identifying third party resources. When speaking with a member, if a hint of another payer is made, the information is collected in CLARIS for further research and verification. The Member Handbook also addresses the question, "What happens if I have other insurance?"

Providers are an important component of our third party recovery process and our ability to assure that Medicaid is the payer of last resort. We educate providers through a variety of avenues. First, we require them to contractually agree that they will cooperate in the identification and determination of coverage liability. Second, we confirm this requirement and outline the processes for maximizing cost avoidance in our Provider Handbook and new provider orientation.

Additionally, Provider Network Management Representatives will conduct periodic provider education and information sessions to address our third party liability requirements and other claim payment processes and procedures. The Provider Educator will accompany the Provider Network Management Representative on provider visits, as needed, to assist with payment issues and conduct additional education if appropriate.

Providers are notified about TPL every time an authorization is issued if the member is known to have other insurance. Every authorization letter has an accompanying letter about other payers. The letter shows the details of the insurance carrier and policy information. This gives providers an opportunity process this information in a timely manner before claims submission.

Lastly, providers are notified about the TPL process when we process certain claims. In cases where a claim is received for a member whose eligibility record contains active TPL coverage in our system, and a third-party Evidence of Benefits (EOB) is not received with the claim, the claim is denied and returned to the provider with a note on our EOB informing the provider that an EOB from the primary carrier is required. Our EOB includes a snapshot of the TPL information contained in our system so that the provider will know what other carrier is liable for the covered service. This process supports the education of our providers, and ensures that future claim submissions from this provider are submitted for payment only after all other carriers have paid their liability.

PerformCare has participated in annual audits of our TPL processes from the state of Pennsylvania TPL division and have always received 100% compliance. Verification is made that all TPL resources supplied are accurately updated and audit is made of claims payment that every member with other insurance had payment appropriately cost avoided or coordinated with the other payer.

PerformCare performs regular processes in verification of TPL resources and reporting such resources to other agencies for sharing. This is described in more detail in the next section.

PerformCare will coordinate benefits in accordance with 42 CFR 433.135 et seq., Louisiana Revised Statutes Title 46, and section 5.12.2 of the Louisiana CCN-P RFP. We will utilize cost avoidance methodology whenever there is a verified third party resource.

PerformCare has experience in loading TPL data and completes on a daily basis. Once it is loaded it is immediately available and every member who has COB is immediately flagged in RED in the Claims Module as having COB. This alerts any clinician or claims processor to address the COB. The processor can within one click see the detail of COB information from any screen within the system.

Details of COB

xxxiv. Describe the Proposer's third party liability and COB process for identifying other health insurance. Include the capture and storing of other health insurance information. Include any system edits invoked during claims processing.

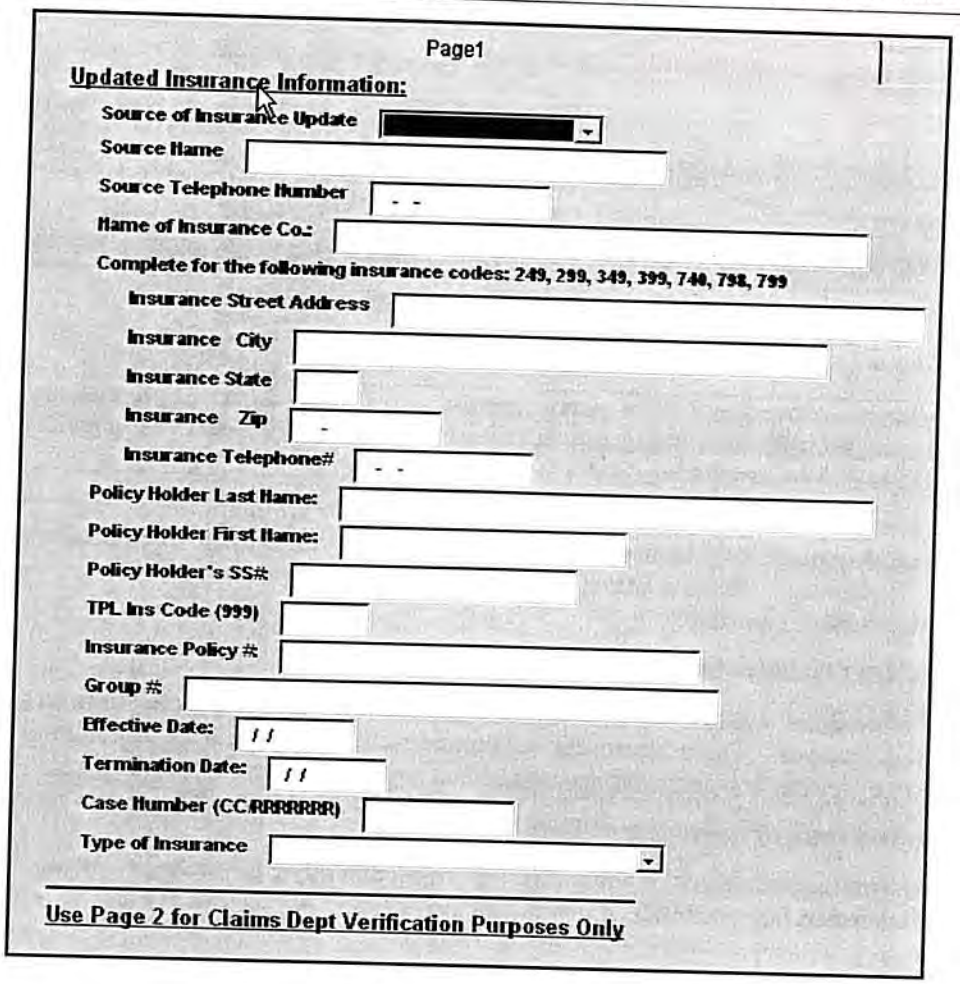
PerformCare is committed to helping to keep the Louisiana program as cost effective as possible. When PerformCare can actively identify TPL information, the total net cost of providing services to the member will be reduced. PerformCare always takes a firm approach to cost avoiding claims payment when another payer is responsible.

