Section J – Quality Management

The substantial background of the AmeriHealth Mercy Family of Companies in implementing quality programs throughout the country will enable AmeriHealth Mercy to have an immediate impact on Louisiana Medicaid recipients. AmeriHealth Mercy's experience is summarized below.

J.1: Quality Management Experience

J.1 Document experience in other States to positively impact the healthcare status of Medicaid and or CHIP populations. Examples of areas of interest include, but are not limited to the following:

- *Management of high risk pregnancy*
- *Reductions in low birth weight babies*
- *Pediatric Obesity (children under the age of 19)*
- *Reduction of inappropriate utilization of emergent services*
- *EPSDT*
- *Children with special health care needs*
- *Asthma*
- *Diabetes*
- *Cardiovascular diseases*
- *Case management*
- *Reduction in racial and ethnic health care disparities to improve health status*
- *Hospital readmissions and avoidable hospitalizations*

Management of High Risk Pregnancy

With children and women of childbearing age comprising a large percentage of the Medicaid population, one of AmeriHealth Mercy's primary focus is on improving performance on maternal-child health outcomes and pediatric preventive care.

Getting early prenatal care is the first step toward a healthy, full-term delivery. Two of AmeriHealth Mercy's plans perform above the NCQA Medicaid 75th percentile in this measure, with all plans above the Medicaid National Average.

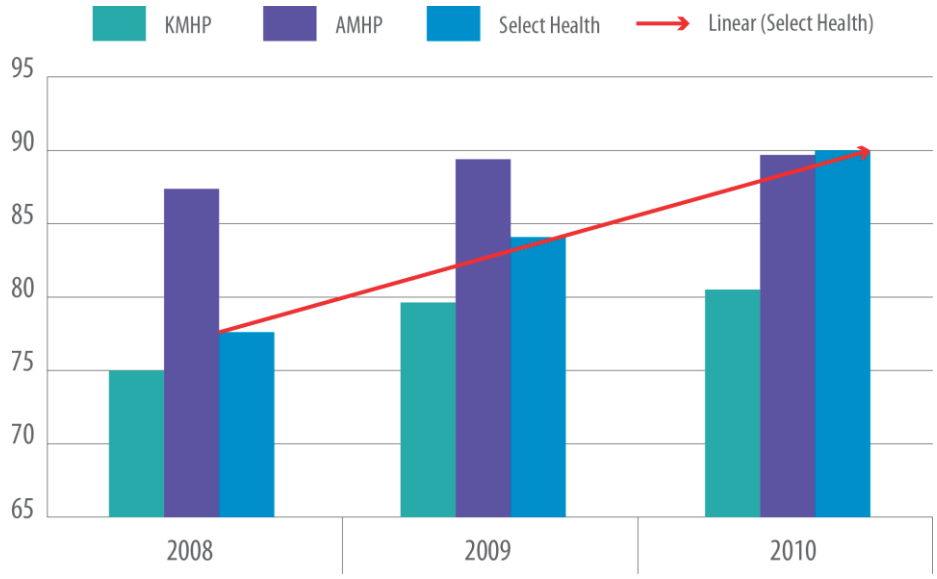


Figure 1: Timeliness of Prenatal Care

AmeriHealth Mercy will implement its prenatal program, WeeCare, in Louisiana. Once AmeriHealth Mercy members are identified as pregnant, they will be automatically enrolled in the WeeCare program. The WeeCare program works to improve birth outcomes and reduce the incidence of pregnancy-related complications through early prenatal education and intervention. The program uses the Institute for Clinical Systems Improvement guidelines for the treatment and management of at-risk pregnancy. Additional information on our WeeCare program can be found in Section F.2.

Through the WeeCare program, AmeriHealth Mercy affiliates have improved performance with respect to the percent of pregnant women who receive 81 percent or more of the expected prenatal care visits, with all plans above the national Mediaid Average, and the Central Pennsylvania plan in the 75th percentile.

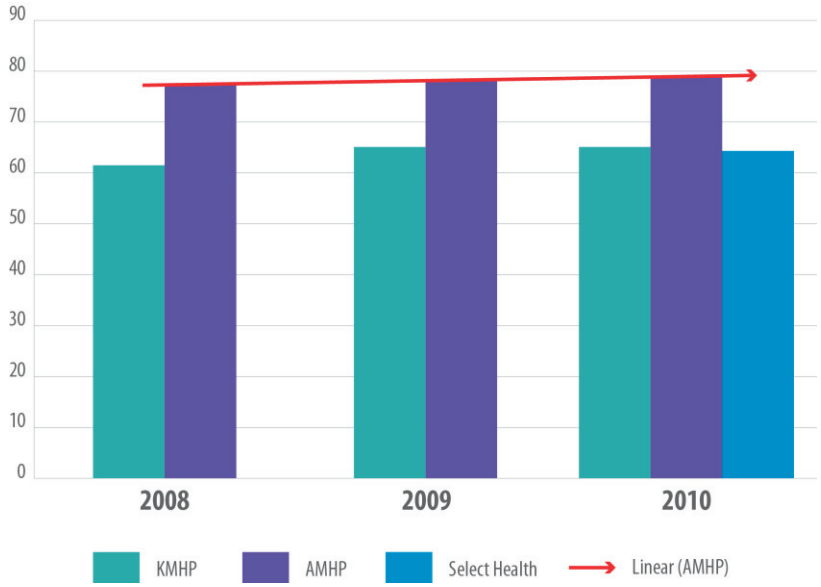


Figure 2: Frequency of Prenatal Care

Another example of AmeriHealth Mercy's commitment to improving birth outcomes is the 17P program. The hormone injection 17-alphahydroxyprogesterone caproate (17P) is used to reduce the incidence of preterm labor in women with a history of it prior to 37 weeks. The use of 17P has been supported by The American College of Obstetricians and Gynecologists' (ACOG) Committee on Obstetric Practice since 2003, but is still greatly underused and is not covered by FFS Medicaid in several states.

AmeriHealth Mercy's South Carolina affiliate, Select Health, offered 17-P as an enhanced benefit even before it was covered by Medicaid FFS.

We support DHH's coverage of 17P and will launch a targeted educational campaign to our obstetrical network and members to promote the use of 17P. Taking full advantage of this intervention is expected to reduce preterm births in eligible women by 33 percent.

AmeriHealth Mercy's WeeCare nurses will also provide care management for NICU babies and their parents. We believe this provides continuity of care and builds on the relationships established during the prenatal period. It is important for our nurses to be involved in the discharge planning of these babies to make sure the families have the supplies, equipment and training needed for a safe and successful discharge. Our Care Managers follow these infants through the first year of life.

Reductions in Low Birth Weight Babies

We continue to focus aggressively on decreasing the incidence of preterm births and are just beginning to see slight improvements. We are an active partner with the March of Dimes and have already contacted Dr. Frankie Robertson, Louisiana State Director of the March of Dimes, to explore opportunities to work on joint initiatives in Louisiana. sponsored and walked in the recent *Walk for Babies* in Baton Rouge and New Orleans.

Our South Carolina plan has made a long-term commitment to South Carolina's March of Dimes chapter as statewide sponsor of the Premature Birth Campaign in that state. That sponsorship has facilitated research on the effectiveness of 17P, provided Centering Training for a number of the state's OB-Gyn offices and raised public awareness regarding South Carolina's rates of infant mortality. There is much work to do in South Carolina, but recent figures for statewide infant mortality have improved and significant improvements within the Select Health population have been encouraging. Select Health's compliance rates increased by 12 percent for prenatal and postpartum care. At the same time, the percentage of infants of low birth weight has decreased 8 percent and percentage of infants of very low birth weight has decreased five percent.

AmeriHealth Mercy's South Carolina plan, Select Health, was nominated for the 2011 Medicaid Health Plans of America (MPHA) Center for Best Practice "Making a Difference Award" for their efforts to improve birth outcomes and reduce pregnancy-related complications.

Watch the video at
http://www.mhpa.org/Education_Resources/MHPA_Center_for_Best_Practices/Keeping_You_Healthy_Videos/

AmeriHealth Mercy fully expects to carry on this tradition of partnership with Louisiana's March of Dimes. We continue to engage in discussions with Dr. Robertson and others to form the basis of that partnership. Additional information on this partnership appears in Section F.7.

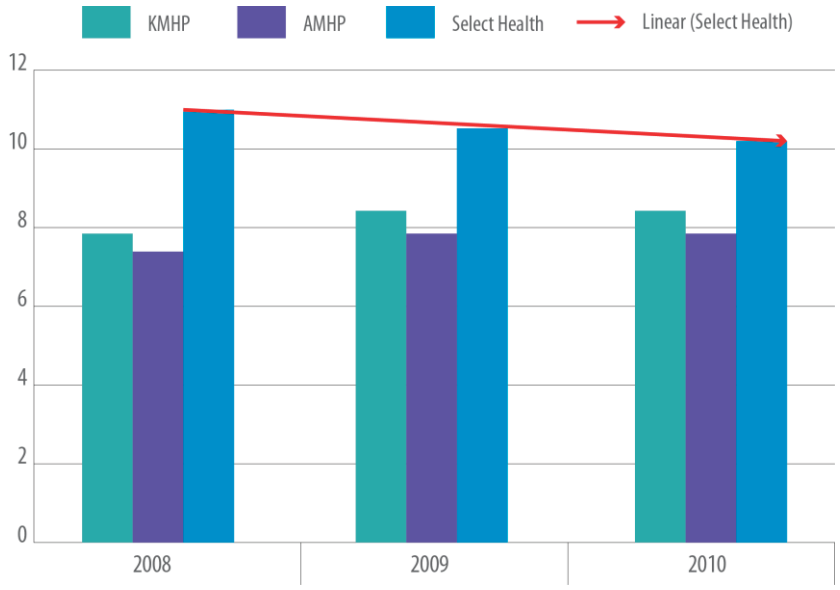


Figure 3: Percent of Low Birth Weight Deliveries

Pediatric Obesity (Children under age 19)

AmeriHealth Mercy is experienced in dealing with the rising incidence of pediatric obesity. In our South Carolina plan, obesity rates more than doubled since 1990, mirroring the growing problem in Southern states like Louisiana. To address this issue, AmeriHealth Mercy uses a combination of focused programs and community interventions.

5-2-1-0

AmeriHealth Mercy's *5-2-1-0: Healthy Habits Families Should Know* program is designed to increase awareness of activity and healthy eating as weapons against obesity. Using principles from Michele Obama's *Lets Move* campaign, AmeriHealth Mercy's program involves the parent, child and primary care provider in a basic assessment and goal-setting process, supported by automated counseling and individual case management.

The program begins in the PCP's waiting room, where the member's parent is given a simple assessment tool asking about the child's habits with respect to servings of fruit and vegetables, hours of screen time (television, computer or game), hours of exercise and consumption of sweetened drinks, like soda or sweet tea. The PCP, parent/guardian and child review the assessment and discuss whether there is an area the family would like to focus on.

***5**–Children should have five portions of fruits and vegetables per day.*

***2**–Children should watch no more than two hours of television per day.*

***1–**Children should participate in some type of physical activity for at least one hour a day.*

***0**–Children should avoid drinking soda, sports drinks or other sweetened drinks.*

The parent/guardian is also offered access to an automated phone counseling program and case management. The eight-week counseling calls can be set up as inbound or outbound calls at the parent/guardian's request. During each call, parents/guardians are asked to report their progress on the selected goal. Depending on their response, they receive additional educational tips and messaging or the option of selecting a new goal. A Care Manager works with the parent/guardian to provide additional support and reinforcement. The family is eligible for an incentive for completing the eight-week program.

The provider section of the assessment contains a place for the physician to document height, weight, BMI and BMI percentile, along with any counseling provided. These components enable to provider to bill for Childhood Nutritional and Weight services during the visit.

We will explore implementing a similar initiative in for LaCare members.

A 7-year-old member who weighed more than 250 pounds was referred to the Care Management Program through her pediatrician. She was exhibiting increasing temper tantrums, which her caregiver would assuage with high calorie food. AmeriHealth Mercy worked with the behavioral health agency and coordinated a home assessment. The assessment identified that she was urine incontinent. The Medical Director arranged for her admission to a special facility that combines medical care with diet and behavior modification. To date, she has lost 42.5 pounds. Her tantrums have been reduced in number and severity, and she is able to use the bathroom herself with minimal prompting. Her parents are visiting and spending time with her in the facility and the behavioral health care managers participate in her treatment team meetings.

Individual Care Management

BMI measurement and percentile are components of our comprehensive care management assessment. For children who are obese, the Care Manager follows a Childhood Obesity Plan of Care to coordinate care and services. The plan includes a complete assessment to identify medical and behavioral health problems that may be contributing to, or be a result of, the child's weight. The family is

assessed for knowledge in regards to diet, exercise, and the significant impact being overweight can have on the child now and in the future. Community resources are shared with the family. The Care Managers provide support by mailing educational materials and discussing them with the child/family, providing monitoring charts and tables, and connecting members to community programs.

Provider Tool Kits

To assist providers with approaches and resources related to pediatric obesity, AmeriHealth Mercy provides physicians with a Pediatric Obesity Tool Kit designed to assist them in screening for pediatric obesity and addressing the issue with parents/guardians. The kit contains:

- A short assessment tool for members based on the 5-2-1-0 national campaign
- Laminated BMI percentile charts for boys and girls
- A guide for effectively communicating with parents
- The "BMI screening by category guide" to assist providers to effectively screen members based on additional health variables

Asthma and Pediatric Obesity

AmeriHealth Mercy will use a variety of proven health education programs to improve quality of life and health outcomes for its members under the age of 19. One of the most innovative is the award-winning Healthy Hoops® program developed by our plan in Pennsylvania.

Healthy Hoops is a holistic, community-based approach to asthma and childhood obesity education that uses basketball as a platform to educate young asthmatics and their families about asthma and weight management.

Now in its sixth successful year, the program targets children ages 3-16 and their parents or caregivers in a fun, interactive program that educates families about identifying asthma triggers, appropriate use of asthma medications, and the importance of exercise, nutrition, and monitored recreational activities as they relate to asthma management.

The goal of Healthy Hoops is to integrate fitness into a comprehensive program for children, families and caregivers. The program continues to show its impact through reduced emergency room utilization and flat inpatient admission rates among participants throughout Pennsylvania. More information on Healthy Hoops can be found in Section F.6.

Reduction of Inappropriate Utilization of Emergent Services

AmeriHealth Mercy has developed a comprehensive strategy to avoid unnecessary use of the emergency room (ER), using a variety of interventions to address the unique socio-economic and cultural characteristics that influence how our members access care, and will implement these programs in Louisiana. Through initiatives such as outreach to members with high ER utilization, we have worked to curtail the rise of ER overuse in our membership.

Overuse of the ER is a growing national problem that transcends all demographic groups, and is particularly acute within the Medicaid Program. In the 10-year period ending in 2005, the number of emergency department visits in the United States increased nearly 20 percent from 96.5 million to 115.3 million, according to the New England Health Institute. Emergency Department Overuse, August 1, 2008.

Inappropriate visits continue to rise sharply. Visits made to the ER for a condition that does not require emergency treatment are a concern across the country. Estimates of avoidable ER use range as high as 50 percent of all visits, according to De Alteris, Martin. Health Care Financing Review, Spring, 1991.

Many people resort to using the ER for minor injuries or illnesses both day and night and on weekends. Receiving non-urgent care in the ER setting lends itself to fragmented care, lack of continuity of medical history, duplicate testing and inadequate post-ER follow up.

The 2007 Institute of Medicine publication "Hospital-Based Emergency Care – At the Breaking Point," reported that Medicaid patients use the ER twice as often as the uninsured, and four times as often as those with commercial insurance. The challenge of reducing inappropriate ER use in a Medicaid population is complex and requires a multifaceted approach.

Our approach is aligned with Louisiana's priority of establishing a true medical home for members, aligning provider reimbursement with desired health outcomes, and moving from an episodic care model to a comprehensive chronic care model to address the needs of members with chronic illness. Our experience has shown that such measures, in combination with appropriate care management for those with chronic conditions, drive substantial reductions in inappropriate ER use.

Emergency Room Initiatives

Reduction of inappropriate utilization of the emergency room will be a key focus, and one of the initiatives we work on with the Partnership Council (details on our Partnership Council can be found in Section G). We will tailor our interventions to fit with Louisiana health care delivery resources and complement existing programs. We will concentrate our initiatives on identification of frequent ER users, building strong care management relationships in that population, educating all members on when to use the ER versus the PCP or an urgent care center, and encouraging self-management of non-emergent issues.

AmeriHealth Mercy will regularly review emergency department utilization reports to identify the underlying issues causing members to seek emergency care. Often, we find that members who frequently use emergency department services have behavioral health conditions. Our Care Managers will reach out to these members to assess their needs and attempt to connect those with reported or suspected behavioral health needs to appropriate behavioral health services. In addition, the Care Manager may become aware of potential or actual behavioral health needs through predictive modeling, assessment or during routine care coordination activities.

ER Data

Analysis of ER data from AmeriHealth Mercy's plan in Southeastern Pennsylvania showed the following:

- Close to 40 percent of the ER visits appear to be for non-emergent conditions or appear to be avoidable. The initial review of non-urgent ER diagnoses showed that viral infections, otitis media, dental issues, upper respiratory infections, bronchitis and pharyngitis are some of the primary drivers of non-emergent visits to the ER. Most of these conditions could have waited at least 24 hours to be addressed or could have been treated in a doctor's office or urgent care center.
- An ER utilization race and ethnicity analysis was completed based on 2007-08 data. It found that among African-Americans, low acuity utilization is about 25 percent; Caucasians about 21 percent; Asians 23 percent; Hispanics 28 percent. The other/default category is also 28 percent. The conclusion from this analysis was that race and ethnicity is not a primary factor in this situation.
- Further analysis of ER claims data (1/1/08-6/30/08), showed that the majority of ER visits typically take place during normal business hours of the PCP office and not during the evening and weekends as suspected. Re-analysis of claims data 6/30/08 – 5/31/09 confirmed this finding.
- Claim submission review found that less than five percent of ER claims are submitted within five days of treatment. 80 percent are submitted with 30-45 days. In addition, the diagnosis on the claim is often vague and not updated from the chief complaint. Up to 10 percent of ER claims for 2007 and 2008 fell into the category "Signs/Symptoms/OthCond, NEC." These finding significantly impacted the plan's ability to establish a corresponding ER outreach based on the ER claim submission. A real time data exchange or onsite resource would be necessary.

- An analysis of continuity of care after ER visits indicated a minor increase in follow-up visits to the PCP office within 30 days of an ER visit when comparing 2007 to 2008. The rate of follow-up visits is 40.58 percent and 42.93 percent, respectively, further showing that members are not receiving adequate, efficient and coordinated care following an emergency room visit.
- A review of telephonic outreach survey to members indicated that there were several recurring themes, which lead the member to utilize the emergency room rather than the primary care provider or urgent care center. As a result of that survey, the following barriers were identified:
  - Members' knowledge deficit of appropriate use of ER versus PCP
  - Members' knowledge deficit regarding the importance of medical follow up
  - Ineffective implementation of the discharge planning
  - Lack of pharmacy benefit (for members in some aid categories)

In 2009, the plan's emergency room utilization increased 5.7 percent over 2008, however, the threshold for 90th percentile nationally rose 12 percent that year. ER utilization was impacted nationally in the late 3rd and 4th quarter of 2009 by the appearance of the the H1N1 virus. There was over a 20 percent increase in ER visits in September 2009, with diseases of the respiratory system surpassing the injury and poisoning category for the first time in volume of visits reported. Flu educational materials and outreach helped to reduce the trend by the end of the fourth quarter. With continued intervention, ER utilization decreased significantly from 69.21 in 2009 to 64.47 in 2010, representing a 6-percent decrease. AmeriHealth Mercy's Central Pennsylvania plan achieved a similar decrease. (We are awaiting the publication of the current HEDIS benchmarks and completion of internal analysis.)

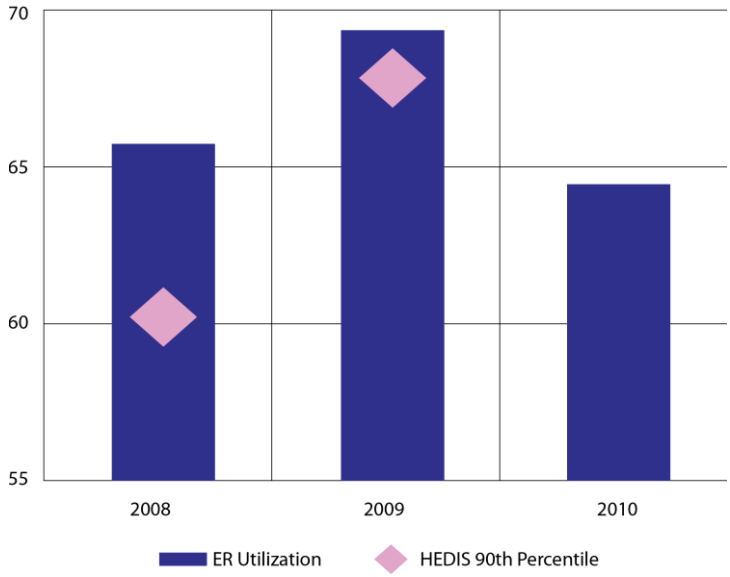


Figure 4: HEDIS ER Utilization 2008-10

Our experience has shown that our interventions, described below, in combination with appropriate care management for those with chronic conditions, drive substantial reductions in inappropriate ER use. We use a portfolio of initiatives in our other markets to combat ER overuse and will employ many of these initiatives in Louisiana, including:

- **Data-driven Outreach** – AmeriHealth Mercy uses claim data to identify frequent ER users. Our care management team then contacts identified members by phone to offer education and assistance in finding the right care. We also receive daily reports from the Nurse Triage vendor detailing members who called the service in the previous 24 hours, the problem identified and the advice given. Rapid Response Care Connectors contact the member to check the outcome of the

advice they received, assess for unmet needs and connect the member back to the Primary Care Physician through an appointment.

- **Transition Managers** – In addition, we place care management resources in the emergency rooms of our high-volume facilities. Through personal contact with ER users during the ER event, we avoid the issue of inaccurate contact information and are able to assess, onsite, the barriers and drivers that led the individual to the emergency room. We also use the opportunity to strengthen the care management relationship with the member, make an appointment with the PCP, and forward the ER discharge summary to the PCP office.
- **"For Your Kids"** – We run community education programs to educate mothers of young infants on how to care for sick children, effective home treatments and when to seek medical or emergency care. Interested participants can become lay instructors for the program. Each participant is given an easy-to-read reference book outlining symptoms and recommended care for common childhood illnesses. We also supply thermometers to those participants who don't have them. We learned early on in the program that the advice regarding fever in the book will not help a woman who has no means to take the child's temperature.

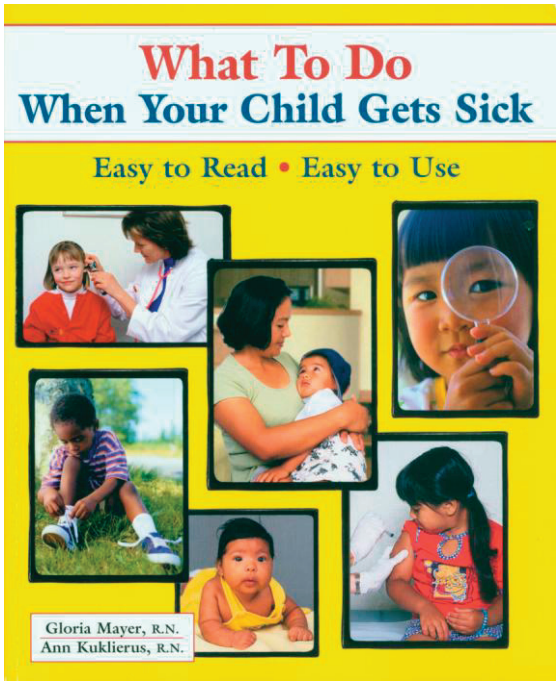


Figure 5: *For Your Kids* Education Piece

Additional initiatives include:

- Automated Discharge Outreach Surveys to support successful discharge plan and ensure follow–up with the primary care physician
- Targeted mailings for ER utilizers based on common non-emergent diagnoses, i.e., otitis media or frequent usage
- Increased visibility of Urgent Care Centers and PCP offices that offer after-hour appointments
- Asthma home assessments/educational visits in collaboration with the National Nursing Centers Consortium's Asthma Safe Kids program
- New Member Assessment ER question (Has anyone in the household been to the ER 4 times or more in the last 6 months?) – Members who respond "yes" receive assessment and follow-up through the Rapid Response team.

- Monthly medication adherence letters to members with prescribed Asthma, Heart Failure and Diabetes medications
- Sponsorship of several community playground builds to provide safe play areas

EPSDT and Pediatric Preventive Health Care

Pediatric preventive care is another key focus for AmeriHealth Mercy. When our Indiana plan, MDwise Hoosier Alliance, entered the market in 2007 the state was ranked 35th in the nation for well-child screening. After just three years, MDwise increased well-child visits by 48 percent and moved from 54 percent to 80 percent compliance as shown in the graphic below.

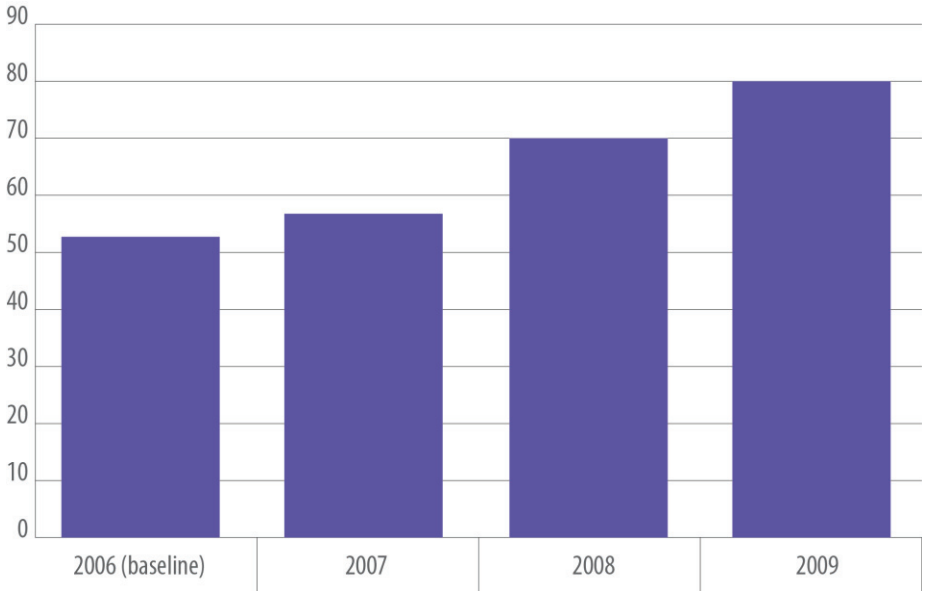


Figure 6: Well-Child Visits Increase

Our programs have also positively impacted other EPSDT-related measures, as well, including improvements in Adolescent Access, Immunizations and Dental Access as shown in the following graphics.

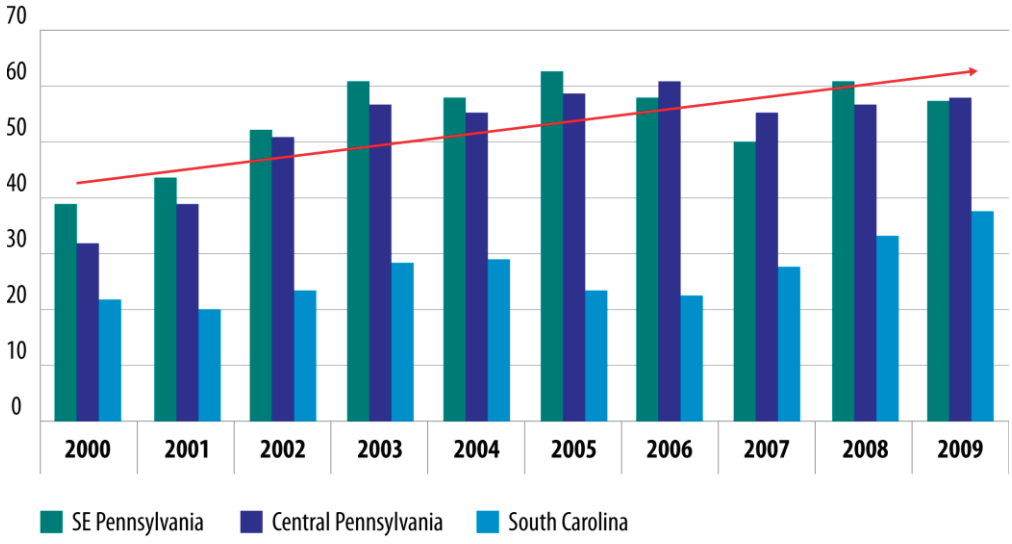


Figure 7: Improved Adolescent Access

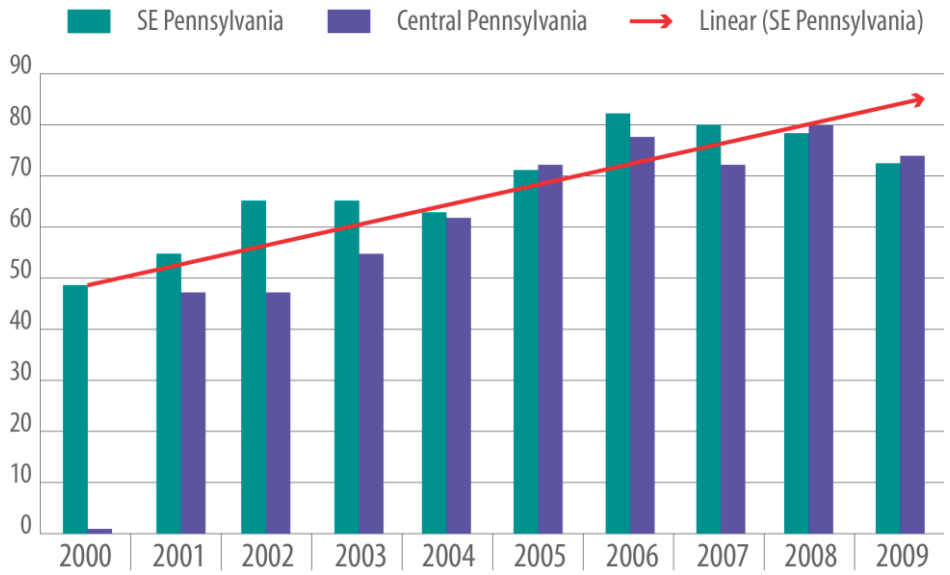


Figure 8: Improved Immunization Rates (Combo 2)

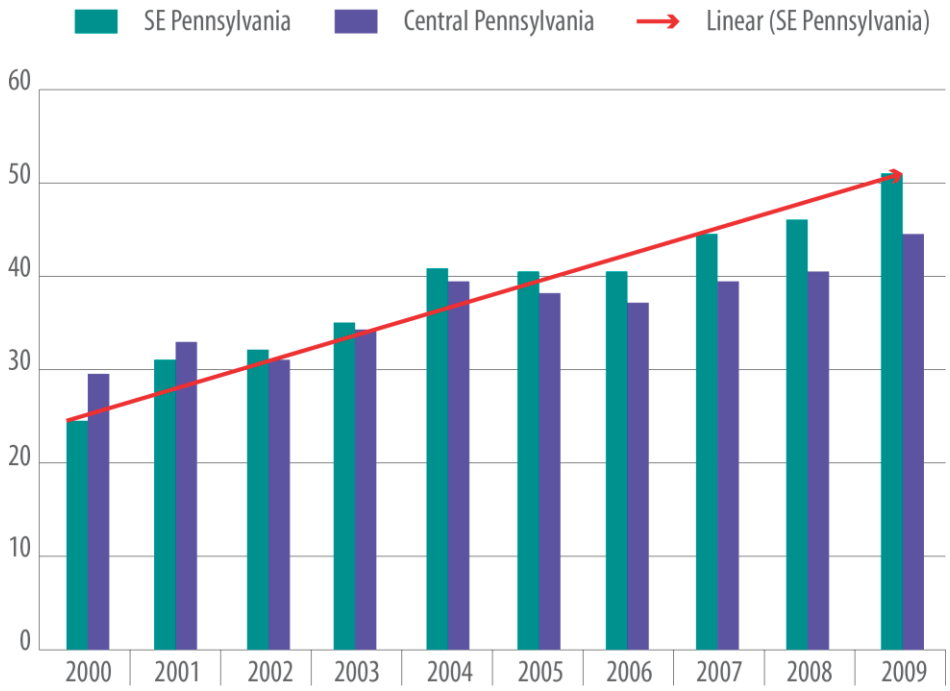


Figure 9: Improved Dental Access

AmeriHealth Mercy is committed to designing and implementing quality improvement initiatives that fit the needs of the population. As part of our process we routinely solicit input from providers on areas they would like to strengthen in their practices, so that we can align resources and goals. In discussions with Dr. Michael Kaiser, Chief Medical Officer, of Louisiana State University Health System (LSU), we have identified performance around pediatric immunizations and EPSDT screenings as an area on which LSU and AmeriHealth Mercy will collaborate. Through AmeriHealth Mercy's robust analytic and information dissemination infrastructure, we can provide risk-adjusted practice-level performance data and peer comparisons to assist LSU with baseline and ongoing measurement. In addition, AmeriHealth Mercy's EPSDT outreach infrastructure and Care Gap strategy (detailed in Sections E and I) will support LSU's efforts to improve adherence to recommended screening and vaccination guidelines.

Children with Special Health Care Needs

AmeriHealth Mercy has a strong history of successful programs and processes to improve health outcomes for children with special needs. We work closely with the employees of agencies and government entities already involved with the Special Needs population to augment available services. Our process is tailored to meet the distinct needs of each population.

Defined populations include, but are not limited to:

- **Seriously and chronically ill participants**: These members will receive Integrated Care Management services tailored to their conditions as well as wrap-around special needs services. Their care plans will frequently include home-based, school-based, and community support services, as well as family caregiver education and support.
- **Persons with behavioral/physical health dual diagnoses**: We will work closely with the behavioral health community to coordinate care for members who need integrated behavioral and physical health care services. We will pay additional attention to medication adherence and biometric monitoring for these members.
- **Persons with mental retardation/developmental disabilities**: We will make sure members and caregivers living with mental retardation and developmental disabilities get comprehensive support. We will pay special attention to coordinating dental care for members with mental retardation and work with the advocacy community and providers to identify dentists who can meet this need. We also try to coordinate the provision of multiple services for members with profound mental retardation. For example, dental and gynecologic services are often performed under sedation for these members, so our employees coordinate the delivery of multiple services in a short-procedure unit.
- **Medically fragile children**: We are adept at coordinating care and services for children waiting for transplants, children with multiple diseases of pre-maturity, and other medically fragile children. We will maintain up-to-date evidence-based care plans and processes to provide seamless access to appropriate services for such conditions as hemophilia and short bowel syndrome.
- **Children in substitute care/medical foster care**: We will work closely with state and local agencies and community resources to ensure seamless care coordination for children in substitute care, including children placed in Medical Foster Care homes. We will make a special effort to ensure that these members, who typically move frequently, have a consistent Medical Home and consistent, appropriate, and timely care.

For example, AmeriHealth Mercy's plan in Central Pennsylvania has identified liaisons in each of the 10-county Pennsylvania Offices of Children, Youth and Families (OCYF) in the Lehigh/Capital Zone. Our assigned Care Manager affords OCYF a single point of contact to make it easy for them to communicate with us. The assigned Care Manager also maintains regular contact, provides trainings upon request, and works with County Children and Youth Agencies as needed for member-specific coordination of care.

Our processes for working with OCYF include the following:

- Coordinating abuse screenings within mandated timeframes
- Managing adherence to EPSDT guidelines through the coordination of preventive services
- Educating OCYF staff and foster parents about covered benefits and how to use available health benefits
- Arranging dental and other specialty care services
- Coordinating behavioral health services, including home-based wrap-around services
- Coordinating shift nursing services
- Arranging for lead screenings
- Coordinating maternity care and infant wellness
- Helping OCYF staff and foster parents coordinate benefits with primary insurers

AmeriHealth Mercy recognizes the special needs of children with mental illness and their families and is committed to improving health outcomes and minimizing disparities in health care that are often associated with this population. AmeriHealth Mercy is particularly attentive to the interaction of clinical, psychological, and social factors contributing to a member's health, since these factors can easily be overlooked in children with significant needs.

Addressing Special Needs

E was born with a rare neurological disorder and is confined to a wheelchair. Her mom, J, described the important role of the case manager and the help she provides when coordinating and scheduling her equipment and office visits, as well as helping her with multiple prescriptions. E also received physical and occupational therapy both in and outside the home. J says, "It is a weight lifted off my shoulders to know that I have support of Keystone Mercy and her case manager."

To address the complex issues surrounding care of children with behavorial illness, AmeriHealth Mercy's model draws on the expertise of a multidisciplinary team with clinical experience in caring for the special needs of this population, strong relationships with local providers and organizations that care for these members, and integrated software support to facilitate an active care coordination program. Care management interventions will vary based on the unique needs of the member, but the goal is to address all conditions and issues, and to coordinate with the member/family/guardian and a multidisciplinary team of providers to set priorities, goals and tasks. This multidisciplinary team, combined with community partnerships and strong primary and ancillary provider relationships strengthens the comprehensive approach to care.

Asthma, Diabetes and Cardiovascular Disease

As AmeriHealth Mercy has worked with Medicaid members over the last 25 years, we know it is imperative to recognize, understand and address inter-relationships among chronic conditions. In our work across the nation, we have taken a holistic approach to care, with good results, and we are prepared to do the same for AmeriHealth Mercy members as well.

Medicaid recipients with chronic illnesses often have multiple co-morbid conditions, which frequently have behavioral health impacts and/or show the results of the lack of an adequate support system. Our development and use of holistic care plans for each member allows us to mix actions and approaches which are customized to address the particular member's co-morbidities, including precursor conditions, chronic illnesses, behavioral health issues, and seemingly unrelated health issues, such as psychosocial problems. The "problem portfolio" approach and corresponding care plan for each member is unique, focusing on the member's specific needs.

Our blended Integrated Care Management model combines case and disease management into a holistic approach that addresses co-morbid conditions, behavioral health needs and social/environmental support needs. Our assessments are structured using a modular approach. As co-morbid conditions are identified

in the initial assessment, more detailed assessments, specific to those conditions, are added to the comprehensive assessment. Our blended approach allows us to combine all condition-specific assessments for multiple co-morbidities into one care plan supporting the entire body and mind system.

Our Condition Management Blue Prints (described more fully in Section E) detail the priority areas our Care Managers need to focus on for each co-morbid condition. Evidence-based Blue Prints are available for asthma, diabetes, chronic obstructive pulmonary disease (COPD), heart disease, sickle cell anemia, and depression.

The chart below depicts reductions in inpatient hospitalization rates for the chronic disease populations in AmeriHealth Mercy's Pennsylvania affiliates from 2009 to 2010.

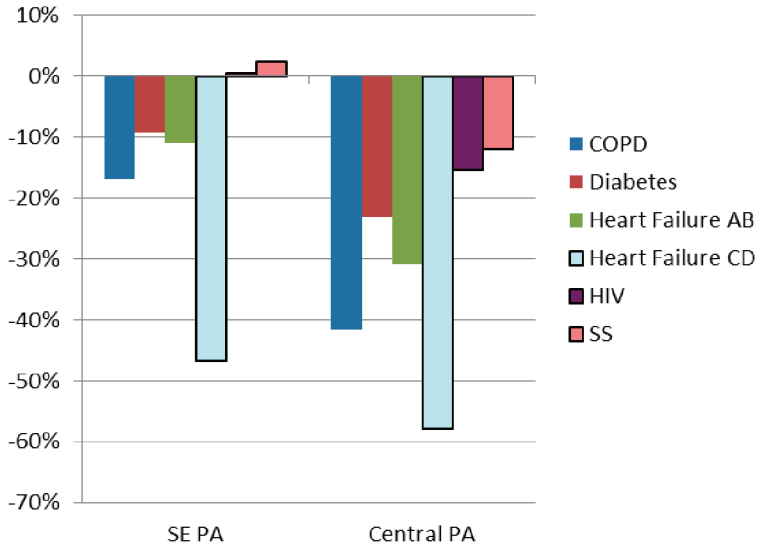


Figure 10: Reduction in Inpatient Hospitalization

In addition, we have improved the management of asthma, diabetes, cardiovascular disease, and COPD and the related health outcomes. Data from three of AmeriHealth Mercy's plans appear in the following figures.

Asthma

For asthma, all of AmeriHealth Mercy's plans reporting HEDIS data related to asthma maintained rates for appropriate use of asthma medication over 90-percent for the last 5 reporting years.