Identifying Other Health Insurance

PerformCare utilizes a third party liability (TPL) resource file and loads such files on a daily basis or as often as it is received. There are several additional sources of TPL data available to PerformCare. Providers have, often, the best and most up-to-date data regarding alternative coverage.

Verification Process of Newly Identified TPL

When PerformCare is notified of alternative coverage, either by a provider or a member, PerformCare will enter as much as is known about the other insurance into a TPL resource event.

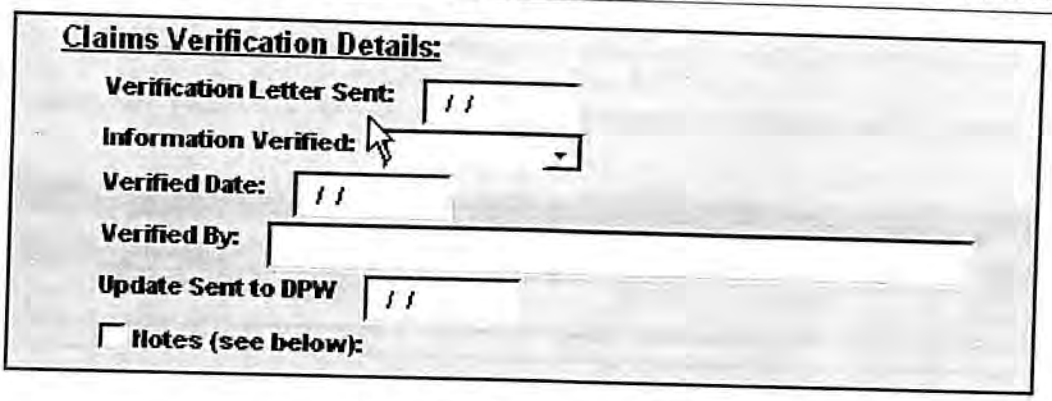


TPL Resource Event

This will begin the TPL verification process. Weekly, a report is sent to the claims department consisting of events entered that require verification. The verification team uses the list and attempts to verify the resource by sending a verification letter to the insurance company provided in the event.

After the insurance information is verified, the claims department completes page 2 of the event.

Once PerformCare has confirmed the TPL information, it will be passed onto the TPL unit of the state agency. In the state of Pennsylvania, this is done through an electronic process. A weekly job gathers all of the newly verified TPL resources and creates a data file according to the agreed upon format. The original resource events are updated to include the date they were sent to the state agency.



TPL Resource Verification

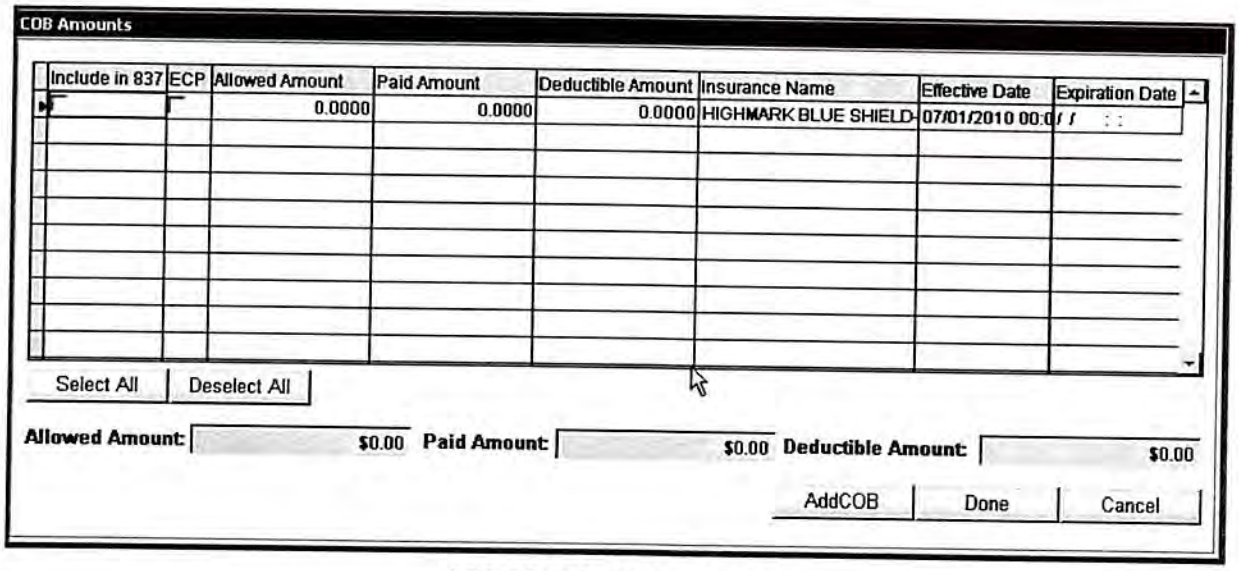
If it is successfully verified, in addition to reporting the resource, then the member's other insurance is updated and all claims within the effective range of the other insurance will use this information during adjudication.