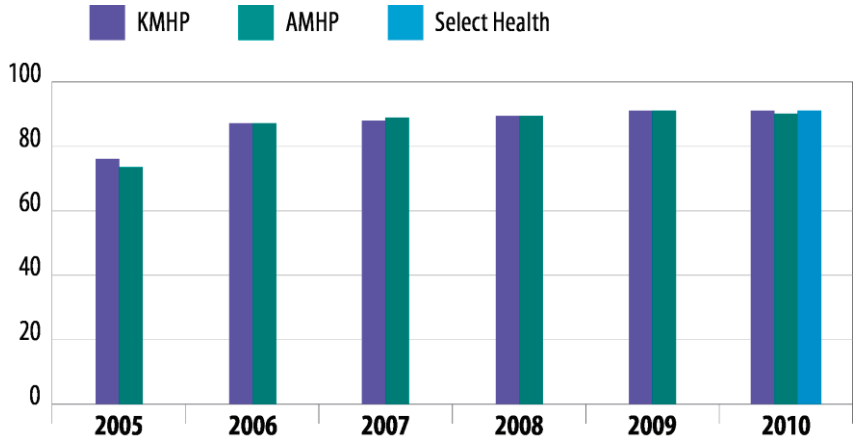


Figure 11: Appropriate Use of Asthma Medication

Diabetes

For diabetic members, AmeriHealth Mercy plans continue to improve blood sugar control, with both plans performing better than the Medicaid national average.

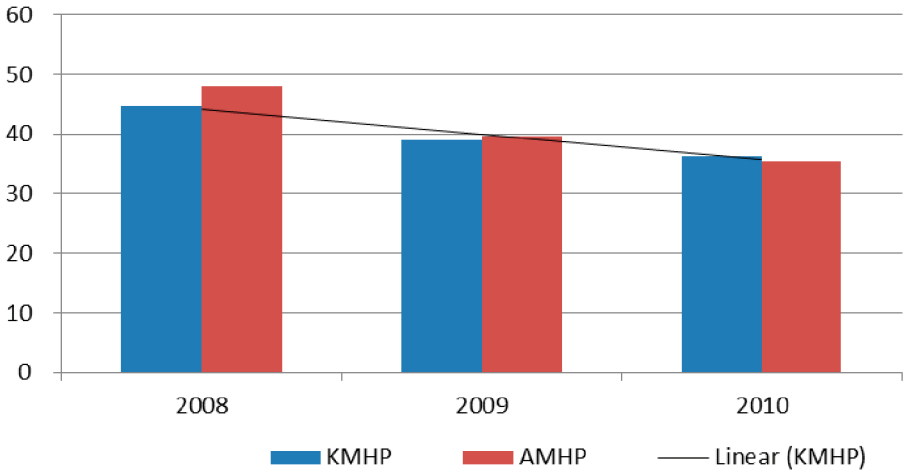


Figure 12: Diabetes – Poor A1c Control

Cardiovascular Disease

For blood pressure control, an important factor in cardiovascular disease, stroke and chronic kidney disease, both AmeriHealth Mercy's Central and Southeastern Pennsylvania plans are in the 75 th and 90th national Medicaid percentiles, respectively.

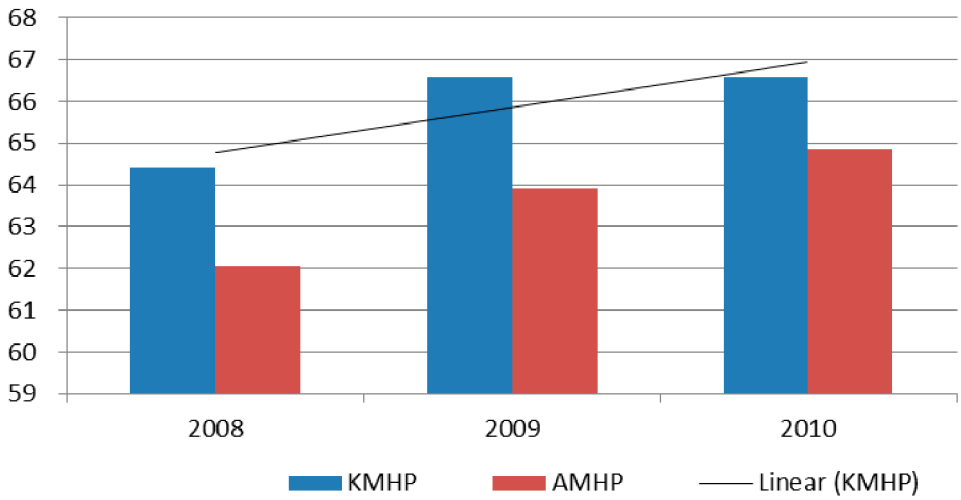


Figure 13: Controlling High Blood Pressure

COPD

For bronchodilator management of COPD, AmeriHealth Mercy's southeastern Pennsylvania plan is in the 90th Medicaid National percentile.

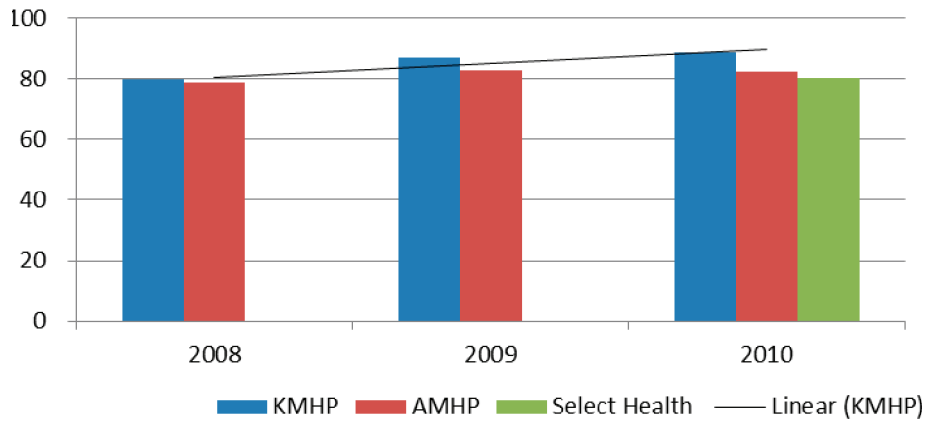


Figure 14: Pharmacotherapy Management of COPD – Bronchodilator

Case Management

AmeriHealth Mercy's Integrated Care Management strategy uses a holistic approach to our member's health care, to understand and address inter-relationships among chronic conditions. In our work across the nation, we have integrated medical, behavioral health and pharmacy management with strong results, and are prepared to do the same in Louisiana.

Using a combination of predictive modeling, focused assessments and data mining, we identify members most at risk for avoidable episodes of care and proactively engage them in care management. This approach brings coordination and education to the member before a critical event occurs.

AmeriHealth Mercy's population receiving complex care management services has shown higher adherence rates (HEDIS rates) than those of populations at-large, due to the targeted, focused efforts of our Integrated Care Management Program. It is not unusual to see the majority of measures reported to be favorably higher for those with special needs receiving care coordination than for those in the general population. The following data is taken from our southeastern Pennsylvania program.

Ms. L is a 55 year old female with new diagnosis of Heart Failure. She had three inpatient admissions in the year prior to becoming our member. Our Care Manager contacted Ms. L and upon assessment determined that she had a limited understanding of her heart disease and needed assistance with arranging transportation and follow-up physician visits.

Due to her new diagnosis, recent history of inpatient hospitalizations, and lack of understanding of her disease and proper monitoring of it, our Care Manager arranged for home health for Ms. L to do an environmental assessment and provide training in blood pressure monitoring, a heart healthy diet, and weight monitoring for fluid retention.

Our Care Manager also arranged for Ms. L to have her own blood pressure monitor and scales at home and reinforced the need for medication compliance with every contact. After our Care Manager conducted several three way calls with Ms. L and the transportation provider, Ms. L became comfortable scheduling her own transportation arrangements. She has been compliant with her treatment program and has not had any additional inpatient admissions.

Table 1: Comparison of Care Management and HEDIS Rates to Health Plan Population Rates–2010

HEDIS 2010	Health Plan Rate	Care Management HEDIS Rate
Breast Cancer Screening	57.87%	**64.35%**
Controlling High Blood Pressure	66.58%	**74.19%**

HEDIS 2010	Health Plan Rate	Care Management HEDIS Rate
Persistence of Beta Blocker After a Heart Attack	78.32%	**93.55%**
Cholesterol Management After Acute Cardio Events		
Chol Mgmt-Received LDL-C Screening	82.97%	80.77%
Chol Mgmt-Screening Revealed Low LDL-C levels <100	46.23%	**47.12%**
Comprehensive Diabetes Care		
HbA1C Testing	82.26%	**91.79%**
Poor HbA1C Control (lower is better)	36.29%	**29.85%**
HbA1c Control (<8.0%)	54.52%	**58.21%**
Eye Exam	49.03%	**53.73%**
LDL-C Screening	80.00%	**86.57%**
LDL-C Level (<100)	41.45%	**51.49%**
Monitoring for Nephropathy	79.35%	**85.07%**
HbA1C Good Control (<7.0%)	39.54%	**47.69%**
Blood Pressure <130/80	35.32%	35.82%
Blood Pressure <140/90	62.74%	**67.16%**
Use of Appropriate Medications for People with Asthma		
5-11 Years	93.80%	**96.04%**
12-50 Years	90.08%	**94.15%**
All Ages	91.62%	**94.73%**
Adult Access to Preventative/ Ambulatory Health Services		
20-44 Years	81.74%	**91.13%**
45-64 Years	88.93%	**96.27%**
65+ Years	85.93%	**93.85%**
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	22.32%	**28.44%**
Pharmacotherapy Management of COPD Exacerbation		
Systemic corticosteroid	62.56%	**63.37%**
Bronchodilator	88.44%	**93.42%**

Results in **bold** indicate a statistically significant increase over the health plan rate

Reduction in Racial and Ethnic Health Care Disparities to Improve Health Status

AmeriHealth Mercy has implemented a variety of strategies to reduce racial and ethnic health care disparities in order to improve health status of our members. As identified in Section F, three of AmeriHealth Mercy's health plans are early adopters of NCQA's Multicultural Healthcare Distinction standards. This prestigious and innovative distinction was designed to recognize health plans that provide culturally and linguistically appropriate services and demonstrate quality improvement methods. Achievement of distinction in this area indicates that AmeriHealth Mercy has been able to meet or exceed NCQA's rigorous requirements. NCQA's goal is to encourage outstanding organizations to continue to raise the bar on eliminating health care disparities and to recognize them for the efforts.

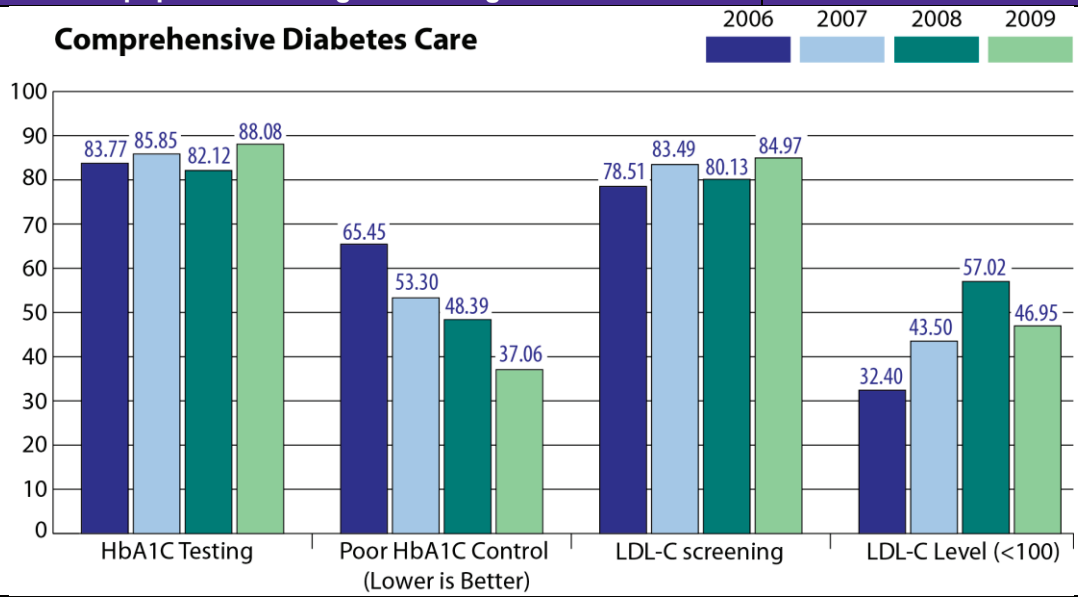
The example below describes successful efforts in AmeriHealth Mercy's plans in Central Pennsylvania, to improve the management of diabetes in the Latino population.

Topic	Improving the Management of Diabetes in the Latino population through screening measures	Type: Clinical
Relevance	Diabetes is a significant national issue, especially among the Latino population. There are 23.6 million people in the United States, or 8.0 percent of the population who have diabetes. Of the 23.6 million, 17.9 million people were diagnosed with diabetes and 5.7 million were undiagnosed. The total prevalence of diabetes increased 13.5 percent from 2005-07. A 2004-06 national survey for people aged 20 years or older indicated that 6.6 percent of non-Hispanic whites, 10.4 percent of Hispanics and 11.8 percent of non-Hispanic blacks had diabetes. Complications of diabetes include heart disease and stroke, hypertension, blindness, kidney disease, amputation, impairment of the nervous system, and increased dental disease. Poorly controlled diabetes can complicate pregnancy and pose a risk to mother and child. The risk of death is twice that of people without diabetes. Total cost of diabetes in the United States in 2007 was estimated at $174 billion ($116 billion direct and $58 billion indirect). Average medical expenditures among people with diabetes were 2.3 times higher than what expenditures would be in the absence of diabetes. [1] Diabetes disproportionately burdens Hispanics. Although the prevalence of diabetes is found in all racial, ethnic and socio economic groups, some groups are disproportionately burdened by diabetes. The Pennsylvania Diabetes Action Plan 2007 indicated that diabetes in Hispanics is more prevalent than white, non-Hispanics; 8.9 percent compared to 7.6 percent, respectively. The report refers to “health disparities” differences in health status, the delivery of health services, or the use of health services that occur by gender, race, and ethnicity, education and income, disability and geographic location. The report also indicates that since 1990, the death rate for Hispanics has been higher at times than for whites. The Health People 2010 Objective (age adjusted to 2000 standard population, rates per 1,000 ages 18+) states that the age-adjusted rate per 1,000 diagnosed with diabetes is three times to five times higher than the Healthy People 2010 Goal. In 2005, the Pennsylvania death rate per 1,000 for the Hispanic population was 78+ as compared to white, non-Hispanics at 69+. Diabetic Hispanic AMHP members have poorer diabetes monitoring performance than non-Hispanic diabetic members. Latino individuals with diabetes comprise approximately 4 percent of the AMHP population. Review of claim data indicates approximately 4,300 AMHP members (4,700 including pediatric members) have diabetes. AMHP data shows that Hispanics are less likely to have their HbA1c tested than their white and non-Hispanic counterparts, 81 percent compared to 85 percent, respectively. Also, when compared to their Asian counterparts, Hispanics were less likely to have an LDL-C screening done, 67 percent compared to 36 percent, respectively. We will analyze and compare the differences between rates. Our membership has seen a steady growth in Lehigh and Northampton counties. These two counties comprise the highest population of Latino members as compared to the other counties. Because of the growing diabetic population in these counties, particular interventions have been designed to address the cultural barriers to fight the disease. [2]	
Baseline Data	2006 calendar year results as measured through HEDIS 2007	

[1] American Diabetes Association. Economic Costs of Diabetes in the U.S. in 2007. doi: 10.2337/dc08-9017 Diabetes Care March 2008 vol. 31 no. 3 596-615

[2] References: Centers for Disease Control, www.CDC.gov, 2008 and American Diabetes Association, www.diabetes.org/diabetes-statistics/prevelance.jsp, 2/23/2006

Topic	Improving the Management of Diabetes in the Latino population through screening measures	Type: Clinical
Goal	Achieve the 90th NCQA percentile for each measure. Annual incremental goals are set using the following formula: X + ((1-x)/20) where X = baseline Up to a maximum of 5 percent (5 percent change in one year is the highest realistic annual goal)	
Benchmark	NCQA 90th percentile	
Barriers	AmeriHealth Mercy Health Plan conducted research to collect information from compliant and non-compliant diabetic members to determine possible barriers to care. The research included two focus groups held in May 2008, 24 in-depth interviews conducted in June 2008 and a quantitative survey completed in July 2008. Among diabetics surveyed, 18 percent have not had an HbA1c in the last 12 months (non-compliant 17 percent; compliant 22 percent). Despite fewer whites reporting that they have a glucose monitor, 86 percent of diabetic whites report a higher testing compliance rate than Hispanics (75 percent). The survey assessed the potential barriers to care influenced members' decisions to see a physician. Common barriers identified by focus groups, the ADA and CDC include: ▪ Member knowledge deficit of the long-term effects of diabetes. The side effects and complications of diabetes don't appear until later in the disease. Since members do not see immediate consequences of poor control, they do not prioritize screening measures and treatment. ▪ Transportation is a barrier against obtaining preventive health services. ▪ Availability of healthy and culturally relevant diet options. Health disparities can also be related to unequal access to healthy food, as well as to lack of knowledge regarding culturally acceptable food alternatives. Evidence suggests that poor access to healthy food in neighborhoods is associated with poor food outcomes ▪ Fear of needle; fear of pain.	
Interventions	During the measurement years, various interventions were identified and implemented. These interventions included: ▪ Diabetes Day events conducted at Centre De Salud, including a Promotora program to train community members as healthy diabetes advocates/lay educators and distribution of Platillos Latinos !Sabrosos y Saludables! (Delicious Heart Healthy Latino Recipes) cookbook. ▪ New Member Portal with various educational topics in Spanish and English. ▪ Implementation of NaviNet at all provider sites, allowing providers to access the members' Care Gaps, run the individual office reports and identify/target at risk members. ▪ Diabetes education program at multiple sites/counties by community outreach staff (clinics, doctor's offices, churches and community centers). ▪ Case management outreach calls to coordinate provider visits and laboratory testing and pharmacy needs. Diabetic wellness workshops conducted at health fairs. ▪ Pharmacy mailing to members regarding medication adherence, lipid and HgbA1c testing. ▪ Pharmacy mailings to providers regarding members with high HgbA1c results. ▪ Member newsletters with diabetic information. ▪ Educational in-services for staff to increase their diabetic knowledge.	

Topic	Improving the Management of Diabetes in the Latino population through screening measures	Type: Clinical
Results		
Analysis	The analysis showed a significant improvement for both LDL and HgbA1c management measures for the Latino population, exceeding the incremental improvement goals with the exception of LDL management in year three. Both LDL screening and management were in the 90th NCQA percentile for year three, with HgbA1c testing and poor control in the 75th and 50th percentiles, respectively. A comparison of the Hispanic population versus the non-Hispanic population showed the Hispanic population has a higher testing rate for both A1c and LDL as compared to the non-Hispanic population.	

Collection of Race and Ethnicity Data

As part of our evaluation of health care disparities, we identified that the racial, ethnicity and language data received in the state eligibility file for some of our plans is incomplete and, depending on the collection method available to the state, may be incorrect. Additionally, the state data only identifies members using the five minimum categories put forth by the federal Office of Management and Budget (OMB): American Indiana or Alaska Native, Asian, Black or African American, Native Hawaiian or Pacific Islander or white. Ethnicity is limited to two categories, Hispanic or Latino and Not Hispanic or Latino. Use of these categories limits the ability of an organization dealing with the Medicaid population to fully identify and address healthcare disparities.

We know that the health needs and experience of an individual with black skin color who recently immigrated from Nigeria is different from a black-skinned US citizen who has been in the United States for three generations. Similarly, the experience and healthcare needs of a recent Mexican immigrant are different from those of an individual of Puerto Rican descent who was born in New Orleans.

To enable us to better understand the health status and needs of specific sub populations within our membership, we recently updated our information systems to better capture the cultural and linguistic needs of our members. We are able, without over-writing the state data, to capture up to five additional categories of race and ethnicity and written and spoken preferred language. All plans have expanded data storage capacity to over 300 distinct granular levels of Race, Ethnicity and Language groups with the capacity to roll up to the Office of Management and Budget (OMB) standard categories. As we collect this information on our membership, it will be a powerful driver of future initiatives to reduce healthcare disparities.

Hospital Readmissions and Avoidable Hospitalizations

Performance around inpatient hospital admissions is monitored through analysis of claim data. Comprehensive reports are produced identifying the rate of admission, as well as the category (adult medical, adult surgical, pediatric, maternity, Neonatal ICU, etc.) Coupled with diagnostic breakdowns, this data allows us to identify and target drivers for avoidable admissions, as well as monitor how programs reduce overall admissions.

AmeriHealth Mercy's program is designed to decrease avoidable episodes of care – especially inpatient events. In our Central Pennsylvania and Southeastern Pennsylvania plans, we saw decreases in inpatient admissions for the diabetic populations of 23 percent and nine percent, respectively (for the year 2009 compared to 2010). For the same period, the Central Pennsylvania Heart Failure population had a 47 percent decrease in inpatient admissions and the Southeastern Pennsylvania Heart Failure population's inpatient admissions dropped by 58 percent. The COPD population experienced similar reductions of 17 percent and 42 percent, respectively.

Rather than offering one or two singular activities aimed to reduce inpatient events, the Hospital Readmission program incorporates a centralized philosophy focused on appropriate inpatient utilization and optimizing member education and self-management skills. To validate our success in managing chronic conditions, we had the program data evaluated by the Disease Management Purchasing Consortium (DPMC). Committed to promoting transparency in outcome measurements, the DMPC is experienced in evaluating health care programs and contracts using the translation of well-established principles of biostatistics into understandable transparent terms.

The auditor letter from DMPC reports, "… The health plans comprising the AmeriHealth Mercy Family of Companies have achieved a reduction in adverse event rates for common chronic disease which is in the top decile [10 percent] for health plans in the DMPC database."

The 2011 auditor letter from DMPC reports, "… the health plans comprising the AmeriHealth Mercy Family of Companies have achieved a reduction in adverse event rates for common chronic disease which is in the top decile [10 percent] for health plans in the DMPC database. Further, since participation in the DMPC benchmarking survey is voluntary, participants themselves tend to self-select, participating only if they believe that their performance exceeds most others, so that 'top decile' may understate performance relative to the universe of all other plans."

AmeriHealth Mercy is one of a handful of Medicaid organizations that received Certification for Validation in Savings Measurement for using plausibility indicators as part of savings measurement for common chronic diseases from the DMPC.

J.2: Quality Management Policies and Procedures

J2. Describe the policies and procedures you have in place to reduce health care associated infection, medical errors, preventable serious adverse events (never events) and unnecessary and ineffective performance in these areas.

AmeriHealth Mercy will maintain a comprehensive process to investigate, review and take action where appropriate for potential quality of care issues. The goal of our efforts is to identify and communicate issues to prevent future errors and adverse events.

Quality of Care Review

Our employees are trained to make referrals to the Quality Management department using a list of sentinel events, including health-care associated infections, adverse events and unnecessary and ineffective care. Comprehensive investigations include review of medical records and interviews with members and providers. The Quality Management staff and its leadership will be based in LaCare's Baton Rouge offices.

If it is determined that the delivery of care in the situation led to a potential quality issue, the case and all supporting documentation is reviewed by the Quality Management department. Quality Management clinicians determine whether the case requires additional follow-up or action, such as provider education or corrective disciplinary action up to and including termination. These events are monitored, tracked and trended by institution/provider. If a pattern emerges at any hospital or provider's office, our network staff and medical management staff meet to discuss the findings and plan appropriate action.

Preventable Serious Adverse Events

AmeriHealth Mercy has a well-defined process for identifying and processing claims related to preventable serious adverse events (PSAEs). System edits, as well as information collected during inpatient medical necessity review, are used to identify cases for review by a clinician. In cases where a PSAE is identified, the facility and provider are notified by letter and the claim is adjusted to reflect the level of payment appropriate if the adverse event had been avoided. Information on the event is tracked and trended as part of the Quality of Care review process described above.

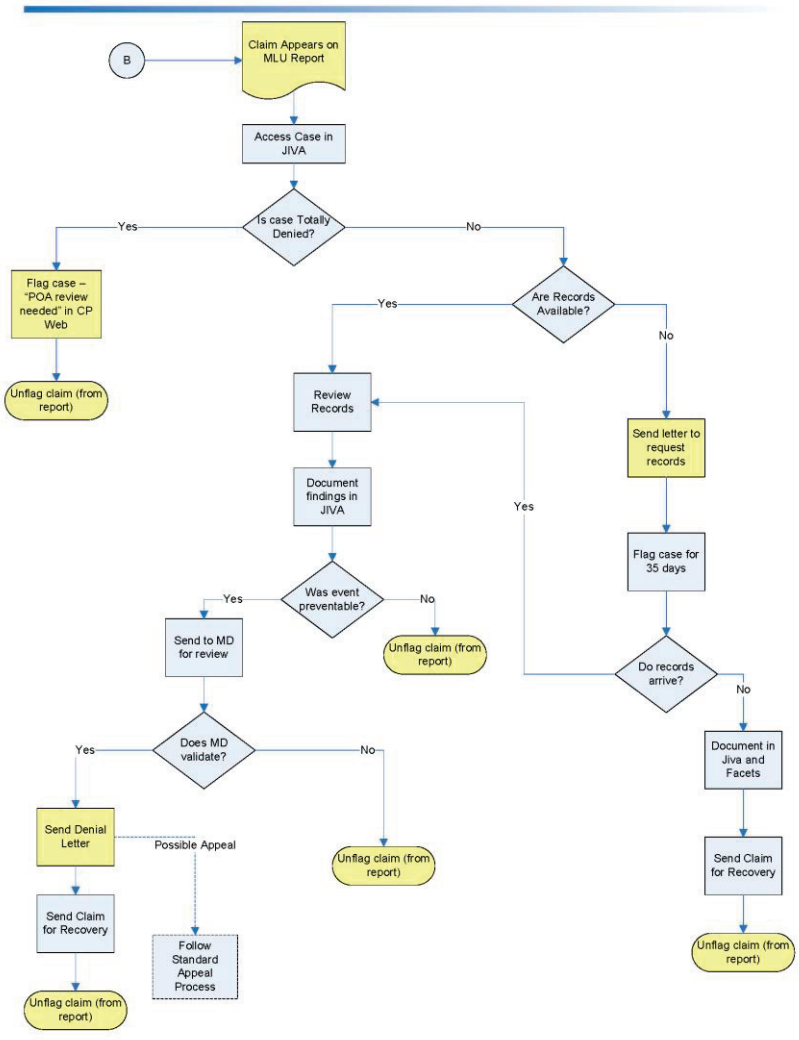
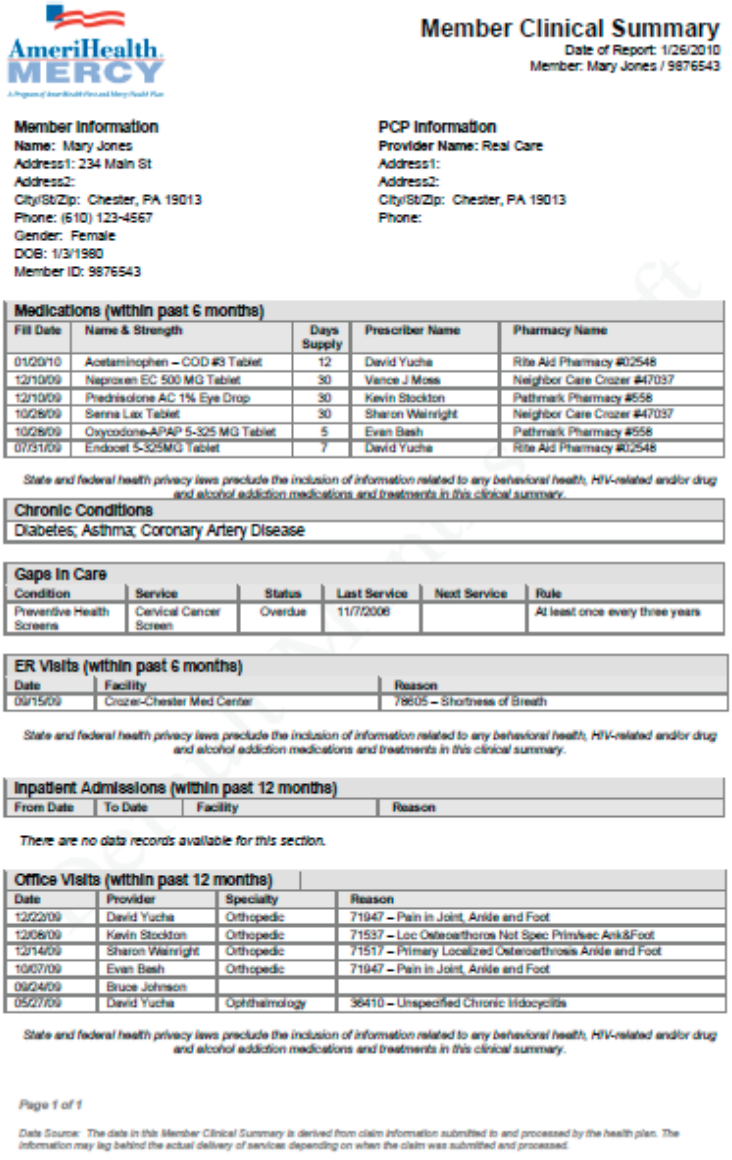


Figure 145: Preventable Events – Case Review

AmeriHealth Mercy will devote significant resources to improving the quality and cost-effectiveness of care for our Medicaid members with complex health care needs. AmeriHealth Mercy will employ a range of complementary approaches to engage our providers in a partnership to reduce health care-associated infections, medical errors, preventable serious adverse events, and unnecessary and ineffective care.

Member Clinical Summary

AmeriHealth Mercy's Member Clinical Summary is one component of our comprehensive strategy designed to prevent medical errors and unnecessary care. The Member Clinical Summary (MCS) is a claim-based clinical history available for each member through our Provider Portal. Providers using the portal can access the MCS from the eligibility inquiry screen or the referral screen. This tool gives providers real-time access to diagnoses, medications and providers associated with the member.



AmeriHealth MERCY

Member Clinical Summary
Date of Report: 1/26/2010
Member: Mary Jones / 9876543

Member Information
Name: Mary Jones
Address1: 234 Main St
Address2:
City/St/Zip: Chester, PA 19013
Phone: (610) 123-4567
Gender: Female
DOB: 1/3/1980
Member ID: 9876543

PCP Information
Provider Name: Real Care
Address1:
Address2:
City/St/Zip: Chester, PA 19013
Phone:

Medications (within past 6 months)

Fill Date	Name & Strength	Days Supply	Prescriber Name	Pharmacy Name
01/20/10	Acetaminophen – COD #3 Tablet	12	David Yucha	Rite Aid Pharmacy #02548
12/10/09	Naproxen EC 500 MG Tablet	30	Vence J Moss	Neighbor Care Crozer #47037
12/10/09	Prednisolone AC 1% Eye Drop	30	Kevin Stockton	Pathmark Pharmacy #558
10/28/09	Senna Lax Tablet	30	Sharon Wainright	Neighbor Care Crozer #47037
10/28/09	Oxycodone-APAP 5-325 MG Tablet	5	Evan Bash	Pathmark Pharmacy #558
07/31/09	Endocet 5-325MG Tablet	7	David Yucha	Rite Aid Pharmacy #02548

State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Chronic Conditions
Diabetes; Asthma; Coronary Artery Disease

Gaps in Care

Condition	Service	Status	Last Service	Next Service	Rule
Preventive Health Screens	Cervical Cancer Screen	Overdue	11/7/2008		At least once every three years

ER Visits (within past 6 months)

Date	Facility	Reason
09/15/09	Crozer-Chester Med Center	78605 – Shortness of Breath

State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Inpatient Admissions (within past 12 months)

From Date	To Date	Facility	Reason

There are no data records available for this section.

Office Visits (within past 12 months)

Date	Provider	Specialty	Reason
12/22/09	David Yucha	Orthopedic	71947 – Pain in Joint, Ankle and Foot
12/08/09	Kevin Stockton	Orthopedic	71537 – Loc Osteoarthoros Not Spec Prim/sec Ank&Foot
12/14/09	Sharon Wainright	Orthopedic	71517 – Primary Localized Osteoarthrosis Ankle and Foot
10/07/09	Evan Bash	Orthopedic	71947 – Pain in Joint, Ankle and Foot
09/24/09	Bruce Johnson		
05/27/09	David Yucha	Ophthalmology	36410 – Unspecified Chronic Iridocyclitis

State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Page 1 of 1

Data Source: The data in this Member Clinical Summary is derived from claim information submitted to and processed by the health plan. The information may lag behind the actual delivery of services depending on when the claim was submitted and processed.

Figure 16: Member Clinical Summary

Because the MCS is available to all providers using the Provider Portal, it serves as a real-time tool alerting providers in the office and emergency room setting to key elements of the member's health care.

The MCS alerts providers to medication prescriptions that are not being filled, so that the provider does not increase the prescribed dose for a member who is not taking the originally prescribed dose. For members taking antihypertensive, hyperglycemic or anticoagulant medications, suddenly taking a higher dose when the lower dose was never tried may be life-threatening.

Additionally, the MCS provides emergency room staff with important information on a member's history and medications. This information is vital for members who are poor historians, or who are not able to respond to questions upon presentation to the ER. The MCS also alerts emergency room providers to patterns of emergency room and inpatient utilization, a key element in identifying members who are over-utilizing available services.

Our state-of-the-art data systems allow providers to print or download the MCS in the standard Continuity of Care Document (CCD) format for integration in an electronic medical record. In discussions with Dr. Michael Kaiser, Chief Medical Officer, of Louisiana State University Health System (LSU), we learned that LSU is in the process of implementing EPIC clinical data management software. We will work with LSU staff to identify and implement routine data exchange mechanisms for the MCS that will interface with LSU's EPIC system.

J.3: Quality Improvement Projects

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

AmeriHealth Mercy develops and monitors key performance indicator and quality activities to guide implementation of quality improvement program opportunities, and will utilize that experience when it proposes its Quality Assessment Performance Improvement Plan to DHH. Key performance monitors include collection of data related to areas of clinical priority and quality of care and service. Objective, measurable quality indicators are defined to provide a consistent means to evaluate internal performance and demonstrate quality of care and service to members and improvements that positively affect the quality of care and services members receive.

AmeriHealth Mercy will incorporate internal performance targets, standards and external benchmarks into our internal key indicator monitoring and reporting to identify areas for additional analysis and, as necessary, implementation of quality improvement activities and corrective actions.

Each functional area is responsible for reviewing and analyzing data findings and quality activities within the department. Included in the analysis, as applicable, are the following:

- Actual performance compared with established performance goals and thresholds
- Data trends
- Actions taken that positively impacted outcomes and action plans
- Resources and responsible persons to achieve desired result for measures not meeting expectations

The Quality Assessment Performance Improvement Committee (QAPIC) and its subcommittees are responsible for reviewing and analyzing key performance monitoring data to evaluate internal and subcontractor performance and quality improvement activities. Our quality committees provide:

- Multidisciplinary oversight of key clinical and service performance indicators
- Coordination and integration of clinical and service improvement into organizational QI activities
- Monitoring of targeted performance against actual performance
- Identification of areas for improvement based on review of data

- Implemention and/or oversight actions needed to achieve clinical, service and organizational objectives
- Monitoring of the of effectiveness of action plans

These key performance indicators are collected and reported to the appropriate governing quality committee. This upward reporting provides ongoing feedback to each department on key performance indicators and assists the us in identifying opportunities for performance improvement.

Identifying Performance Improvement Projects

AmeriHealth Mercy will actively seek opportunities to improve the quality of care and services we provide for our members and providers. We will monitor performance, analyze process and outcome data, compare our results to benchmarks and prioritize areas of focus for quality improvement plans. Highest priority is given to those areas that affect large segments of our population and evidence a strategic fit with our goals: improving efficiency, effectiveness, or customer satisfaction.

As we frame the opportunity and begin to develop the plan, we ask ourselves three questions:

- What are we trying to accomplish?
- What changes can we make that will result in improvement?
- How will we know that the intervention resulted in an improvement?

We set "SMART" goals, ensuring that each is:

- **S**pecific
- **M**easurable
- **A**ttainable
- **R**ealistic
- **T**imely

We understand that some projects will have a lifecycle where results are not available until late in the next measurement period. Projects using HEDIS measures as metrics are one example. In these situations, we attempt to identify interim measurement strategies, to assist us in performing ongoing evaluation of our efforts. For annual incremental goals, we use a formula to identify expected annual achievement where the goal is equal to the lower of five percent or (1-x)/20 where "x" equals the baseline result.

Where possible, we use national benchmarks, such as the NCQA Medicaid HEDIS/CAHPS percentiles or state averages. When those metrics are not available, we use our past experience, looking for year-over-year improvement.

Improving Care and Services

As part of the planning process, we form a workgroup consisting of representation from stakeholders and subject matter experts. The workgroup conducts additional analysis using techniques appropriate to the identified opportunity. For example, to understand the cause of member dissatisfactions related to the primary care office, the group analyzed data and collected information to outline the drivers. A similar approach was used by AmeriHealth Mercy's southeastern Pennsylvania plan, Keystone Mercy, to outline the drivers behind low performance on early prenatal care metrics as illustrated in the graphic below.

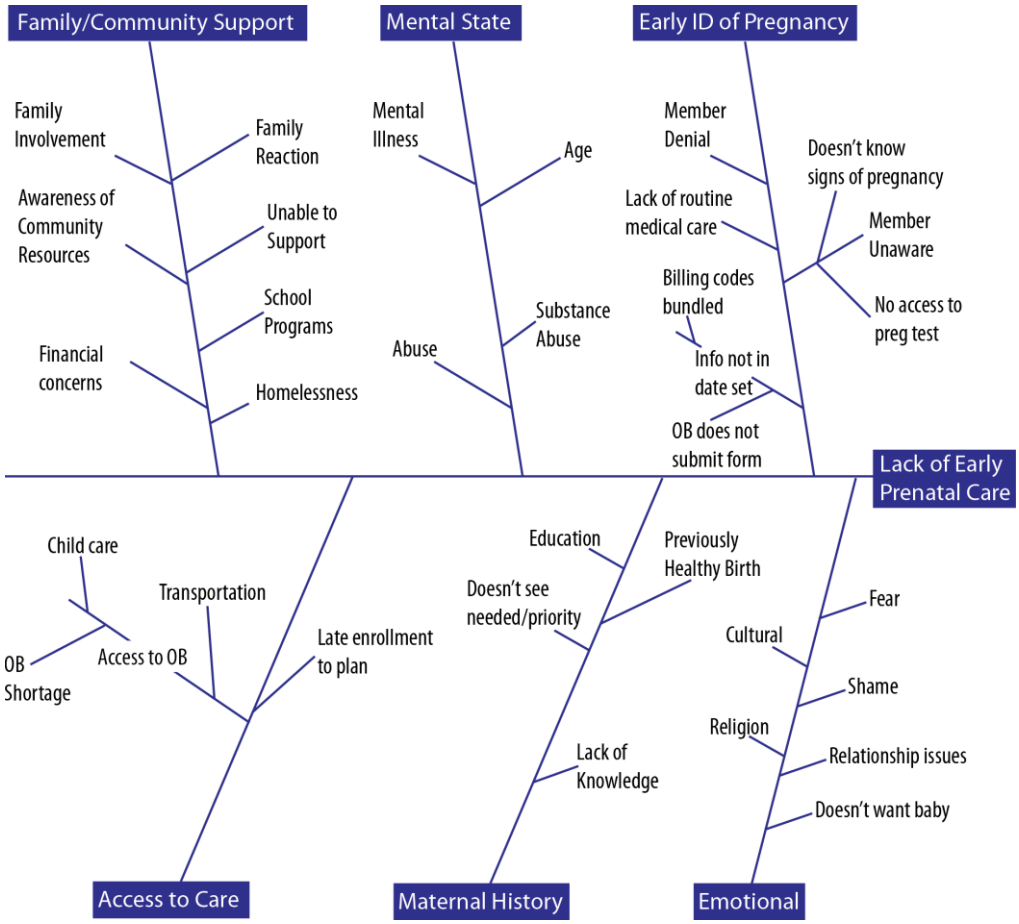


Figure 157: Drivers Behind Low Performance on Early Prenatal Care Metrics

To better understand and to plan interventions to address women's preventive health measures, Keystone Mercy conducted focus groups with women who were compliant with screening recommendations and those who were overdue or had no record of screening. We added supplemental questions to the CAHPS tool to understand the reasons members had difficulty accessing care from a specialist. When addressing high emergency room utilization, we identified otitis media as a high volume/low acuity ER diagnosis, and analyzed the member zip codes from the claims to use in our Urgent Care Center contracting efforts.

Interventions are designed by the work group based on understanding of the drivers, review of industry best practices, and consideration of input from stakeholders and subject matter experts. Intervention costs are weighed against the benefit and supplemental funding sources are considered. For example, when Pennsylvania introduced funding for Medicaid Pay-for-Performance, we were able to use some of the money we anticipated we would earn to reimburse primary care physicians above the capitation rate for performing a cervical cancer screening (PAP test) in their office, one of the incented Pay-For-Performance measures. Other interventions include contracting with a vendor to provide network physicians with finger-stick lead screening test kits and implementing a point-of-service incentive program for members receiving screening mammograms.

Evaluation

Where possible, we use the same methodology to evaluate the program as was used for the baseline measurement. Occasionally we need to revise our metrics if we are using national specifications, such as HEDIS or CAHPS, and changes were made to subsequent year measure specifications.