It is PerformCare's policy to cost avoid any claim where primary insurance is valid. Members have a responsibility to fully disclose and use their access to other insurance. Medical Assistance is the payer of last resort. Members with a primary insurer will be directed to access service through the primary insurer's network, even if the primary insurer does not contract with the member's provider of choice. PerformCare recognizes that many in-plan services under Medicaid are typically not covered by commercial plans, and therefore, PerformCare may consider those services for coverage.

The following steps are taken to assure cost avoidance policy is followed:

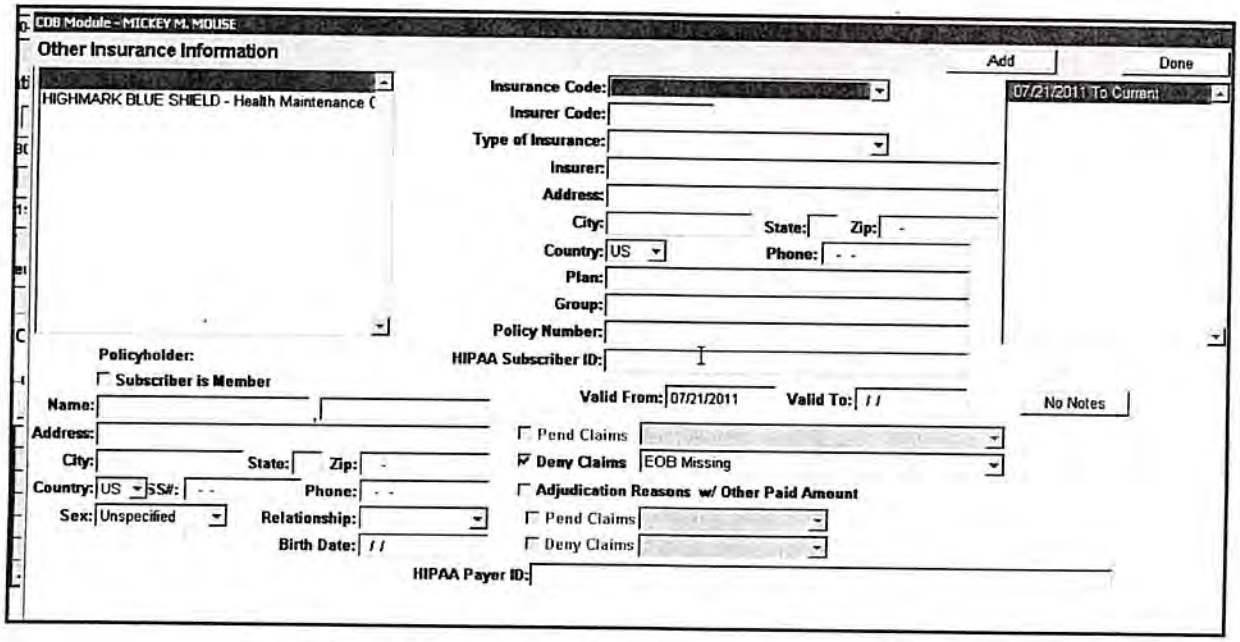
- The member record will be reviewed for primary insurance coverage information prior to authorizing service or recommending service providers.
- Members will be asked to verify primary insurance information.
- If the member is no longer covered by that primary insurance, PerformCare may consider the service for authorization. Member Services will complete the COB event to notify IS of change in primary insurance. During business hours, a claims Service Representative will verify this change in coverage.
- If the member continues to be valid with that primary insurance, member will be directed to access services through the primary insurer first, except in the case of request for services listed below.
- The member will be informed that if they choose to go outside the private insurance or not follow the procedure of their primary insurance, there typically is no obligation for Medicaid to pay for the service. The member cannot by-pass the first insurer provider to avoid the co-pay.
- The member will also be informed that an Explanation of Benefits (EOB) will be required from the primary insurer before PerformCare can pay any bills.
- If the member has Medicare, the PerformCare staff can access the Medicare Provider Search Web site for Medicare beneficiaries: http://www.medicare.gov/Physician/Search/PhysicianSearch.asp or direct members to call the Medicare toll-free number (1-800-MEDICAR; 1-800-633-4227), to find providers who are Medicare enrolled. Members will be directed to Medicare providers in their area.

Every claim received, whether electronically or on paper, has the associated explanation of benefits from other payers logged in the system. This other payer information is linked directly to the pre-existing TPL information. The other payer's payment information is entered and directly associated with the claim line.



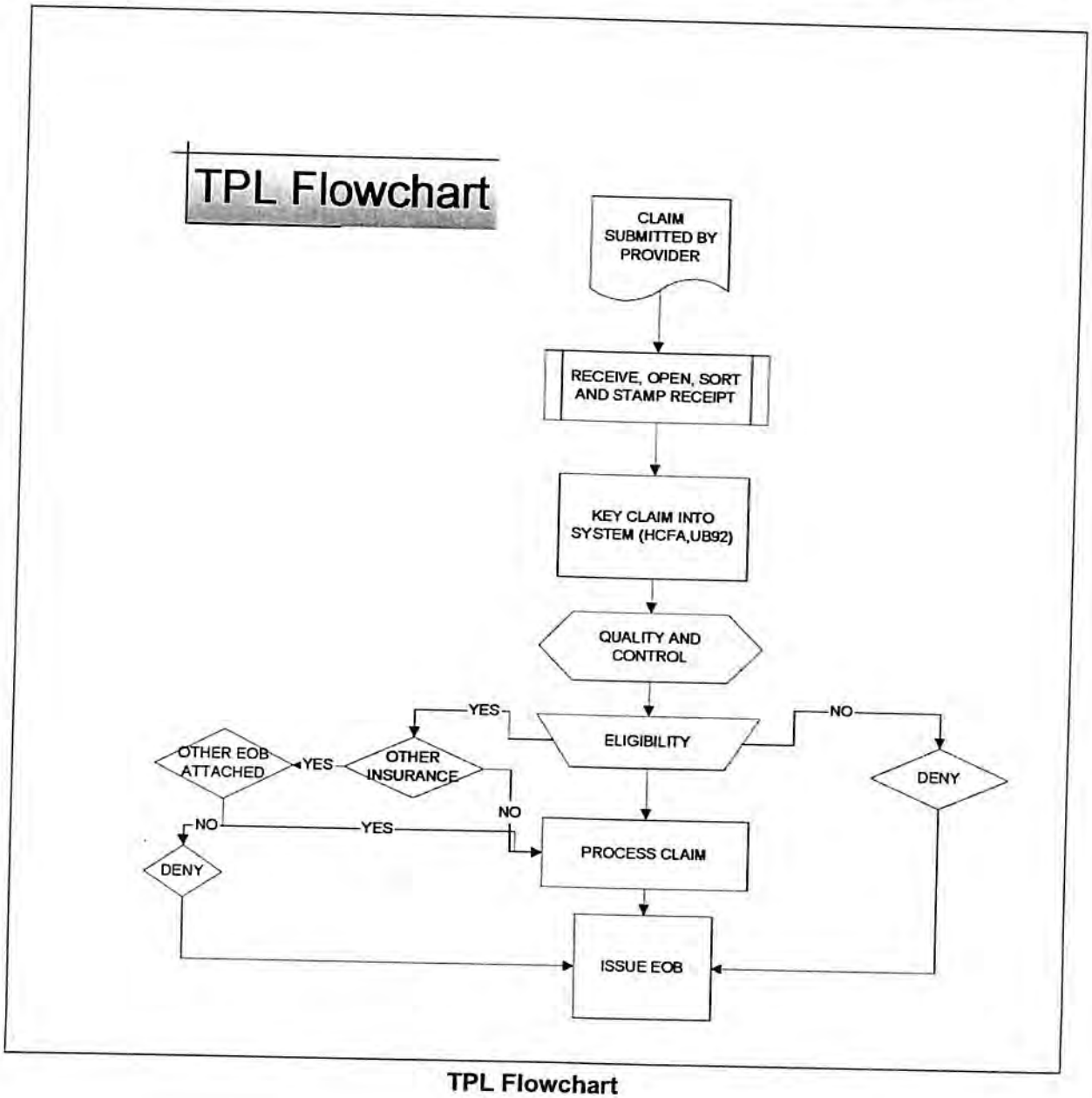
COB Link to Claims Entry

If the other payer does not yet exist, it is added immediately by the processor by clicking the AddCOB button. Such new TPL information from an EOB of another payer is considered a verified resource and is forwarded back to the state agency as a resource referral.



COB –Other Insurance Information Add/Import Screen

Each time a claim is processed, the system will check the member to determine whether the COB/TPL flag has a value. If the member has COB resources is positive, the system will attempt to match the claimed service with applicable insurance using the TPL matrix and if it finds a match the claim will automatically deny. If the claim is accompanied by the primary insurer's EOB, the claims processor can enter the EOB information and the system's adjudication decision will include the other payer's paid amount. PerformCare would be considered the secondary payer and payment would be determined using procedures defined. All claims verified to have COB/TPL and not accompanied with an EOB will be denied.



TPL Flowchart

xxxv. Describe the Proposer's hardware and platform on which the software runs. Describe the environment in which the processor is or will be located.

The PerformCare system utilizes clustered application servers and clustered Microsoft SQL servers that are attached to a storage area network (SAN). In addition, there are web servers that are load balanced. These systems are part of an enterprise data center that exists in Harrisburg, PA with connectivity to the AmeriHealth Mercy corporate headquarters in Philadelphia, PA. Furthermore, the Harrisburg, PA data center supports many regional offices, of which, Louisiana would be included. Within each regional office, the appropriate local file servers, domain controllers and infrastructure would be configured to allow a high availability environment and seamless access to the data center. The diagram on the following page outlines the PerformCare network location in our Harrisburg, PA Data Center.

Hardware Platform

PerformCare's environment consists of a Windows 2008 Server environment with a mix of 32-bit and 64-bit servers operating in a single Domain. The network includes an Active/Active NetApp Data OnTap File Cluster, Active/Active IIS/Application Cluster, an Active/Active Windows 2008 SQL 2005 Cluster, load balanced web servers, load balanced Exchange servers, and 30TB worth of SAN (Storage Area Network) Storage. All LAN/WAN and SAN fiber channel connectivity is powered by Cisco and Cisco MDS hardware. PerformCare only supports Windows XP Professional and Windows 7 clients. IP addresses are assigned dynamically to all workstations and Name Resolution is done via WINS and DNS (Primarily DNS). Please note the expanded details to the hardware in the next section under the Local Area Network.