The results of re-measurements are compared to the cycle goal and the identified benchmark. In addition to looking at trends, we measure for statistical significance using a t-test or other appropriate statistical vehicle. The analysis includes identification of barriers that impacted the interventions. Where possible, strategies are designed to address identified barriers in the next measurement cycle.

Quality projects are terminated when project goals are met, new technology or guidelines diminish the value of the project; measure specifications change to such an extent that no future comparison is possible; or the goals remain unmet and a decision is made to take a radically different approach.

The Quality Assessment Performance Improvement Committee reviews the prioritization, plans and results of quality improvement activities and projects. The workgroup lead presents the findings and recommendations to appropriate Quality Committee. The committee approves and/or makes additional recommendations to workgroup. Any decision to end or revise the approach to a quality project is reviewed and approved by the committee.

Lines of Accountability for QAPI Program

The Board of Directors of the AmeriHealth Mercy Family of Companies provides strategic direction for the Quality Assessment Performance Improvement (QAPI) program and will retain ultimate responsibility for ensuring that the QAPI program is incorporated into AmeriHealth Mercy operations. Operational responsibility for the development, implementation, monitoring, and evaluation of the QAPI Program are delegated by the Board of Directors through the Chief Executive Officer to the Regional President, LaCare Executive Director and Quality Assessment Performance Improvement Committee (QAPIC). The QAPIC provides direction for all aspects of clinical and service quality assurance processes for AmeriHealth Mercy.

Quality Assessment Performance Improvement Committee

AmeriHealth Mercy's quality committee structure is designed to provide a framework for the data collection, assessment, planning and evaluation of processes and outcomes related to QAPI program goals and objectives. The QAPIC is the lead committee responsible for oversight, development and implementation of QAPI activities.

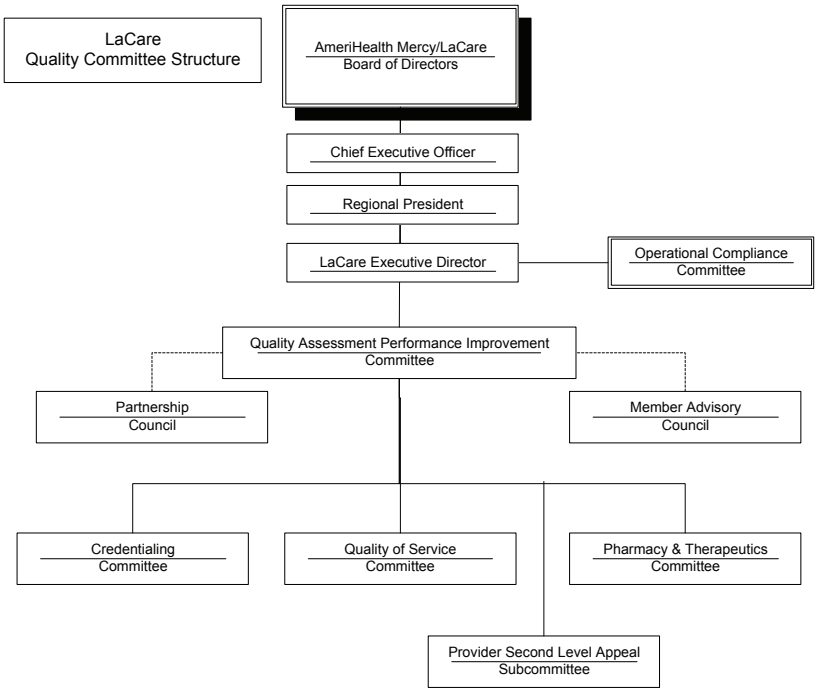


Figure 168: QAPIC Committee Structure

The Quality Assessment Performance Improvement Committee (QAPIC) will coordinate the program's efforts to measure, manage and improve quality of care and services delivered to AmeriHealth Mercy members, and evaluate the effectiveness of the QAPI program. The primary responsibilities of the QAPIC are:

- Review and approve clinical and preventive practice guidelines used by the program
- Assess the effectiveness of AmeriHealth Mercy health management programs
- Monitor and evaluate utilization of health services and the effectiveness of utilization management activities
- Assess the effectiveness of performance improvement projects through analysis and evaluation of results; initiation of needed action, and follow up, as appropriate
- Approve program policies and procedures related to quality improvement activities and committee infrastructure
- Monitor and evaluate performance related to credentialing/recredentialing activity, complaint/grievance processing, service indicators
- Review program peer review activity and recommend any appropriate actions
- Review results of program clinical outcome collection, including HEDIS-like measures and utilization results, to identify opportunities for improvement
- Review results of member and provider satisfaction and complaint/grievance data to identify opportunities for improvement
- Review and approve results of service initiatives
- Review and approve the QAPI program description, evaluation and QAPI work plan
- Monitor performance of program vendors and recommend interventions, as appropriate

The following committees report to the QAPIC:

- Credentialing – Oversees credentialing and recredentialing of practitioners and providers
- Quality of Service – Assesses, monitors and evaluates service indicators, satisfaction and related initiatives
- Pharmacy and Therapeutics – Administers and manages the formulary system; continuously appraises, evaluates and selects medications for the formulary.
- Second Level Appeals Subcommittee – reviews second level appeal submissions

In addition, feedback and input from members and providers is received through two stakeholder groups:

- Partnership Council – solicit input from provider stakeholders regarding the structure and implementation of new and existing clinical policies, initiatives and strategies
- Member Advisory Council – solicit input from members and community stakeholders regarding program design, quality initiatives and health outcome programs

The QAPIC is chaired by the LaCare Medical Director, who will be located full-time in the Baton Rouge office. Voting membership consists of participating primary care practitioners (PCPs), specialists and ancillary providers, the Quality Director (Quality Management Coordinator), Care Coordination Director (Medical Management Coordinator), Director of Provider Network Management (Provider Services Manager, and lead staff from utilization management, care coordination, credentialing, informatics and Rapid Response. LaCare's Quality Director will represent LaCare at DHH's Quality Committee meetings.

Partnership Council

The primary goals of the Partnership Council will be to improve the health status of members and to enhance service delivery to providers and members. The Council will provide input and feedback to the QAPIC. Information gathered from the Council will provide AmeriHealth Mercy with direction, feedback and the necessary support for our member outreach and quality improvement initiatives. We will use this

forum to promote the medical home, develop policies and procedures, share best practices, establish priorities, evaluate findings and implement action plans as needed.

These exchanges serve to allow for valuable discussion, sharing of perspectives, and enhancing knowledge and appreciation of care and service concerns across programs, providers, community organizations, external organizations and the Department as we work together on common quality initiatives. Through the Council, AmeriHealth Mercy will obtain a greater perspective of regional needs and priorities, creating the opportunity for flexibility and creativity in pursuing solutions to local health challenges and sustaining long-term improvement. Additional information on the Partnership Council can be found in Section G.

Delegates to the AmeriHealth Mercy Partnership Council may include representatives of the following constituencies:

- Hospitals
- Physicians
- Physician extenders
- Specialty providers
- Durable Medical Equipment providers
- Dental providers
- EMS and transportation providers
- Behavioral Health providers
- Nurses
- Pharmacies
- Rehab/Skilled Nursing Facilities
- Home Health and Hospice providers
- Home Infusion and Home Medical Equipment providers
- Federally Qualified Health Centers, Rural Health Centers and other Health Centers or Clinics
- Local Health Departments
- School-Based Health Centers
- Social Service agencies
- Community based organizations and groups (For example, homeless shelters, food pantries, churches)
- Schools of Medicine
- Targeted Care Management Programs
- LaCare staff
- Health information technology representatives
- Member advocates (consumer groups such as county/regional mental health association for example)

Figure 19: Partnership Council

Quality Committee Members

We have already obtained agreement from Dr. Michael Kaiser, Associate Chief Medical Officer of LSU and Rene Ragas, Special Projects Director for the Franciscan Missionaries of Our Lady Health System (FMOLHS) to support AmeriHealth Mercy through representation on our Quality Committee and Partnership Council. We have also invited the following individuals and institutions to participate in our Council and quality committee structure:

Institution	Name
Woman's Hospital	Sherry Poss *Director of Managed Care*
Children's Hospital and Children's Healthcare Network	Cindy Nuesslein *Vice President, Hospital Operations*
CHRISTUS Health Louisiana	Les Tompkins *Louisiana Regional Director of Managed Care* Kevin Parsley *Senior Director Managed Care for Southern Region*
St. Charles Community Health Centers	Mark Keiser *Chief Executive Officer*
Natchitoches Regional Medical Center	Mark E Marley *Chief Executive Officer*
Louisiana Academy of Family Physicians	Ragan LeBlanc *Executive Vice President*
Louisiana Chapter American Academy of Pediatrics (LAAAP)	H. Jay Collinsworth, MD *Vice President*
Louisiana Rural Hospital Coalition	Linda Welch *Executive Director*
MedicineLouisiana	Berkley Durbin *Director*
Lake Senior Care Center	Susan E. Nelson, MD *Physician*
Tulane University	Frank Elliot *VP, HCA Mid-West Division*

Institution	Name
Tulane Community Health Center	Eboni Price, MD MPH *Chief Medical Officer, Tulane School of Medicine Community Health*
The Ellis Clinic	Michael Ellis, MD, FACS *Physician*
Surgical Hospital of Greater Baton Rouge	Ernest Mencer, MD *Principal* Jeffrey Littleton, MD *Principal* Kenneth Cranor, MD *Principal*
Ochsner Health System (including North Shore Medical Center)	Mary Armstrong *Assistant Vice President, Managed Care*
Saint Thomas Community Health Center	Donald Erwin, MD *President/CEO*

J.4: Focused Studies

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

AmeriHealth Mercy has a strong track record of improving clinical outcomes and reducing medical costs in the Medicaid population. In evaluating our programs, we analyze a combination of utilization, cost and clinical outcome data. This gives us a complete view of our impact on the member's health status. We also compare members receiving the intervention with a control group, when possible, to evaluate the difference between populations. The below examples highlight our experience in several of our markets.

Improving Health Status

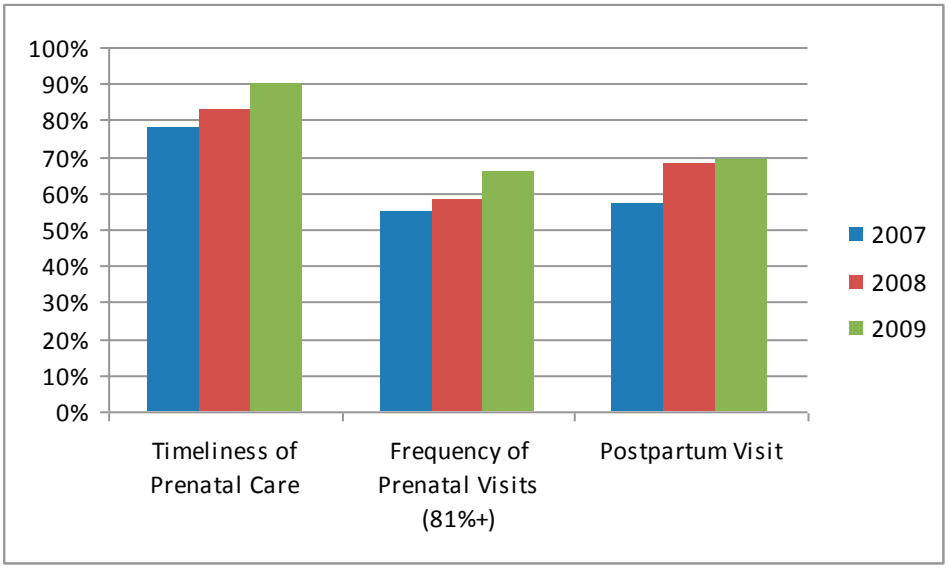
Improving Prenatal Care and Birth Outcomes

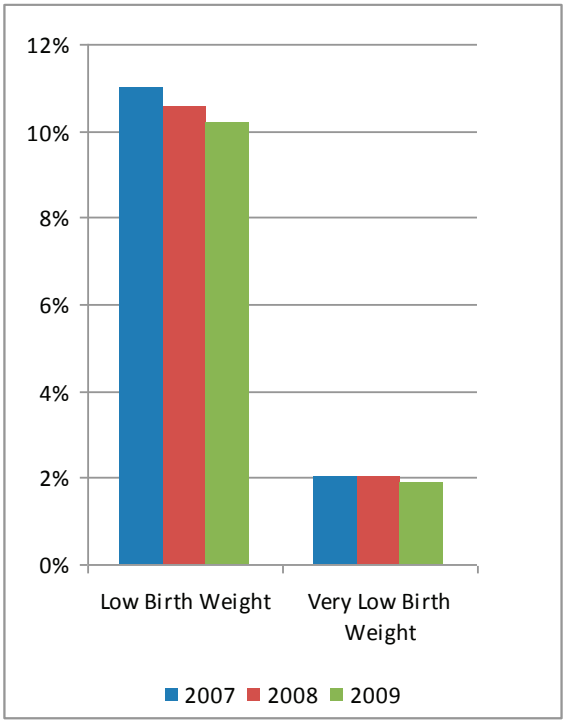
AmeriHealth Mercy Market:	SHSC – South Carolina	
Topic	**Improving Prenatal/Postpartum Care**	**Type:** Clinical
Relevance	**Preterm births are a significant national issue** Statistics (March of Dimes) show that rates for preterm births and low birth weight infants continue to rise throughout the United States over the last decade. The long term effects of prematurity and low birth weights have been well documented in the form of chronic illnesses, delayed development and learning disabilities. NCQA reported in their 2005 State of Health Care Quality that mothers who receive no prenatal care have an infant mortality rate over five times that of mothers whose prenatal care is initiated in the first trimester of pregnancy. **Pregnancy impacts a significant portion of the Select Health population.** Select Health has reported pregnancy-associated diagnoses, both inpatient and outpatient, among its top 10 reported diagnosis for several consecutive years. The majority of Select Health membership is children and women of childbearing age. Based on the prevalence of this diagnosis and the membership demographics of the plan, Select Health has elected to concentrate resources in the development of a prenatal health management program targeting high and low-risk pregnant	

AmeriHealth Mercy Market:	SHSC – South Carolina
	members. Select Health implemented a high-risk prenatal program (Healthy Babies) July 1st 2000. **Prenatal care is an important determinant of birth outcomes.** One of the most important factors that impact pregnancy outcomes is the quality and quantity of prenatal care. It has been recognized that prenatal care leads to healthier births. For every dollar spent on providing adequate prenatal care to low-income women, avoiding direct medical care for a low-weight baby during its first year of life could save $3.38. (S.C. DHEC Healthy People Living in Healthy Communities) **Birth outcomes in South Carolina are related to prenatal care experience.** The March of Dimes reports the following **2005** statistics for the South Carolina population: (births 57,711) ▪ 10.2 % of infants were born low birth weight (less than 2500 grams) ▪ 2.0 % of infants were born very low birth weight (less than 1500 grams) ▪ 15.6 % of infants were born preterm (less than 37 weeks gestation) ▪ 2.8 % of infants were born very preterm (less than 32 weeks gestation) ▪ 69.0% of live births were to women receiving early prenatal care, 23.6% were to women beginning care in the second trimester, and 7.4% were to women receiving late or no prenatal care ▪ 1 in 14 infants (7.4% of live births) was born to a woman receiving late or no prenatal care South Carolina DHEC reports the following birth statistics for the **2006** reporting year: (births 62,191) ▪ 8.3 % of infants were born with low birth weight (less than 2500 grams) ▪ 1.9 % of infants were born with very low birth weight (less than 1500 grams) ▪ 10 % of infants were born preterm (less than 37 weeks gestation) ▪ 2.2% of infants were born very preterm (less than 32 weeks gestation)
Baseline Data	2006 Calendar Year results as measured through HEDIS 2007
Goal	Achieve the 90th NCQA percentile for each measure. Annual incremental goals are set using the following formula: X + ((1-x)/20) where X = baseline Up to a maximum of 5% (5% change in one year is the highest realistic annual goal
Benchmark	NCQA 90th Percentile
Barriers	▪ Timely identification of pregnant members and early risk factors for pregnancy to encourage appropriate prenatal care. ▪ Members do not realize the importance or need for consistent prenatal care. ▪ Provider practice variation in adherence to recommended guidance for appropriate use of 17-P by the American College of Obstetricians and Gynecologist. ▪ High-risk behavior, lifestyle choices of pregnant members contributing to poor birth outcomes.
Interventions	1. Monthly SOBRA maternity identification report used to identify pregnant members and conduct outreach to encourage prenatal care. The report allows the prenatal team to identify pregnant members early for prenatal outreach interventions to establish more consistent prenatal care. Members identified are initially contacted by a CSR in member services and then referred to the prenatal team if risk factors are identified during the outreach call. 2. Network Management team education to providers on the risk assessment form

AmeriHealth Mercy Market:	SHSC – South Carolina
	though provider site visits and a provider newsletter article to state the importance of the form in identifying high risk members for case management. 3. Outreach campaign targeting "first time" moms, emphasizing the importance of prenatal care, addressing any misconceptions or lack of knowledge 4. Identifying pregnant members for early outreach who are on the plan but have not been identified through the use of: a. maternity claim reports b. Pharmacy claim report to identify high risk pregnant members through prescribed medications (ex; anti-hypertensive, anti-virals, insulin, oral hyperglycemic agents and/or tocolytics) for targeted member outreach 5. Educational visits to OB providers in conjunction with a representative from the plan's contracted OB home care vendor, distributing material on OB case management services provided by the vendor and SH that are covered by the plan. 6. Article's placed in the "Healthy Now" Member Newsletters to emphasize the guidelines for appropriate prenatal care. 7. Promotion of the "Text4Baby" national program. This program provides maternal health information and topics via phone text messaging 8. Guidelines for appropriate use of 17-p by the American College of Obstetricians and Gynecologist posted on the plan's website for provider access 9. Promotion of the plan's 17-P program and guidelines article in the Provider Newsletter 10. On site visits to high volume providers by prenatal staff to provide education regarding the plan's requirements for 17-P 11. Development of universal 17-P authorization form for all SC MCO's 12. Begin providing alternatives to identified high risk members on bed rest or non-compliant with their 17-P treatment plan through the provider's office. The plan's contracted OB home care vendor to provide members with 17-P injections and monitoring in their home. 13. Referral of first time pregnant mothers to the Nurse Family Partnership program in the Low Country. a. This program will follow the pregnant mother and child with mentoring and education for two years to increase compliance with improved healthcare 14. Collaboration with community liaison for community baby shower. This is in coordination with the March of Dimes. This event will promote education on the importance of early and consistent prenatal care
Results	

AmeriHealth Mercy Market:	SHSC – South Carolina





Analysis

Timeliness of Prenatal Care result for 2009 was 90.04%: this was an increase of 7.9% from 2008 results of 83.44%. Results for this measure jumped from the just below the 50th to the 75th percentile this year and is well above the 2009 Medicaid Mean of 81.88%.

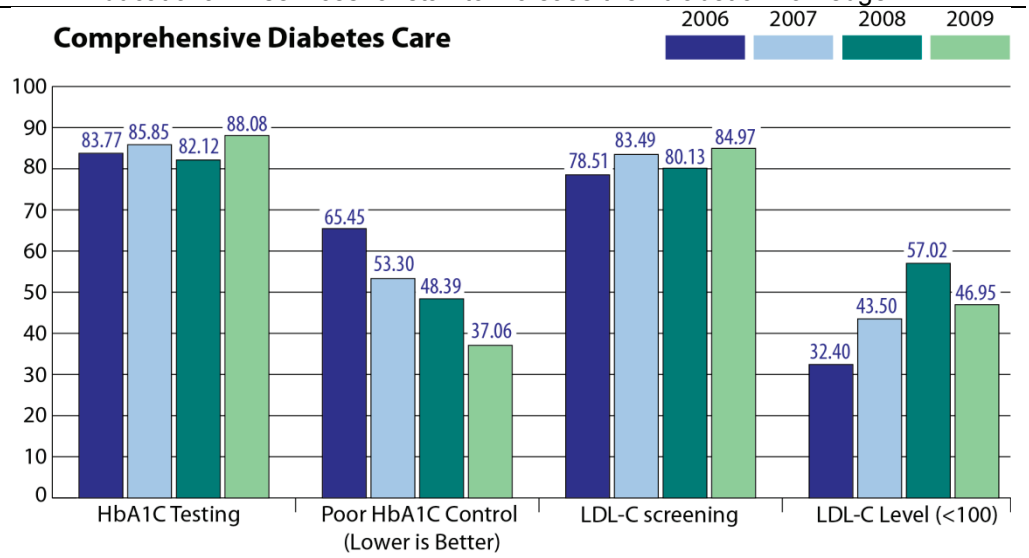
Frequency of Prenatal Care (those members who received greater than or equal to 81% of their expected number of prenatal visits) result for 2009 was 66.46% and demonstrated an increase of 14.9% from the previous year's results of 57.85%. This places the plan's results well above the Medicaid Mean of 62.60% and at the 75th percentile.

Postpartum Care results for 2009 were 69.03%, an increase of 2.2% from 2008

AmeriHealth Mercy Market:	SHSC – South Carolina
	results of 67.55%. Although the plan did not meet the goal of a 5% annual increase, the 2009 results are above the Medicaid Mean of 58.51% and reported at the 75th percentile threshold. All three measures improved but fell short of the 90th percentile indicating continued need for improvement.

AmeriHealth Mercy Market	AMHP – Central Pennsylvania	
Topic	**Improving the Management of Diabetes in the Latino population through screening measures**	**Type:** Clinical
Relevance	**Diabetes is a significant national issue, especially among the Latino population.** There are 23.6 million people in the United States, or 8.0% of the population, who have diabetes. Of the 23.6 million, 17.9 million people were diagnosed with diabetes and 5.7 million were undiagnosed. The total prevalence of diabetes increased 13.5% from 2005-2007. A 2004-2006 national survey for people aged 20 years or older indicated that 6.6% of non-Hispanic whites, 10.4% of Hispanics and 11.8% of non-Hispanic blacks had diabetes. Complications of diabetes include: heart disease and stroke, hypertension, blindness, kidney disease, amputation, impairment of the nervous system, and increased dental disease. Poorly controlled diabetes can complicate pregnancy and pose a risk to mother and child. The risk for death is twice more than that of people without diabetes. Total cost (direct= $116 billion and indirect =$58 billion) of diabetes in the United States in 2007 was estimated at $174 billion. Average medical expenditures among people with diabetes were 2.3 times higher than what expenditures would be in the absence of diabetes. [1] **Diabetes disproportionately burdens Hispanics.** Although the prevalence of diabetes is found in all racial, ethnic and socio economic groups, some groups are disproportionately burdened by Diabetes. The Pennsylvania Diabetes Action Plan 2007 indicated that Hispanics are more prevalent than White, Non-Hispanics, 8.9% compared to 7.6%, respectively. The report refers to “health disparities” to differences in health status, the delivery of health services or the use of health services that occur by gender, race, and ethnicity, education and income, disability and geographic location. The report also indicates that since 1990, the death rate for Hispanics has been higher at times than for Whites. The Health People 2010 Objective (age adjusted to 2000 standard population, rates per 1,000 ages 18+) states that the age-adjusted rate per 1,000 diagnosed with diabetes is three times to five times higher than the Healthy People 2010 Goal. In 2005, the Pennsylvania death rate per 1,000 for the Hispanic population was 78+ as compared to White, non-Hispanics at 69+. **Diabetic Hispanic AMHP members have poorer diabetes monitoring performance than non-Hispanic diabetic members.** Latino individuals with diabetes comprise approximately 4% of the AMHP population. Review of claim data indicates approximately 4,300 AMHP members (4,700 including pediatric members) have diabetes. AMHP data shows that Hispanics are less likely to have their HbA1c tested than their White and non-Hispanic counterparts, 81% compared to 85%, respectively. Also, when compared to their Asian counterparts, Hispanics were less likely to have	

AmeriHealth Mercy Market	AMHP – Central Pennsylvania
	an LDL-C screening done, 67% compared to 36%, respectively. We will analyze and compare the differences between rates. Our membership has seen a steady growth in Lehigh and Northampton counties. These two counties comprise the highest population of Latino members as compared to the other counties. Because of the growing diabetic population in these counties particular interventions have been designed to address the cultural barriers to fight the disease. **References:** Centers for Disease Control, www.CDC.gov, 2008 American Diabetes Association, www.diabetes.org/diabetes-statistics/prevelance.jsp, 2/23/2006
Baseline Data	2006 Calendar Year results as measured through HEDIS 2007
Goal	Achieve the 90th NCQA percentile for each measure. Annual incremental goals are set using the following formula: X + ((1-x)/20) where X = baseline Up to a maximum of 5% (5% change in one year is the highest realistic annual goal)
Benchmark	NCQA 90th Percentile
Barriers	AmeriHealth Mercy Health Plan conducted research to collect information from compliant and non-compliant diabetic members to determine possible barriers to care. The research included two focus groups held in May 2008, 24 in-depth interviews conducted in June 2008 and a quantitative survey completed in July 2008. Among diabetics surveyed, 18% have not had an HbA1c in the last 12 months (non-compliant 17%; compliant 22%). Despite fewer Whites reporting that they have a glucose monitor, 86% of diabetic Whites report a higher testing compliance rate than Hispanics (75%). The survey assessed the potential barriers to care influenced members' decisions to see a physician. Common barriers identified by focus groups, the ADA and CDC include: ▪ Member knowledge deficit of the long term effects of diabetes. The side effects and complications of diabetes don't appear until later in the disease. Since members do not see immediate consequences of poor control, they do not prioritize screening measures and treatment. ▪ Transportation is a barrier against obtaining preventive health services. ▪ Availability of healthy and culturally relevant diet options. Health disparities can also be related to unequal access to healthy food, as well as to lack of knowledge regarding culturally acceptable food alternatives. Evidence suggests that poor access to healthy food in neighborhoods is associated with poor food outcomes ▪ Fear of needle; fear of pain.

AmeriHealth Mercy Market	AMHP – Central Pennsylvania
Interventions	During the measurement years various interventions were identified and implemented. These interventions included: ▪ Diabetes Day Events conducted at Centre De Salud – including a Promotora program to train community members as healthy diabetes advocates/lay educators and distribution of Platillos Latinos !Sabrosos y Saludables! (Delicious Heart Healthy Latino Recipes) cookbook. ▪ Implemented New Member Portal with various educational topics in Spanish and English. ▪ Implemented NaviNet at all provided sites allowing providers to access the members gaps in care, run the individual office's report and identify/target at risk members with Care Gaps. ▪ Diabetes education program done at multiple sites/counties by community outreach staff (Clinics, doctor's offices, churches and community centers). ▪ Case management outreach calls to coordinate provider visits and laboratory testing and pharmacy needs. Diabetic wellness workshops conducted at Health Fairs. ▪ Pharmacy mailing to the members regarding medication adherence, lipid and HgbA1c testing. ▪ Pharmacy mailings to providers regarding their members with high HgbA1c results. ▪ Member newsletters with diabetic information. ▪ Educational In-services for staff to increase their diabetic knowledge.
Results	
Analysis	The analysis showed a significant improvement for both LDL and HgbA1c management measures for the Latino population, exceeding the incremental improvement goals, with the exception of LDL management in year three. Both LDL screening and management were in the 90th NCQA percentile for year 3, with HgbA1c testing and poor control in the 75th and 50th percentiles, respectively. A comparison of the Hispanic population versus the non-Hispanic population showed the Hispanic population has a higher testing rate for both A1c and LDL as compared to the non-Hispanic population.

Improving Provider Service

Another example is how we have used outcome data to improve provider service. Ongoing monitoring of Provider Claim Service Unit call answer time in our South Carolina plan during 2010 revealed that

performance goals of an Average Speed of Answer (ASA) less than or equal to 30 seconds and an abandonment rate of less than 5 percent were not being met. Analysis of the call data showed a marked increase in call volume. Drill-down analysis looking at call type identified that the excess calls were related to a state-mandated claim-rebasing project that required reprocessing of hospital claims, many of which had to be reprocessed manually. The plan took several actions:

- Three additional FTEs were hired and trained (by May 2010)
- A second call queue was created allowing simple calls to be handled by one team and moving complex calls to a team with a higher skill level
- A new supervisor with experience in call center processes was added to the team
- Staff training was augmented to address issues identified by error trends and keep employees informed of updates and changes

As a result, performance improved steadily beginning in June with both 3rd and 4th quarter results meeting goals.

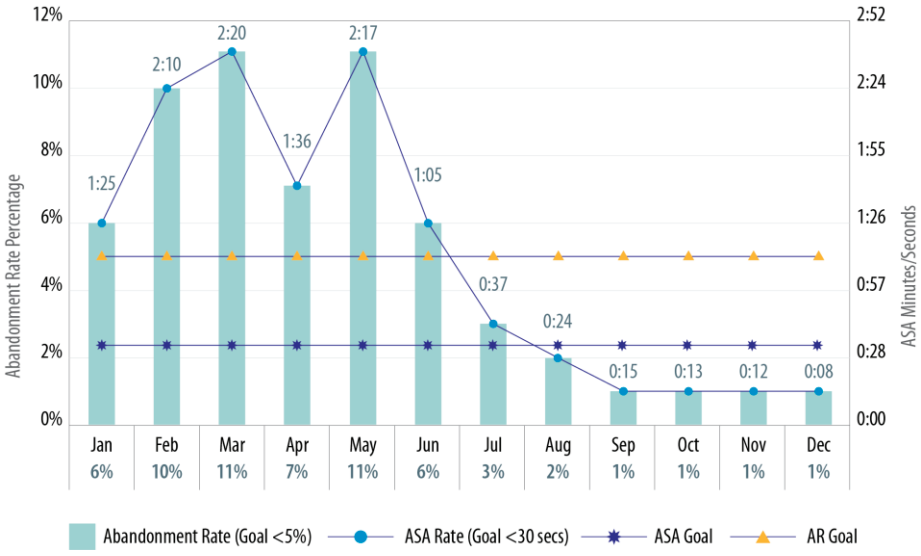
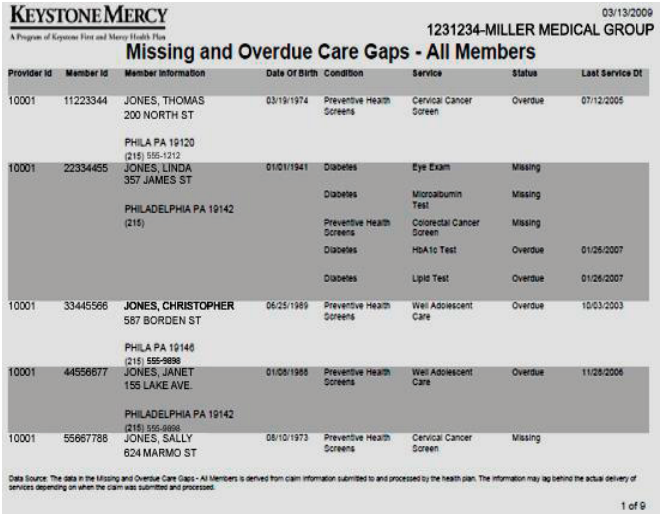


Figure20: 2010 PCSU Telephone Abandonment Rate/ASA Rate

Improving Process Efficiencies through Information Sharing

AmeriHealth Mercy uses robust information sharing capabilities through our Provider Portal to improve clinical outcomes for members. Through this initiative, we created online capabilities for providers to access and use critical information on needed health care services (Care Gaps) during a member encounter. Every time a provider does an on-line check of the member's eligibility, information on unmet health care services is displayed along with the eligibility information. The purpose of these "Care Gap alerts" is to ensure the provider is aware that the member is overdue for one or more of over 30 care needs from breast cancer screens to asthma medication check-ups. Providers typically


KEYSTONE MERCY
A Program of Keystone First and Mercy Health Plan
03/13/2009
1231234-MILLER MEDICAL GROUP

Missing and Overdue Care Gaps - All Members

Provider Id	Member Id	Member Information	Date Of Birth	Condition	Service	Status	Last Service Dt
10001	11223344	JONES, THOMAS 200 NORTH ST PHILA PA 19120 (215) 555-1212	03/19/1974	Preventive Health Screens	Cervical Cancer Screen	Overdue	07/12/2005
10001	22334455	JONES, LINDA 357 JAMES ST PHILADELPHIA PA 19142 (215)	01/01/1941	Diabetes	Eye Exam	Missing	
				Diabetes	Microalbumin Test	Missing	
				Preventive Health Screens	Colorectal Cancer Screen	Missing	
				Diabetes	HbA1c Test	Overdue	01/26/2007
				Diabetes	Lipid Test	Overdue	01/26/2007
10001	33445566	JONES, CHRISTOPHER 587 BORDEN ST PHILA PA 19146 (215) 555-9898	06/25/1989	Preventive Health Screens	Well Adolescent Care	Overdue	10/03/2003
10001	44556677	JONES, JANET 155 LAKE AVE. PHILADELPHIA PA 19142 (215) 555-9898	01/08/1988	Preventive Health Screens	Well Adolescent Care	Overdue	11/28/2006
10001	55667788	JONES, SALLY 624 MARMO ST	08/10/1973	Preventive Health Screens	Cervical Cancer Screen	Missing	

Data Source: The data in the Missing and Overdue Care Gaps - All Members is derived from claim information submitted to and processed by the health plan. The information may lag behind the actual delivery of services depending on when the claim was submitted and processed.

1 of 9

check the patient's eligibility via the Provider Portal when the member schedules an appointment or appears for a visit. If the member has a Care Gap, the alert flashes on the eligibility screen and allows the provider to print the information for inclusion in the member's chart. The provider can open up the alert, displaying all Care Gaps that are overdue as well as those that have been met. The provider can print the Care Gap information and put it in the chart. When a health care provider sees the patient, the information is easily available and can be addressed. (Additional descriptions and illustrations of this functionality can be found in Section E.1.)

Alerts are sent on Care Gaps that relate to preventive health and chronic disease management. Chronic disease alerts are provided for asthma, coronary artery disease and diabetes care. Alerts are also provided for preventive care including breast cancer and cervical cancer screening, colorectal screening, and vaccinations. Nationally recognized standards for care are used to determine if a care needs exists.

Using the eligibility check process to deliver this important information has several benefits. First, eligibility is checked on almost every member when they come in for a visit. Over 2.4 million web eligibility checks were made by providers for the company's Pennsylvania lines of business alone in 2008. Second, getting the information is easy because it fits in with the existing office workflow. Third, the information provided is actionable since the patient is coming into the office for a visit.

Care Gap alerts are an important method for promoting appropriate care when a patient comes in for a visit. However, providers also need a mechanism to identify needs for their patients who have not made an appointment. For this need, AmeriHealth Mercy developed a set of easy to use Care Gap reports that providers can also access through NaviNet. These reports assist primary care offices to identify any member in their practice who might be overdue for a screening or chronic care visit. Providers have the ability to customize the reports to meet their practice needs. Reports are available both for printing and as an electronic version that can be downloaded.

As stated above, we have committed to work with LSU Health System to electronically feed relevant health plan data to the EPIC medical record system they are implementing. We have also been in contact with Vindell Washginton, the CMIO/CAO for the Fransiscan Missionaries of Our Lady Health System to understand their needs and ways to electronically integrate with their systems.

Provider Response

Providers have responded enthusiastically to the availability of the Care Gap information. Dr Stephen Diamantoni, who manages a multi-office primary care practice in the Lancaster, Pennsylvania area, reported, "This is a perfect example of how the health plan and the provider can use technology to improve patient care. I wish all the health plans were doing this." Other practices have begun to use the report capability to support their own internal quality improvement efforts.

One of the mechanisms we used to evaluate the effectiveness of our Care Gap strategy was to compare the percent of Care Gaps closed for members where the provider viewed the detail associated with the Care Gap alert. A "closed" Care Gap is one that is removed from the data set because the member received the service. We looked at three populations of members who had Care Gaps at the start of the measurement period: members who did not have eligibility checked through the Provider Portal during the period; members who had an eligibility check, but where the Care Gap detail was not viewed; and members who had an eligibility check where the Care Gap data was viewed.

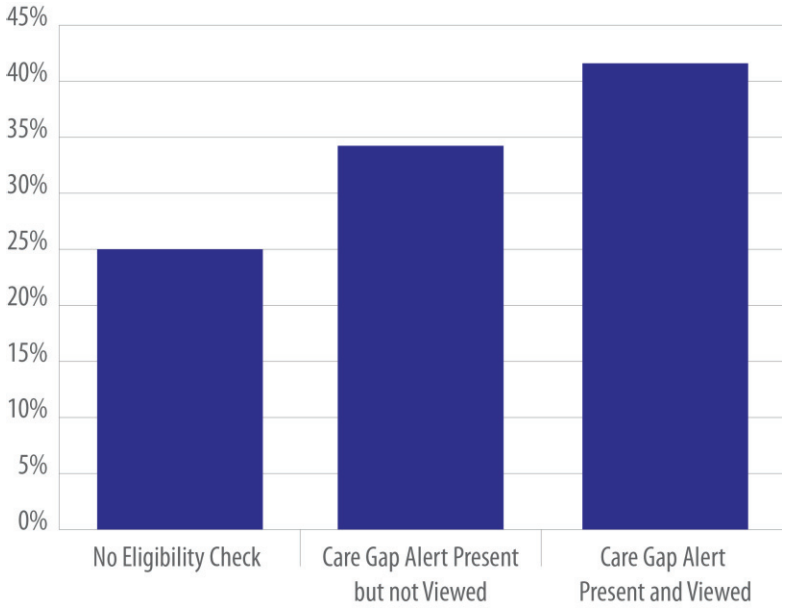


Figure 21: Percent of Care Gaps Closed

The finding showed that there was a nine point improvement where gaps were viewed, a better than 25 percent improvement.

Realizing Cost Savings

Embedded Care Management

AmeriHealth Mercy's Pennsylvania plan implemented an innovative care coordination program aimed at improving care coordination for members in a clinic setting. In the program, AmeriHealth Mercy placed a Care Manager in the clinic office, working with the staff and interacting with plan members during their visits. The embedded Care Manager shared information on filled prescriptions, Care Gaps, emergency room visits and inpatient admissions with the office staff to assist them to prepare for the member's visit. The Care Manager helped to supplement the member's health care by addressing the members' social concerns such as transportation and child care, and by providing coaching on self-care issues such as medication adherence and preventive care measures. In addition, the Care Manager assessed each member for ongoing needs and coordinated care management services for the member in between visits.

The Care Manager also facilitated proactive outreach to members of the practice who had not had a visit in the last year or who were missing key recommended services (Care Gaps). The program resulted in decreased health care costs, a decrease in the average length of stay, a decrease in inpatient days and reduced readmission rates for the pilot population. When the most recent 12 months were compared with the prior 12 months, the following key changes were observed:

Members managed by the embedded Care Manager had:

- 10 percent decrease in hospital admissions
- 6 percent decrease in ER visits
- $3.88 per member per month cost decrease

In contrast, members managed by the more "traditional" telephonic case management approach at other PCP practices in that health system over the same 12 month period, had:

- 11 percent increase in hospital admissions
- 1 percent decrease in ER visits
- cost increase of $137.95 per member per month

Gross savings and cost avoidance of the on-site case management pilot was nearly $600,000. In addition, the practice saw increased persistency (fewer members changing primary care providers). The success of this program was featured in the March edition of *Health Affairs* journal, presented to the Centers for Medicare and Medicaid Services during the 2010 Health Affairs Innovations conference and recognized with the Medicaid Health Plans of America Innovation Award.

Performance-Based Contracting

AmeriHealth Mercy's Pennsylvania plan entered into a performance based contract with a large tertiary care hospital system in March of 2010. The shared objective was to reduce costs and improve the delivery of care to our members. The reduction in cost is measured annually and the savings associated with the performance metrics are shared equally between the health plan and the health system.

The performance program included two key goals:

1. To reduce the number of readmissions for conditions that could or should have been treated during the previous admission
2. To encourage admission to the most appropriate level of care at the system's acute-care facilities by reducing the number of Short-Stay Admissions.

To accomplish the first goal, we developed a multi-year pay for performance model based upon 3M's Potentially Preventable Readmission (PPR) Classification System. The PPR Classification System is a clinically-based classification system that identifies acute care hospital readmissions that are potentially preventable (based on discharge data and proprietary 3M clinical guidelines). A reduction in readmissions is a direct savings to the plan and the incentive program shares 50 percent of these savings with the hospital system.

To accomplish the second goal, a performance model was developed that encourages admission to the most appropriate level of care at the system's acute-care facilities by reducing the number of Short-Stay Admissions. Short-Stay Admissions are defined as inpatient cases that have a length of stay that is less than two days. The system receives incentive compensation based on the difference between the expected cost for the expected Short-Stay Admission rate for the measurement year and the actual cost for the actual Short-Stay Admission rate for that year. The Short Stay incentive is designed to reduce these types of cases that would otherwise be admitted.

Based upon the most recent measurement period, these two cost and quality initiatives have resulted in a reduction in medical expense of approximately $2 million.