SAN (Storage Area Network)

Due to the Storage needs of the overall PerformCare network– we have 2 Storage Area Networks. Our Production SAN (where our most critical production data is housed) is a NetApp FAS2050 with a current capacity of 30TB with the capability of expanding to 69TB. It is a fully redundant Fiber Channel SAN with 2 redundant Cisco MDS Fiber Channel Switches. All Servers that access the SAN have redundant HBA's and the data flow across the redundant paths are managed via native OS MPIO. All Management is done via the Web Based FilerView Interface on each Controller.

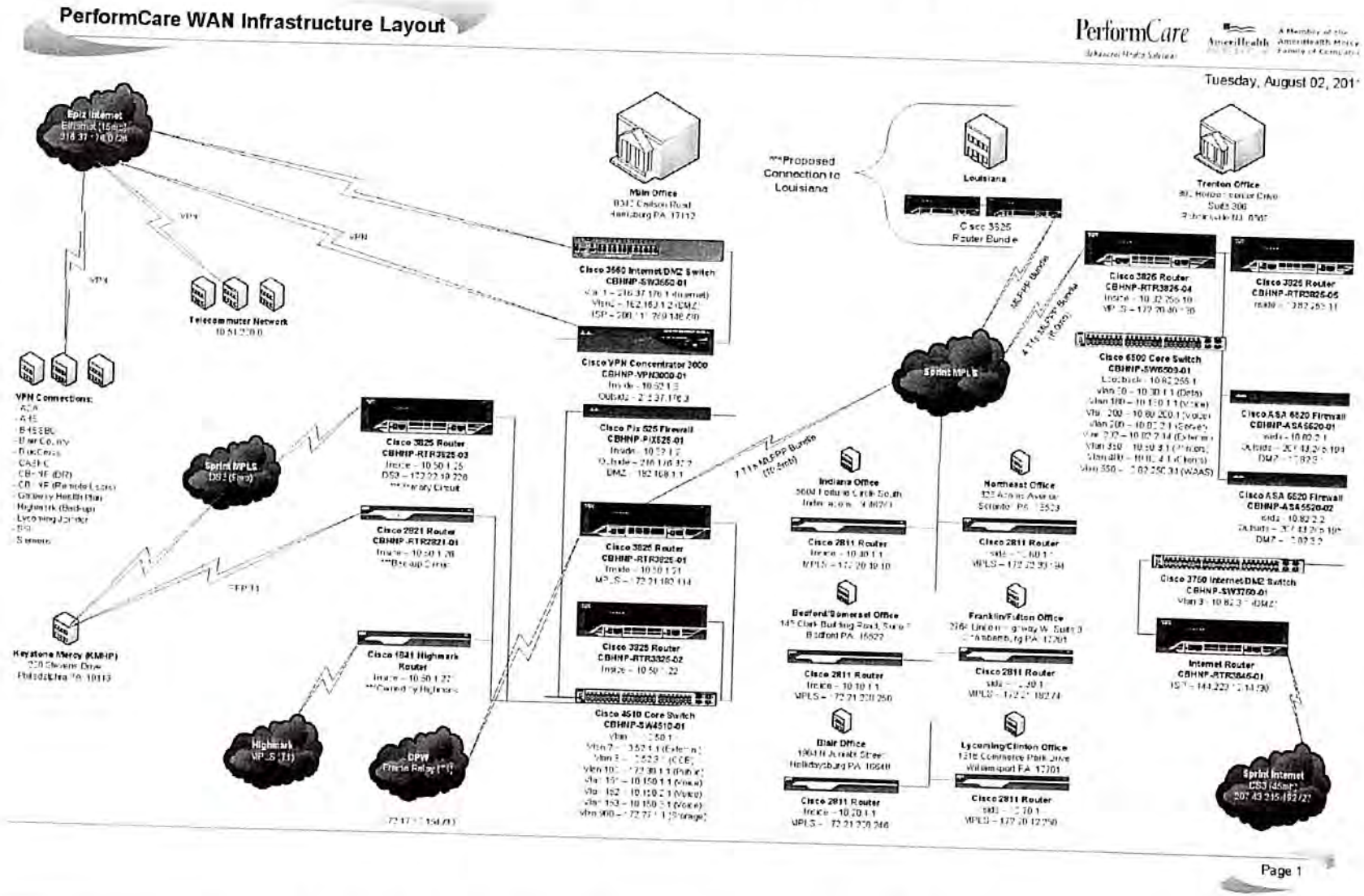
We also have a secondary SAN as well (HP MSA1000) – which houses our backup/archive data and ultimately servers as the storage mechanism for our Information Lifecycle Management (ILM). The current capacity is 2TB with the capability of expanding to 6TB. It is a fully redundant Fiber Channel SAN with 2 integrated redundant Fiber Channel Switches. All Servers that access the SAN have redundant HBA's and the data flow across the redundant paths are managed via HP SecurePath. The LUN's on the SAN can be managed and viewed from any Server that is Fiber Attached to the SAN via the ACU (Array Configuration Utility).

Monitoring

PerformCare monitors all systems in different ways. GFI Network Monitor is used to monitor all systems (Infrastructure and Servers) for availability. If a device goes down, notifications are sent to designated staff included but not limited to Network Systems Manager, Network Administrator, and Telecommunications and Security Administrator. PerformCare also utilized Orion for systems monitoring. Orion can see detailed information regarding traffic (netflows) and also monitors systems for availability. Again, notifications are sent from Orion to internal staff. Orion is hosted by AmeriHealth Mercy. PerformCare also monitors firewall dashboards for possible intrusion or attacks.