J.5: Quality Assessment and Performance Improvement (QAPI)

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

- *The QAPI proposed to be implemented during the term of the contract.*
- *How the proposed QAPIs will expand quality improvement services.*
- *How the proposed QAPI will improve the health care status of the Louisiana Medicaid population.*
- *Rationale for selecting the particular programs including the identification of particular health care problems and issues identified within the Louisiana Medicaid population that each program will address and the underlying cause(s) of such problems and issues.*
- *How you will keep DHH informed of QAPI program actions, recommendations and outcomes on an ongoing and timely manner.*
- *How the proposed QAPIs may include, but is not necessarily, limited to the following:*
  - *New innovative programs and processes.*

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

AmeriHealth Mercy has a strong history of partnering with states and local governments to customize quality assessment/performance improvement (QAPI) program offerings to support specific quality goals and objectives. Our staff recognizes the QAPI program as critical to all aspects of clinical care and service. We create and strengthen environments that help providers improve the quality and safety of clinical practice, through the use of evidenced-based guidelines and flexible multi-channel information sharing.

AmeriHealth Mercy's QAPI Program adheres to the program structure requirements mandated by NCQA. Our QAPI program integrates knowledge, structure and processes throughout the health care delivery system to assess risk and to improve quality and safety of clinical care and services provided to members. The QAPI program will provide the infrastructure to systematically monitor, objectively evaluate and ultimately improve the quality, appropriateness, efficiency, effectiveness and safety of the care and service provided to AmeriHealth Mercy members.

The AmeriHealth Mercy QAPI program will seek to accomplish the following:

- Maximize utilization of collected information about the quality of clinical care, health outcomes and service and identify clinical and service improvement initiatives for targeted interventions
- Evaluate access to care, availability of services, continuity of care health care outcomes, and services provided and arranged by AmeriHealth Mercy
- Assess the quality and appropriateness of care furnished to members with special needs
- Strengthen provider capabilities and performance related to the provision of evidence-based clinical care
- Coordinate services between various levels of care, network practitioners, behavioral health entities and community resources to assure continuity of care and promote optimal physical, psychosocial, and functional wellness
- Utilize results of member and practitioner/provider satisfaction measures when identifying and prioritizing quality activities
- Incorporate the results of external quality evaluations (EQR results, NCQA accreditation feedback, department findings) and internally generated evaluations such as HEDIS, Louisiana Performance Improvement Measures, satisfaction monitoring and internal audits and monitoring into quality program activities
- Implement and evaluate condition management programs to effectively address chronic illnesses affecting the population
- Design and implement provider outreach and education activities
- Maintain compliance with evolving NCQA accreditation standards
- Communicate results of clinical and service measures to practitioners, providers, and members.
- Identify and implement activities that promote member safety
- Document and report the results of monitoring activities and quality improvement initiatives to appropriate stakeholders.

We utilize HEDIS and HEDIS-like measures to evaluate the effectiveness of the program interventions for specified diseases and utilization of medical services. We also use additional measurements associated with Agency for Healthcare Quality and Research Prevention Quality Indicators (PQIs), Ambulatory Care Senstivie Conditions (ACSCs), ER utilization/redirection; provider visits; hospitalization; and others as indicated by the population being managed.

Selection of Performance Improvement Projects

Areas for focus are identified and prioritized according to their ability to meet the following criteria:

- Clinical importance and scientific validity

- High-risk and/or high-volume service or process
- Relevance to the LaCare population
- Alignment with Louisiana DHH priorities

The areas targeted for improvement projects are based on current performance and greatest impact on member outcomes and health status. AmeriHealth Mercy use evidence-based guidelines as the baseline for Performance Improvement Projects (PIPs). Performance measurements will relate to the important aspects of care found within the guidelines that are most likely to affect care and produce desired outcomes. Performance goals and benchmarks are identified based on performance targets, industry trends, state experience and quality committee recommendations. Creation of benchmarks and goals include consideration of data from the following, though not all inclusive data sources:

- HEDIS/CHIPRA
- CAHPS [Adult and Child versions]
- AHRQ Prevention Quality Indicators (PQIs)
- State data
- Provider satisfaction surveys
- Member disenrollment surveys
- Utilization data
- Member dissatisfaction data
- Access and availability data
- Internal service data
- Delegate subcontractor reports

In addition to initiatives focused on the Performance Improvement areas identified in Appendix DD, AmeriHealth Mercy will design and implement Performance Improvement Projects (PIPs) to address Birth Outcomes, Well Child Care and Diabetes Management.

Expanding Quality Improvement Services

AmeriHealth Mercy PIPs will support the advancement and acceleration of quality improvement services by building on expertise attained through over 25 years of Medicaid experience to incorporate sound analysis, industry best practices and tested implementation techniques into our PIPs. Our plans and interventions will be designed to support and complement existing initiatives increase access to evidence-based services and promote awareness and behavior change. We understand the combination of access, evidentiary basis and motivation necessary to move from a quality initiative to a repeatable well-established practice. The interventions we implement will be designed to drive sustainable change for Louisiana Medicaid recipients.

Improving Birth Outcomes

Rationale for Selection: As identified by DHH in their comprehensive Louisiana Health Report Card (2009),[3] Louisiana has the second highest percent of low birth weight (less than 2,500 grams) in the United States. African-American women in Louisiana were twice as likely to have a low birth weight infant and less likely to receive first-trimester prenatal care. Since Medicaid pays for 70 percent of births in Louisiana,[4] birth outcomes are an important focus for CCN organizations.

In keeping with the strategies outlined in the DHH Louisiana Birth Outcomes project identified in the FY 11 Road Map for a Healthier Louisiana,[5] AmeriHealth Mercy will design and implement a PIP focused on improving Perinatal care and reducing the incidence of low birth weight deliveries.

[3] 2009 Louisiana Health Report Card. DHH
[4] DHH Secretary Announces Action Steps to Reduce Rate of Premature Births. http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/1352
[5] FY 11 A Road Map for a Healthier Louisiana. DHH. October 2010

Improving Health Care Status: As a Medicaid payer in five states, we understand the impact of preterm birth on health care delivery resources, both initially during the Neonatal Intensive Care Unit stay and longer term related to developmental, neurological, respiratory and gastrointestinal problems for which these children are at higher risk. In addition to the stress and costs associated with the initial period following birth, many preterm infants experience lifelong effects, including cerebral palsy, mental retardation, visual and hearing impairment and poor health and growth. The impact to the family is mirrored in society, with greater need for public support as parents are not able to return to work and increased populations receiving public-subsidized health care.

Focusing on Underlying Causes: Interventions will focus on causal factors related to pre-term delivery, including late or inadequate prenatal care; alcohol, substance and tobacco use during pregnancy; and treatment strategies to mitigate the risk associated with a prior pre-term delivery. In addition to aggressive outreach to keep pregnant members connected to prenatal care, direct interventions will include contracting for Doula services to assist high-risk pregnant women with maintaining prescribed bed rest; the use of a modified Adult Needs and Strength Assessment (ANSA) to screen all pregnant women for depression anxiety, trauma exposure, substance abuse and suicide risk; and use of the Edinburgh Postnatal Depression Scale (EDPS) to screen postpartum women for depression. We will work with the behavioral health community to connect women who screen positive for any of these conditions to appropriate behavioral health resources.

In addition, we will implement a member incentive program, as described in Section S, to encourage pregnant women to obtain early and regular prenatal care and to receive a post-partum check-up. The incentive program will provide rewards at three phases during the pregnancy, after a first-trimester prenatal care visit; after completion of 80-percent of expected visits prior to delivery and after completion of a post-partum check-up. Pregnant members completing those milestones will receive over-the-counter items of their choosing related to infant or personal care from a reward menu. The items will be mailed at no cost to the member to the address the member supplies.

We will also mirror DHH's payment policy to pay vaginal birth claims at a higher rate than claims for caesarian sections; promote the appropriate use of 17-Alpha-Hydroxyprogesterone (17P) for women at risk for preterm delivery and provide education to women on preterm delivery risks and the importance of birth intervals.

AmeriHealth Mercy health plans have covered 17P for women at-risk for pre-term delivery since 2005, with results similar to those reported by Mason, Pool-Yaeger, Krueger, etl. in February 2010, who showed decreases in less than 35-week gestational age births and Neonatal Intensive Care Unit (NICU) admissions in a five-year study.[6]

Expanding Quality: This initiative will expand quality improvement services for Louisiana by paralleling the goals in the Louisiana Birth Outcomes project, specifically around addressing disparities in access and coordinating care across disciplines. AmeriHealth Mercy's work with members who screen positive as a result of our intense screening for depression and other behavioral health disorders will create pathways for pregnant women outside of AmeriHealth Mercy's membership.

Partnerships: We established relationships with the following behavioral health providers across the state to assist us with creating the pathways necessary to coordinate care for members with behavioral health needs:

- Howard Osofsky, MD, Chairman of the Department of Psychiatry, LSU
- Carl Clark, Executive Vice President, NHS Human Services,
- Jan Tarantino, Assistant Director, Louisiana, Resources for Development

[6] Mason, M. Poole-Yaeger, A. Krueger, C. etal. Impact of 17P Usage on NICU Admissions in a Managed Medicaid Population – A Five-Year Review. Managed Care. February 2010. p. 46-52.

- Barry Chauvin, CEO, Options for Independence
- Judge Calvin Johnson (ret), Executive Director and Craig Coenson, MD, Medical Director, Metropolitan Human Services District, New Orleans
- Michael Teague, Executive Director, Jefferson Parish Human Services Authority, Metairie
- Jan Kasofsky, Executive Director, Capital Area Human Services District, Baton Rouge

In addition, we are working with the March of Dimes on their initiatives to reduce preterm births. Additional information on this partnership can be found in Section F.

Evaluation: In addition to HEDIS measures for frequency of prenatal care and post-partum care, we will measure the percent of low-birth weight infants; the percent of pregnant women who are screened for alcohol, tobacco, substance abuse and mental health needs; and the percent of those who screen positive who are referred for and make a connection with the appropriate services.

Improving Well Child Care – Ages 3-21

Rationale for Selection: Periodic well child visits provide an opportunity for children to receive physical assessments for growth and development, vision and hearing tests, and the full range of immunizations recommended by the American Academy of Pediatrics (AAP). With the increasing incidence of childhood obesity, type-2 diabetes and hypertension seen in younger children, these well child visits are fundamental in early identification for potential risk of chronic diseases nationally, and in the Louisiana population. During well-child visits in the adolescent years, health care practitioners can provide critical guidance on avoiding risky behaviors that can result in poor health outcomes. Low-income children often have not received the full range of preventive care benefits that are critical to promoting their long-term health and well-being.

Improving Health Care Status: It is important that health plans implement programs to encourage parents and their children to obtain well-visit services. Early screening, diagnosis, treatment and education can prevent or reduce pain and disability from health problems. Additionally, issues identified and treated early will have less of a negative impact on school performance. Discussions with the pediatrician focusing on parenting practices, nutrition and exercise provide parents with guidance. Well child visits also provide a time for parents to learn and problem-solve in a low-stress environment.

Focus on underlying causes: Interventions will focus poor understanding of the benefits of well child care, improving convenience and ensuring providers are aware when a child in their office needs well-child care and counseling, in addition to the child's presenting problem. We will use customized education and outreach to increase member/caregiver knowledge regarding the importance of preventive care and AAP guidelines and provide timely reminders. We will implement state-of-the-art information systems to alert physicians to the date of the member's last well child visit and any needed immunizations; Our new member outreach will assist new members to schedule a visit with their PCP as soon as possible after they join AmeriHealth Mercy. We will also conduct focused outreach for members who are due or overdue for well child care and incorporate well child care into our community outreach and social media strategy. As described in Section S, we will also implement a member incentive component to this project, providing a reward to parents/guardians who take their child in for a well-care visit. After completing the visit, the parent/guardian will receive over-the-counter items of their choosing related to health or personal care from a reward menu. The items will be mailed at no cost to the family to the address the parent/guardian supplies.

In addition, we are in discussions with several School-Based Health Centers (SBHCs) to evaluate ways to utilize school-based clinics as primary care sites. For many children, the easiest place to obtain health care is right in their own school. We see working directly with school-based clinics as a way to remove barriers for children and leverage an underused resource. Details on this collaboration can be found in Section I.

Expanding Quality: This initiative will expand quality improvement services for Louisiana through our use of SBHCs as primary care sites. The additional revenue stream for the SBHCs will enable them to remain a viable component of Louisiana's health care delivery system, while addressing the need for reliable and convenient access for parents.

Partnerships: As detailed in Section I, we have contacted several school boards and SBHCs who are eager to work with us as primary care practice sites.

- Health Care Centers in Schools – operates 11 SBHC's and manages the school nurse program for East Baton Rouge Parish and Recovery School District public schools.
- Family Service Center, the SBHC operated by West Feliciana Parish School Board
- St. Martin Parish School Board,
- Lafayette Parish School Board
- Vernon Parish School Board

Evaluation: Quantifiable measures will include HEDIS Well Child rates for ages 3 through adolescent. The goal will be to measure the baseline the first year and improve by five percent for the second and subsequent years.

Improving Diabetes Management

Rationale for Selection: Often called the silent killer, diabetes quadruples the risk of heart disease and stroke and is the leading cause of blindness, end-stage renal disease and lower-limb amputation in the United States. Costing an estimated $218 billion a year in health care costs and lost productivity nationwide,[7] diabetes is also responsible for 16 percent of Louisiana hospital discharges and 18 percent of costs.[8] An estimated 10 percent of Louisiana residents have diabetes, with higher prevalence rates in blacks.[9]

The American Diabetes Association put forth clear recommendations on the management of diabetes, including HgbA1c levels, low-density-lipid (LDL) levels, nephropathy monitoring, retinal examination, foot assessment and blood pressure control. In addition, self-management skills, including blood sugar monitoring, exercise and diet control are critical to the management of diabetes and avoidance of complications.

Improving Health Care Status: Management of diabetes through blood sugar, LDL and blood pressure control, coupled with regular exercise and adherence to dietary guidelines can delay the progression of the disease and prevent or slow the development of heart, blood vessel and other complications.

Focus on underlying causes: Interventions will focus on poor understanding of diabetes self-management, the benefits of regular medical care for diabetes monitoring and treatment; improving access and convenience for screening; ensuring providers are aware of members in need of screening or medication; and adherence to medication regimens for members prescribed medications for blood sugar, cholesterol and/or blood pressure management.

AmeriHealth Mercy will identify at-risk members from the historical claims data provided by DHH, outreach to those members to provide education on diabetes management and identification and removal of any barriers to facilitate compliance with testing and medical care (such as arranging transportation to and from the physician's office). We will identify members who can benefit from a diabetes self-management course and arrange for them to attend. We will conduct general education programs through member newsletters, social media campaigns and community events. Education will focus on diabetic management through nutrition, lifestyle modification, and exercise.

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[7] The Impact of Diabetes. Diabetes Prevention & Control Program. Accessed at http://www.doh.state.fl.us/family/dcp/whatis/impact.html on 6/18/11.
[8] 2009 Louisiana Health Report Card. Department of Health and Hospitals. 2010. p. 95.
[9] Ibid.

Our integrated Care Gap strategy and Provider Portal information systems will alert providers of members in need of testing and those with elevated cholesterol or HgbA1c levels who are not receiving or controlled with medication. To increase attention to this program, AmeriHealth Mercy will include performance metrics related to diabetes management in our provider incentive payments, discussed in Section S. In addition, providers will be able to see their members' refill history to assess medication adherence. Care Management staff will monitor and remind members who are late to refill medications. Additional information on our Care Gap strategy and Provider Portal can be found in Section E.

We will also implement an incentive program for members with diabetes to encourage adherence to recommended condition monitoring. Described fully in Section S, the program will provide diabetic members with rewards for completing a physician visit including blood pressure management, foot exam, and blood tests to monitor LDL level and HgbA1c percent and for completing a dilated retinal eye examination. After receiving the identified monitoring services, members will receive over-the-counter items of their choosing related to health or personal care from a reward menu. The items will be mailed at no cost to the member to the address the member supplies.

Additionally, we will explore opportunities to offer our award-winning Lose-to-Win program for Louisiana residents. Developed in cooperation with the YMCA's Activate America Program, this 12-week program targets adults with type II diabetes. The program combines diabetic monitoring, nutrition education and weight management with monitored exercise. A full description of the Lose-to-Win program can be found in Section F.

Expanding Quality: This initiative will expand quality improvement services by increasing access to evidence-based diabetes screening and management. Our Care Gap strategy will increase the percent of members who receive monitoring tests, as well as improve outcomes for those with diabetes. By including related measures in our provider quality incentives, we will move the performance needle related to diabetes management.

Partnerships: Dr. Michael Kaiser, Chief Medical Officer of LSU, has agreed to partner with us on programs addressing the management of chronic conditions, such as diabetes. AmeriHealth Mercy employees will participate with LSU's interdisciplinary clinical teams to promote integration between LSU's program and AmeriHealth Mercy's approach. Additionally, through our partnership with the School-Based Health Centers, described above, we will offer school-based programs on exercise, nutrition and screen-time to lower the risk of diabetes development. Examples of our Media Smart, Healthy You…Healthy Me! and Young Philly Fit programs can be found in Section F.

Evaluation: HEDIS measures will be used to objectively quantify the impact of AmeriHealth Mercy's efforts to improve the health outcomes of Louisiana members. The baseline year of 2012 will provide HEDIS information for HgbA1c testing and management, LDL testing and management, blood pressure management, diabetic retinal examination and nephropathy monitoring. Once the baseline has been established, annual incremental goals for improvement will be set to a maximum of 5 percent in one year (the highest realistic improvement feasible in one year).

Keeping DHH Informed

Progress on PIPs is monitored through the QAPI work plan under the direction of the Quality Assessment Performance Improvement Committee. AmeriHealth Mercy will work with DHH to identify a mutually agreeable mechanism to provide DHH with timely information on PIPs and other QAPI program activities and outcomes. At a minimum, DHH will receive a quarterly update to the QAPI work plan, and a comprehensive annual QAPI Program Evaluation.

J.6: Using Feedback to Drive Improvements in Operations

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

Member and Provider Feedback

We use a variety of mechanisms to understand and incorporate member and provider feedback into our operations. We capture and trend member and provider dissatisfactions and grievances, to alert us to operational areas that need improvement. Our Partnership Council and Member Advisory Council provide input, feedback and recommendations into many of our program areas. We also use member focus groups, as needed, to help us understand how best to design our programs. Finally, we do formal member and provider satisfaction surveys to evaluate key program areas.

Member Satisfaction Surveys

AmeriHealth Mercy will conduct a Member Satisfaction Survey using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) tool annually. CAHPS is designed to collect information on consumers' experiences with health plans. Results of the surveys are analyzed and compared against NCQA and AHRQ benchmarks, our plan goals and plans nationally.

For findings that do not meet organizational goals, an analysis is completed with the organizational staff so that potential barriers can be addressed. This thorough analysis includes additional data to assist in the identification of improvement opportunities. Information, such as member complaint/grievance data and member disenrollment data, are included in the analysis. This information provides more details around the CAHPS results, as well as supports identification of geographic drivers. Identified opportunities are prioritized based on several factors, including relevance to the membership, barriers, likelihood to affect change, and ability to implement.

Survey results and resulting analysis are shared with the Partnership Council for input on plans. The results and final plans are reviewed by the Quality Assessment Performance Improvement Committee (QAPIC) for additional discussion, evaluation and approval. Results of member satisfaction surveys and any resulting plans or initiatives are communicated to members and providers through the quarterly newsletters.

An example of our survey results is provided below from the AmeriHealth Mercy plan in South Carolina for CAHPS 2010 Medicaid Child.

Table 2: 2010 CAHPS Medicaid Child Survey Results

Composite/Rating Item	2010 Plan Summary Rate	Benchmark*
Getting Needed Care	86.3%	79.4%
How Well Doctors Communicate	94.7%	90.9%
Customer Service	89.3%	81.3%
Rating of Personal Doctor	88.8%	84.2%
Rating of Specialist	84.4%	82.5%
Getting Care Quickly	90.1%	86.3%

*Source for benchmark data is 2009 CAHPS booklet percentiles/mean.

Member Focus Groups and Targeted Surveys

In addition to a formal annual CAHPS-driven member satisfaction survey, AmeriHealth Mercy will systematically monitor members' patterns of accessing health care with a variety of qualitative surveys and focus groups for all of our programs.

Plans for new surveys and focus groups will address the issue of why members do not regularly get preventive health care, specifically breast and cervical cancer screenings, and prenatal care. Survey results

will enable us to identify opportunities for improvement in the delivery of care, support the development of new community health initiatives, and assist us in eliminating barriers to preventive health services for the LaCare population.

Analysis of Dissatisfactions and Grievances

AmeriHealth Mercy will analyze data on dissatisfactiosn and grievances captured through provider and member call tracking and the Grievance System. Data is analyzed looking at a combination of broad and specific topics, enabling us to zero in on specific drivers. As an example, tracking information related to calls expressing dissatisfaction with service from a provider capture the name of the provider, the nature of the service and the nature of the dissatisfaction or grievance. For a call related to a AmeriHealth Mercy process, such as not receiving an ID card timely, we can identify the grievance as a plan issue related to ID cards and related to timeliness. This allows us to trend issues related to a specific provider, plan process or service and aggregate the data in a meaningful way.

Provider Surveys

AmeriHealth Mercy will build partnerships with network providers by monitoring their satisfaction, especially with administrative processes and our responsiveness to their inquiries. We will also assess provider satisfaction through regular surveys of practitioners and hospitals, inviting suggestions on how we can improve our services. Providers also offer feedback through the Partnership Council and other quality committees. Our Quality of Service Committee will gather this information and consider any patterns of provider complaints in making regular assessments of provider satisfaction and planning interventions and improvements.

Using an external vendor, AmeriHealth Mercy will perform a full provider satisfaction survey on an annual basis to assess provider satisfaction with our processes, staff, and systems. Survey results will enable AmeriHealth Mercy to plan interventions and check the effectiveness of past strategies in improving provider satisfaction.

Provider Service Interactions

Provider Network Management Representatives located throughout Louisiana will make site visits to providers on a regular basis to ascertain provider satisfaction. These informal, collegial meetings help provide an opportunity to listen to the concerns of the Provider and/or staff on a personalized basis. During these visits providers are encouraged to discuss issues they may not have voiced, which will allow follow-up and resolution any problem or situation.

Provider education is critical to satisfaction and AmeriHealth Mercy will conduct personal training on a variety of topics, including plan orientation, quarterly claims training, and cultural competence for provider staff. Our provider newsletter, in hard-copy mailings and available on our website, contains valuable information on provider concerns, including prior authorization procedures, the latest HEDIS statistics, provider incentive programs, and other topics of interest.

"Their Feedback Becomes Our Actions"

Member Feedback

In one example of member feedback driving change, a survey completed by the AmeriHealth Mercy's South Carolina plan indicated an opportunity to expand the use of telephone messaging to members eligible for screening with primary care physician voice recordings. This activity was identified in response to survey findings that members may be more strongly influenced to receive preventive services when recommended by their personal physician. Since implementing this program HEDIS measures for well visits for adolescents and the three- through six-year age group have improved.

In another AmeriHealth Mercy plan, feedback solicited from members who had eligibility gaps indicated that these members often were not aware when their eligibility would end, or what they needed to do to retain eligibility. In response, the plan created a Retention Unit. Staffed with individuals from a

transition-to-work program, the unit contacts members whose eligibility is set to end in the coming month. Retention workers coach members on the process they need to follow to remain eligible in the Medicaid program. Since implementation, the plan's involuntary disenrollment rate dropped from 3.6 percent to 2.6 percent, a 30 percent reduction.

Provider Feedback

Our Indiana plan worked with the Residency Program located in Fort Wayne, Indiana in response to their feedback on our performance assessment of their practice. The large practice, had been an underperforming group with regard to HEDIS and seemed to be unable to integrate the processes necessary to improve their performance. With the help of Elizabeth Woodcock (National MGMA Consultant), Network Provider Representatives, the Medical Director and his team, our Indiana plan hosted a forum for the practice to review the findings and share their issues. They began to describe barriers they were experiencing with their assigned membership. They did not feel many of their members were coming to the office. The plan was able to provide the practice with a missed opportunities report that described the many encounters that were missed opportunities for a well visit. The office lacked administrative support and coordination of their membership appointments. The plan provided member lists and the office developed a process to contact and remind members of their appointments, emphasizing the need for well visits.

Together the plan and the practice developed plans to overcome the identified barriers which not only improved the programs HEDIS rates but also improved their no-show rates and overall back office efficiency. The practice came to own the data results and worked towards improving their own performance. Their feedback also helped the plan improve its Network Management educational outreach and redesign some reports. Many of these same solutions have spread to other practices and other AmeriHealth Mercy plans.

Provider feedback was also the impetus behind several other enhancements to our provider payment system and our Provider Portal, including:

- Implementation of electronic referral submission and inquiry
- Development and distribution of a Care Gap explanation guide, detailing the specifications used to assign a Care Gap to a member

J.7: Results of HEDIS Measures

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

If you do not have results for a particular measure or year, provide the results that you do have.

If you do not have results for your Medicaid product line in a state where you have a Medicaid contract, provide the commercial product line results with an indicator stating the product line.

If you do not have Medicaid HEDIS results for at least five states, provide your commercial HEDIS measures for your largest contracts for up to five states (e.g., if you have HEDIS results for the three states where you have a Medicaid contract, you only have Medicare HEDIS for one other state, provide commercial HEDIS results for another state).

If you do not have HEDIS results for five states, provide the results that you do have.

In addition to the spreadsheet, please provide an explanation of how you selected the states, contracts, product lines, etc. that are included in the spreadsheet and explain any missing information (measure, year, or Medicaid contract). Include the Proposer's parent organization, affiliates, and subsidiaries.

Provide results for the following HEDIS measures:

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

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

HEDIS Rates

Below are Medicaid HEDIS rates for measurement years 2007, 2008 and 2009 for the following AmeriHealth Mercy Family of Companies (AMFC) health plans:

- Keystone Mercy Health Plan – serving more than 300,000 members in southeastern Pennsylvania
- AmeriHealth Mercy Health Plan – serving approximately 109,000 members in northeastern and central Pennsylvania
- Select Health of South Carolina – serving more than 210,000 members in South Carolina

Except as described below, all AMFC healthplans submit audited HEDIS results to the National Commission for Quality Assurance (NCQA) annually.

AMFC does not submit HEIDS results if the health plan membership does not comprise the complete population for the HEDIS submission. This is the case with our Indiana plan, MDwise Hoosier Alliance, which is one delivery system of the eight delivery systems that operate under the MDwise, Inc. HMO license. MDwise, Inc. submits HEDIS results for their entire population; separate audited results are not available for MDwise Hoosier Alliance.

Table 3: HEDIS Results – Measurement Year 2007

HEDIS Results			
Measurement Year 2007			
	Keystone Mercy	**AmeriHealth Mercy**	**Select Health**
Measure/Data Element	**Rate**	**Rate**	**Rate**
Effectiveness of Care: Prevention and Screening			
Childhood Immunization Status (cis)			
DTaP	84.22%	79.32%	NR
IPV	94.43%	89.54%	NR
MMR	93.50%	88.81%	NR
HiB	92.81%	88.56%	NR
Hepatitis B	95.82%	92.70%	NR
VZV	93.04%	86.86%	NR
Pneumococcal Conjugate	82.13%	70.80%	NR

HEDIS Results			
Measurement Year 2007			
	Keystone Mercy	**AmeriHealth Mercy**	**Select Health**
Measure/Data Element	**Rate**	**Rate**	**Rate**
Combination #2	80.05%	72.75%	NR
Combination #3	75.41%	64.23%	NR
Breast Cancer Screening (bcs)	46.72%	54.89%	46.66%
Chlamydia Screening in Women (chl)			
16-20 Years	50.42%	39.76%	53.76%
21-24 Years	53.70%	45.02%	57.09%
Total	52.07%	42.44%	54.57%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	80.60%	83.45%	76.73%
HbA1c Poor Control (>9.0%)	44.57%	47.93%	NR
HbA1c Control (<8.0%)	32.33%		NR
HbA1c Control (<7.0%)	47.34%	32.60%	NR
Access/Availability of Care			
Adults' Access to Preventive/Am (aap)			
20-44 Years	83.19%	82.43%	85.28%
45-64 Years	89.17%	88.83%	89.59%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	75.18%	87.35%	77.73%
Postpartum Care	56.50%	60.83%	57.26%
Use of Services			
Well-Child Visits Third, Sixth Years (w34)	69.91%	62.53%	54.05%
Adolescent Well-Care Visits (awc)	49.54%	55.23%	26.86%
Ambulatory Care- ER Utilization	65.75%	79.17%	65.42%

NR – Not Reported

Table 4: HEDIS Results – Measurement Year 2008

HEDIS Results			
Measurement Year 2008			
	Keystone Mercy	**AmeriHealth Mercy**	**Select Health**
Measure/Data Element	**Rate**	**Rate**	**Rate**
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counsel (wcc)			
BMI Percentile	24.33%	23.60%	NR
Counseling for Nutrition	53.53%	42.58%	NR
Counseling for Physical Activity	41.61%	39.42%	NR
Childhood Immunization Status (cis)			
DTaP	79.51%	82.37%	NR
IPV	91.53%	92.63%	NR
MMR	91.80%	91.84%	NR
HiB	93.72%	96.32%	NR
Hepatitis B	92.35%	95.26%	NR
VZV	91.26%	90.79%	NR
Pneumococcal Conjugate	81.42%	79.74%	NR
Combination #2	78.14%	80.00%	NR
Combination #3	76.50%	74.74%	NR
Breast Cancer Screening (bcs)	52.28%	59.17%	50.87%
Chlamydia Screening in Women (chl)			
16-20 Years	57.76%	42.05%	47.17%
21-24 Years	60.93%	49.55%	60.12%
Total	59.18%	45.48%	49.63%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	78.59%	83.21%	80.57%
HbA1c Poor Control (>9.0%)	38.93%	39.66%	NR
HbA1c Control (<8.0%)	54.50%	52.55%	NR
Access/Availability of Care			
Adults' Access to Preventive/Am (aap)			
20-44 Years	82.23%	81.96%	88.01%
45-64 Years	89.03%	89.86%	91.44%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	79.81%	89.29%	83.44%
Postpartum Care	55.72%	67.40%	67.55%

HEDIS Results			
Measurement Year 2008			
	Keystone Mercy	**AmeriHealth Mercy**	**Select Health**
Measure/Data Element	**Rate**	**Rate**	**Rate**
Effectiveness of Care: Prevention and Screening			
Use of Services			
Well-Child Visits Third, Sixth Years (w34)	74.01%	73.45%	60.84%
Adolescent Well-Care Visits (awc)	60.83%	56.27%	33.49%
Ambulatory Care- ER Utilization	65.77%	80.44%	63.71%

NR – Not Reported

Table 5: HEDIS Results – Measurement Year 2009

HEDIS Results			
Measurement Year 2009			
	Keystone Mercy	**AmeriHealth Mercy**	**Select Health**
Measure/Data Element	**Rate**	**Rate**	**Rate**
Effectiveness of Care: Prevention and Screening			
Weight Assessment and Counsel(wcc)			
BMI Percentile	36.01%	37.71%	NR
Counseling for Nutrition	55.96%	44.77%	NR
Counseling for Physical Activity	41.12%	40.15%	NR
Childhood Immunization Status (cis)			
DTaP	81.02%	80.29%	69.98%
IPV	91.00%	92.21%	84.11%
MMR	92.21%	93.19%	81.46%
HiB	94.89%	94.40%	88.30%
Hepatitis B	89.29%	94.40%	80.79%
VZV	90.75%	92.21%	81.90%
Pneumococcal Conjugate	76.40%	80.78%	70.20%
Hepatitis A	39.17%	37.47%	25.61%
Rotavirus	54.26%	59.61%	46.58%
Influenza	55.23%	53.04%	29.58%
Combination #2	73.97%	75.43%	61.81%
Combination #3	66.91%	71.78%	57.62%
Combination #4	34.55%	33.82%	20.09%

HEDIS Results

Measurement Year 2009

	Keystone Mercy	AmeriHealth Mercy	Select Health
Measure/Data Element	**Rate**	**Rate**	**Rate**
Effectiveness of Care: Prevention and Screening			
Combination #5	42.34%	49.15%	30.91%
Combination #6	45.50%	42.58%	21.63%
Combination #7	25.30%	24.09%	15.67%
Combination #8	26.03%	23.60%	10.60%
Combination #9	30.66%	31.39%	15.01%
Combination #10	18.98%	17.52%	9.27%
Breast Cancer Screening (bcs)	57.87%	61.49%	53.61%
Chlamydia Screening in Women (chl)			
16-20 Years	56.14%	43.75%	47.79%
21-24 Years	61.18%	50.08%	57.39%
Total	58.36%	46.58%	49.95%
Effectiveness of Care: Diabetes			
Comprehensive Diabetes Care (cdc)			
Hemoglobin A1c (HbA1c) Testing	82.26%	86.31%	80.78%
HbA1c Poor Control (>9.0%)	36.29%	35.40%	57.65%
HbA1c Control (<8.0%)	54.52%	52.74%	34.89%
HbA1c Control (<7.0%)	39.54%	35.53%	27.32%
Access/Availability of Care			
Adults' Access to Preventive/Am (aap)			
20-44 Years	81.74%	80.61%	86.69%
45-64 Years	88.93%	89.45%	88.95%
Prenatal and Postpartum Care (ppc)			
Timeliness of Prenatal Care	81.08%	89.89%	90.04%
Postpartum Care	61.43%	68.58%	69.03%
Use of Services			
Well-Child Visits Third, Sixth Years (w34)	74.77%	78.05%	62.49%
Adolescent Well-Care Visits (awc)	57.47%	57.78%	36.24%
Ambulatory Care- ER Utilization	69.21%	86.68%	68.28%

NR – Not Reported

Section K – Member Materials

K.1: Member Educational Materials

K.1 Describe proposed content for your member educational materials and attach examples used with Medicaid or CHIP populations in other states.

AmeriHealth Mercy's member materials are designed to be easy to understand and accessible. We strive to eliminate cultural disparities and for our members to be able to understand and apply our recommendations. In an effort to continually provide high-quality care and support for our members, AmeriHealth Mercy will have a comprehensive library of member materials in accordance with all DHH requirements. Our membership materials will be available in English, Spanish, and Vietnamese and will be easily accessible to individuals with sensory disabilities.

AmeriHealth Mercy will develop a detailed member education plan for each Geographic Service Area (GSA) that will incorporate all DHH requirements and will address development and distribution of member educational materials. Members will be provided educational materials and tools that:

- Explain health care options
- Describe plan benefits and services
- Educate on how to care for their health by understanding health conditions and learning how to prevent illness
- Improve learning around how to stay healthy and/or manage a specific disease or condition.

Without exception, member educational materials will not be used until DHH has reviewed and approved our member education plan and materials. All requests for approval will be submitted to DHH using the Marketing and Member Education Materials Approval Form, or such other form required by DHH. An electronic version of the final printed product will also be submitted to DHH ten calendar days from the printed date.

AmeriHealth Mercy will ensure all member educational and marketing materials do not discriminate against Medicaid members on the basis of their health history, health status or need for health care services.

Member Educational Materials

The proposed content of the member educational materials will include:

- New member welcome calls which will be scripted to include a brief explanation of the program, a statement of confidentiality, an explanation of the availability of and ways to access oral interpretation and written translation services, a description of primary care providers and patient-centered medical homes, and a discussion to discover whether the member is pregnant, has a chronic condition or any other special health care. The welcome calls will also addresses the role of the PCP, what to do during the transition period, how to utilize services, what to do in an emergency and how to file a grievance and appeal.
- Welcome packets will include, at minimum, a welcome letter, Provider Directory, Member Handbook, and ID card. All welcome packet components will initially be made available in English, Spanish and Vietnamese. (Additional languages will be offered as the need develops.)
  - **Welcome Letter** - The introductory letter, along with the Member Handbook and other materials, will welcome new members. The letter will ask the member to expect the welcome call but also encourage them to call the Contact Center if they have any questions. Additionally, the letter will provide a brief checklist reminding the member to read the Member Handbook, select a Primary Care Provider if they have not already done so, and make an appointment with their Primary Care Provider within 90 days of enrollment.

- **Provider Directory** - Members will receive a Provider Directory that includes names of Primary Care Providers, hospitals, urgent care center, and specialists. Each listing gives the provider name, location, telephone number, office hours, accepted age range, languages spoken, special needs accessibility and whether the provider is accepting new patients. The directory will include important telephone numbers for the Contact Center, Provider Services and Medical Services. The Directory will also identify any restrictions that could influence the enrollee's freedom of choice.
- **Member Handbook** - Members will also receive a Member Handbook that includes critical information on CCN. The Handbook will include a general description about how CCNs operate, the member's right to disenroll, the member's right to change providers within the CCN, any restrictions on the member's freedom of choice among CCN providers, summary of benefits, summary of prior authorization requirements, description of the identification card and how to use both the Medicaid card and the LaCare card, how to access family planning providers, after hours and emergency coverage, post stabilization services, referrals to other entities and all of the other requirements set forth in Section 12.12.2 of the RFP.
- **ID Card** - Members will also receive an identification card from LaCare, which is described in Section K.3.

Additional materials will be provided to the members such as:

- Advance Directives which will detail the CCN policies related to advance directives; the member's rights under Louisiana state law, and information that members can file complaints about the failure to comply with an Advance Directive
- Members' Bill of Rights
- Member notices that include, for example, notices of provider termination
- Notification of a member's right to request and obtain a welcome packet at least once per year
- Notification of any change that DHH defines as significant at least 30 calendar days before the intended effective date

In addition to the education materials described above, AmeriHealth Mercy will provide a comprehensive library of useful, relevant and valuable educational materials through various communications channels which include, but are not limited to:

- Member education mailings
- Newsletters
- Online library of health information
- Social media and secure Member Portal sites
- Materials that support community outreach initiatives
- Public Service Announcements
- Posters and flyers

These materials include an extensive library of health promotion materials on topics such as asthma control, diabetes management, healthy living, stress and high blood pressure. They are designed to educate members about specific health issues, as well as encourage the member to take responsibility for their health. AmeriHealth Mercy will make these materials available to our members through our medical management programs, but also through the website and upon request. In addition, throughout the year we will mail specific health care disease state information to a specific segment of the membership that has been identified as having symptoms and/or diagnosis with a condition through our aggressive case management programs.

AmeriHealth Mercy will provide all of the required marketing materials necessary to be included in the enrollment package to the Enrollment Broker. All materials will meet DHH content requirements as

outlined in Section 12.10 of the CCN-P Request for Proposals. In addition, all written materials will not exceed a 6.9 grade reading level and will also meet style and quality requirements.

Samples

Samples of the following material that have been developed and approved for use by our affiliated plans are included as attachments:

- New Member Welcome Packet
- Member Handbook
- Identification Cards
- Provider Directories Summaries
- Member Newsletter
- Health Education Material
- Member Letters
- Print outs of member section of an external Web site

K.2: Meeting Language and Grade Level Requirements

K.2 Describe how you will ensure that all written materials meet the language requirements and which reference material you anticipate you will use to meet the sixth (6th) grade reading level requirement.

Members must have the ability to understand and act on health care information and instructions. Members who understand health care information - medication directions, their physicians' guidance, plan benefits, instructions provided over nurse advice lines and websites - benefit in improved health status as a result. A lack of understanding also has significant implications for both the cost and quality of health care, particularly for members who have chronic conditions and need to carefully follow the treatment regimens prescribed by their physicians. AmeriHealth Mercy will comply with the Office of Minority Health, Department of Health and Human Services, "Cultural and Linguistically Appropriate Services Guidelines."

AmeriHealth Mercy has a documented process to ensure that all materials are developed by writers trained in cultural competency and literacy requirements. The writers will ensure that written materials are developed at a 6.9 grade reading level as required by the State. We will use the Flesch-Kincaid reading index as our primary tool to measure

The Rapid Response team received a call from the mother of "P," a 4-year old Hispanic boy with asthma. P's mother called and said that P had asthma for about a year and recently developed frequent night time coughing. In talking with P's mother, the Care Manager found that "P" was not taking any daily medication, but he did have a nebulizer for as needed use. P's mother also had a portable inhaler and spacer but was not sure how to use it properly. P also did not have any emergency medications at school. P's mother did not speak or read English, limiting her ability to effectively communicate with P's physician.

The Care Manager arranged for P to see his PCP, calling ahead to the office to explain the needs and arrange for a translator. She had P's mother bring the spacer and inhaler to the visit. The Care Manager sent P's mother asthma education material in Spanish and provided follow-up education over the phone. The Care Manager also found a Spanish-speaking primary care physician in P's neighborhood and helped P's mother change to that practice.

In the course of working with P and his mother over several months, P's asthma improved. He was started on daily asthma medication and was seen by an asthma/allergy specialist. P has not had any hospital or Emergency Room visits related to asthma. P's mother made changes to her home to reduce triggers and keeps inhalers at home and at school that P can use, if needed.

reading levels.

All welcome packet components initially will be made available in English, Spanish and Vietnamese. To facilitate effective communications with our membership, we will continually monitor the special needs of our plan membership by reviewing monthly demographic reports that include racial, ethnic and preferred language background in order to identify if translation of materials to additional languages is needed. In addition, we will also monitor the usage of the Contact Center's Language Line to identify emerging language trends.

Member Handbooks, mass mailing materials and other material that communicates plan benefits information will all include a "tagline" that advises a member who has a visual or hearing impairment to contact Customer Services when s/he wishes to request something in an alternative medium.

Member materials will be available in alternative formats– Braille, large print and/or audio tape– to accommodate those members with sensory impairments. Members with a hearing impairment can call AmeriHealth Mercy's toll-free Teletypewriter (TTY)/telecommunication device for the deaf (TDD) number to request materials in an alternative medium. This line will be accessible 24 hours per day, 7 days per week.

Members may also contact AmeriHealth Mercy via the Louisiana Relay Service (LRS). Through this text to voice/voice to text service, Communication Assistants facilitate communication between TTY/TDD and voice telephones by voicing everything typed on TTY/TDD and typing everything voiced on the conventional telephone. All calls are strictly confidential.

Materials will go through two additional reviews before being considered "final" and ready for DHH review. The first is through our Editorial Review Committee – an internal editorial review team – and the second, through a member of the regulatory team. Both will check materials to ensure they meet both DHH requirements and our own strict standards for cultural competency and literacy before being sent to DHH for approval. Our internal material production ("traffic") management system ensures materials have the proper approvals from the regulatory departments, the Editorial Review Committee and DHH before they are printed or distributed. The writer, Editorial Review Committee, regulatory reviewer and DHH must all document their review and approvals before the final production will commence.

Additionally, AmeriHealth Mercy has a documented process for the annual review of member materials. Through this process, we review for accuracy, cultural competency and literacy. These processes have all been proven over time and through the experience of our affiliate plans, and will be customized to meet Louisiana requirements.

K.3: Member ID Cards

K.3 Describe your process for producing Member ID cards and information that will accompany the card. Include a layout of the card front and back. Explain how you will ensure that a Member receives a new Member ID Card whenever there has been a change in of the information appearing on the Member ID Card.

Member ID cards are generated through AmeriHealth Mercy's claims processing system, Facets. The system is configured to ensure member ID cards meet the requirements outlined in Section 12.13 of the CCN-P RFP.

The LaCare ID cards will be produced as follows:

- The eligibility file received from DHH and/or the approved Enrollment Broker will be used to generate a CCN issued ID card for each new member. The Facets system has the functionality to identify all new members and automatically generate an ID card request. The Facets system maintains and provides member data.

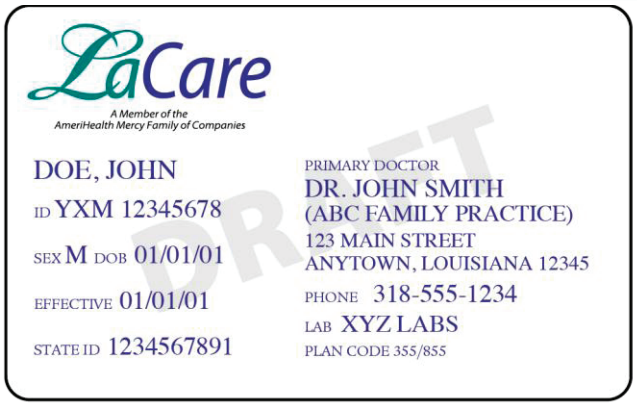
- ID cards are produced on a daily basis through a batch process. ID cards for new members are included in the new member welcome packet with a letter instructing the member on the purpose of the card, how to use the card to access services and how to use the card along with their DHH card. The letter also informs the member about the ID card they will receive from the State.
- Members who have not had a PCP assignment will be issued an ID card without a named PCP. The card carrier will contain information telling the member how to contact LaCare to assistance choosing or changing a PCP assignment. The Contact Center is available to assist members with the identification and selection of a PCP assignment.
- Members who have not selected a PCP after 10 days will be assigned a PCP utilizing selection algorithms as approved by DHH. Additional information on our proposed algorithms can be found in Section G. Once the auto assignment is complete and all error reports are reconciled, a new ID card will be mailed to the member. The new ID card will be accompanied by a letter providing an explanation for the new ID card, identifying the change(s) made to the card and describing what the member should do with the old ID card. All reissued cards will be mailed within 10 calendar days of the auto assignment.
- If a member has selected a PCP and the selected PCP is not able to accept new members, the member will be assigned to a different PCP through the auto assignment process. Information explaining the change will be included in the letter accompanying the ID card.

The Member ID Card

The member ID card will include the LaCare logo and the following information:

- Member name
- Member date of birth
- LaCare's name and address
- Instructions for emergencies
- PCP name and address
- PCP telephone numbers (including after-hours contact information, if different from business hours)
- Toll-Free Numbers for:
  - 24-hour Contact Center and Filing Grievances
  - Provider Services and Prior Authorization and
  - Reporting Medicaid Fraud (1-800-488-2917)

A sample of the LaCare Member ID Card is shown in Figure 1.



Front

Back

Figure 1: Picture of LaCare Member ID Card (Front and Back)

New ID Cards

Facets automatically generates a new member card when we receive additional information when any of the following information changes are received in the Membership File received from the state, or when we become aware of the information from other sources:

- PCP Change
- Address Change
- Benefit Change
- Name Change

A new card can also be reissued when a member reports that he or she has lost his card. In addition to generating the card, the system also generates a letter to the member defining the purpose of the reissuance of the card. The new card and letter will be mailed to the member within ten (10) calendar days of notice of the reasons for the new card.

The Facets system will track all ID card requests and ID card issues. This information will be used to help identify any potential member fraud and trigger the need for further member education.

K.4: Provider Directory

K.4 Describe your strategy for ensuring the information in your provider directory is accurate and up to date, including the types and frequency of monitoring activities and how often the directory is updated.

Up-to-date and accurate provider information is important to members, providers, the State's enrollment broker, and to plan operations. AmeriHealth Mercy will develop and maintain a Provider Directory in four formats:

- A hard copy for members and potential members
- A Web-based, searchable online directory for members and the public
- An electronic file of the directory for the Enrollment Broker
- A hard copy, abbreviated version for the Enrollment Broker

Ensuring Accuracy of the Provider Directory

Provider Directories will be available in the four formats noted above. The hard copy Provider Directory will be reprinted with updates at least annually, pursuant to DHH requirements. The web-based online version will be updated in real time, however no less than weekly. The electronic version will be updated prior to each submission to DHH's Fiscal Intermediary within the time frames required by DHH. The abbreviated hard copy version for the Enrollment Broker will be distributed to new Medicaid enrollees, formatted in a version to be specified by DHH following award of the contract.

We will ensure that our Provider Directories are accurate and updated by regularly reviewing and auditing the provider information on file. The Provider Directory is pulled directly from our claims processing system, which serves as the official source for all provider data. The accuracy of our provider database is monitored regularly through a quality auditing process that evaluates transactional activity associated with updating and maintaining the provider database. Daily we conduct an audit of five pieces of work per employee to assess the accuracy of their work. Real time results are available to the Provider Maintenance Management team and are used to correct identified errors and coach employees. Additionally, queries are run against the provider database on a regular basis to identify errors and discrepancies are corrected by the Provider Maintenance team.

Additionally, the Provider Network Management representatives will validate provider demographic data at least quarterly to ensure the accuracy of provider data. Validation will occur through a combination of personal visits, telephonic, electronic media and faxed confirmation.

Lastly, on an annual basis, AmeriHealth Mercy will perform a Provider Panel Roster Validation. Through this process, all providers will be required to validate and edit the data stored in our provider database. This process has proven to be very effective for our affiliate plans as a means to ensure accuracy of provider directories, and we will implement the same process for LaCare.

K.5: Internet and Website Requirements

K.5 Describe how you will fulfill Internet presence and Web site requirements, including:

- *Your procedures for up-dating information on the Web site;*
- *Your procedures for monitoring e-mail inquiries and providing accurate and timely responses; and*
- *The procedures, tools, and reports you will use to track all interactions and transactions conducted via the Web site activity, including the timeliness of a response and resolution for said interaction/transaction.*

WWW.LACARELOUISIANA.COM

In the fall of 2010, we conducted extensive focus group research in New Orleans, Baton Rouge and Shreveport with the intention to learn as much as possible regarding Louisiana Medicaid recipients' communications preferences. Interestingly, we learned that the single most preferred mode of communication was electronic – email, text, internet, etc. When asked how they would like to receive communication regarding their plan benefits and services, focus group participants overwhelmingly stated

electronic communications (social media and email) tools as their preferred communications channel. Only one of the nearly 100 research participants indicated they did not have access to electronic communication via either a smart phone or computer. AmeriHealth Mercy will promote our member web portal capabilities and use of popular media such as Facebook and Twitter to deliver health-related reminders to members. AmeriHealth Mercy may also share information on LaCare sponsored community events such as baby showers, post information on obtaining necessary health screenings, vaccinations, or warnings about potential pandemics via Facebook.

With that information in-hand, recognizing the extreme importance of electronic communication, we have been in the process of carefully and purposefully building the LaCare internet and website presence. Key components of the site will include:

- Online library of health information
- Member Portal that will provide members with interactive tools to perform self-service for specific activities. For example, the portal will give members the ability to view demographic information about their doctor or find a new PCP using a link to the online Provider Directory. Members will also be able to see detailed information about medications they have been prescribed within the past six months including the date prescribed, medication name, dosage and prescribing physician. Members will be able to view their recent visits to the doctor, hospital and emergency room and link to the Health and Wellness Section of the LaCare website.
  The objective of the secure portal is to maintain or increase member satisfaction by offering user friendly capabilities and to provide members with sufficient, secure interactive tools to help them have a clear picture of their medical care. By giving members added access, it will improve clinical outcomes through better medication adherence and reduce gaps in care.
- Provider Portal enables easy access to information, maximizing efficiency and inspiring collaboration among our providers. In addition, the system links our caregivers to ensure our physicians have the vital information they need to provide the best, coordinated care for our members. The following figure outlines the functionality of the Provider Portal.

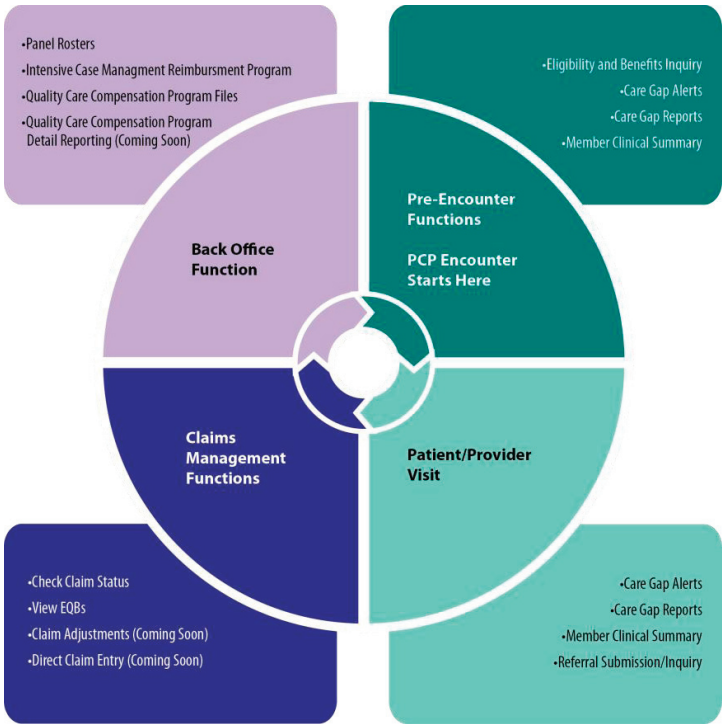


Figure 2: AmeriHealth Mercy Provider Portal Functionality

The LaCare website will use best practice designs based on the US Government's Web Guidelines on usability to ensure that members and providers can easily find information and services that AmeriHealth Mercy provides. All the features and offerings on the website will meet or exceed the Section 508 of the Americans with Disabilities Act Requirements and meet all standards the Act sets for people with visual impairments and disabilities that make usability a concern including the Web Content Accessibility Guidelines (WCAG) 1.0 "Triple A" Conformance Level.

AmeriHealth Mercy will ensure the web site follows all written guidelines included in Section 12.10 of the CCN-P Request for Proposal issued by DHH. In addition, the AmeriHealth Mercy website will be tested for cross-browser compatibility, which will allow it to display and behave consistently in the following browsers: Internet Explorer (version 7, 8 and 9), Firefox (version 3 and 4), Safari (version 4 and 5), and Google Chrome (version 10 and 11). The LaCare website will meet all coding standards set by the World Wide Web Consortium for markup language, link validation and CSS.

A screen shot of the proposed home page for the LaCare Web site follows.

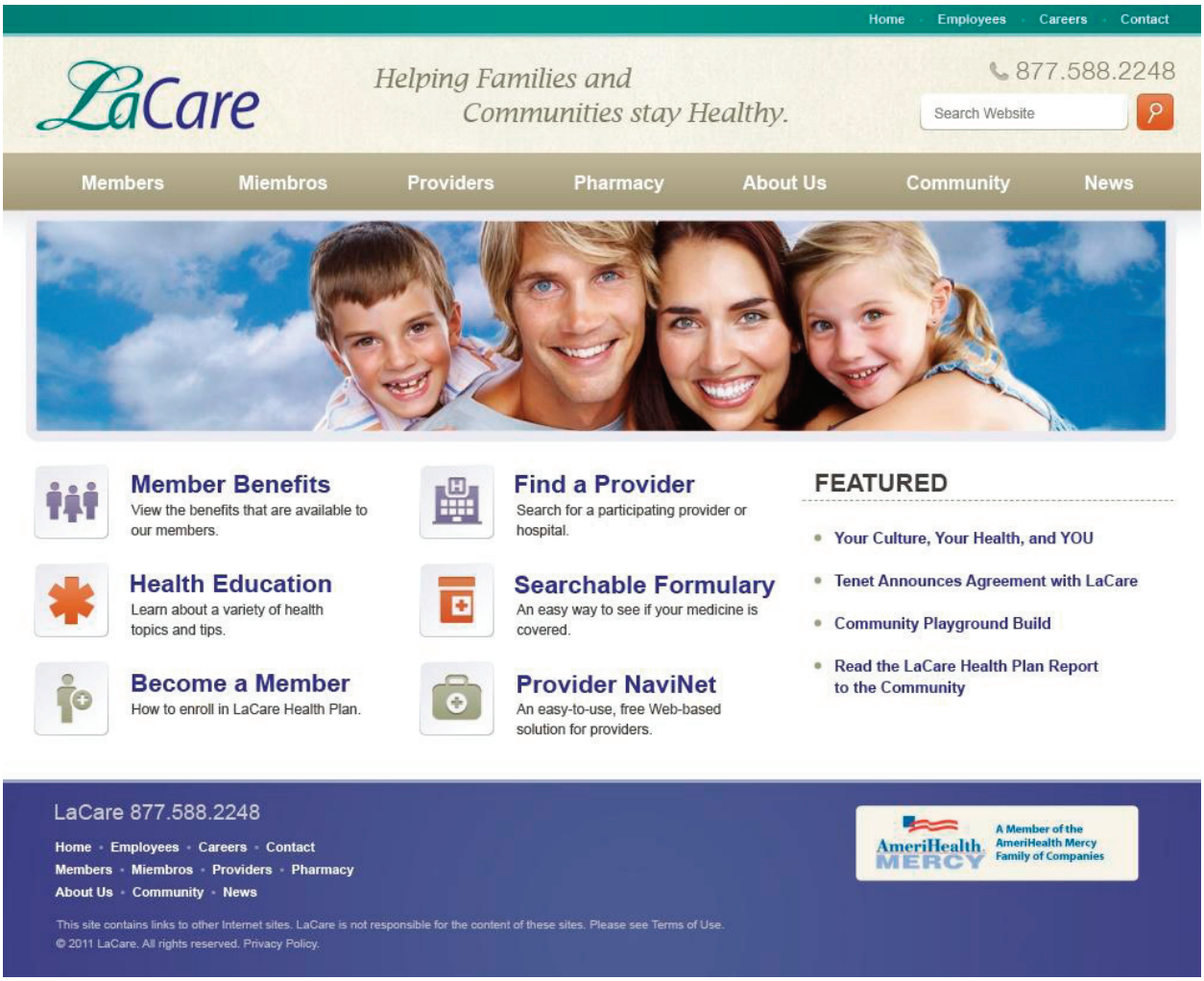


Figure 3: www.lacarelouisiana.com

The LaCare website will meet all requirements stated in the request for proposal. For example, the website will have telephone contact information including the toll-free Contact Center number prominently displayed and a Telecommunications Device for the DFF (TDD) number. There will be also be a searchable list of network providers with their contact information, and a designation of open versus

closed panels that will be updated in real-time. Information about how to file grievances and appeals will also be included, as well how to contact the enrollment broker or DHH. Additionally, site content will be available in both Spanish and Vietnamese. And finally, members will have the opportunity to submit questions and comments to AmeriHealth Mercy and receive responses back.

Procedures for Up-Dating Information on the Website

Content and information for the LaCare website will be updated and managed via an enterprise Content Management System, Autonomy TeamSite. Through TeamSite, designated content experts are granted a license to manage their content via TeamSite and receive internal training and support. New and updated content that has already been approved by DHH will be managed through a workflow process to allow for any required internal reviews from a legal and technical prospective. TeamSite also provides content version management and control.

Procedures, Tools and Reports Used to Track Interactions and Transactions Conducted via the Web Site Activity

Each email inquiry is entered into EXP Macess. (EXP Macess is an electronic health care call documentation and inquiry routing system used to document and route all inquiry data, phone interaction notes, and case related email or electronic correspondence within and between the companies). The status of each email is tracked through EXP Macess, and tracked through resolution. Based on the subject of the email, the system provides automatic routing to one of two mailboxes. Member and provider-related inquiries are handled by a dedicated team from the Operations department.

All inquiries are responded to within two business days. Responses to email inquiries are audited for accuracy and timeliness using the same audit process that is used for phone inquiries. LaCare web properties, both internal and external, will be monitored using HP OpenView software, in addition to proactive monitoring through Microsoft Application Center 2000 Health Monitoring. HP OpenView will alert AmeriHealth Mercy management if there are response time and availability issues to responding to emails.

Incoming email from the website is tracked through two monthly reports. The first report provides the detail of the inquiry, including the member's name, email address, ID number and the date/time received. The second report summarizes the inquiries by category, allowing AmeriHealth Mercy to identify the most common reasons for inquiry. The Quality Service Committee reviews the trends and determines if any policies or processes need to be modified.

Since the web content is public and viewable by the entire internet community, it has been difficult to precisely state how many members visit our site compared to general public visits compared to provider visits. However, to help understand the trends and traffic, we have partitioned our current reports by using Content Groups to show activity in the member section or the provider section of the web site. We have observed more than 3,000 visits per month on a typical member section.

All activity on the website is measured and analyzed through standard web server logging through IIS 6.0, web server software. AmeriHealth Mercy will leverage two solutions for tracking interaction and transactions. The first solution is WebTrends, a Web-based enterprise solution, which analyzes and reports on hits, visits and trends for a website. These reports will provide a summary metrics as well as detailed drill-down reports. By granting access via licenses, specific employees from AmeriHealth Mercy will have the ability to view and export on-demand reports for their website. The second solution is Google Analytics, another Web-based tool, which tracks visitor information related to visits, browser and operating system types, screen resolutions and traffic sources such as search engines.

Section L – Customer Service

AmeriHealth Mercy will have access to AmeriHealth Mercy's state-of-the-art Contact Center, allowing us to provide industry-leading customer service any time of day or night. Staffed 24/7, 365 days a year by trained Customer Services Representatives, our employees are always available to handle member inquiries, whether telephonic, written or web-generated. Our technology systems enable employees to access member or provider information at the touch of a button, and calls can be quickly routed throughout the organization to handle any type of potential inquiry.

L.1: Member Service Telephone Lines

L.1 Provide a narrative with details regarding your member services line including:

- *Training of customer service staff (both initial and ongoing);*
- *Process for routing calls to appropriate persons, including escalation;*
- *The type of information that is available to customer service staff and how this is provided (e.g., hard copy at the person's desk or on-line search capacity);*
- *Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired;*
- *Monitoring process for ensuring the quality and accuracy of information provided to members;*
- *Monitoring process for ensuring adherence to performance standards;*
- *How your customer service line will interact with other customer service lines maintained by state, parish, or city organizations (e.g., Partners for Healthy Babies, WIC, housing assistance, and homeless shelters); and Gap- need to develop process*
- *After hours procedures.*

Contact Center of Excellence

AmeriHealth Mercy has a state of the art Contact Center of Excellence (CCOE) that enables highly effective customer interactions with very efficient use of resources to "Make Every Member Contact Count." As an enhanced benefit, Customer Service Representatives will be available 24 hours/seven days a week/365 days a year to service member inquiries, whether telephonic, written or web-generated. Our technology allows our representatives to have access to all member information so they are able to handle all types of member calls: calls that range from a general benefit question to reminding a member to schedule a follow up appointment with their doctor. The ready availability of data allows us to take advantage of opportunities to maximize the dissemination of information on important benefits and support services when we talk with a member, as well as better serve the member without having to transfer the call to different departments of the company.

The CCOE is exemplified by best-in-class technology, use of industry best-practices, constant organizational improvement and member and provider contact maximization. The CCOE is designed to manage any inbound and outbound contacts with members regardless of the communication vehicle. The CCOE will accommodate the queuing of calls, emails, text messages, as well as web chat. Our CCOE is the product of identification and deployment of industry best-practices and strictly monitored internal practices to enhance the member's experience and improve member satisfaction.

As an enhanced benefit, Member Service Representatives will be available 24 hours/seven days a week/365 days a year to service member inquiries, whether telephonic, written or web-generated

AmeriHealth Mercy has also made significant investment in quality monitoring capabilities. By utilizing the Verint Impact 360 Suite, the CCOE records calls while simultaneously recording the desktop screens

that are accessed during the call. The analytic capabilities of the suite rapidly identify representatives with skill sets that need improvement. Since the suite is integrated with the representative's desktop, required eLearning courses can be automatically sent and scheduled for the representative to directly access.

CCOE Technology Highlights include:

- Avaya Aura Contact Center and Verint Impact 360 Workforce Optimization Suites. These 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
- 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
- Primary Care Physician 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

In addition, AmeriHealth Mercy's telephony infrastructure has a comprehensive back-up system with full redundancy capabilities. AmeriHealth Mercy utilizes the Avaya Single Image Switch architecture; a fully distributed IP-based phone system. This system provides feature transparency across the AmeriHealth Mercy infrastructure and also extends contact center and other telephony applications throughout the enterprise. The main Avaya Communication Manager server resides in Philadelphia, Pennsylvania and supports all AmeriHealth Mercy locations including our data center and all affiliates. The secondary standby server is located in a separate location to ensure continuity of service. Since AmeriHealth Mercy 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 AmeriHealth Mercy site were to lose connectivity to the main Avaya server, the local Avaya gateway(s) at the affiliate site would register to the local Avaya Communication Manager standby server. In essence this site would 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 would 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 function uninterrupted.

The CCOE will be fully implemented throughout AmeriHealth Mercy during the calendar year 2011 and will be fully operational for the first phase of operation in Louisiana. Future enhancements will include speech analytics that can evaluate the emotions of the caller on the call as well as screen for particular words of significance to indicate adjustments that are needed in the center.

Training of Customer Service Representatives (both initial and ongoing)

Initial Training

From the first day of employment, the representative trainee is preparing to become an integral part of the CCOE. The training process begins with our recruitment strategy, which is geared to identify potential candidates with the necessary experience and skills to provide high quality customer service to our members. A major step in the process is our upfront skills and computer proficiency testing. Every candidate must pass this test to be considered as a potential applicant and move forward with the interview process.

Upon hire, our dedicated Training Unit conducts an extensive training program for new hires and on-going training for our seasoned representatives. The New Hire Training program consist of six weeks of classroom instruction, as well as, side-by-side "on the job" training.

Examples of Training Topics

- Louisiana Geography
- Louisiana specific Medicaid Benefits
- Key contact numbers (such as the Enrollment Broker and DHH)

Health Care Fundamentals

- Health Care Terminology
- Medicaid Basics/Program Overview
- Member Eligibility
- Benefits
- Soft Skills
- How to handle difficult member
- How to handle a member with limited English proficiency skills
- What it means to provide superior customer service
- Corporate Compliance, including HIPAA
- How to handle member complaints and dissatisfaction
- Diversity and Cultural Competency
- Use of core technology and system
- Phone Lab – Supervised live calls

Through our continuous quality assurance process we are able to identify gaps in training and/or specific areas where a particular trainee is challenged. Throughout the formal training program the trainees are required to complete skill based assessments which test the trainee's knowledge. At the completion of the formal training all trainees are required to pass a readiness exam which evaluates their general knowledge and assesses their readiness to be released from training. Refresher training is scheduled as needed to address the specific needs of the employees.

Prior to independently taking live telephone calls, new representatives are required to participate in a phone lab training session as well as side-by-side training with an experienced representative. During the phone lab training session, the new representative actually services live telephone calls from members and providers with the assistance of the trainer.

Ongoing Training

Anytime Learning is a self-paced, online instruction for all employees. It provides access to online reference materials and training on skills in many different areas. Modules include topics such as systems software skills, assorted business and accounting skills and various personal/professional effectiveness skills. It is aptly named ***Anytime Learning*** because it can be accessed anytime, from any location, for all our employees, 24 hours a day, 7 days a week.

Customer service modules are developed based on training needs and are stored in a web-based training portal for ease of access. This portal allows for self-directed, self-paced web-based training for immediate "on the spot" training without having to utilize a trainer or wait for available individual training. Both of these mechanisms can be used for a representative if their supervisor identifies a deficiency for a specific topic.

Challenging Customers

Self-paced Courses

- Dealing with Challenging Customer Interactions: Establishing a Solid Customer Relationship (Includes Simulation)
- Dealing with Challenging Customer Interactions: Overcoming Communication Issues (Includes Simulation)
- Dealing with Challenging Customer Interactions: Resolving Challenging Situations (Includes Simulation)

Client Relationship Management

Self-paced Courses

- Client Relationship Management 1: Managing Relationships During Initiation and Planning (Includes Simulation)
- Client Relationship Management 2: Managing Relationships During Execution and Close-Out (Includes Simulation)
- Client Relationship Management 3: Managing Interaction-Based Causes for Project Failure (Includes Simulation)

Client Relationship Management

Self-paced Courses

- Customer Service Via Phone and Email (Includes Simulation)
- Customer Service: Customer Care (Includes Simulation)
- Customer Service: Customer Relationship Management (Includes Simulation)
- Customer Service: Increasing Sales via Service (Includes Simulation)
- Customer Service: Making a Difference With Customers (Includes Simulation)
- Customer Service: Positive Outcomes (Includes Simulation)
- Excellence in Technical Customer Service (Includes Simulation)
- Fundamentals of Customer Service

Figure 1: Examples of Available Anytime Learning

All AmeriHealth Mercy employees, including the representatives, are required to attend a series of training sessions per year to meet their individual and departmental goals. The training courses can be related to specific issues in their department or other professional and career development training. The following is a list of some of the training classes the representatives attended in 2010:

- Caring for Customers
- Creative Decision Making and Problem Solving
- Cultivating Winning Attitudes and Countering Negativity
- Defusing Emotionally Charged Situations
- Handling Difficult People
- Handling Conflict with Tact & Finesse
- Team Grammar – The Essentials of English Grammar for Business

In addition, all employees are required to take annual compliance training regarding the Code of Conduct, fraud, waste and abuse and HIPAA.

The goals and objectives for the training include:

- An expanded understanding of cultural competency
- A better understanding of how culture affects communication in the workplace
- Promoting awareness of cultural values, beliefs and personal biases
- An overview of the diversity of our membership
- An overview of AmeriHealth Mercy's Cultural Competency Initiative

Cultural Competency - Upon hire and annually, all AmeriHealth Mercy employees are required to complete a cultural competency training program.

Continuous learning is also supported through feedback sessions with supervisors and our quality assurance department on a daily, weekly, and monthly basis.

In fact, the National Committee for Quality Assurance (NCQA) has recently recognized three of AmeriHealth Mercy's plans, including the largest plan, with their NCQA Multicultural Heath Care Distinction. This is a new program from NCQA that offers merit to organizations that engage in efforts to improve culturally and linguistically appropriate services and reduce health care disparities. AmeriHealth Mercy's plans are three of only six nationwide plans currently recognized in this fashion.

Routing Calls to appropriate persons, including escalation

The CCOE uses Automated Call Distribution (ACD) technology to route calls and ensure timely response to member inquiries.

Members are presented with a series of prompts that begin with the selection of the preferred language. The ACD routes the call depending upon the option selected (member vs. provider) and agent skill set, directly to either a representative or one of several internal departments. For example, if a member wishes to speak to the medical management department, the member would select the medical management telephone prompt. The call would be automatically routed to the medical management department.

In addition, the ACD technology has the ability to load balance calls and automatically route calls to other regions as needed. The system has a predetermined threshold which will identify the number and length of time a call is waiting in queue. If the call volume exceeds the threshold, the system will transfer the overload to another contact center for services. Load balancing allows us to meet key performance indicators and member needs.

The Contact Center Management team also has access to real-time data, refreshing every three seconds, which is used to determine staffing needs in 30 minute intervals throughout the day. Accurate staff forecasting is another critical component to ensure that the appropriate number of staff are available based on types of call received. Call load balancing will be critical during the open enrollment period where a very high volume of calls is anticipated. In addition to the two main Contact Centers (located in South Carolina and Philadelphia) we will have a contract with a strategic partner to assist with call overflow. It is our intent to utilize this strategic partner during the open enrollment period to ensure there is capacity to handle the expected call volume.

In addition to being routed to representatives, members will have the option of handling routine transactions through our Interactive Voice Response (IVR) system. The IVR system handles calls that are routed, by caller request, via our call center Private Branch Exchange (PBX) prompting. For instance, if a provider calls to validate a member's eligibility status through the PBX, the IVR system accesses the Facets system which contains member eligibility data via a real-time system interface. Similarly, the IVR process can also provide general benefit information. The IVR system, through the Forms Faxback application, can provide doctor's offices access to prescription drug Prior Authorization forms via fax. This interface can also be modified for other forms, as needed.

Additional IVR options for members include requests for an ID card, Provider Directory, and Member Handbook. The goal of these applications is to expedite obtaining information for relatively simple tasks, while leveraging our representatives to work with members and providers to resolve more complex requests.

Escalated Call Process

A call may need to be escalated to a supervisor for resolution for a variety of reasons. For example, a call may need to be escalated because a member specifically requests to speak with a supervisor, or the representative is unable to fully service the member. These calls are handled on a priority basis. In every situation, AmeriHealth Mercy has a detailed process that every representative must follow:

- The representative will utilize all available tools to service the member or provider
- If the representative is not able to provide the service, or if a supervisor is requested, the representative will immediately contact a supervisor
- The supervisor will accept the member or provider call by either taking the call at the representative's desk or the caller will be transferred directly to the supervisor
- The supervisor will complete the call and document the call as required
- The supervisors are physically located along side of the representatives for easy access

Additionally as a routine, supervisors silently monitor calls handled by representatives. This form of monitoring is especially important with new trainees. During the call-monitoring process, the supervisor has the ability to intervene in a call if the need arises. This intervention helps to quickly address a situation without the member having to speak with a supervisor.

Information Available to Member Service Staff

AmeriHealth Mercy's "*Online Benefits Directory*" and resource materials will be available for representatives. The web based Online Benefits Directory (Online Help) is a comprehensive reference guide explaining benefits and services and will serve as the primary resource to representatives for reference information.

This information is prepared by AmeriHealth Mercy technical writers. The writers are responsible for analyzing new and current business processes and initiatives to optimize information delivery. They manage all aspects of the technical documentation life cycle (planning, writing, editing, illustration, print and online production). They create Online Help Files that are stand-alone HTML-based files users can access directly from their desktops.

These Help Files function as centralized resource tools for employees in various business units throughout our multiple locations. The Online Help Files contain line of business specific benefit and policy information, daily operational and procedural information, and key updates and important notifications. These files ensure the consistent delivery of accurate information to internal and external customers. AmeriHealth Mercy understands that each Medicaid plan is unique, so we adapt the On-Line Help File content for each state based on needs.

Figure 2: Sample of On-Line Help Documents for Member Services Staff (Broad Categories)

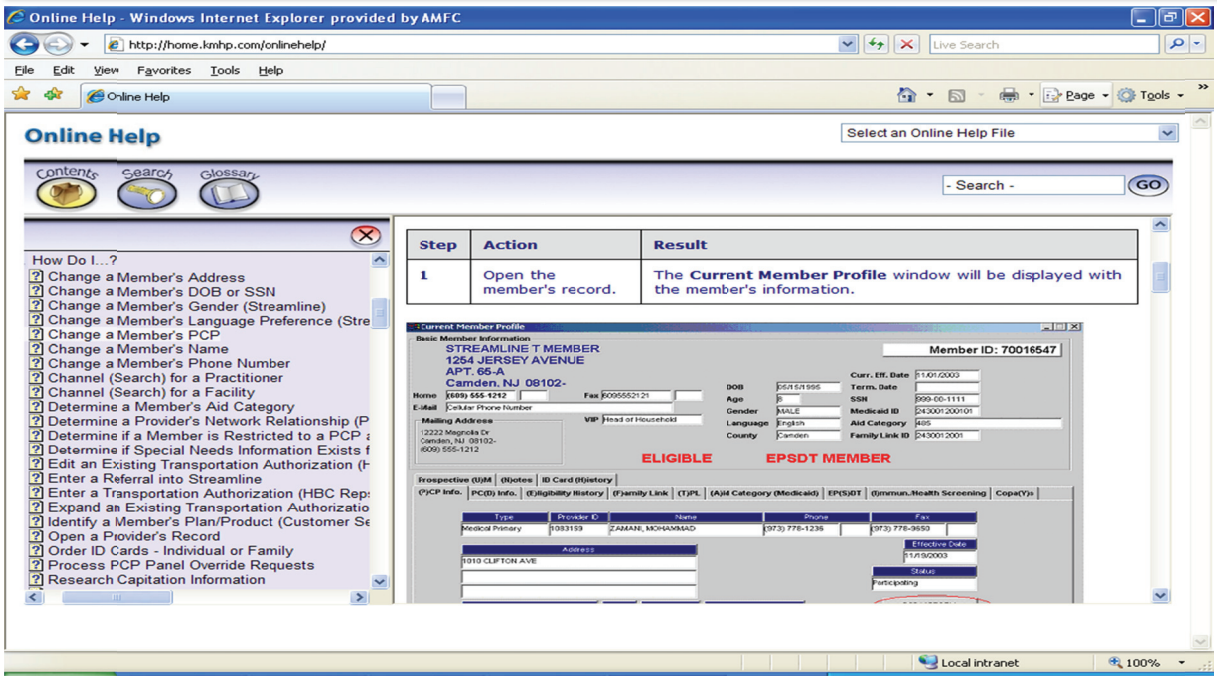


Figure 3: Online Help Tool

Process for handling calls from members with Limited English Proficiency and persons who are hearing impaired

AmeriHealth Mercy serves Medicaid members in a variety of states and is accustomed to communicating effectively with members who have very limited English skills or who are hearing impaired. In addition to representatives communicating in English, we also provide bilingual services for Spanish and Russian in-house. To meet the limited English needs in Louisiana we are actively recruiting for Vietnamese speaking representatives. (Additional languages will be added as needed.)

To assist callers who require other language assistance, we utilize the services of Language Services Associates (LSA), which enables customer communication in more than 170 languages. The representative will facilitate a three-way call between the members and LSA. This service is available through our Contact Center at no charge to our members. Our years of experience in providing service to the Medicaid population have demonstrated that members prefer to speak with someone who speaks their language and understands their cultural needs. LSA employees understand the specific needs of the Medicaid population which helps to facilitate the call to meet the member's needs.

Additionally, the Contact Center has the technology to respond to Deaf/Teletypewriter (TTY/TDD) calls. A desktop application is loaded on the representative's desktop, where the representative logs in to a TTY/TDD server, "sharing" central TTY modems over a network. When a call is received an alert will appear on the desktop notifying them of a call waiting. This optimizes call-handling procedures because the representative is equipped to handle an incoming TTY/TDD call without the need for additional equipment.

Monitoring process for ensuring the quality and accuracy of information provided to members

Monitoring of representatives is necessary to assess if there are areas of concern regarding courtesy, accuracy, consistency and completeness. Calls are monitored through a silent monitoring and recording. First, we silently monitor calls of our representatives. Every supervisor is required to monitor calls for representatives on a monthly basis. Each supervisor has the capability through their desk phone to listen

in on calls throughout the day. The supervisor is able to provide real time feedback and coach and assist representatives as needed. In many of our contracts in other regions we have provided the State with the ability to monitor calls remotely. This capability will be available to DHH.

Quality Assurance

In addition to silent monitoring capabilities, the CCOE has defined criteria and protocols for quality monitoring and assurance. On a monthly basis, the Call Quality Auditor reviews a random sample of calls, listening to conversations and viewing what action the representative took in the system to ensure accuracy of responses and use of appropriate phone etiquette. AmeriHealth Mercy will use the Verint Technology to record all calls and "screen scrape" so every activity performed on the call is captured. The "screen scrape" technology also captures any system activity generated by the representative during the call. The Quality Auditors audit 10 – 14 calls per month for each representative. This is a critical tool used when providing feedback to staff and for the quality process. The system is capable of capturing every keystroke and screen the representative accessed to service the call and hear what was said.

The Quality Department provides feedback to representatives on a weekly basis. Specifically, the Auditor verifies that the incoming/outgoing calls were appropriately handled in the following areas:

- Proper verification of the caller's identity
- Accuracy and content of provided information
- Courtesy
- Appropriate handling of the call
- Quality of Documentation of calls
- Phone etiquette
- First call resolution

Based on the quality scores, the supervisor will create an individual action plan for the representative. If trends are identified, the training department is engaged to provide refresher training. Quality grades are part of the Customer Service Representative's monthly feedback as well as their annual appraisal. The supervisor meets with every representative monthly or as needed to review their quality scores and address any issues.

AmeriHealth Mercy will submit call center quality criteria and protocols to DHH for review and approval annually.

Monitoring process for ensuring adherence to performance standards

The Contact Center Management team has an extensive list of real-time and historical reports that are used to manage performance. The Avaya system comes with the suite of standard reports as well as customizable reports that will allow AmeriHealth Mercy to monitor specifically defined performance requirements such as those dictated in the Louisiana CCN-P Request for Proposal section 12.16. As needed, reports will be modified based on the specific service level expectations for Louisiana. Alert thresholds will be set to ensure performance expectations are achieved. Multiple processes and systems are used to manage performance:

Workforce Management

Performance management begins with the appropriate forecasting and staffing to meet the expected call volumes. The CCOE has a sophisticated staffing model that utilizes the following assumptions to determine general staffing needs: Calls per 1,000 members; membership; total average handle time goals; Off the Phone Time (OPT); shrinkage rate; average hold time and days per month. In addition, we utilize Pipkins technology which utilizes historical information and service goals to determine hourly and daily staff needs. This data is critical to allow for quick staffing adjustments to meet call standards during high call volume.

Monitoring for Performance

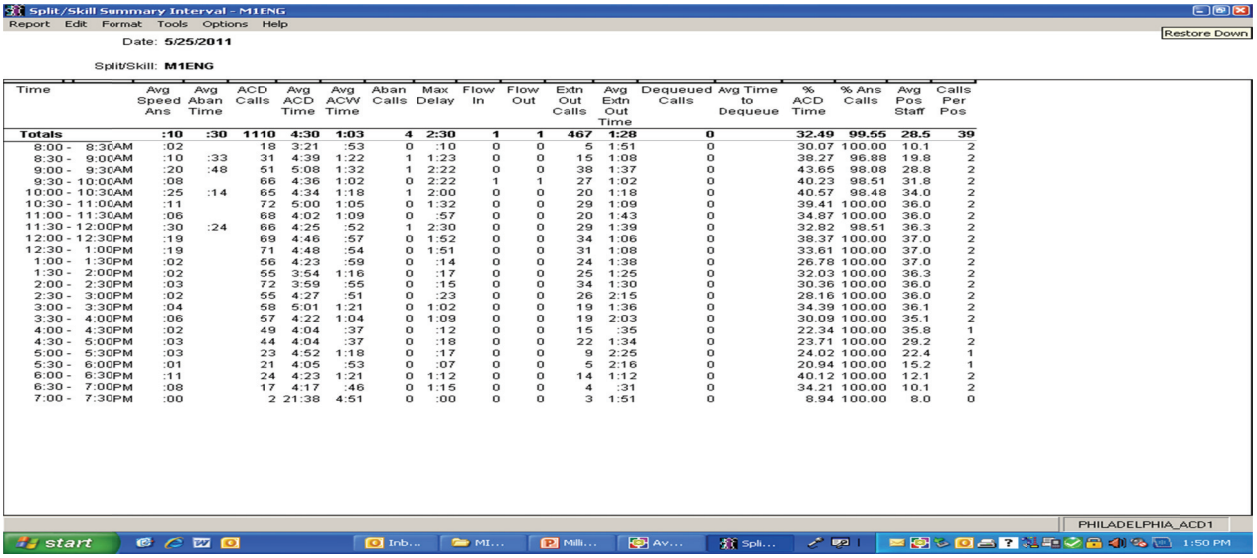
A dedicated Workforce Management team monitors individual and department performance measures such as the following individual and departmental goals:

- Individual Goals
  - Real time adherence
  - Total average handle time
  - Average hold time
  - Off the phone time
- Department Goals
  - Answer 90 percent of calls within 30 seconds or an automatic call pickup system;
  - No more than one percent of incoming calls receive a busy signal;
  - Maintain an average hold time of three minutes or less;
  - Maintain abandoned rate of calls of not more than five percent;
  - Service level
  - Shrinkage rate
  - Trunk usage rate
  - Number of calls in queue

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. 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.