PerformCare Network Location in Harrisburg Headquarters Data Center

PerformCare WAN Infrastructure Layout



Clients

The client Operating Systems installed on all workstations on the PerformCare network consist of Windows XP Professional and Windows 7 Professional. They are all managed via Group Policy, Desktop Authority, and Altiris Notification Server/Deployment Server. All PC/Laptop Imaging is done via Altiris Deployment Server. All PC's/Laptops are all locked down via Group Policy and Altiris Notification Server and all User Data is stored on the SAN.

Antivirus

Mc Afee ePolicy Orchestrator 4.0 – McAfee Enterprise

- VirusScan Enterprise 8.7i
- ePO Server – PERFORMCAREVS01
- All updates are downloaded by PERFORMCAREVS01 and all clients point to PERFORMCAREVS01 for regular Virus Definition Updates.

High Availability Power

The data center in the *Harrisburg, PA operations center, Clover Hill Business Park* center is served by separate power grids. When one grid fails, a building-wide UPS system immediately activates. It powers the building for the 5-9 seconds it takes for power to switch to the alternate grid. Should both power grids fail, the backup generator will power critical areas of the building (the data center, the call center, the claims processing area, and others) indefinitely. The backup generator is tested two times per year and has maintenance contracts with qualified generator service mechanics.

Fire Suppression System

The Clover Hill office server room has a clean agent total flood fire suppression system installed. This system, when activated will release HFC125 – an odorless, colorless, no mess, electrically non-conductive, residue free, and people safe gas into the room to extinguish the fire. It suppresses fire by absorbing heat energy at its molecular level, faster than heat can be generated. This gas is stored in a pressurized container in the corner of the server room. The room has three smoke detectors mounted in the ceiling. If one detector detects smoke the alarm bell will activate. If both detectors detect smoke the alarm bell will activate and the horn-strobe will activate. The detector in the center is linked to the building sprinkler system, and is not linked specifically to the server room fire suppression system. The unit is serviced and tested two times per year.

End User Configuration

End users are required to run a system with at least Windows Vista but Windows 7 is preferred. Mac Leopard 10.5 or better is also supported. We recommended that the screen resolution be 1280x1024 or greater, but this not required. Lower resolutions will force the end-user to use the scroll bars to navigate around the screen.

- **End-User Hardware**
  - 1.5 GHz processor or better
  - 2 GB of system memory or greater
  - Recommended 1280x1024 display for best viewing experience but lesser resolutions are supported.

End-User Software

- Windows Vista (32 or 64 bit), Windows 7, or newer, Mac Leopard 10.5 or better.
- Silverlight 4
- Internet Explorer 8.x or newer
- Firefox 4.x or newer

xxxvi. Describe the Proposer's operating system/network infrastructure on which the software runs. Describe the programming language utilized and the software used to develop it. Describe how the source code can be purchased and if the Proposer can customize the software. Describe the Proposer's policy and procedure on software updates.

Operating system/network infrastructure

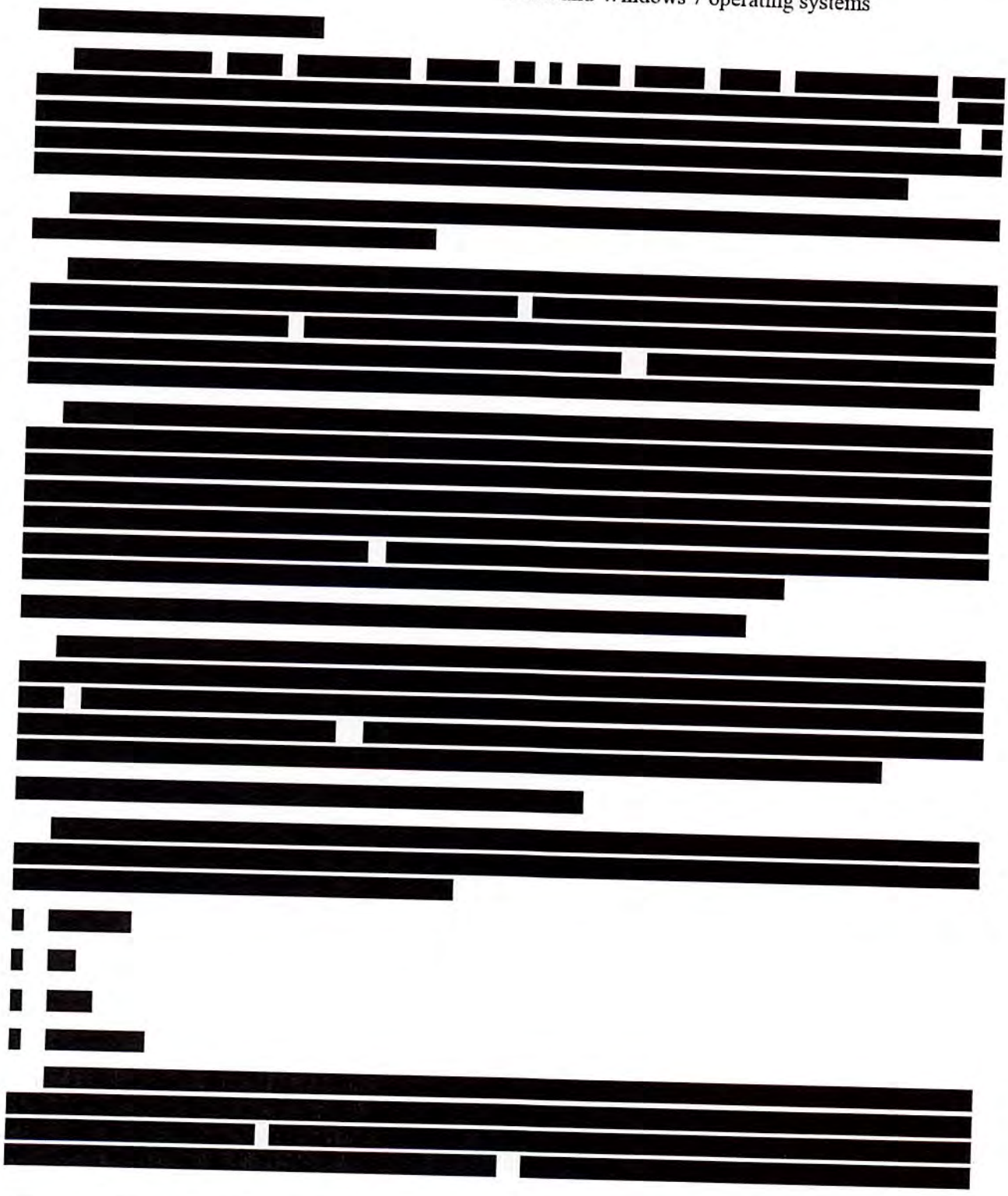
Local Area Network (LAN) and Operating System