Daily, Weekly and Monthly Historical Reports

Historical reporting is used to help forecast and track call trends as well as monitor the performance of staff.


Split/Skill Summary Interval - M1ENG

Report Edit Format Tools Options Help

Restore Down

Date: 5/25/2011

Split/Skill: M1ENG

Time	Avg Speed Ans	Avg Aban Time	ACD Calls	Avg ACD Time	Avg ACW Time	Aban Calls	Max Delay	Flow In	Flow Out	Extn Out Calls	Avg Extn Out Time	Dequeued Calls	Avg Time to Dequeue	% ACD Time	% Ans Calls	Avg Pos Staff	Calls Per Pos
Totals	**:10**	**:30**	**1110**	**4:30**	**1:03**	**4**	**2:30**	**1**	**1**	**467**	**1:28**	**0**		**32.49**	**99.55**	**28.5**	**39**
8:00 - 8:30AM	:02		18	3:21	:53	0	:10	0	0	5	1:51	0		30.07	100.00	10.1	2
8:30 - 9:00AM	:10	:33	31	4:39	1:22	1	1:23	0	0	15	1:08	0		38.27	96.88	19.8	2
9:00 - 9:30AM	:20	:48	51	5:08	1:32	1	2:22	0	0	38	1:37	0		43.65	98.08	28.8	2
9:30 - 10:00AM	:08		66	4:36	1:02	0	2:22	1	1	27	1:02	0		40.23	98.51	31.8	2
10:00 - 10:30AM	:25	:14	65	4:34	1:18	1	2:00	0	0	20	1:18	0		40.57	98.48	34.0	2
10:30 - 11:00AM	:11		72	5:00	1:05	0	1:32	0	0	29	1:09	0		39.41	100.00	36.0	2
11:00 - 11:30AM	:06		68	4:02	1:09	0	:57	0	0	20	1:43	0		34.87	100.00	36.0	2
11:30 - 12:00PM	:30	:24	66	4:25	:52	1	2:30	0	0	29	1:39	0		32.82	98.51	36.3	2
12:00 - 12:30PM	:19		69	4:46	:57	0	1:52	0	0	34	1:06	0		38.37	100.00	37.0	2
12:30 - 1:00PM	:19		71	4:48	:54	0	1:51	0	0	31	1:08	0		33.61	100.00	37.0	2
1:00 - 1:30PM	:02		56	4:23	:59	0	:14	0	0	24	1:38	0		26.78	100.00	37.0	2
1:30 - 2:00PM	:02		55	3:54	1:18	0	:17	0	0	25	1:25	0		32.03	100.00	36.3	2
2:00 - 2:30PM	:03		72	3:59	:55	0	:15	0	0	34	1:30	0		30.36	100.00	36.0	2
2:30 - 3:00PM	:02		55	4:27	:51	0	:23	0	0	26	2:15	0		28.16	100.00	36.0	2
3:00 - 3:30PM	:04		58	5:01	1:21	0	1:02	0	0	19	1:36	0		34.39	100.00	36.1	2
3:30 - 4:00PM	:06		57	4:22	1:04	0	1:09	0	0	19	2:03	0		30.09	100.00	35.1	2
4:00 - 4:30PM	:02		49	4:04	:37	0	:12	0	0	15	:35	0		22.34	100.00	35.8	1
4:30 - 5:00PM	:03		44	4:04	:37	0	:18	0	0	22	1:34	0		23.71	100.00	29.2	2
5:00 - 5:30PM	:03		23	4:52	1:18	0	:17	0	0	9	2:25	0		24.02	100.00	22.4	1
5:30 - 6:00PM	:01		21	4:05	:53	0	:07	0	0	5	2:16	0		20.94	100.00	15.2	1
6:00 - 6:30PM	:11		24	4:23	1:21	0	1:12	0	0	14	1:12	0		40.12	100.00	12.1	2
6:30 - 7:00PM	:08		17	4:17	:46	0	1:15	0	0	4	:31	0		34.21	100.00	10.1	2
7:00 - 7:30PM	:00		2	21:38	4:51	0	:00	0	0	3	1:51	0		8.94	100.00	8.0	0

PHILADELPHIA_ACD1

start Inb... MI... Milli... Av... Spli... 1:50 PM

Figure 4: Avaya Daily Summary Report

Planning for Special Events

AmeriHealth Mercy's CCOE and Medical Management Department will work closely with DHH and the Enrollment Broker to effectively plan for special events to assure appropriate staff levels are available to handle increased volume and contacts relative to each special event. For example, mass member mailings will generate increased calls to the Contact Center, and staffing levels will be automatically adjusted to accommodate service level requirements and quality standards. Although these events are often labeled as "special events" they are routine in managing our members' care, and based upon AmeriHealth Mercy's experience, we adjust our staffing levels to effectively respond to our member's needs.

Coordination with Other Agencies

AmeriHealth Mercy's will maintain the telephone numbers for critical state, parish, or city organization under the "Important Telephone Number" section in the Online Benefits Directory (e.g., Healthy Babies, WIC, Housing Assistance, Homeless Shelters, Protective Services, Louisiana Safe Kids, Council on Obesity Prevention and Management, Utility Assistance). We work with the State, Parish and City agencies in order to incorporate the information specific to their programs into our training program. If a member needs assistance in accessing other services during a call, the representative will perform a warm transfer to the specific agency to help advocate for the member. For example, if we are talking with a member who needs information about domestic violence, we can transfer them to the appropriate agency and/or our Rapid Response team. The Rapid Response team will be engaged to provide more in-depth assistance to the member. The Rapid Response team is a dedicated unit of trained staff, who understand how to access social services in a particular region. For example, the Rapid Response Team has helped members access utility assistance programs, housing assistance, community support agencies, and crisis hotlines.

In the future, AmeriHealth Mercy's will integrate critical social and community support data and information into the system and develop interfaces with State, Parish and City government systems to maximize each member contact and truly make every member contact count. Indeed, when a member calls, the representative will receive a screen pop that includes all of the members' key information, care gaps, as well as health initiatives and even services offered by State, Parish and City agencies. This future integration of systems and availability of information will greatly enhance the customer experience as well as provide critical information to impact the member's health outcomes and quality of life. For example, a contact with a member would not only prompt them to choose a PCP, but might also inform them of other services and supports for which they may be eligible or to which they may avail themselves in their local community. AmeriHealth Mercy's recognizes the importance of integrating medical and social services to address all of the needs of its members. AmeriHealth Mercy's will work with DHH to develop a strategy and timeline to further define this integrated model of care.

After Hour Procedures

Our experience has shown us that having a live representative after hours is more effective than an answering service. Therefore we will go beyond the State requirements and offer a 24 hour /7 days a week/365 days a year Contact Center. Some of the benefits include:

- Providing members with better access to care and services
- Enhancing Member Satisfaction
- Enhanced coordination between behavioral health and physical health
- Enhanced coordination with Nurse 24/7 Hotline
- Fitting with our mission to help our members get care, stay well and build health communities

The same procedures utilized during normal business hours will be followed after hours. Contact Center management employees, as well as a Utilization Management nurse and physician, are available on-call to assist with any issues that may arise. The After Hours services that will be provided by AmeriHealth

Mercy's have been proven successful for AmeriHealth Mercy's other plans and will ensure members receive access to needed services quickly, which improves the overall quality of care provided.

L.2 Member Hotline

L.2 Provide member hotline telephone reports for your Medicaid or CHIP managed care contract with the largest enrollment as of January 1, 2011 for the most recent four (4) quarters, with data that show the monthly call volume, the trends for average speed of answer (where answer is defined by reaching a live voice, not an automated call system) and the monthly trends for the rate.

The chart below provides call statistics for Keystone Mercy Health Plan, the largest of AmeriHealth Mercy's plans, for the last three quarters of 2010 and the first quarter of 2011. The number of calls received trend is very consistent with our historical experience.

Understanding and managing call trends is critical to meeting the expected service levels. A basic understanding of the following results and forecasts are necessary when performing any trend analysis:

- Membership call patterns
- Membership growth strategy
- Performance metrics
- Staffing models
- Call forecasting

Operations in Louisiana will benefit from the years of experience and state-of-the-art technology deployed in AmeriHealth Mercy's Contact Center. Understanding the drivers and having a system with the flexibility to scale up or down to meet capacity is critical.

The data below shows our call center performance for our Keystone Mercy Health Plan (314,000 Member Medicaid Plan in Pennsylvania). The Average Speed of Answer goal in Pennsylvania is 30 seconds or less. As you can see, for the past four quarters we have exceeded that goal. We have exceeded performance expectations by having:

- State of the art workforce management tool Pipkins: Staffing Model, Call Forecasting
- Multiple Contact Centers to load balance calls
- Real time reporting which is used to shift resources
- Online self-services capabilities
- Individual performance goals that drive departmental performance
- Experienced Management Team

Table 1: Call Center Performance

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Total Call	35,240	30,893	28,084	25,976	28,057	25,942	25,562	30,079	24,481	27,911	26,683	31,969
ASA	0:27	0:17	0:19	0:22	0:25	0:10	0:09	0:25	0:06	0:07	0:06	0:10
Abandon Rate	2%	1%	1%	2%	2%	1%	1%	2%	1%	0%	0%	1%
Total Average Handle Time	7:39	7:08	7:40	7:48	7:59	8:07	8:04	7:30	7:15	7:05	6:59	7:12
Call Accuracy Rate	99.4%	99.3%	99.3%	99.3%	99.3%	99.3%	99.5%	99.5%	99.3%	99.3%	99.1%	98.9%

L.3 Member Services Representative Procedures

L.3 *Describe the procedures a Member Services representative will follow to respond to the following situations:*

- *A member has received a bill for payment of covered services from a network provider or out-of-network provider;*
- *A member is unable to reach her PCP after normal business hours;*
- *A Member is having difficulty scheduling an appointment for preventive care with her PCP; and*
- *A Member becomes ill while traveling outside of the GSA.*

A member has received a bill for payment of covered services from a network provider or out-of-network provider

Members should never receive a bill, however, if they do, we have specially trained representatives who specifically help members with billing issues. Providers, on occasion, will bill a member for a covered service and/or a member will agree to have a non-covered service provided. In either situation, the representative will reach out to the provider to resolve the payment issue. The most common resolution is provider education. All billing issues are tracked and trended. If a trend is identified, the Provider Network Management department is notified and they will conduct further provider education regarding appropriate billing processes.

Non-participating providers may not know where to submit a claim and participating providers may not understand which services are covered under the Medicaid Program. The representative will also outreach to the Billing Agency or the Collections Department on behalf of the member and will follow up with the member to inform them of the outcome. If the representative is not able to resolve the billing issue, the member will be instructed of their rights to file a formal complaint or grievance.

A member is unable to reach her PCP after normal business hours

Members have the option to contact the Contact Center anytime of the day and any day of the week to get assistance with accessing their PCP. The representative will immediately call the PCP to verify if there is a recorded message on the line that provides instructions for after normal business hours or an answering service responsible for calls after normal business hours. If there is no message with instructions for after business hours or answering service available, the representative will document the contact and outreach to Provider Network Management to inform them of the situation. Provider Network Management will outreach to the PCP to educate them on contractual requirements for physician coverage after normal business hours. All provider complaints are documented and reviewed.

Members with emergent medical needs are instructed to hang up and immediately dial 911 or to go to the nearest emergency room for services. Members with immediate, but not emergent, medical needs are informed to call their primary care provider for advice and are assisted with transportation arrangements, if needed. In the event of a non-emergent issue the member can also contact the Nurse Hotline for advice and symptom counseling.

A member is having difficulty scheduling an appointment for preventive care with her PCP

The representative will outreach to the PCP on behalf of the member to assist them with scheduling an appointment for preventive care with the physician. We often use three-way calling so that the representative can help advocate for the member during the call. If needed, the representative will educate the provider on the contractual requirements for preventive care appointment scheduling time frames. AmeriHealth Mercy has written policies and procedures for educating providers about appointment time requirements. The representative will send a communication to the Provider Network Management

department to follow up with the provider. If needed, the Provider Network Management Representative will work with the provider to develop a corrective action plan. Appointment standards are included in the Provider Manual and also included in the provider contract. Additional information on our processes for non-compliant providers can be found in Section G.

A member becomes ill while traveling outside of the GSA

Members with emergent medical needs are told to hang up and dial 911 immediately or to go to the nearest emergency room for services. Members with immediate, but not emergent, medical needs are referred to the Rapid Response Team for assistance for making arrangement for an out-of-area provider or to travel back to the service area. If appropriate, the Rapid Response Team will authorize services for Urgent Care (as defined by DHH).

L.4 Ensuring Culturally Competent Services

L.4 Describe how you will ensure culturally competent services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each.

AmeriHealth Mercy fully recognizes the importance of serving members in a culturally and linguistically appropriate manner. We will apply the programs and expertise of our parent company, AmeriHealth Mercy, a national leader in the delivery of culturally and linguistically appropriate services, to the Louisiana market.

AmeriHealth Mercy has developed, implemented and strengthened strategies and programs to improve services to its culturally diverse members for more than 25 years. Our commitment to the provision of culturally competent services is embedded in our core values of dignity, diversity and hospitality. These values are imbued in our employees and nurtured in our providers. Through our programs, training and tools, we will make certain that members either seeking health care services from providers or requiring information about health care services will be treated in a manner that recognizes their values, respects their worth as individuals, and protects and preserves their dignity.

Three AmeriHealth Mercy plans are among the six plans nationwide that were awarded NCQA's Multicultural Health Care (MHC) Distinction. To earn the MHC Distinction each plan had to pass a rigorous examination of NCQA standards in the following areas:

- Race/Ethnicity and Language Data Collection
- Access and Availability of Language Services
- Practitioner Network Cultural Responsiveness
- Culturally and Linguistically Appropriate Services Programs
- Reducing Health Care Disparities

AmeriHealth Mercy Core Values

Advocacy - The promotion of justice, especially for those without power

Care of the Poor - A special concern for, and collaboration with, the materially poor

Compassion - Feeling another's pain and comforting them

Competence- Maintaining the skills and wisdom to do our work with excellence

Dignity - The inherent worth of each person as gifted by the Creator

Diversity - The fostering of an environment that values understanding, acceptance and respect of individuals in their multicultural richness

Hospitality - Respect, inclusion, community-building and collaboration

Stewardship - The responsible use of resources - human, financial, and material for the greater good

All three plans received a score of 100 percent during their respective reviews.

Nationally, all AmeriHealth Mercy health plans follow the Department of Health and Human Services, Office of Minority Health, Culturally Linguistic Appropriate Services (CLAS) guidelines in the delivery of health care related services. These programs enrich the lives of our members, support the community, and give the providers vital tools in treating their patients. They do not represent an additional cost, but are successful in creating indirect savings by effectively teaching the members how to get access and how to understand their treatment regimens.

Training for Employees

All employees undergo training on Culturally and Linguistically Appropriate Services (CLAS) as part of their general orientation. The CLAS program provides an overview of what each employee is required to do to ensure members are provided services that meet their specific needs. Employees evaluate scenarios and case studies, applying CLAS principles and integrating the use of available tools, such as translation and interpreter services. In addition, we teach new hire employees how to access and use the language line and text telephone system (TTD/ TTY).

Also, to address the needs of those members who speak a language other than English, we implemented assessments to test the spoken language skills of our bilingual employees. At this time, we administer assessments for languages deemed threshold languages as determined by our member population. We will continue to assess candidates going forward as part of the hiring process to ensure competency in the spoken language required. For Louisiana, we will recruit and test for proficiency in Spanish and Vietnamese.

In addition to new hire training, all employees are required to take mandatory CLAS training annually. The goals and objectives of this training include an expanded understanding of cultural competency; a better understanding of how culture affects communication; promoting awareness of cultural values, beliefs and personal biases; an overview of the diversity of our membership; and an overview of AmeriHealth Mercy's Cultural Competency Initiative. Our clinicians receive additional cultural competence training on a regular basis.

CLAS Coordinator

Like other AmeriHealth Mercy plans, Louisiana will have a CLAS Coordinator. The CLAS Coordinator's responsibilities include:

- Adherence to Limited English Proficiency (LEP) standards that require member literature be provided in 6.9-grade reading levels in the threshold languages of the regions. (For Louisiana, those languages are English, Spanish and Vietnamese). Also included in LEP standards are Braille and Large Print documents for visual impairments.
- CLAS / LEP Training for all Member Service/Medical Management employees that interface telephonically with members on a periodic basis.
- Interaction with the HEDIS (Healthcare Effectiveness Data and Information Set) and CAHPS (Consumer Assessment of Health Care Providers and Systems) Committees to provide input on CLAS guidelines to increase Plan/Provider awareness of members' diverse cultural and communication needs.
- CLAS Best Practices Workgroup: Quarterly meeting of each Plan's CLAS Coordinator to discuss current initiatives.

Interpretation and Translation Services

AmeriHealth Mercy provides interpreter and translation services through Language Services Associates (LSA). Our employees who have direct interaction with the members use telephonic interpreters through LSA. We also arrange for and send face-to-face interpreters to provider offices on an as-needed basis to translate for members during a provider visit. We also have bilingual employees on site to handle phone calls in the member's preferred language. Bilingual employees have separate job descriptions and are

tested for proficiency in English and the target language. In 2011, all current bilingual employees were tested, with 98 percent passing. Additional training and re-testing was provided for employees who did not pass.

We use a combination of three vendors to provide translation services. Through these vendors, we are able to translate documents in over 170 languages. Documents requiring translation are sent electronically to our Integrated Document Services department, where they are forwarded to a translation vendor with instructions identifying the language in which the document is needed. The vendor completes the translation, verifying terminology, vocabulary, grammar and sentence structure. A proofreader makes a final review of the entire document to confirm that there are no grammatical or spelling errors and that the fluidity of the translation is accurate, precise, and true to the original language. The vendor ensures that the translation is completed in a culturally sensitive and linguistically appropriate manner for the target audience. The final document is returned to the IDS area for printing, mailing and imaging in our document management system.

Race, Ethnicity and Language Data

To keep abreast of the changing demographics of our membership, we conduct an annual review of the language and cultural needs of members and match it with our provider network. If gaps are identified, our provider network team works with community and national organizations to recruit the needed providers. We also review current census data and immigration statistics to monitor the immigrant/refugee population in our service area.

AmeriHealth Mercy recently updated our IT systems to better capture the cultural and linguistic needs of our members. We are able, without over-writing the state data, to capture up to five categories of race and ethnicity and written and spoken preferred language. All plans have expanded data storage capacity to over 300 distinct granular levels of Race, Ethnicity and Language groups with the capacity to roll up to the Office of Management and Budget standard categories. This gives our Customer Services teams the ability to enter member Race/Ethnicity/Language data into the system and not have it affected by the next state file we receive.

Provider Services has incorporated collection of Race/Ethnicity/Language of the provider, office staff, and language services available at the practice site into the Provider Roster Validation Process. By asking all participating providers to check the information in our system on an annual basis, we have the most current race, ethnicity and language data on our provider network. This information is used to monitor that we have enough providers available to service our members in their preferred language. We also provide this information to members as part of the provider directory, allowing them to choose providers who match their language preference.

Assisting Providers

AmeriHealth Mercy researches and publicizes free or low-cost continuing education opportunities to our provider network on CLAS issues. Our provider newsletter contains information on the demographics of the service area on an annual basis and articles that bring attention to cultural appropriateness. The language needs of members are included in the monthly panel roster mailing to the PCP network and available on the return screen when any provider checks eligibility. This ensures our providers are acutely aware of the need for an interpreter when a member arrives at their office. We hold regular seminars with participating providers' office staff which includes the importance of culturally competent care and the tools we offer to our network of providers.

Community Needs

We work with community organizations to identify the needs of culturally diverse populations in our service area. As an example, our Southeastern Pennsylvania plan partnered with Intercultural Family Services to address the needs around maternity care for the recent African immigrant population in West

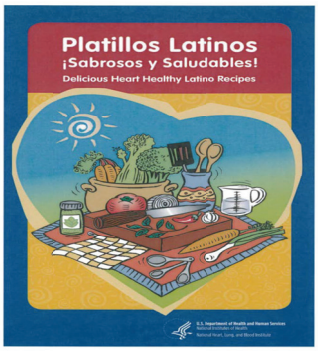
Philadelphia. Intercultural Family Services employs community workers fluent in the populations' dialects and cultural norms. Intercultural Family Services employees meet our members in their community and bring a trust to the health care encounter.

Health Care Disparities

AmeriHealth Mercy will work aggressively to identify and reduce health care disparities. We routinely analyze outcome data by race, ethnicity and language sub-populations to identify opportunities to reduce disparities. Our HEDIS and CAHPS results are examined to flesh out disparities in the communities we serve. Our Integrated Care Management employees use member health assessment tools which include direct questions about the members' culture and health to identify any barriers to care. We develop programs and initiatives to address disparate areas, involving members of the community to ensure program recognizes and addresses cultural norms.

Louisiana, we will continue our tradition of actively addressing health disparities in the communities we serve. Examples of specific programs from other AmeriHealth Mercy health plans include:

Type You: First Choice Women in Control – Created in our South Carolina plan, Type You was developed to address the disproportionate number of African-American women in that population with diabetes. A team began by examining cultural influences affecting self-management of diabetes among its African-American members. The data was used to create health education materials that addressed cultural barriers associated with diabetes self-management, as well as internal training for staff nurses who worked with Type You participants. Post assessment survey results among Type You participants indicated high levels of satisfaction with mailings and other health information tailored to their cultural background. Participants' frequency of A1C and LDL testing remains regular and consistent following Type You program completion.



Promotora Program - Our Central Pennsylvania plan faced a similar challenge around diabetes in the Latino population. They developed a Promotora Program that uses an American Diabetes Association curriculum to train provider office staff in a culturally competent approach to diabetes for Hispanics. In addition, the plan distributed Plattillos Latinos !Sobrosos y Saudables!, a heart-healthy Latino cookbook, to assist their Latino members to prepare heart-healthy versions of their favorite foods.

Healthy Hoops® – First created to address the high number of children with asthma in specific Philadelphia zip codes with a majority of African-American members, Healthy Hoops uses basketball as the base for teaching asthmatic children and their families that being healthy enough to play basketball is possible with the proper treatment and care of the child's asthma. Healthy Hoops expanded to eight cities in five states as a way to address the disproportionate share of African-American children with asthma. Additional information on our Healthy Hoops program can be found in Section F6.

National Conference on Health Disparities

AmeriHealth Mercy is also a proud sponsor and active participant in the Annual National Conference on Health Disparities and served as host of the most recent conference Nov. 10-13 in Philadelphia. The conference theme was "Reducing Health Disparities through Strengthening and Sustaining Healthy Communities."

The focus of the conference was on the non-medical determinants of health, including education levels, health literacy, poverty, public safety, community design, access to care, environmental justice and

personal, governmental and corporate responsibility. In addition to keynote speakers from the Department of Health and Human Services and Whole Life Associates, the three-day conference held a Congressional Panel Discussion on access and advocacy. Conference leaders stressed the importance of taking an active role in the community, whether it is through places of worship, the neighborhood, or an organization in order to continue to close the gap in health disparities.

Caption: Assistant Secretary for Health U.S. Department of Health and Human Services, Howard K. Koh MD, MPH delivers a keynote address at the 2010 Conference on Health Disparities

Public Affairs and Health Promotion Teams Coordination

AmeriHealth Mercy will stay connected to our members and our community through direct contact. First, we will have Member Councils. This group will include providers, members, advocates and community leaders from the diverse communities we serve. The purpose of this group is to advise our Plan of the community needs and help spread the word about the diverse programs we develop to help our members. The group will help monitor community feedback on Plan services.

Second, AmeriHealth Mercy will have a prominent position at local health fairs representing the diverse communities of the membership. At these health fairs we will promote critical health care services including pediatric asthma, mammography, cervical cancer screenings, blood glucose monitoring for diabetes, and nutrition to name a few. Health Fair/Promotion events are held at least quarterly and in some regions events are held weekly.

L.5 Ensuring Services to Members with Limited English Proficiency or Hearing Impairment

L.5 Describe how you will ensure that covered services are provided in an appropriate manner to members with Limited English proficiency and members who are hearing impaired, including the provision of interpreter services.

AmeriHealth Mercy makes every effort to accommodate our Limited English Proficient or Deaf/Hard of Hearing members. We have separate call center queues for the predominant languages in the area where

members choose their language at the beginning of the call. These call lines are staffed by bilingual employees. All bilingual employees are tested to determine their level of proficiency in both English and the target language. New bilingual employees are tested before they are hired. We recently tested all current bilingual employees with 98 percent passing. The two employees who did not pass, were removed from the bilingual phone lines.

When a member calls the Contact Center and cannot communicate in English, the representative immediately calls our provider, Language Services Associates (LSA). If the target language is readily identifiable, the representative informs the LSA. If not, the LSA works with the member in a three-way conversation to determine the language and a target language interpreter is connected to the call. Our LSA has interpreters available in over 170 languages.

For our members who are deaf or hard of hearing, we have a TTY/TTD number available, with a desk-top application for the representative to use on the call. These services are at no cost to the member. AmeriHealth Mercy has also extended our corporate rate for interpreter services to all participating providers so that they, too, can service our members in the appropriate language.

All areas of the company that have direct contact with members adhere to our policy 124.01.008-Services for Members with Limited English Proficiency (LEP), LLP and Sensory Impairments. This policy ensures that all members receive the best possible care and interaction with our plan no matter what language they speak or how they communicate in any setting whether it be requesting a new ID card or working with a care manager on a treatment plan or question.

AmeriHealth Mercy recently updated our IT systems to better capture the cultural and linguistic needs of our members. We are able, without over-writing the state data, to capture up to five categories of race and ethnicity and written and spoken preferred language. Therefore, if a representative identifies an error it is noted and is not affected with the next state file we receive.

All member materials are sent with a language tagline in all languages that the state mandates. The tagline advises the member of their right to have an interpreter or materials translated. We also provide member materials in audio format, large print and Braille. All member materials that affect a member's ability to access health care services are provided in the required language of choice for our members. This is done automatically in the languages mandated by the state and on request for any other language. We annually advise our members of their right to have any health care materials in their preferred language in the member newsletter.

The NCQA Multicultural Health Care (MHC) Distinction Program recently reviewed our CLAS procedures. AmeriHealth Mercy received the MHC Distinction and were commended for our approach to identifying and servicing these members.

Section M – Emergency Management Plan

M.1: Emergency Preparedness and Response

M.1 Describe your emergency response continuity of operations plan. Attach a copy of your plan or, at a minimum, summarize how your plan addresses the following aspects of pandemic preparedness and natural disaster recovery:

- *Employee training;*
- *Identified essential business functions and key employees within your organization necessary to carry them out;*
- *Contingency plans for covering essential business functions in the event key employees are incapacitated or the primary workplace is unavailable;*
- *Communication with staff and suppliers when normal systems are unavailable;*
- *Specifically address your plans to ensure continuity of services to providers and members; and*
- *How your plan will be tested.*

Program Overview

Throughout our experience in operating Medicaid managed care plans in other states, we have responded to hurricanes, fires, floods, snow storms and technology failures. Our practical experience through lessons learned, combined with our use of industry best practices, makes AmeriHealth Mercy uniquely equipped to respond quickly and efficiently to any disaster. The final details of our Louisiana Business Continuity and Disaster Recovery plan are being completed as we finalize our connectivity infrastructure. AmeriHealth Mercy's comprehensive Enterprise Business Continuity and Disaster Recovery plan serves as the foundation for LaCare's plan. The LaCare Contingency Plan will be submitted to DHH within thirty days of the contract being signed with DHH, if the event we are selected to serve the Louisiana Medicaid population.

The AmeriHealth Mercy Business Continuity and Disaster Recovery program enables us to quickly return to operating capacity in the event of a hurricane, natural disaster, pandemic, technology failure, fire or other catastrophic scenario. Our program combines our plans to recover systems, networks, work stations and applications in the event of a disaster (disaster recovery), with plans to expeditiously restore all operational functions (business recovery).

The goals of our program, an overview of the management team and the critical components of our program are described below.

We have designed our Business Continuity and Disaster Recovery Program to:

- Prepare employees to respond to a crisis, emergency or disaster in a safe manner
- Help control risks and exposures to members, employees and providers
- Provide methods and decision guidance for preventive measures, where appropriate
- Provide the ability to efficiently respond to a business or technology interruption to resume critical business operations and limit the operational downtime and costs
- Minimize delays and improve guidance for decision-making during an interruption/disaster
- Provide a connection between parish, state, and federal information (senders) and members, employees, and providers (receivers)
- Prepare AmeriHealth Mercy to continue to deliver critical business functions if employees are impacted due to influenza, other infectious diseases, or other disasters
- Re-integrate members and providers into the community

AmeriHealth Mercy's Business Recovery Management Team

AmeriHealth Mercy has a Business Continuity Program Management Office (BCPMO). The full focus of the BCPMO is not only to quickly respond to any types of crises that need to be managed, but also to plan for such events and to coordinate the response.

The BCPMO is led by our Business Continuity Program Manager, Danny Pellegrini, who is responsible for the Business Continuity Program that integrates emergency response, crisis management, pandemic preparedness and disaster recovery. He and his team work closely with all functional areas across the company to facilitate the development and testing of preparedness plans. Mr. Pellegrini is a Certified Business Continuity Professional (CBCP) and Member, Business Continuity Institute (MBCI). He has over 10 years of demonstrated subject matter expertise working with such national companies as SunGard and Siemens Medical Solutions. Under Mr. Pellegrini's leadership and experience, AmeriHealth Mercy has developed a state-of-the-art business continuity management program using a discipline that follows industry standards,

Mr. Pellegrini also facilitates and supports AmeriHealth Mercy's Business Recovery Management Team. The Business Recovery Management Team is responsible for making all critical decisions and directing the recovery process for all AmeriHealth Mercy affiliates and offices. The management team members will include the LaCare Executive Director, as well as the leaders from the key AmeriHealth Mercy functional areas (such as the Contact Center, claims, facilities and medical management). The Executive Director will provide guidance and advice regarding LaCare's specific Business Continuity needs. In the event that the Executive Director or other members of the Management Team are unable to participate due to the nature of the incident, our Executive Team will immediately identify and mobilize a team of personnel to establish contact with local authorities, the state and other relevant emergency contacts.

Table 1: Emergency Management Team

AmeriHealth Mercy Executive Team	
Chief Executive Officer	Chief Legal Counsel
Executive Vice President and Chief Operations Officer	Senior Vice President and Chief Human Resources Officer
Chief Financial Officer	Senior Vice President, Chief Mission Integration Officer
On Call Recovery Executive – Senior Vice President of Operational Initiatives	Chief Medical Officer
Business Recovery Management Team	
VP of Corporate Communications and Marketing	Louisiana Executive Director
Regional President	Vice President of Clinical Services
Vice President of Information Solutions	Vice President of Operations
Director of Government Relations	Director of Facilities

Business Continuity and Disaster Recovery Plan Overview

Our program combines how we will recover from a disaster with how we will restore the operational function of the organization. Our business continuity and disaster recovery planning methodology begins with categorizing types of disasters, the business severity and priority levels for each type of severity level and an assessment of the business impact analysis (BIA) of critical functions. Each of these critical elements is summarized below prior to describing how we will manage the disaster and restore operations.

Our plan for responding to a disaster begins by classifying the disasters into three categories: minor, major, and catastrophic. The disaster categories are summarized below.

Table 2: Disaster Recovery

Table 2. Disaster Categories	
Disaster Type	**Definition**
Minor Disaster Time Frame: 24 hours or less	A minor disaster is an operational disruption that generally does not require a declaration process. However, it does require incident management. A minor disaster usually involves an outage duration anticipated to be one day less. Damage due to a minor disaster is not extensive. It may consist of component failure, minor damage, or unavailability of hardware, software, or supporting electrical equipment. ▪ Partial or total loss of hardware for a period of several hours ▪ Recoverable loss of critical data; full recoverability in twenty-four hours or less ▪ Loss of an important computer application ▪ Temporary loss of services such as power or network ▪ No foreseeable impact on the covered population, providers, or employees
Major Disaster Time Frame: From 24 hours to 7 days	A major disaster is an outage that is likely to be greater than one day but not more than seven calendar days. Damage due to a major disaster may be more severe than that associated with a minor disaster and operations can be restored within seven calendar days. ▪ Damage to infrastructure and/or facility ▪ Major impact on the covered population, providers, or employees ▪ Damage to hardware resulting in downtime of more than 24 hours ▪ Loss of services (air conditioning, electrical power, etc.) ▪ Recoverable loss of critical data; full recovery taking more than 24 hours ▪ Loss of network caused by severe weather
Catastrophic Disaster Time Frame: Greater than seven days	A catastrophic disaster is one in which the outage is anticipated to be more than seven calendar days. Damage due to a catastrophic disaster is usually severe and could involve total destruction of data center facilities requiring major replacement of equipment and/or facility and/or major renovation of the data center facility. ▪ Serious damage or total destruction of the data center facilities and/or equipment ▪ Widespread impact on the covered population, providers, or employees with some loss of knowledge of their whereabouts. ▪ Loss of operations center staff due to uncontrollable factors (e.g. outbreak of epidemic disease) ▪ Major telecommunications failure ▪ Unrecoverable loss of critical data ▪ Total loss of a facility or workplace

In addition to classifying the categories of disaster, we have also defined business severity and priority levels. The Business Impact Analysis (BIA) is used to gather information and assign criticality, recovery point objectives, recovery time objectives, daily business process steps, accompanying resources, applications, tools, dependencies and manual work-around procedures. The BIA is used to identify the extent and timescale of the impact on different levels of our organization. The BIA not only assesses the current activities but also the effect of disruption on major business changes. Below is a table summarizing how we categorize business severity and priority levels.

Table 3: Business Severity and Priority Levels

Business	
Critical or Severity Level	**Four**
Priority Level	**No Business Impact**
Business Impact	Minimal to no business impact, this indicates the problem causes little impact on operations or that a reasonable circumvention to the problem has been implemented.
Critical or Severity Level	**Three**
Priority Level	**Low (Some Business Impact)**
Business Impact	A department or individual's ability to perform a job function may be impacted or inconvenienced, but can continue business as normal operations. ▪ Public transportation disruption (strike) ▪ Inclement weather storm ▪ Threat of a pandemic, epidemic ▪ Threat of a bomb scare ▪ Threat of inclement weather
Critical or Severity Level	**Two**
Priority Level	**Medium (Significant Business Impact)**
Business Impact	A department or individual's ability to perform a mission critical function is in jeopardy or unavailable but a workaround is or can be established within a reasonable time. ▪ Severe Inclement Weather (Hurricane, Nor'easter, Ice Storm) ▪ Partial loss of a facility (Structural damage) ▪ Loss of services or utilities (power, gas, water, HVAC, air and water contamination – 3 to 24 hours) ▪ Food Services Unavailable ▪ Increase in absenteeism (Pandemic, Epidemic) ▪ Disgruntled employee, workplace violence
Critical or Severity Level	**One**
Priority Level	**High (Critical Business Impact)**
Business Impact	Business processes are adversely affected resulting in a major impact in business operations. The impact of the problem causes a complete loss of service and work cannot reasonably continue. ▪ Severe Weather (State of emergency/state shut down) ▪ Total Loss of a Facility/Workplace (Fire, Flood Plains, Regional Power Outage, collapsed building, regional disaster lasting greater than 24 hours) ▪ Hazardous materials spill (Area roads shut down) ▪ Transportation Accidents (Area roads shut down, airplane crash) ▪ Employee Walkout/Loss of Internal Personnel ▪ Total Loss of Workforce (Pandemic, Epidemic, Walkout)

After we classify the types of disasters and the impact to the business, we identify the critical business functions needed to assist us in recovering from the disaster and to commence the continuation of our business.

We use an Employee Impact Analysis to evaluate all functions performed by an employee to determine their impact on the organization should they become unavailable for work. Employees with highly specialized skill sets that will immediately impact the business if unavailable are identified as Critical Associates. Those who perform a business function that will impact the business if unavailable are identified as Essential Associates.

Each quarter, every business area is required to review its Employee Impact Analysis. Additionally, the business function requirements and recovery time objectives are reviewed by each business area each year. Table 4 below shows a listing of the critical functions and employees that we utilize throughout the company, and will use in Louisiana.

Table 4: Critical and Essential Business Functions and Key Employees

Department	Business Function	Recovery Timeframe Objective (RTO)	Classification	Critical and Essential Personnel (Title Of Person Who Performs)
Medical Affairs - Care Management	Fulfilling Inbound & Outbound Calls for Episodic/SHN Case Management & Complex Care Management	0-4 business hours	Critical	▪ Care Management Director ▪ Care Manager RN/MSW ▪ Sr. Care Manager ▪ Care Management – Manager ▪ Car Manager RN/MSW ▪ Care Management - Supervisor
Medical Affairs - Utilization Management	Fulfilling Shift Care Requests	0-4 business hours	Critical	▪ Care Management - Prior Authorization Nurse
Medical Affairs - Rapid Response & Outreach Team	Case Management Tasks/Support (Fulfilling/Handling) Inbound Call Center (Fulfilling/Handling Member or Provider Calls) Outbound Call Center (Fulfilling/Handling Member or Provider Calls)	0-4 business hours	Critical	▪ Care Management – Director ▪ Care Management – Manager ▪ Care Management – Supervisor ▪ Care Connector ▪ Care Manager
Operations - Staffing and Scheduling	Provide business continuity support for crisis event	0-4 business hours	Critical	▪ Business Continuity Program Manager
	Review Prior Authorizations for Oral/Specialty/Home Infusion (Member - Provider Coverage Determination Outcomes)			▪ Medical Management - Medical Director ▪ Pharmacist ▪ Pharmacy - Director ▪ Pharmacy - Technician
Medical Affairs - Utilization Management - Appeals	Appeals - Member	8 business hours	Critical	▪ Medical Management - Medical Director

Department	Business Function	Recovery Timeframe Objective (RTO)	Classification	Critical and Essential Personnel (Title Of Person Who Performs)
Medical Affairs - Utilization Management	Concurrent/Retro Reviewer / Discharge Planning	8 business hours	Critical	▪ Medical Affairs - Social Worker ▪ Medical Affairs - Nurse
Medical Affairs - Utilization Management - Medical Loss Review	Durable Medical Equipment (DME) Request Processing	8 business hours	Critical	▪ Utilization Management - DME Supervisor ▪ Utilization Management - Supervisor
	Medical Loss Review - Ad Hoc Report Creation/Review			
	Medical Loss Review - DME Rehabilitation Equipment Review			
	Medical Loss Review - Electronic DME Claim Referral Review			
	Medical Loss Review - Electronic Implant Review			
	Medical Loss Review - Electronic Shift Care Claim Referral Review			
	Medical Loss Review - Hard Copy Claim Implant Review			
	Medical Loss Review - Present on Admission/Never Events Review			
	Medical Loss Review - Preventable Serious Adverse Events Review			
Medical Affairs - Utilization Management - Prior Authorization	Prior Authorization	8 business hours	Critical	▪ Prior Authorization – Nurse ▪ Intake Specialist – Non-Clinical
Operations - Call Centers	Fielding a Member Call and Fulfilling the Member's Inquiry	8 business hours	Critical	▪ Operations - Call Center Team Lead ▪ Operations - Call Center Supervisor ▪ Operations - Call Center Representative ▪ Operations - Call Center Manager ▪ Operations – Service Director
	Fielding a Provider and Provider Claims Services' Call and Fulfilling the Provider's Inquiry			

Department	Business Function	Recovery Timeframe Objective (RTO)	Classification	Critical and Essential Personnel (Title Of Person Who Performs)
Operations - IS Service Desk	Fulfill Service Desk Requests	8 business hours	Critical	▪ Desktop Engineering Analyst ▪ Desktop Manager ▪ Service Desk Engineer ▪ Service Desk Manager
Operations - Enrollment	Enrollment Eligibility Updates	1 business day	Critical	▪ Operations - Enrollment Manager ▪ Operations - Enrollment Specialist ▪ Operations - Enrollment Supervisor ▪ Operations - Enrollment Team Lead ▪ Operations – Service Director
	Fulfillment of Pharmacy Communications			▪
	Fulfillment of Processing Pharmacy Contracting			
	Handling Provider Phone Calls			▪ Pharmacy Auditor ▪ Pharmacy Networking & Contracting Manager ▪ Director of Networking and Contracting ▪ Pharmacy Network Communications Specialist ▪ Pharmacy Network Technician II
Operations (Ops Support) - Provider Maintenance	Invalid Provider Claim Queue Maintenance	3 business days	Critical	▪ Ops Support - Provider Maintenance Technicians
	Provide On Call Support during Check Runs			
	Provider Database Maintenance			
	Respond to Requests and Inquiries from External Customers			
	Support Directory Process			
Operations - Claims Processing	Processing a Claim	3 business days	Critical	▪ Operations - Claims Examiner ▪ Operations - Claims Processing Manager ▪ Operations - Claims

Department	Business Function	Recovery Timeframe Objective (RTO)	Classification	Critical and Essential Personnel (Title Of Person Who Performs)
				Processing Supervisor ▪ Operations - Claims Processing Team Lead ▪ Operations - Service Director
Operations (Ops Support) - Quality Auditing	Audit Member Enrollment in Health Plan	3 business days	Critical	▪ IS Solutions Delivery - Quality Analysts ▪ Ops Support - Quality Analysts
Operations - Research & Analysis	Complete Research and Analysis Projects	3 business days	Critical	▪ Operations - R&A Team Lead ▪ Operations - R&A Team Manager ▪ Operations - Research Analyst
Operations (Ops Support) - Quality Auditing	Audit Medical and Hospital Claims from Providers Monitor Live and Archived Phone Conversations	1 business week	Essential	▪ IS Solutions Delivery - Quality Analysts ▪ Ops Support - Quality Analysts
Operations (Ops Support) - Cost Containment, Robot, Subrogation, TPL	Cost Containment Robot Team (system and data analysis) Subrogation TPL (third-party liability)	1 business week	Essential	▪ Recovery – Supervisor ▪ Recovery Analyst ▪ Recovery Specialist I ▪ Recovery Specialist II ▪ Recovery Specialist III ▪ Ops Support - Quality Analyst
Operations (Ops Support) - Facets Configuration	Fulfillment of Clinical Edit Maintenance and Code Maintenance Fulfillment of Special Project(s) Fulfillment of Time to Pay (TTPs) Fulfillment of Work Request(s)	1 business week	Essential	▪ Facets Business Systems Analyst Associate ▪ Facets Configuration – Analyst ▪ Facets Systems - Analyst Lead ▪ Facets Configuration – Manager ▪ Facets Configuration – Director ▪ Facets Systems - Analyst Lead

Each business area (for example LaCare) annually reviews and updates its business continuity needs through a formal Business Impact Analysis program managed by AmeriHealth Mercy's Enterprise Business Continuity Program Management Office (BCPMO). We use the results of this review to perform a "gap analysis" that identifies potential areas of improvement for our continuity plans. The business areas will address any significant gaps and revise the continuity plans accordingly.

Disaster Management. The next important part of our Business Continuity and Disaster Recovery plan is how to manage crises or disaster. Our crisis management methodology ensures a controlled and managed response to an incident/problem or crisis event by identifying resources needed to respond to a significant incident or crisis. In addition to our general approach to disasters, we have a specific response plans for hurricane or pandemic crises outlined in this section.

Our incident management process begins with the detection of a problem as outlined in Figure 1 below. We may become aware of a problem from a variety of sources, such as a potential weather event, an event occurring in a facility, a report from an associate or a technology error. However, the root cause of the problem may originate from unexpected sources. We use a "crisis management" approach to quickly help us identify and address the root cause of the problem.

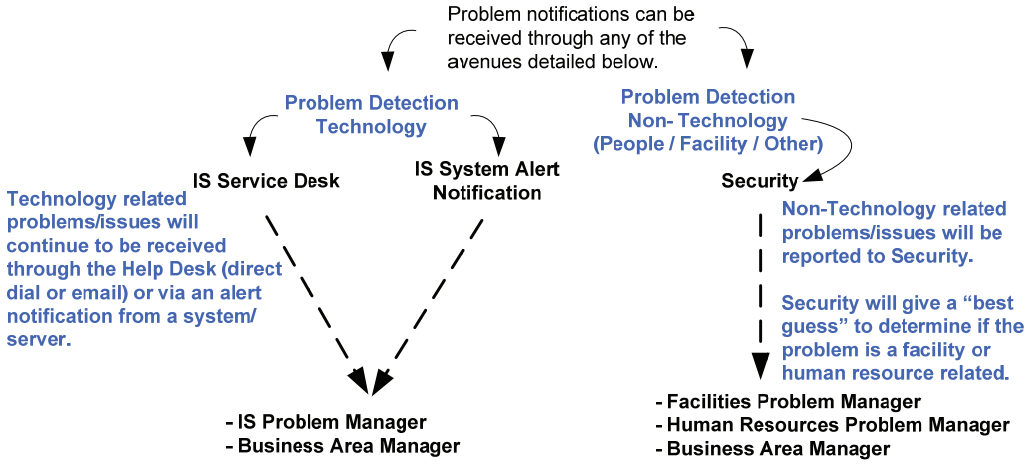


Figure 1: Problem Detection and Notification Procedure

The leader of our Business Continuity and Disaster Recovery Office facilitates an applicable subject matter expert to serve as the "Problem Manager." The Problem Manager assesses the impact of the problem and ensures that the problem is managed to resolution. For example, if the problem is technological in nature, we have predetermined who will serve as the Problem Manager. The Problem Manager adheres to our Problem Management process, which includes diagnosing the root cause of problems and critical incidents. If a problem escalates to a critical incident, the Problem Manager will escalate the incident to the designated Recovery Executive and triggers the Incident Command/Crisis Management System/Team. Figure 1 above shows our incident detection and notification system. This system is designed to quickly evaluate the problem, rank its severity, and begin the process of informing the necessary individuals and teams throughout the organization

For example, our servers must be kept in the appropriate climate controlled environment, or they will overheat. If servers overheat, significant malfunctioning may result which could significantly negatively impact our ability to process claims accurately. We have implemented many controls to mitigate the possibility of this occurring, including automatic alert messaging when temperatures exceed a certain temperature. This permits many leaders of the organization to quickly respond and mitigate any possible negative outcomes.

Figure 2 below illustrates our comprehensive crisis management methodology which integrates incident management, problem identification, and problem resolution into its process (detailed in Blue) which is designed to streamline communication (detailed in Teal) during events and accelerate business decisions. This methodology is the framework for detecting and escalating a problem, critical incident, or disaster potentially or actually impacting operations or services.

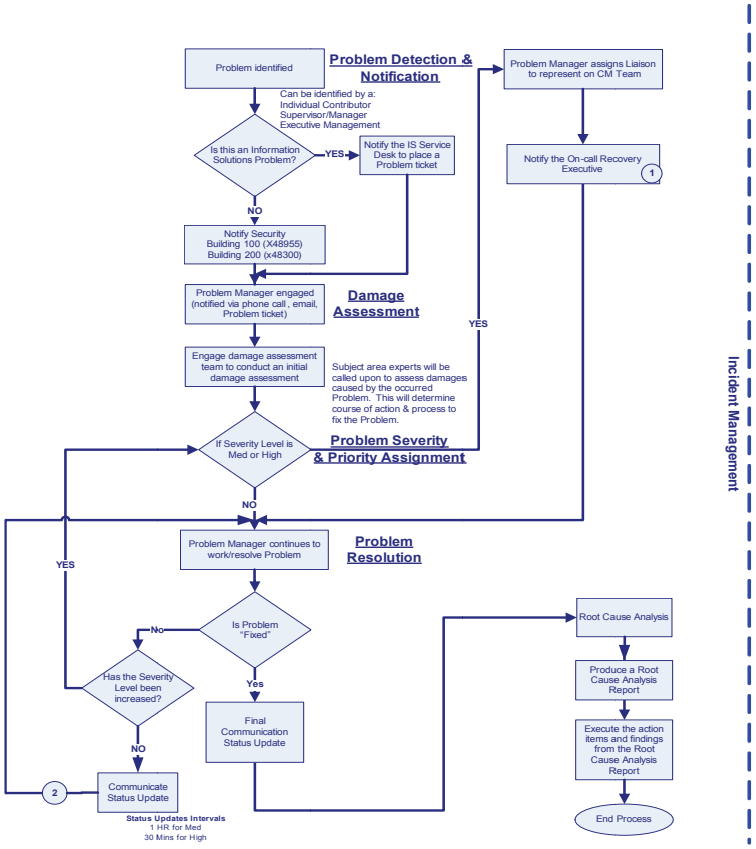


Figure 2: Problem Detection and Notification System

The diagram below demonstrates the overall crisis management process.

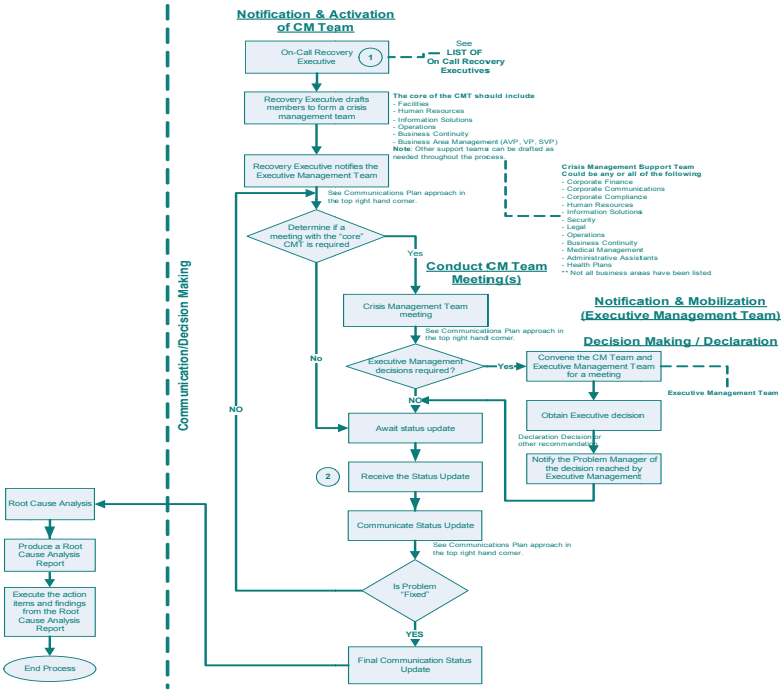


Figure 3: Incident Command/Crisis Management Process

Hurricane and Tropical Storm Plan

Our Business and Continuity and Disaster Recovery program also has a Hurricane and Tropical Storm Preparedness section. This section, unfortunately, has been implemented on a variety of occasions by our South Carolina and Florida campuses. Lessons we learned from these experiences will enable us to create a comprehensive plan for our Louisiana campus. The initial draft of our LaCare Hurricane Plan is attached, and as indicated before, we will finalize the plan after the technological infrastructure is complete. Our plan encompasses the actions and planning taken before a hurricane or tropical storm strikes to mitigate damage and injury from the storm.

Our Hurricane and Tropical Storm plans for the Louisiana campus and all of its critical functions and processes will be finalized in conjunction with the overall LaCare Business Continuity and Disaster Recovery Plan. The LaCare plan will include response and recovery strategies for our members, providers, employees, data, communications and information processing as well as the following components:

- Prioritized lists of business functions and technology services, with target recovery timeframes
- Manual work-around procedures
- Processes to receive information from parish, state, and federal sources for redistribution
- Tools to direct notification and information streams to our covered population, providers, employees, and other responders
- Guidelines for immediate response, outside party notification and damage assessment
- Procedures to activate the appropriate level of response and recovery plan, and for the management of the recovery effort
- Procedures for providing training for employees and management in the effective implementation of this plan
- Procedures for exercises and testing of response and recovery plans
- Contact information for employees, technology vendors, recovery service vendor and other critical contacts
- Alternate recovery site to continue critical operations individuals as well as centralized efforts by governments or other organizations.

We are sensitive to the impact hurricanes and national disasters have had on the State of Louisiana. Some members of AmeriHealth Mercy senior management witness first-hand the destruction and damage from hurricane Gustav to the Baton Rouge area. Members of our management team spent an afternoon helping to rebuild some houses in the St. Bernard District in Louisiana.

Figure 4: AmeriHealth Mercy employees help rebuild houses in St. Bernard

While we hope that such a disaster never occurs again, we are ready to work with the below agencies to support all of the people of Louisiana, including our Medicaid members, in the event another disaster occurs. AmeriHealth Mercy is an active community member in every community we serve and looks forward to extending our community involvement to Louisiana, if given the chance to serve. One of our community focuses will be preparing our executive staff to help the community in the event of emergencies. All of the executive staff located in Louisiana will participate in volunteer training for emergencies, with some or all of the organizations described below. We will also encourage our providers to participate in such programs.

ESAR-VHP

The Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) is a federal program created to support states and territories in establishing standardized volunteer registration programs for disasters and public health and medical emergencies.

The program, administered on the state level, verifies health professionals' identification and credentials so that they can respond more quickly when disaster strikes. By registering through ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified in advance, saving valuable time in emergency situations. LaCare will encourage all of our providers to register.
http://www.phe.gov/esarvhp/pages/default.aspx

Medical Reserve Corps

Medical Reserve Corp (MRC) units are community-based and function as a way to locally organize and utilize volunteers who want to donate their time and expertise to prepare for and respond to emergencies and promote healthy living throughout the year. MRC volunteers supplement existing emergency and public health resources.

MRC volunteers include medical and public health professionals such as physicians, nurses, pharmacists, dentists, veterinarians, and epidemiologists. Many community members—interpreters, chaplains, office workers, legal advisors, and others—can fill key support positions.

American Red Cross

According to the American Red Cross Disaster Relief website, all volunteers must participate in specific Red Cross provided training in one or more specialty areas of service, and participate in at least one annual disaster drill for the volunteer's specific unit. Additionally, volunteers may be asked to stand ready for on-site training to take on additional roles and to consider participating in non-disaster volunteer opportunities in the chapter.

Pandemic Crisis

Another important part of our Business Continuity and Disaster Recovery program involves how to address a pandemic crisis. The pandemic action plan uses five stages to monitor changes in demand for services and our capacity to meet that demand. We have identified essential business functions, critical skills and strategies to manage essential business activities up to and during the declaration of a pandemic. Each department has identified changes they will implement in their business processes to address increased demand and/or decreased capacity. LaCare will have direct access to AmeriHealth Mercy's enterprise-wide resources of trained professionals to assure the ability to respond to increased demand and decreased availability of local staff in the event of a disease outbreak. Key strategic partnerships with select vendors give us the ability to expand capacity quickly to meet the demand.

Employee Education and Awareness Training

AmeriHealth Mercy uses several methods to keep employees aware of the critical role that they play in preparing for any potential disruption or incident. Our primary methods include recovery tests, tabletop exercises, building evacuation (i.e., fire drills) and regular employee communications. Employees from key areas are included in all testing and exercises.

Recovery Tests

The first method used to assure our employees are aware of our business continuity strategies is testing responses to disaster scenarios. Our recovery tests are designed to enhance our ability to perform necessary procedures and critical business function as well as to identify opportunities to improve our plans. Successive tests are typically performed by different employees to increase the number of people who are familiar with the recovery procedures, Testing also builds organizational acceptance that the business and technology recovery strategies satisfy the organization's business requirements. Testing includes but is not limited to:

- Technical tests from primary to secondary work locations
- Application and data recovery tests
- Business process tests and execution performed by the end users

At minimum, testing is generally conducted on an annual schedule. Problems, issues and lessons learned identified during testing are rolled up into the maintenance phase and retested during the next test cycle.

Proactive Pandemic Response

During 2009, the nation was concerned about a pandemic crisis related to the H1N1 virus. AmeriHealth Mercy's Chief Medical Officer sent an email to all employees. The following is an excerpt from the email, dated September 4, 2009:

What you can do to stop the spread of germs and illness:

As the flu season approaches, please be mindful of the things you can continue to do to stop the spread of germs and illnesses. The precautions we are taking to prevent the H1N1 virus also apply to the annual Seasonal Flu. The Business Continuity Office's Web page (Pandemic Planning), which is located on inSIGHT, provides information on the Seasonal Flu as well as the H1N1 virus. This page will be updated throughout the coming weeks

Table-top Exercises

Table-top exercises are simulated scenarios designed to test the response capability of an organization to a given event. Examples of table top exercises conducted by AmeriHealth Mercy include identifying safe locations during a tornado watch. Our table-top scenarios require a coordinated response to a realistic situation that develops in real time with participants gathered to formulate responses to each development. This is a facilitated group analysis of an emergency situation in an informal, stress-free environment. The Table-top Exercise allows us to examine our operational plans, identify problems, and conduct in-depth problem solving.

Building Evacuation (Fire Drills)

Each AmeriHealth Mercy location has an evacuation plan and procedure designed for the unique requirements of their area. Our evacuation plans are evaluated regularly by the Business Continuity Program Management Office. All of our employees receive evacuation training that provides an understanding of their own responsibilities during an emergency situation. In addition, we provide each work station or office with directions of how to evacuate the building.

As has been the case in our affiliate plans, LaCare will implement an online evacuation awareness and education training course. All employees will be required to complete the online training course once each year and new employees will complete the course as part of the new hire orientation. The evacuation awareness and education training course prepares employees for a safe and efficient building evacuation with defined roles and responsibilities for employees, and visitors/vendors. Designated Floor Marshals, Floor Captains and Security team members are appointed to assist with evacuation. We also educate employees on how to assist and account for all persons with disabilities, including employees, visitors and vendors. The course concludes with a ten-question assessment of the employee's specific knowledge.

Employee Communications

We communicate regularly with our employees to keep them mindful of the actions they need to take in the event of a disaster. We distribute messages through several different outlets, as outlined below:

- **Business Continuity Program Brochure**
  We use a tri-fold brochure that explains and illustrates the program in detail to make sure that any new employees are familiar with the components of our business continuity program. We distribute the introductory brochure to new hires as part of their welcome kit.

- **iNSIGHT – (Internal employee website)**
  iNSIGHT is our Intranet website and is available to employees in all our offices who have access to our computer network.

  The BCPMO uses iNSIGHT to share information, updates and tools about the our Business Continuity Program. The site allows us to easily and efficiently share information regarding business continuity planning. Specific information such as crisis management (emergency notification, evacuation, and inclement weather), business continuity planning (planning and software tools, business recovery, and glossary terms), disaster recovery (disaster recovery test information) and pandemic awareness (flu information and inter-office communications) are also available on this site.

  iNSIGHT is routinely maintained and refreshed. New or updated information is highlighted using a recognizable graphic icon with the change date identified.

- **e-News**
  The Business Continuity Program Office uses eNews, our periodic employee email newsletter, to disseminate important information about evacuations, inclement weather, our emergency notification system information, or to create general awareness of our business continuity program. For instance, during the flu season months, employees across all AmeriHealth Mercy locations receive awareness communications about flu prevention, recommendations for proper hand sanitation and other flu-related information and awareness. When extreme weather emergencies are predicted, eNews alerts encourage employees to monitor local radio and television news programs for information on evacuation directives.

Contingency Plans

In the event a disaster affects staff, physical buildings, or other portions of the business, we have contingency plans in place that allow us to continue operations while minimizing down time. Because LaCare is part of a national organization with facilities in other states, we are able to rapidly shift operations as necessary to other affiliate locations. For instance, if a hurricane, fire or other natural disaster were to impact LaCare's Baton Rouge facility, we can quickly route incoming calls and local operations to a call centers run by an affiliate plan in another state. Because our IS infrastructure is shared throughout the organization, member services, provider services, and medical management employees in other regions can be quickly granted permission to access AmeriHealth Mercy member and provider data, making the transition seamless to the caller.

All data will be stored at an off-site location and backed up regularly. In the event of a physical disaster, AmeriHealth Mercy's data can be retrieved by other affiliate locations and used to resume operations elsewhere.

The formal Contingency Plan (Business Continuity and Disaster Recovery Plan) will be submitted within 30 days of the contract signing, and will address the specific scenarios in compliance with Section 16.11.4 of the RFP.

Communications with Staff, Members, Providers, and Suppliers

Effective and quick communication is another critical element to the success of AmeriHealth Mercy's Business Continuity and Disaster Plan, and AmeriHealth Mercy has developed the infrastructure for an effective and responsive communication plan, which is the foundation for LaCare's plan. AmeriHealth Mercy's communication plan includes representatives from all levels of the organization to make sure that everyone is on the same page and working together to quickly manage the incident. Our communication infrastructure provides a framework to:

- Receive critical community and company information and accurately decide on the scope of the event and the need to expand a response.
- Communicate and escalate the critical incident or emergency situation to the appropriate crisis management team structure and the AmeriHealth Mercy executives who are the key decision makers;
- Obtain support and assistance from other Incident Command/Crisis Management Support Teams (listed in the flow process in Figure 4).

The communication process is engaged when a problem escalates into a critical incident that significantly impacts our members, providers, and employees, business operations or technology services. For example, in the event we anticipate a hurricane approaching Louisiana, the communication infrastructure will be implemented to make sure that management teams in all AmeriHealth Mercy affiliates understand how we will respond and work together to minimize the impact to LaCare.
AmeriHealth Mercy implemented an automated tool, AlertFind (Emergency Notification System) to assist us to quickly communicate in a crisis. AlertFind quickly and automatically notifies internal crisis management team members, senior management and employees of issues that may affect our operations. AlertFind sends emails, two-way SMS (text) messages, or makes voice calls to anyone, anywhere, at any time and on any device. These notifications provide instructions, ask questions and/or collect responses. AlertFind is also used to provide updates, additional instructions or information to business continuity coordinators and employees related to business recovery.

The contact information used by the AlertFind system is collected directly from our PeopleSoft human resources application. Human resources employees enter contact information in the system whenever an associate is hired, and employees can change or update the information in the PeopleSoft system through our intranet. We periodically remind employees to update their contact information in PeopleSoft to maintain a current list. Employees receive AlertFind notifications in one of six ways:

- Incoming call on a company-supplied Blackberry
- Incoming call on an office work phone
- Incoming e-mail to Microsoft Outlook
- Text message to a company-supplied Blackberry
- Incoming call to a personal cell phone
- Incoming call to a home phone (used after hours and on weekends only)

If AlertFind is not able to make contact with the first device in the list above, or if the contact information for one of the devices listed in PeopleSoft does not exist, it automatically moves on to the next device. AlertFind continues through the list until AlertFind receives a confirmation from the associate, leaves a voice mail or an email or exhausts all device options. Associates must reply to any one of the AlertFind message to confirm receipt of the message.

For example, AmeriHealth Mercy Business Continuity and Disaster Recovery Office routinely use AlertFind during winter to address snow storms. When a snow storm is projected to occur, and we are concerned that the snow storm will create a significant hazard for our employees to travel to work, the Management Team is notified through AlertFind. Notification occurs through one of the devices listed above instructing management employees to attend a conference call the next morning, usually at 5:00 a.m. During the call, the Management Team evaluates the situation, using information on school closings,

weather reports, and how other businesses are addressing the storm. The Management Team may decide to close one campus and route services from that campus to another campus to minimize the impact to our members in the area in which the snow storm is impacted. After a decision is made, we update the companywide emergency hotline and forward emails to make sure all employees are aware of the decision.

AlertFind is supplemented by other methods of communication, such as email or the company-wide emergency hotline number. The Emergency Hotline is an available tool to provide updates, additional instructions or information for crisis management team members, senior management and employees to make sure that any new employees are familiar with the components of our business continuity program. It is a long-term tool, frequently updated, to allow for the passive dissemination of information.

In addition, to our utilization of AlertFind, we have identified new uses for existing technology and reviewed specifications for alternative technologies to provide "push" information services to members, providers and suppliers. This proactive method of delivering information to both audiences helps to keep them aware of seasonal information such as the opening of hurricane season, supplies early warnings, pandemic information, major road closures, etc., and informs them of any effect on internal business practices. This critical information distribution method will be periodically and seasonally exercised preparing for any potential disruption or incident, large or small.

Our Plan also includes an educational program for members to assure that, upon joining our plan, we provide them with information in an understandable format, using various media formats. We supply educational information on a variety of topics, such as:

- Hurricane preparedness
- Seasonal flu and pandemic flu
- Environmental emergencies
- Evacuation pathways
- Sources of information seasonally and prior to an anticipated event (H-72, H-48, H-24, etc. before a hurricane)

Through our Member Clinical Summary (discussed in Section E) and EPSDT Clinical Summary (also discussed in Section I) we provide members, physicians and emergency rooms with portable, Internet-based summaries of medications, chronic conditions, medical services and immunizations. A member forced to relocate due to a disaster, or choosing to relocate for other reasons, can access this information from any Internet browser at their new location.

LaCare and AmeriHealth Mercy websites can be used to provide information, updates, current impact, best practices, care recommendations, schedules of preventive activities (such as immunizations), and in the event of larger and longer lasting events, instructions, methods to access care, pandemic instructions, and instructions to distant providers in the care of our members.

Certain information will be pre-scripted and seasonal, such as hurricane season reminders and preparedness activities. We also will distribute materials regarding childhood immunizations, disease outbreaks, pandemic briefings, and environmental events (flu, H1N1, H5N1, West Nile Virus, etc.) that could affect the health or safety of our members, providers and employees. This will directly benefit the public health professionals of Louisiana. It also will reduce the impact of insidious disease on the members that AmeriHealth Mercy serves.

The ultimate goal of these communication programs is to assist our members, providers, and employees to appropriately and quickly respond to events that may affect their health, health care, safety, resilience, and recovery. We will partner with providers locally and remotely to ensure access to quality and safe care for our members, regardless of their location.

Plan to Ensure Continuity of Services

Maintaining a constant flow of information with all members, providers, suppliers and employees is key to managing continuity of services during an emergency. During an emergency, the state, local

parishes, and the federal government will release information that is of direct benefit to our stakeholders. We will gather and distribute this information through multiple communication vehicles, including websites, telephone, email and text messages to all groups to assure they receive timely, accurate updates and instructions.

We will provide information on encouraged prophylaxis, road closures in external emergencies, immunization recommendations, or other pertinent other topics. Following a disaster, we will also distribute information to help members reintegrate to the community of providers and to provide community safety and wellness information. We will also gather and distribute information generated by governmental entities related to wellness or the re-establishment of primary care and other covered care.

AmeriHealth Mercy will use Emergency Contracting Specialists to assure that our members – whether they are in Louisiana or out-of -state – receive needed care from providers. During a declared public health emergency, a presidentially declared emergency, and/or a Stafford Act Disaster declaration, we will closely coordinate with DHH and any other state or federal regulatory authorities to make sure all LaCare members and providers obtain necessary details. To fully support primary, urgent, and emergent care needs of our members, we will consider and use, as necessary, contracts, Memorandums of Agreement (MOA), Memorandum of Understanding (MOU) and other aggressive contracting methods with providers throughout Louisiana and in states where our members have relocated. The use of Electronic Health Records and Member Clinical Summaries will facilitate the continuity of service for our most fragile members who receive extensive services.

Our ability to rapidly resume normal business operations in support of our members is of great importance and major priority. To improve our ability to resume operations, we also plan to distribute information to our employees to help them maintain health and wellness after significant events so that they can quickly return to normal operations or alternative work sites if necessary.

As discussed earlier, under the Contingency Planning section, AmeriHealth Mercy can quickly and easily transfer operations to affiliates in other states. In the event of a disaster that affects LaCare's facility, or if a pandemic affects our workforce, we can route incoming member or provider calls, faxes and electronic communications to contact centers in other states. LaCare member and provider details will be accessible to employees in those affiliate plans, making the transition seamless to the caller. The affiliate sites can also handle claims payment and other operations activities. If appropriate, and with DHH's approval we will temporarily suspend prior authorization request or revise our system to accept nonparticipating providers.

Special Needs Populations

AmeriHealth Mercy has a particular concern for the portion of the covered population with additional functional or access needs. These needs are especially acute if these members require additional resources to participate in an organized and timely evacuation. These members may require special transportation, such as a wheelchair car, ambu-van, ambulance, or other special vehicle. This population may, based on functional and access needs, require a destination specifically capable of providing special services, such as dialysis, chemotherapy or related care. AmeriHealth Mercy will identify members who are part of a functional and access needs population and assure their needs, locations, and related information are delivered to the appropriate agency, including Emergency Support Function – 8 (ESF-8) (if an appropriately sized disaster), LA DHH, or other state or parish resources. For example, for an extended electrical outage AmeriHealth Mercy will use existing member data to identify members who utilize special equipment (Oxygen, Dialysis machines, etc.). AmeriHealth Mercy will coordinate with the appropriate Emergency Support Function and Governor's Office of Homeland Security and Emergency Preparedness (GOSHEP) personnel for assistance in evacuation as necessary.

We will also coordinate this information with DHH and other agencies. AmeriHealth Mercy is committed to successful and safe evacuations to appropriate shelters and alternate sites when required, and ensuring member care following an evacuation.

Plan Testing

AmeriHealth Mercy has developed a detailed testing strategy which includes at a minimum, an annual system test to assure full recovery of our operations at our contacted recovery facility. The overall goals for the tests are:

- Enhance AmeriHealth Mercy's ability to perform necessary procedures and critical business functions in the event of a disaster
- Identify areas of potential improvement in the plans
- Problems, issues and lessons learned which are identified during testing are rolled up into the maintenance phase and retested during the next test cycle

The Disaster Recovery Plan and Business Area Continuity Plans will be tested during our annual test to ensure the adequacy of the Business Continuity and Disaster Recovery Plans such as technical recovery procedures, recovery teams' contact information, communication, recovery of all critical system and critical vendor information (e.g., names, phone numbers, escalation process, etc.) Our annual test is a simulation of a disaster and recovery of all of our critical systems at our contracted recovery location. This ensures critical systems will be available to meet the recovery time objectives and business requirements.

In parallel with the Disaster Recovery technology recovery activities, the business recovery activities will also be tested. Some of the types of tests that will be built into the exercise are as follows:

Crisis Management Component Test

Table-top walk-through test(s) of the Crisis Management Action Plan to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- Notification test of the On-Call Recovery Executive
- Establishment of a Crisis Command Center is to determine if On-Call Recovery Executive can set up a location from which to control the crisis and recovery effort.
- Notification test of Crisis Management Team members and other support staff members as needed
- Notification test of the Business Recovery Coordinator and Disaster Recovery Coordinator
- Notification test of the Senior Executive Management Team

Business Recovery Activation Component Test

Table-top walk-through test(s) of the Business Continuity Activation Plan to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- Notification test of business continuity coordinator
- Notification test of critical employees, and/or outside vendors and services

Business Recovery Component Test

Table-top walk-through tests of the Business Area Continuity Plans to determine if team members are aware of their assigned activities, if the document is complete and accurate, and if the communication among teams is appropriate.

- A test of defined resources to support specific team tasks. (These are typically such items as manual procedures to be used only if the automated support is not available, pre-defined alternate work locations, specific procedures required to recover "work in progress" lost during the disaster, or any other measurable resource required by a recovery team).

M.2: Emergency Plan Scenarios

M.2 Describe your plan in the following Emergency Management Plan scenario for being responsive to DHH, to members who evacuate, to network providers, and to the community.

Scenario 1: You have thirty thousand (30,000) or more CCN members residing in hurricane prone parishes. All three GSAs include coastal Parishes and inland parishes subject to mandatory evacuation orders during a major hurricane. A category 5 hurricane is approaching, with landfall predicted in 72 hours and parishes within the GSA are under a mandatory evacuation order. State assisted evacuations and self-evacuations are underway. Members are evacuated to or have evacuated themselves to not only all other areas of Louisiana, but to other States.

Ensuring member care during a disaster is a critical component of any managed care program. Once AmeriHealth Mercy becomes aware of the approaching storm, the Business Continuity Program Management Office (BCPMO) will convene AmeriHealth Mercy's Emergency Response Team. A BCPMO will track the storm's path through the National Oceanic and Atmospheric Administration's (NOAA's) National Hurricane Center, providing updates to the local AmeriHealth Mercy emergency team and their counterparts in other states.

We will implement our highest priority communication plan as described in our response to Section M1, including in our communication information on the storm's strength, its track, and its estimated time of arrival. We contact the Governor's Office of Homeland Security & Emergency Preparedness (GOSHEP) and DHH to inform them of our alert status, solidify communication routes, update them on our actions and identify other ways we can assist.

Routine Preparedness Communications

On or before May 1 of each year, the Hurricane Committee will have reviewed its plan, and updated the plan as necessary. One of the critical elements is to update its list of all members with special needs each year. This list is compiled from New Member Assessments, care management plans and a claim files analyses. We will maintain a list of all members who may need help in a disaster, such as a hurricane.

In addition, LaCare will update its websites as appropriate. LaCare will also send information by multiple media and pathways to all members, providers, and employees informing them of how we monitor storms, how to prepare for a storm, and how we plan to communicate with them should there be a storm that affects their geographic area. We will also supply a listing of informational outlets that can be used to obtain hurricane-related information before and during any approaching emergency. These include, but are not limited to:

- GOSHEP
- 511LA.org
- Emergency.Louisiana.gov
- The LaCare website
- Internal LaCare phone numbers
- FEMA.gov

72 hours prior to scheduled event

Approximately 72 hours before the scheduled arrival of the storm, LaCare and AmeriHealth Mercy will activate and fully staff the LaCare Emergency Operations Center and the Enterprise Emergency Operations Center. At this point, the team begins to implement protective measures, such as data backups, and notification to employees, members and providers of evacuation plans, methods, routes, and estimated time for implementation of contra-flow traffic using information from GOSHEP.

Using existing member data, LaCare will update its list of members who have disabilities or are who have functional and access special needs. During the next 72 hours, we will attempt to contact all of these members who may need special assistance during an evacuation or hurricane and determine what we can

do to help them. We pass this information to the appropriate Emergency Support Function (ESF) #8 and GOSHEP personnel for assistance in evacuation as necessary.

48 hours prior to scheduled event

Approximately 48 hours before the storm's arrival, LaCare will distribute updated details to members, providers and employees to ensure all individuals have the most current information regarding evacuations, safety and health issues, and details on what to do following the storm.

At this time, LaCare's emergency operations staff will begin planning for emergency power activation and final data transfer to off-site locations. We will also begin providing instructions to our employees regarding our immediate needs and plans moving forward. Any non-critical staff will be evacuated. If the LaCare building is at risk from the storm, remaining personnel may be moved to an off-site operations center. The Emergency Operations Center can at any point be relocated to an off-site or out-of-state location depending on the potential impact. Throughout the process, LaCare will maintain contact with the LA DHH Emergency Operations Center and the GOSHEP Emergency Operations Center as appropriate.

LaCare will review updates on emergency procedures. We will share this information with our providers and the LaCare EOC, especially the Emergency Medical Treatment and Active Labor Act (EMTALA) and HIPAA waivers associated with the Secretary's declaration of a Public Health Emergency.

24 hours prior to scheduled event

Approximately 24 hours before the storm's scheduled arrival, AmeriHealth Mercy will distribute updated details to all remaining and non-evacuated members and providers, including current recommendations from DHH and GOSHEP. Any remaining members with disabilities or those that are part of the Functional and Access Needs populations (as identified by staff in the Emergency Operations Center) will be referred to the state and LA DHH for assisted evacuation. LaCare will brief providers through multiple media on methods to re-establish contact with LaCare staff following the Hurricane. Employees and members will be reminded to monitor local radio and television coverage for updated information and instructions.

Immediately prior to the event, AmeriHealth Mercy will make final efforts to anticipate and mitigate damage to the structure, function, and internal equipment of the LaCare facility. These efforts are further discussed in the draft of the AmeriHealth Mercy Hurricane Plan. To the best of our ability, we will maintain near constant communications with DHH and GOSHEP Emergency Operations Centers, and remind employees, members and providers to tune into their local radio and television station for up to the minute information.

The Storm arrives and passes

AmeriHealth Mercy will perform a damage assessment and determine the estimated time needed to return to full operations. We will provide DHH – and others as necessary – with our estimated time to recovery and update all available informational communication vehicles, including phone messages, emails and websites. At this point, we will officially begin the process of re-establishing contact with all members that do not self-report in accordance with the pre-event instructions. For those members who do not self-report, AmeriHealth Mercy will provide a report to other local, State and Federal agencies to assist with recovery activities. If we have an alternative phone number and/or address for a member, the Contact Center and Care Managers will attempt to contact the member. AmeriHealth Mercy will work with local community agencies to assist members with finding temporary housing, obtaining needed medications, identifying available medical specialists, food assistance, etc. In addition, we will outreach to our provider network to determine their availability to service members. This list will be used to help direct member who are seeking medical care.

AmeriHealth Mercy recognizes that providers may have some challenges in getting back into their offices and/or accessing member data. As needed, AmeriHealth Mercy will help providers in accessing our web based Provider Portal to access member, clinical and claims data.

We will also start providing damage assessments through GOSHEP to FEMA, and additional information, as needed, to ensure that we can guide members to participating providers in other areas. The Emergency Operations Center will re-staff with Contracting Specialists to assist with coordinating urgent or emergent contracts, Memorandums of Agreement (MOA), Memorandum of Understanding (MOU), or related contracting vehicles so that we are able to coordinate necessary care for our members regardless of their location. If appropriate, we will revise our system to accept and honor out of state, non-participating provider service claims for a defined period of time to ensure service continuity.

We will continue to update all available communication vehicles, including the website and phone messages. Throughout the process, our Contact Center will field telephone calls and share information with providers, members and employees. We will also share any information that would negatively affect self-repatriation with members, providers, and employees as necessary. We will coordinate alternate worksites as necessary for any required employees. We support the repatriation process in accordance with DHH and GOSHEP Emergency Operations Centers, and the Federal Emergency Management Agency (FEMA) Joint Field Office including FEMA ESF-8.

Post Incident Reporting

After each crisis, a detailed debriefing will be conducted to evaluate system readiness and execution during the crisis. The debriefing will cover how well we were able to locate and communicate to members and our provider's readiness. A complete report will be generated and used to modify the existing AmeriHealth Mercy Disaster and Business Continuity plan to prepare for future disasters. The report will be shared with DHH.

Scenario #2: Your provider call center and member call center are both located in Baton Rouge and there is a high likelihood of high winds, major damage, and power outages for 4 days or more in Baton Rouge Area (reference Hurricane Gustav impact on Baton Rouge). It is expected that repatriation of the evacuated, should damages be minimal, will not occur for 14 days. If damage is extensive, there may be limited repatriation, while other members may be indefinitely relocated to other areas in Louisiana or other states.

Because of our affiliation with a national organization that has multiple locations, AmeriHealth Mercy will be well prepared for an event that could damage its physical location. All AmeriHealth Mercy's systems data will be backed up on a regular basis and stored off site, making it accessible to locations in other states that can duplicate AmeriHealth Mercy's provider and member call center functions. By routing incoming calls to an affiliate facility, calls by local or displaced members and/or providers will be answered 24 hours a day, 7 days a week, 365 days a year by a skilled representative that can access their specific care details. For displaced providers in other states, we will pursue the appropriate CMS waiver plus state DHH involvement to ensure that members can obtain care as needed.

Because AmeriHealth Mercy's website will be hosted off-site, it will not be directly affected by a building-damaging event in Baton Rouge. Through our website, displaced members can access their Member Clinical Summary and EPSDT Clinical Summary to assist them when they seek out-of-area care.

Following the storms, AmeriHealth Mercy will perform a damage assessment to evaluate and identify potential structural, technological, and operational issues. Based on this evaluation, we will produce an estimated time to correct any issues and distribute the details to the DHH and GOSHEP Emergency Operations Centers, AmeriHealth Mercy's Enterprise Problem Management and Crisis Management personnel as well as the designated Recovery Manager.

If necessary, we will transfer activities to support the care of our members or respond to provider needs to one of our affiliate locations. If any members have self-evacuated or were evacuated from the local affected area, we will attempt to contact them to determine their location and communicate critical information. AmeriHealth Mercy will work with local community agencies to assist members with finding

temporary housing, obtaining needed medications, identifies available medical specialist, food assistance, etc.

The Emergency Operations Center will re-staff with Contracting Specialists or use resources located from one of its other campuses to assist with coordinating urgent or emergent contracts, Memorandums of Agreement (MOA), Memorandum of Understanding (MOU), or related contracting vehicles. This process ensures that we are able to coordinate necessary care for our members regardless of their location. If appropriate, we will temporarily suspend prior authorization requirement, revise our system to accept and honor out of state, non-participating service claims for a defined period of time to ensure service continuity.

We will continually update all available communication vehicles, and phone messages. Throughout the process, our Contact Center will field telephone calls and share information with providers, members and employees. We will also share any information that would negatively affect self-repatriation with members, providers, and employees as necessary. We will coordinate alternate worksites as necessary for any required employees. We support the repatriation process in accordance with DHH and GOSHEP Emergency Operations Centers, and the Federal Emergency Management Agency (FEMA) Joint Field Office including FEMA ESF-8.

Section N - Grievances and Appeals

AmeriHealth Mercy's Grievance and Appeals system will be based on a proven and rigorous process similar to those implemented previously by AmeriHealth Mercy and customized to meet Louisiana requirements. The Grievance System will quickly and successfully resolve member and provider issues. Employees handling reviews of any grievances or appeals are extensively trained, to ensure that necessary care is not hindered or interrupted as a result of the process. We will also ensure that members fully understand the process every step of the way– regardless of primary language or any other possible communications barriers. Finally, through a regular review of data, trends and other information, we will work to improve our program whenever necessary so that the process remains as timely and fair as possible for our members.