PerformCare's LAN provides a high level of redundancy and system protection of all mission critical server systems by utilizing multiple Fiber-channel SAN's (Storage Area Networks) via NetApp and HP with clustered servers having automatic fail-over capabilities. The server environment consists of all Windows 2003/2008/Vmware ESX servers on HP hardware with various roles operating in a single Windows domain connected via an all Cisco Infrastructure powered environment. The transfer rate between all Servers is a full duplexed 10/100/1000Mbs Network powered by a Cisco core backbone along with multiple fully redundant Fiber attached SAN's connected via redundant HBA's (Host Bus Adapters) and redundant Cisco MDS Fiber Switches.

The LAN and hardware system includes:

- NetApp Storage Area Network (SAN) with 30 terabytes, expandable to 104 terabytes
- Offsite/Replicated NetApp Storage Area Network (SAN) with 48 terabytes of storage capacity, expandable to 104 terabytes
- HP Storage Area Network (SAN) with 2 terabytes, expandable to 6 terabytes
- Active/Active NetApp Data ONTAP CIFS (Common Internet File System) File Server Cluster
- Active/Active Windows Domain Controllers
- Active/Active Windows SQL Server Cluster (houses multiple databases that communicate/integrate data)
- Active/Active Windows Application Cluster
- Vmware ESX Virtual Server Environment (ESX Server v3.5, v4.0)
- Windows Citrix/TS (Terminal Services) Gateway Server Environment
- Windows Exchange Server Environment (Exchange Server Enterprise)
- Symantec Altiris Network Management Server Environment
- Symantec Tape Server Backup Environment
- HP LTO (Linear Tape-Open) Tape Library Hardware
- Windows Web Publishing Server Environment (Internet Information Services v6.0, v7.0)

- Barracuda Load Balancer 340 for Web Services
- LAN/WAN Infrastructure Environment powered and served by all Cisco Hardware
- Client PC's running only Windows XP Professional and Windows 7 operating systems



[redacted]

[redacted]

Policies and Procedures on Software Updates

PerformCare insists on strict quality controls for managing the implementation of software updates and has industry recognized procedures for change control that are audited annually. Software upgrades are received from the developer or the vendor that are based on generally identified enhancements or specific functionality requested by PerformCare based on business driven requirements. Implementations are managed with the Change Control Process. PerformCare maintains development, system testing, user acceptance testing and training versions of the software and databases used in the production environment. Each upgrade goes through a controlled vigorous testing plan that is developed and maintained by the Business Systems Analyst team. The testing scripts are developed based on the functional specifications of the software and full regression testing is executed in every time a change is made to the software to ensure new functionality works as expected and existing functionality continues to work as expected. The Information Technology Department is responsible for retaining personnel with skill levels to communicate with vendors and complete all the testing, implementation, and any related training in a timely and efficient manner.

Change Control Process

System Change

Every system change begins with a change control form that is presented to the change control committee that meets three times per week and includes the Helpdesk Ticket Number associated with it. The form must include a change description, reason/benefits, impact, departments affected, date submitted, date of implementation and a signature of a person with approval authority (Originator's Supervisor or IT Management). The signed form must be submitted to the Change Control Administrator who presents the change at the next Change Control meeting to determine the impact and make a decision on whether to implement, put on hold or cancel.

Testing Evidence

Full system testing including regression testing is an integral part of all software upgrades to ensure all enhancements, custom changes, and interfaces work in the upgraded version. All changes must have associated testing evidence prior to implementation. The Business Owner must indicate they are comfortable with the testing performed.

Business Owner Sign-Off / User Acceptance

A Change Control Packet containing the Change Control Form with Approval Signature, User Testing Evidence, Implementation Plan, and Business Owner Sign-Off/User Acceptance must be submitted. The Business Owner Sign-Off document indicates they approve the deliverable has been sufficiently tested and is ready for implementation in a production environment.

Implementation Plan

This plan must be created prior to the testing effort and should list the actions to be taken to implement the change. The intent is to ensure the same steps are taken during production implementation as were taken during testing implementation.

Post Change Actions

After a change has been implemented, the Change Originator must notify the Business Owner that the change has been made into production and record the communication in the Helpdesk Correspondence. This will ensure we "close the loop" with the Business Owner.

f. Member Rights and Responsibilities

Describe how the Proposer will assure Members understand and know how to exercise their rights. Include a description of how the Proposer will assure members' rights are recognized and supported by employees and providers.

Promoting member rights and responsibilities is a core value woven into every component of our service delivery system. Member rights must be respected and assured by every PerformCare staff member, regardless of position, and all providers and provider staff. It is a fundamental component of the recovery and resiliency model and is also incorporated into the treatment process. PerformCare maintains policies and procedures on member rights, which are similar to those issued by DHH-OBH in the RFP, that are shared with all staff and providers. These policies and procedures are submitted as **Appendix 22**. Member rights and responsibilities are provided to members in the form of a Member Bill of Rights.

PerformCare staff receive initial and ongoing training on community rehabilitation and recovery principles and are expected to use these principles to address member needs. All stakeholders working with PerformCare, including members, family members, community programs, and peer support services must fully observe member rights and responsibilities.

We utilize the following processes to ensure that members and their families are aware of their rights and responsibilities and how to exercise them.

- **Member Handbook** – Each member will be provided with a Member Handbook that includes information on the program, member benefits, accessing services, and the grievance and appeals process. The Handbook includes a Bill of Rights and explains how their rights will be respected by PerformCare employees and providers. The rights are described in detail and the member is provided with information on how to contact PerformCare if they feel that their rights have not been observed.

  Additionally, this section of the Handbook also includes information on the member's responsibilities, including the responsibility to supply information, follow agreed upon treatment plans, learn about and understand their behavioral health problems, and keep appointments or cancel appointments appropriately. The Member Handbook will be provided to members at the time of enrollment. It will be also available through provider offices, community organizations, state and local agencies, and at community educational sessions. Members can also contact PerformCare to request a Handbook. The information in the Handbook, including the Bill of Rights, will be written at no higher than a fifth grade level, and will be updated and re-distributed routinely.

LBHP Member Bill of Rights

Members have the right to:

- To receive information
- Be treated with respect and due consideration
- Receive information on available treatment options and alternatives
- Receive rehabilitative services in a community or home setting
- Participate in decisions regarding their care
- Refuse treatment
- Complete information about their specific condition and treatment options
- Information about available experimental treatments and clinical trials
- Assistance with care coordination
- Be free from any form of restraint or seclusion as a means of coercion, discipline, retaliation or convenience
- Appeal or express a concern about the contractor or care authorized
- Receive a copy of their medical records
- Implement an advance directive
- Choose their provider to the extent possible and appropriate
- Be furnished behavioral health care services in accordance with 42 CFR 438.206
- Freedom to exercise these rights without any adverse effect on their treatment

- **Member Orientation** – Member rights and responsibilities are reviewed during regularly-held member orientations, which are offered to both new and current members. Member orientations generally follow the Member Handbook and will cover all the topics that are important to members, especially the Member Bill of Rights. During member orientations, PerformCare will review each component of the rights and responsibilities, provide information on the expectation that PerformCare staff and providers will follow these rights, provide contact information for complaints regarding the application of these rights, and respond to any questions or concerns that members may have.

- **Member Website** – The entire Bill of Rights as well as its application will also be displayed prominently on the member website. The location of the Bill of Rights will be included in the Member Handbook and any other communication regarding the Bill of Rights. Members will be encouraged to review these rights and their application by PerformCare staff and providers.

- **Member Newsletter** – We will review member rights and responsibilities routinely in the Member Newsletter, focusing on how these rights apply to the member and their participation in the treatment process. Of importance - and a key component of recovery - is providing the members with information on the role they play in meeting their responsibilities as members and how meeting their responsibilities can positively impact their involvement in and benefit from the treatment process and available services. Contact information for any complaints regarding the application of the rights will also be provided in the Newsletters.

- **Provider Manual and Trainings** – PerformCare providers and their staff are expected to fully understand the Member Bill of Rights and its application. This information is included in the Provider Manual that is sent to each provider. It is also included in the provider training that is offered to all providers and their staff, covered at least annually. Providers will be reviewed during the Record Reviews to ensure that the Bill of Rights are mentioned and reviewed with the member. Any complaints from members regarding the application of these rights by providers and their staff are reviewed by our MSR and referred to the quality management team for their review and follow-up as needed.

- **Public Posting** – Member Rights and Responsibilities will be printed and prominently displayed in public places frequented by members, such as state and local agencies, provider offices, community programs, WAA offices, emergency rooms and crisis centers, treatment centers, and libraries.

- **PerformCare Staff** – PerformCare Member Services and Care Management staff will play an important role in educating and ensuring that all members understand their rights and responsibilities. All staff will be trained and updated on these rights and their application, all of which will be included in their regular supervisory meetings and annual performance reviews. They will be expected to fully understand and be able to educate members about these rights, and to advocate for members. Member Services will be the first point of contact for most members and will be responsible for providing information to members on these rights and responsibilities. They will also responsible for filing any complaints regarding the observance of member rights and for following up on the status of the complaints.

  The Care Manager will also be responsible for assisting the member in understanding their rights and responsibilities. They will do so as part of the clinical assessment, provider referral, and review processes. They will also promote member rights in their discussions with families during the review and discharge planning process as well as during any service authorization/denial discussions.

- **Member Surveys** – Information from the member surveys and any written notes are carefully reviewed and any issues identified regarding member rights and responsibilities are addressed expeditiously.