N.1: Member Grievance and Appeals Process

N.1 Provide a flowchart (marked as Chart C) and comprehensive written description of your member grievance and appeals process, including your approach for meeting the general requirements and plan to:

- *Ensure that the Grievance and Appeals System policies and procedures, and all notices will be available in the Member's primary language and that reasonable assistance will be given to Members to file a Grievance or Appeal;*
- *Ensure that individuals who make decisions on Grievances and Appeals have the appropriate expertise and were not involved in any previous level of review; and*
- *Ensure that an expedited process exists when taking the standard time could seriously jeopardize the Member's health. As part of this process, explain how you will determine when the expedited process is necessary.*

Include in the description how data resulting from the grievance system will be used to improve your operational performance.

AmeriHealth Mercy's Grievance and Appeals processes will rigorously ensure that members have access to full and fair filing processes and that they will receive ample help from employees through every step of any grievance or appeal. The Grievance System will comply with 42 CFR, Part 438, Subpart F, and all applicable state and federal laws and regulations. All policies and procedures relating to the Grievance System will be in writing, and approved by DHH. Member materials related to filing grievance and appeals with AmeriHealth Mercy will be available in members' primary languages.

AmeriHealth Mercy will also ensure that employees doing reviews of all grievance and appeals will have clinical training and extensive expertise. There will be a strict requirement that any employee involved in a grievance and appeal review will not have been involved in any adverse decision in the matter and will not be a subordinate of any person who made a prior adverse decision in the matter.

Grievance and Appeals System

The Grievance and Appeals (G&A) system will provide a full and fair process for promptly resolving members' disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. AmeriHealth Mercy will refer all members who are dissatisfied with AmeriHealth Mercy or any of its providers or subcontractors in any respect to the designated AmeriHealth Mercy G&A staff who will be authorized to review and respond to grievances and appeals. A member or their authorized representative will have at least 30 calendar days from the date on the notice of action or inaction to file a grievance or appeal. All grievances and appeals will be acknowledged in writing by AmeriHealth Mercy. Once the Appeal process is exhausted, the member will have access to the State Fair Hearing System.

AmeriHealth Mercy will maintain records of all grievances and appeals. A copy of grievances logs and records of disposition of appeals shall be retained for six years, or for a longer period if required for

matters involving litigation, claim negotiation, audit or other actions involving the applicable documents. AmeriHealth Mercy will electronically provide DHH with a monthly grievances and appeals report in accordance with the requirements outlined in the CNN-P RFP. The report will include, but not be limited to: member's name and Medicaid number; summary of grievances and appeals; date of filing; current status; resolution and resulting corrective action. AmeriHealth Mercy will be responsible for promptly forwarding any adverse decisions to DHH for further review/action upon request by DHH or the member.

The G&A process will be coordinated in AmeriHealth Mercy's Baton Rouge office. The Grievance System Manager and Member Appeals staff will report through the plan's Quality Director (Quality Management Coordinator) to the Medical Director, all of whom will be located in the Baton Rouge office. In addition, the G&A process will incorporate input from the locally-based Provider Network Management staff and Provider Claims Educator to facilitate the exchange of information between the G&A system and the provider community.

All providers and contractors will be provided the information required by 42 CFR 438.10(g)(1) about the Grievance System at the time they enter into a contract with AmeriHealth Mercy.

Definitions

AmeriHealth Mercy's G&A system will operate using the following definitions:

Appeals are requests to reverse an "action" or previous adverse decision made by AmeriHealth Mercy including:

- The denial or limited authorization of a requested service, including the type or level of service
- The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or in part, of payment for a service
- Failure to provide services in a timely manner
- Failure of AmeriHealth Mercy to act within the timeframes provided by the State of Louisiana,
- If AmeriHealth Mercy is the only CCN in a rural area, action will also include the denial of a member's right to obtain services outside the provider network

Grievances are an expression of dissatisfaction about any matter other than an action which may include, but are not limited to:

- The quality of care or services provided
- Aspects of interpersonal relationships such as rudeness of a provider or employee
- Failure to respect the member's rights

Expedited Appeals are appeals where AmeriHealth Mercy determines–based on a member's request or the provider acting on behalf of the member–that the standard resolution timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

Access to the Grievance and Appeals Process

Members may file a grievance or appeal either orally or in writing, including phone, mail or email. Network providers may act on behalf of the member's behalf with the member's written consent. AmeriHealth Mercy will maintain a toll-free number for members who want to access the G&A system. Members may use any form to submit the grievance or appeal in writing. However, AmeriHealth Mercy will also have forms they may use to file grievances, appeals, concerns or other recommendations.

Members will also be provided with numerous publications and materials that notify them of their right to file a grievance and/or appeal, and how to go about the process of seeking appeals, grievances and requests for a State Fair Hearing (when they have exhausted all levels of AmeriHealth Mercy's appeal process). The materials will also include the toll-free telephone number and business address to file appeals or grievances with AmeriHealth Mercy; how to request information about the appeal, grievance and State Fair Hearing processes; and how to inquire about the status of each process will be included.

There will also be information about the availability of employees to assist with the processes. G&A information and directions will be included on the member website and printed in the member handbook, member newsletters and in each denial notice letter. Providers will receive the same information for filing on behalf of a member on the provider website and in the provider manual.

For appeals, members may submit written comments, documents, or other information related to their appeal. AmeriHealth Mercy will provide the member a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. Additionally, AmeriHealth Mercy will provide the member and his or her representative an opportunity to review the member's case at any time during the appeals process. The member may examine the member's case file, including medical records, as well as any other documents and records considered during the appeals process.

Members may be represented by anyone they choose, including an attorney, at any level of the appeal process. Representatives, including the member's provider, can also file as long as they have written authorization of consent from the member to be involved and/or act on the member's behalf. The written authorization or consent must comply with applicable laws, contract requirements and AmeriHealth Mercy procedures.

Oral requests for appeals will be committed to writing by AmeriHealth Mercy and provided to the member and authorized member representative for signature through an acknowledgement letter. The signature may be obtained at any time during the appeal process. The process will not be delayed if the signature of the member or their representative is not received.

Information on the appeal process will also be included in AmeriHealth Mercy's Notice of Action, which is mailed to members and providers following any determination to deny or limit authorization of a requested service; reduce, suspend or terminate a previously authorized service; or deny in whole or in part payment for a service. The information included in AmeriHealth Mercy's Notice of Action will adhere to the requirements of Section 13.6 of the CCN-P RFP.

Informal Reconsiderations

AmeriHealth Mercy will offer members and/or providers appealing on behalf of the member the ability to provide additional information for an informal reconsideration of an adverse determination. The informal reconsideration will occur within one working day of the receipt of the request and will include a discussion or other communication between AmeriHealth Mercy's Medical Director and the provider rendering the service. The member or provider acting on behalf of the member will have the ability to present the additional information in person, via phone or in writing. Where possible, the AmeriHealth Mercy Medical Director who made the initial determination will conduct the informal reconsideration. If the Medical Director making the original decision is not available, a clinical peer designated by AmeriHealth Mercy will conduct the reconsideration. The informal reconsideration process will not extend the 30 day timeframe for appeal resolution.

Timeframes

AmeriHealth Mercy will adhere to the following timeframes for responding to grievances and appeals:

- **Filing-** The member will be allowed at least 30 calendar days from the date of notice on the action or inaction to file a grievance or appeal.
- **Grievances-** Standard disposition of grievances and notice to the affected parties will be done no later than 90 days from the date of receipt of the grievance.
- **Appeals-** Standard resolution of an appeal and notice to the affected parties will be done no later than 30 calendar days from the day of receipt of the appeal.
- **Expedited Appeals:** Expedited resolution of an appeal and notice to the affected parties will occur within 72 hours of AmeriHealth Mercy receiving the appeal, or as expeditiously as the member's health condition requires.

- **Extensions-** Extensions may be provided for filing of grievances, appeals, and expedited appeals up to 14 calendar days if the member requests the extension or AmeriHealth Mercy shows to the satisfaction of the DHH, upon its request, that there is need for additional information and how the delay is in the member's best interest. If AmeriHealth Mercy extends the timeframe without the member's request, AmeriHealth Mercy will provide the member with written notice of the reason for delay and the right to file a grievance if the member disagrees with that decision. In the event of an extension, AmeriHealth Mercy will carry out its determination as expeditiously as the member's health condition requires and no later than the date the extension expires.
- **Informal Resolution:** Informal resolution review will occur within one working day of the request for an informal resolution.

In the event that AmeriHealth Mercy does not make a decision within the applicable time frame, the member's request will be deemed to have been approved as of the date upon which a final determination should have been made. If the request for Expedited Appeals is denied, the standard appeal requirements will be followed, and AmeriHealth Mercy will make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

The following flowchart diagrams the Grievance System and is labeled as Chart C as requested in the RFP.

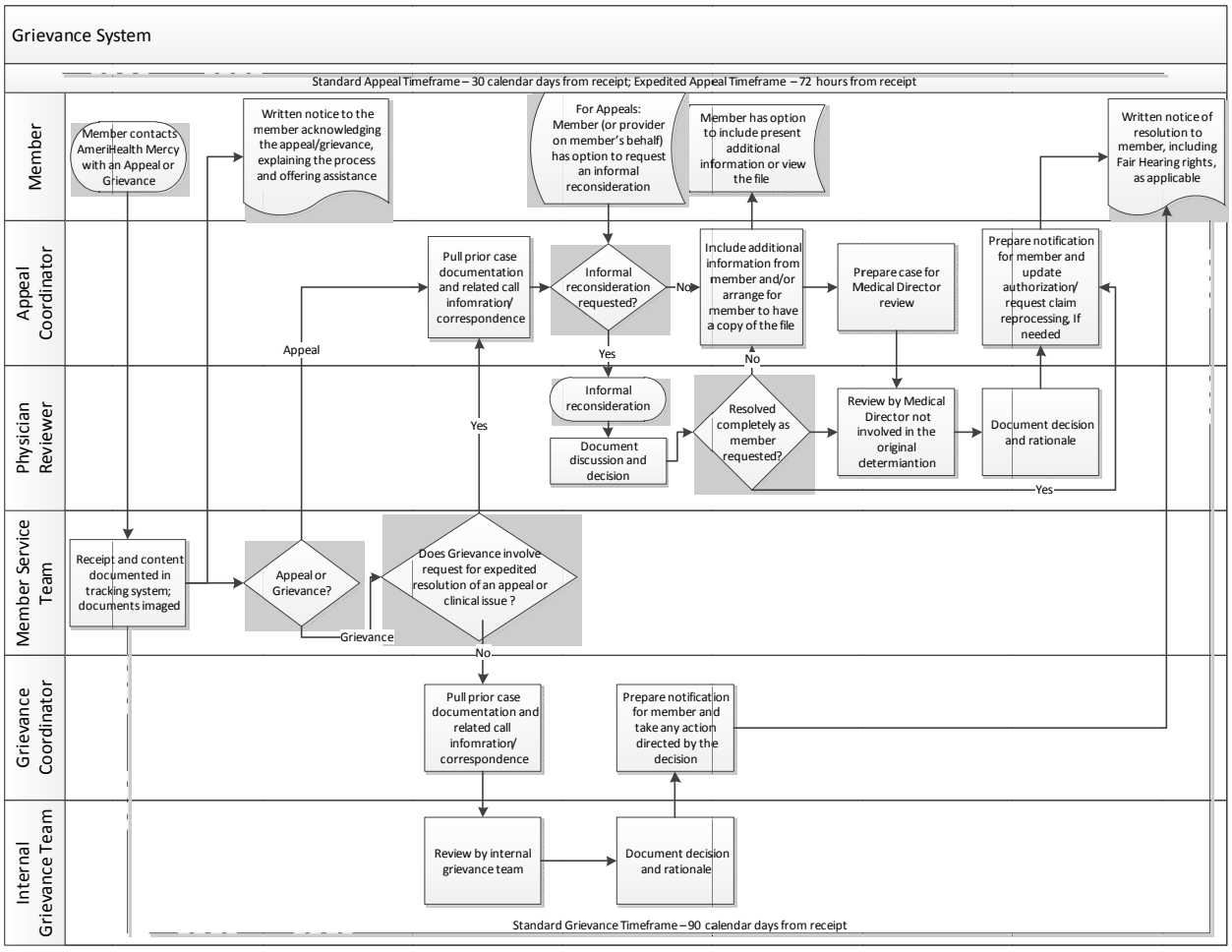


Chart C: Member Grievance and Appeals Process

Written Notice

AmeriHealth Mercy will provide written notice of disposition for all appeals, which will include:

- The results of the resolution process and the date it was completed
- For appeals not resolved wholly in favor of the member:
  - The right to request a State Fair Hearing and how to do so
  - The right to request to receive benefits while the hearing is pending and how to make that request
  - Notify the member they may be held liable for the cost of those benefits if the hearing decision upholds AmeriHealth Mercy's action

If the AmeriHealth Mercy reverses its initial decision to deny, limit or delay services that were not furnished while the appeal was pending, AmeriHealth Mercy will expeditiously authorize or approve the denied services.

Continuation of Benefits During an Appeal

AmeriHealth Mercy will continue the member's benefits during the appeals process if:

- The member or the provider acting on behalf of the member with the member's written consent, files the appeal in a timely manner, as defined by DHH
- The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment
- The services were ordered by an authorized provider
- The original period covered by the original authorization has not expired
- The member requests the extension of benefits

If AmeriHealth Mercy, at the member's request, continues or reinstates the member's benefits while the appeal is pending, the benefits will be continued until one of the following occurs:

- The member withdraws the appeal
- Ten days pass after AmeriHealth Mercy mails the notice providing the resolution of the appeal against the member, unless the member requests a State Fair Hearing with continuation of benefits within the 10-day timeframe
- A State Fair Hearing Officer issues a hearing decision adverse to the member
- The time period or service limits of a previously authorized service has been met

State Fair Hearings

If the member has exhausted the AmeriHealth Mercy level appeal procedures, the member may request a State Fair Hearing within 30 days from the date of AmeriHealth Mercy's notice of resolution. Parties to the State Fair Hearing include AmeriHealth Mercy as well as the member, their representative or the representative of a deceased member's estate. If the State Hearing officer reverses a decision to deny, limit or delay services that were not furnished while the appeal was pending, AmeriHealth Mercy will expeditiously authorize or approve the denied services.

Eliminating Language Barriers

AmeriHealth Mercy will help members file their grievances and appeals, and if they have language issues, AmeriHealth Mercy will provide foreign language interpreter services at no cost.

Translated materials in the member's preferred language will be offered to members who are identified as having Limited English Proficiency. AmeriHealth Mercy will also provide services and materials translated in alternative mediums to members with low literacy proficiency, and/or sensory impairments.

Grievances and appeals from individuals with disabilities will also be accepted by AmeriHealth Mercy in alternative formats, including TTY (teletypewriter)/TDD (telecommunication device for the deaf) for telephone inquiries and appeals and grievances from members who are hearing impaired, Braille, audio tape, computer disk and other commonly accepted alternative forms of communication.

AmeriHealth Mercy will proactively attempt to identify any speech limitations or disabilities of the requesting member from the information stored in the electronic member file and gathered from state eligibility data, prior disclosure by the member, or the documented historical use of TTY/TDD features in order to anticipate the special needs of any member accessing the G&A system.

To promote understanding of written materials, AmeriHealth Mercy maintains information on the member's preferred language as part of our member demographic data set. For members where a language other than English is identified as the preferred language, written notices and materials related to the grievance and appeal process will be translated into the member's preferred language. AmeriHealth Mercy will also provide services and materials translated in alternative mediums for members with sensory impairments. A system flag will alert the AmeriHealth Mercy appeal coordinator that translation or an alternate medium is needed. Based on the flag, the AmeriHealth Mercy system automatically creates a workflow record requesting the translation and setting a reminder for the coordinator to verify that translation was received and sent.

Appropriate Expertise and Impartiality

AmeriHealth Mercy employees performing G&A reviews will be required to undergo rigorous orientation and clinical training and have extensive expertise so they can make informed and impartial determinations. Each employee will also be required to perform responsibilities consistent with his/her training, education, licensure, certification and State Practice Act.

Continuing on-site training of employees will be centered on maintaining proficiency in the core components of their job performance and maintaining knowledge of current clinical knowledge and practice; technologies; software systems and applications; legislation; accreditation requirements; and licensing and certification requirements. The employees will also be required to meet continuing education requirements to maintain their licensing and credentials.

In-services will be offered to employees at least once a month and in-service records will be reviewed quarterly as part of the employee's developmental plan and as needed by administration.

AmeriHealth Mercy's G&A policies and processes require that, for both grievances and appeals, an employee be appointed who was not involved in the prior adverse decision and is not a subordinate of the person who made the prior adverse decision. As with initial utilization management decisions involving medical necessity or clinical issues, a physician or other appropriate clinical peer must evaluate medical necessity decisions for adverse appeal decisions. For appeals involving specialty care, input to the appeal determination will be obtained from a clinician in the same or similar specialty as the care being requested.

AmeriHealth Mercy's information system records the name of the Medical Director making an adverse determination. The Grievance System Manager uses the information associated with the initial determination to ensure that someone conducts the appeal review who was not involved in the original determination or is not a subordinate to the original decision maker. Compliance with this process element is evaluated during internal appeal audits.

Expedited Process

The member and/or provider acting on behalf of the member can request an expedited appeal review if they believe the member's life, health or ability to attain, maintain or regain maximum function would be in jeopardy by following the standard process.

Expedited appeal reviews may be requested verbally or in writing by the member or member's representative. Additionally, expedited appeals can be requested verbally or in writing by the provider, acting on behalf of the member and with the member's written consent. No additional member follow-up is required. If the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's

life or health or ability to attain, maintain, or regain maximum function, the request will automatically be handled as an expedited review. The member or their representative will be allowed to present evidence for and allegations of fact or law in person as well as in writing for expedited appeals as well. However, AmeriHealth Mercy will inform them of the limited time available for doing so in the case of expedited reviews.

AmeriHealth Mercy will complete all expedited appeals as expeditiously as the member's health condition requires but not more than 72 hours after the request. AmeriHealth Mercy will provide an initial oral decision for expedited requests within 72 hours and a written notification no later than three calendar days after the initial oral notification.

Improving Performance Through Data Gathering

AmeriHealth Mercy routinely reviews data to evaluate trends of the grievances and appeals processes, as part of its Quality Assurance and Performance Improvement process. Compliance with policy and regulatory and accreditation requirements will also be monitored through internal reports and case file reviews.

Once grievance and appeals data is gathered, recommendations for improvements in operational performance will be made to the Quality Committee as part of the Quality Management Program Evaluation. The committees 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.

The information we receive assist us improving our performance. For example, in our Indiana plan we identified that we were over-ruling denials for certain lab claims. After researching further, the Indiana plan changed some of its clinical edits to assure that the lab claims would be approved.

The second example involved the appeals of shift care for nursing and home health aide services. An analysis of the process revealed that it was necessary to develop a "Shift Care Grid" that clearly displayed what was requested, approved, denied and appealed. Since instituting the grid, an improvement in the quality of outcomes has been experienced. In addition, the G&A team made a recommendation to allow flexible hours so parents or guardians would have the ability to use shift care hours when needed. The institution of flexible hours also gave parents and guardians the ability to decide when to use shift care hours to best suit their needs. It also decreased errors and misunderstandings around the decision outcome letter.

Another example that we have used to improve operational performance relates to pharmacy appeals. In this particular case, the health plan managed pharmacy services. Pharmacy appeals trend data was gathered and it was discovered that most of the appeals were for maintenance medication. The decision was made to approve maintenance medication for 12 months, which resulted in a decrease in pharmacy appeals being the most appealed category to being the third most frequently appealed. Finally, the last example of improved operational performance involved dental appeals. Rather than outsourcing dental in this particular case, our Medicaid health plan managed dental services through a subcontractor. The dental molds required to process the appeals were not being received in a timely manner. A meeting with our dental provider was arranged and it was decided that high quality X-rays and photographs could be used instead, which was consistent with regional practice. The elimination in the delay resulted in a better performing appeals process.

Summary

In summation, AmeriHealth Mercy's G&A System will make it easily accessible to all members regardless of primary language or any other possible barriers. Members filing grievances and appeals will receive all available assistance from AmeriHealth Mercy employees, and those employees who make decisions on the matters will not have any involvement in any previous adverse decision. Expedited reviews will be completed as expeditiously as the member's health condition requires but not more than

72 hours after the request. Finally, AmeriHealth Mercy will gather data on trends throughout all grievances and appeals processes available to members and will use that data to evaluate timeliness and trends, identify root causes, recommend actions, assign accountability for implementation of recommendations, and ensure follow through on approved changes.

Section O – Fraud and Abuse

O.1: Program Integrity

O.1 Describe your approach for meeting the program integrity requirements including a compliance plan for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services. Discuss your approach for meeting the coordination with DHH and other agencies requirement.

AmeriHealth Mercy program integrity efforts are an important part of AmeriHealth Mercy's overall Corporate Compliance Program. All employees are mandated to follow AmeriHealth Mercy's Corporate Compliance Program. The program requires employees to comply with all relevant state and federal laws and regulations and appropriately report any concerns about business and operational practices. For example, each employee must annually complete AmeriHealth Mercy's Code of Ethics and Conduct training program and a conflict of interest disclosure form as a condition of continued employment.

In addition to focusing on compliance from employees, AmeriHealth Mercy's comprehensive compliance program is designed to prevent, detect and investigate fraud, waste and abuse (FWA) by providers and members. The program is developed in accordance with 42 CFR 438.608, 42 CFR 438.610 and Section 15.0 of the Louisiana CCN-P RFP, and meets the requirements outlined in Appendix EE – Coordination of CCN Fraud and Abuse Complaints and Referrals, and all relevant state and federal laws, regulations, policies, procedures and guidance (including CMS Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks).

Organization

AmeriHealth Mercy will employ a Compliance Director in the Baton Rouge office, who will serve as the local Compliance Officer and local Contract Compliance Officer. The Compliance Director will also oversee the Louisiana Compliance Committee. The Compliance Committee will meet on a regular basis to review compliance activities, including FWA, implement changes needed to strengthen the compliance program. The Louisiana based Compliance Director will serve as liaison to AmeriHealth Mercy's Program Integrity Unit (PIU).

As the local compliance officer, the Compliance Director will have the responsibility and authority for carrying out the provisions of the Louisiana compliance program and will report to the Executive Director with a dotted line reporting relationship to the AmeriHealth Mercy Chief Compliance and Privacy Officer. On behalf of AmeriHealth Mercy, he or she will also cooperate and assist the state and any federal agency charged with the duty of identifying, investigating or prosecuting suspected FWA by making required books and records available, permitting on-site reviews, and cooperating fully for required interviews, consultations and proceedings.

The Louisiana based Compliance Director will be supported by AmeriHealth Mercy's PIU and the Corporate Compliance Program which are managed from our corporate offices in Philadelphia, PA.

Program Integrity Unit

AmeriHealth Mercy's Program Integrity Unit (PIU), internally known as Corporate and Financial Investigations (CFI), was formed in 1996 with a focus on Medicaid FWA. The PIU establishes, controls, evaluates and revises FWA detection, deterrent and prevention procedures to ensure their compliance with federal and state requirements. The PIU reports to AmeriHealth Mercy's Chief Financial Officer. The PIU includes a professional team of investigators and analysts that have FWA investigational, clinical and analytical backgrounds and training. The team currently consists of 12 full-time employees. The PIU team includes members of the National Health Care Anti-Fraud Association, American Academy of Professional Coders, Association of Certified Fraud Examiners, and the International

Association of Special Investigations Units. The PIU also works with vendors that provide medical record reviews, investigative reviews, and facility and professional audits.

Corporate Compliance Support

The AmeriHealth Mercy Chief Compliance and Privacy Officer reports directly to AmeriHealth Mercy's General Counsel, and answers directly to AmeriHealth Mercy's Chief Executive Officer and the Board's Audit Committee. AmeriHealth Mercy's Chief Executive Officer, Michael Rashid, chairs the Corporate Compliance Committee The Corporate Compliance Committee consists of the Chief Executive Officer, Executive Vice President, General Counsel, Chief Financial Officer, Chief Marketing Officer, Senior Vice President of Mission and Values, and Senior Vice President of Operations. The Committee meets on a regular basis, and reviews compliance activity, including FWA, and other trends and specific areas in which AmeriHealth Mercy needs to strengthen its compliance program.

The Chief Compliance and Privacy Officer will report on behalf of the Louisiana based Compliance Director to the Corporate Compliance Committee.

Compliance Plan for Detection of Fraud, Waste and Abuse

AmeriHealth Mercy's Fraud, Waste and Abuse Compliance Plan (FWA Plan) will address prevention, detection, action and notification activities in support of AmeriHealth Mercy compliance policies and DHH requirements. The Louisiana Compliance Director will submit the Louisiana FWA Plan to DHH within 30 days from the date that the contract is signed. A summary of the proposed FWA Plan is provided below.

Prevention

Written policies and procedures will clearly specify how processes are completed, as well as the requirement for all employees to comply with all applicable federal and state laws.

Well publicized disciplinary procedures will apply to all employees. AmeriHealth Mercy has, and will continue, to communicate to employees its zero tolerance of employees violating any law, including failing to report violations. As indicated in Section V. of our Code of Ethics and Conduct,

> "Employees who violate the Code, including failing to report violations, will be subject to disciplinary action, up to and including termination of employment. The company may also have an obligation to contact the appropriate law enforcement authorities, since certain violations may be a violation of federal or state laws."

AmeriHealth Mercy has terminated employees in the past for violations of laws, and commits to continue to do so in the future, as appropriate.

FWA education and training programs for the Compliance Director, managers, employees, providers and members are an integral part of the plan. Training on FWA occurs for all employees as part of their new hire orientation and periodically thereafter, as part of our ongoing compliance training efforts. Annually, each employee is required to participate in False Claim Act training that alerts employees to prohibited activities and to protections provided by the False Claim Act. False Claim Act training is conducted in conjunction with annual Code of Ethics and Conduct training using Kaplan EduNeering's Knowledge Wire training software.

Knowledge Wire tracks the completion status for each employee. In the event that an employee does not pass the test, the employee must continue reviewing the material and retesting until he or she passes. In addition, if employees do not take the test within the time allocated, the employees' supervisors are notified. The supervisor is responsible to ensure compliance with required training. This process assists us to assure that all employees are properly trained.

In addition, Corporate Compliance hosts Brown Bag Lunch Sessions quarterly via video-conference. These one-hour sessions are designed to raise the awareness of and provide education to our employees

on a wide range of compliance and/or Code of Ethics and Conduct topics so that each employee is better equipped to "Do the Right Thing in the Right Way." FWA awareness is addressed in these sessions.

AmeriHealth Mercy routinely educates providers on awareness and prevention of fraud and abuse through newsletters, workshops, the Provider Manual, and its website. Similarly, AmeriHealth Mercy educates members on awareness and prevention of fraud and abuse through member newsletters, the Member Handbook, and the member website.

The plan also requires subcontractors to assure they are in compliance with all applicable laws and regulations, including those relating to compliance and program integrity.

Detection

Ongoing monitoring and auditing of AmeriHealth Mercy systems occurs at various levels of the organization including department Quality Assurance processes, internal auditing processes and oversight of operational processes. The Corporate Audit and Corporate Compliance departments review monitoring and auditing efforts on a routine basis.

The PIU routinely monitors all systems through data analysis to identify possible FWA involving members or providers. While the Compliance Director and PIU will lead the monitoring and auditing processes, several other departments contribute to FWA monitoring and auditing by forwarding information to the PIU. For example, the Quality Management, Medical Management, Informatics, Claims, Internal Audit, and Customer Services departments all forward information on potential issues to the PIU. Through all of these efforts, PIU's ongoing monitoring and auditing processes identified over $4.5 million in financial recoveries last year.

Mechanisms to detect fraud and abuse include:

- Periodic evaluation of claim data to detect apparent abnormalities in provider billing or member utilization patterns
- Periodic sampling of bills/claims to determine propriety of payments
- Sampling of services through member contact to ascertain that billed services were rendered
- Requirement that providers and subcontractors agree to adhere to program standards regarding FWA as a condition of contracting
- Dissemination of information to members and providers concerning FWA

PIU FWA detection efforts are also supported by industry-leading clinical editing during prepayment claim processing procedures. Our prepayment correct-coding edits have led to claim cost avoidance that supports reduction of FWA for a savings of more than two percent of payments when fully operational. For post-payment efforts, the anti-fraud software package provides analytics, case tracking and data manipulation and visualization tools, as well as ad hoc and scheduled analyses.

PIU also uses an internal data warehouse to identify patterns that may be indicative of FWA. The tools used to identify potential FWA include:

- Over-utilization analysis
- Up-coding
- High-dollar claim reviews
- Unusual patterns by members, providers or facilities
- Unusual dates of service
- Excessive time units for time-based codes
- Unusual claim volume by providers or members
- Unbundling services
- Incorrect reimbursement to providers, members, facilities and/or pharmacies
- Incongruous procedure code, prescription and diagnostic code combinations

As it has done in with its health plan in Kentucky, AmeriHealth Mercy will implement a methodology to verify reimbursement is made only for services actually delivered. This DHH requirement is similar to a provision required by the Commonwealth of Kentucky's Medicaid PIU. We proposed to accomplish this verification through routine audits and questions submitted to members when they call.

A pediatrician was billing for infants' sleep monitoring that were never performed. AmeriHealth Mercy worked with the state Medicaid agency. The pediatrician paid $2.5 million in restitution to the state and $400,000 to the plan.

AmeriHealth Mercy will also make sure that all providers maintain an individual medical record for each member and assure that the record contains all of the elements required in Section 15.6 of the RFP. While we will certainly contractually require all providers to adhere to this provision, we will also conduct a random audit of the provider's record. This DHH requirement is similar to the requirement by the State of Indiana. In Indiana, we audit medical records on an annual basis. When we determine that providers are not complying with this request, our Provider Network Management Representatives work with the provider to assure compliance in subsequent audits.

One free copy will be provided to a member of his or her medical record, at the member's request. Documentation will be maintained consistent with DHH requirements, including Section 15.6.4.

Confidential Reporting is available to all employees, members and providers. Several independent paths for reporting FWA are available. One of the paths is through the Compliance Hotline, a telephone line to be used solely for the purpose of receiving reports of suspected improper/illegal activities or misconduct on a confidential basis. While individuals are able to communicate anonymously, employees are encouraged to leave their name so that follow-up is possible. If any employee does identify himself/herself, AmeriHealth Mercy will make every effort to keep the caller's identity confidential.

AmeriHealth Mercy also maintains a toll-free Fraud Hotline for internal and external use. The Fraud Hotline number is promoted to vendors, providers and members through newsletters, handbooks, websites, and contracts. The Fraud Hotline is intended to be dedicated to fraud tips, concentrating on member and provider fraud; however, both Hotlines may be used to report infractions of the Code of Ethics and Conduct or fraud and abuse concerns. Corporate Compliance and PIU coordinate closely on Hotline calls.

In addition to the Hotline, AmeriHealth Mercy has a "Fraud Investigation Tip Form" and a Corporate Compliance intake form on our intranet that permits employees to submit concerns related to fraud and abuse. The Louisiana based Compliance Officer will provide quarterly activity reports on the number calls, Tip Form submissions, and the nature of reported compliance issues to DHH.

Internal monitoring and auditing of reported fraud, abuse and waste in accordance with 42 CFR 438.608(b)(4-6) are part of the FWA Plan and PIU and Corporate Compliance processes.

No employee will be retaliated against for reporting compliance plan violations or suspected fraud. This policy is communicated to employees through the AmeriHealth Mercy Code of Ethics and Conduct. Sections E and K of the Code state that AmeriHealth Mercy "will not tolerate acts of retaliation against anyone who makes a good faith report of known or suspected ethical or legal misconduct" and "[w]histleblowers who report false claims to the government or cooperate in investigations are entitled to protection from retaliation." AmeriHealth Mercy has terminated employees who engaged in retaliatory behaviors.

Employee, Provider and Vendor Selection

AmeriHealth Mercy routinely takes steps to assure compliance with 42 CFR 438.610 and other relevant state and federal laws, regulations, policies, procedures, and guidance (including CMS Guidelines for Constructing a Compliance Program for Medicaid Managed Care Organizations and Prepaid Networks).

None of the AmeriHealth Mercy plans employ individuals or contract with individuals who are debarred, suspended or otherwise excluded from participating in procurement activities.

Upon hire, and annually thereafter, employees, agents and independent contractors are required to complete a Code of Ethics and Conduct Certification form. Among the questions asked on that form are:

1. Have you been convicted of a crime within the past 12 months which involved bribery, payment of illegal gratuities, fraud, perjury, false statements, racketeering, blackmail, extortion, falsification or destruction of records, theft, or embezzlement (a conviction includes a plea of guilty, nolo contendere, or a finding of guilt by a judge or a jury), and
2. Have you been convicted of a crime punishable by exclusion from Medicaid/Medicare, received a civil fine or penalty for activities related to Medicaid/Medicare, or been excluded from participation in Medicaid/Medicare programs (a conviction includes a judgment of conviction regardless of whether an appeal is pending or the record has been expunged, a plea of guilty or nolo contendere, a finding of guilt, or participation in a first offender, deferred adjudication or other program where judgment of conviction has been withheld)?

If an individual or entity answers "yes" to either one of these questions, then the individual or entity is, as applicable, disqualified from employment or conducting business with AmeriHealth Mercy. If a conviction, as described above, occurs after hire or work has commenced, AmeriHealth Mercy's relationship with that individual or entity is terminated upon our becoming aware of such conviction.

Additionally, AmeriHealth Mercy's contracts with providers require prompt notification to AmeriHealth Mercy if the provider is debarred or suspended from participation in Medicaid/Medicare. Such contracts also contain provisions that require prompt notification to AmeriHealth Mercy of any felony convictions or other changes in status that materially affect the provider's ability to perform under the contract. Upon receipt of such notification, as appropriate, AmeriHealth Mercy terminates its contractual relationship with the provider. Compliance is also assured through the credentialing and recredentialing process.

AmeriHealth Mercy, through its recently enhanced sourcing process, identifies whether its vendors (including subcontractors and independent contractors), have been debarred or suspended from participation in Medicaid/Medicare, or have ever been convicted of a felony and/or Medicaid or health care related offenses. Additionally, the vendor contracts used in the sourcing process contain a representation to the effect that the vendor has not been debarred or suspended from participation in Medicaid/Medicare or convicted of a felony or healthcare-related criminal offense; the contracts further require prompt notification to AmeriHealth Mercy if the vendor is debarred or suspended from participation in Medicaid/Medicare, or if the vendor is the subject of any felony convictions or other changes in status that materially affect the vendor's ability to perform under the contract.

AmeriHealth Mercy will conduct monthly monitoring of key websites, such as http://exclusions.oig.hhs.gov/search.aspx; http://www.ngdb-hipodb.hrsa.gov/index.jsp; and www.EPLS.gov. In the event that exclusions are discovered during the research of these websites, the Compliance Director will notify DHH according to the required timeframes.

Action and Notification

Prompt responses are key to our success. In the event that PIU identifies a possible case, or a department within the plan discovers or is made aware of an incident of possible member or provider FWA, the incident is immediately reported to the PIU. All incoming referrals are recorded in the PIU case tracking tool. Within one business day of receipt, an investigator commences an investigation to obtain the necessary data for making a determination as to whether there is likelihood that there is FWA. The PIU notifies the internal departments that are likely to be impacted by the investigation of the provider's or member's status, and of any special instructions relating to utilization by the provider or member.

The Compliance Director will assure that all suspected fraud, abuse, waste and neglect information is promptly reported to the Medicaid Fraud Control Unit (MFCU) and DHH within five (5) business days of

discovery. AmeriHealth Mercy will also assure that DHH is notified within three (3) business days of any actions taken against an employee, a provider, or contractor employee.

AmeriHealth Mercy will provide all required reports to DHH in a timely manner, including the quarterly report. The quarterly report will be in the format requested by DHH and will include, at a minimum, the provisions set out in Section 15.5.2 of the Louisiana CCN-P RFP.

Coordination with DHH

The Louisiana based Compliance Director will meet with DHH and MFCU periodically, and ensure that DHH and MCFU are aware of suspected fraud within the required timelines and to discuss FWA issues. The Compliance Director and the PIU will work closely with the DHH, MFCU, State's Auditor's Office, Office of the Attorney General, General Accounting Office, Comptroller General, and/or any of the designees above, as often as necessary during the contract term, and for a period of six years after the contract ends.

We recommend that we meet monthly for at least the first six months of the agreement to establish protocols and necessary reports. After such time as the parties believe the protocols are working effectively, the meetings can occur on a quarterly basis.

Ongoing Improvement

hms In keeping with our dedication to continuous improvement of our FWA detection abilities, AmeriHealth Mercy is in discussions with Health Management Systems (HMS) to determine how HMS may be able to augment AmeriHealth Mercy's FWA activities for its member health plans, including Louisiana. A national leader in cost containment solutions for government-funded programs, HMS has a strong track record of FWA identification and intervention.

HMS's subsidiary, IntegriGuard, recently won the Investigation of the Year Award from the National Health Care Anti-Fraud Association for its work in the following case:

- Dr. Stephen Schneider and his wife Linda were operating a pain management clinic outside of Wichita, and were found guilty in June of healthcare fraud resulting in death, conspiracy, money laundering, and illegally prescribing narcotics. Each was sentenced to 30 years in prison. Over an 8 year period, investigators found the Schneiders had dispensed potent and addictive medications to hundreds of patients. Many of these patients were later determined to be addicts, who had not exhibited symptoms of pain, and who received little monitoring or follow up. This pill mill resulted in over 100 drug overdoses and 68 deaths.

This case was brought to closure by a collection of agencies working in collaboration for the benefit of the Medicaid and Medicare programs. Together, they detected patterns of fraud and abuse, conducted medical reviews, and pooled their resources to ensure the investigation was airtight.

Section P – Third Party Liability

AmeriHealth Mercy has over 25 years of experience in cost avoidance and collection of third party liability payments. Indeed, our experience and expertise in the area is evidenced by our results. For calendar year 2010, AmeriHealth Mercy avoided inappropriate payment of $67.7 million across all company-affiliated Medicaid risk plans.

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, AmeriHealth Mercy has designed its system capability to have nearly unlimited capacity to capture TPL data from other carriers, agencies and relevant sources.

AmeriHealth Mercy's dedicated Recovery Department identifies and obtains third party payer information, including Medicare, commercial insurance and/or accident-related coverage. The Recovery Department expertly administers the collection and adjudication of third-party liability information for all of the AmeriHealth Mercy-affiliated plans and will do so for Louisiana as well.

The Recovery Department consists of three distinct but related units:

- 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.
- Subrogation - Responsible for identifying, tracking and monitoring casualty-related claims for potential recovery.

P.1: Coordination and Compliance of Cost Avoidance and Collection of Third Party Liability

P.1 Describe how you will coordinate with DHH and comply with the requirements for cost avoidance and the collection of third party liability (TPL), including:

- *How you will conduct diagnosis and trauma edits, including frequency and follow-up action to determine if third party liability exists;*
- *How you will educate providers to maximize cost avoidance;*
- *Collection process for pay and chase activity and how it will be accomplished;*
- *How subrogation activities will be conducted;*
- *How you handle coordination of benefits in your current operations and how you would adapt your current operations to meet contract requirements*
- *Whether you will use a subcontractor and if so, the subcontractor's responsibilities; and*
- *What routine systems/business processes are employed to test, update and validate enrollment and TPL data.*

Coordination with DHH

AmeriHealth Mercy routinely coordinates with other state Medicaid agencies through transmission and sharing of Third Party Liability (TPL) data. Our systems and functionality in place routinely submits updated TPL information to state Medicaid agencies on a daily, weekly, and monthly basis, and will do the same for DHH. At a minimum, we will report existing TPL information to DHH (or its contracted vendor) on a monthly basis by the fifteenth (15th) working day of the month. As requested by DHH, we will make arrangements to accommodate other schedules.

Process for Identifying Diagnosis and Trauma Edits

AmeriHealth Mercy utilizes a third party vendor, ACS Recovery Services, to help identify potential third party liability on claims with trauma code edits. This same vendor is contracted for all subrogation-related activities (see below).

ACS Recovery Services (ACS) receives paid claims and enrollment data on a monthly basis and utilizes sophisticated data mining tools to identify potential accident/trauma-related claims. Once a claim has been identified, ACS mails a letter and questionnaire to the member to determine if the incident was accident-related. Three attempts are made to contact the member. If the member does not respond to the mail inquiries, additional resources are used, including use of ISO ClaimSearch, review of court dockets and searches of other online research sources, to further investigate. After a potential recovery is identified, AmeriHealth Mercy will follow our normal subrogation process, as outlined in the Subrogation section below.

Diagnosis codes 800 through 999.9 and all E codes are used to identify diagnosis and trauma edits**.**

Provider Education to Maximize Cost Avoidance

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 Claims Educator will accompany the Provider Network Management Representative on provider visits, as needed, to assist with payment issues and conduct additional education if appropriate.

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.

Pay and Chase

AmeriHealth Mercy recognizes that specific requirements may dictate that we follow Pay and Chase guidelines, even when we are aware that the member has other primary insurance coverage. For example, claims for medical treatment associated with labor, delivery, prenatal services, court-ordered coverage, and EPSDT require AmeriHealth Mercy to pay first and seek TPL-related recovery after, in accordance with federal and state law

In 2010, HMS helped AmeriHealth Mercy recover more than $8.3 million for pharmacy and select medical claims.

AmeriHealth Mercy has the capability to perform TPL-related overpayment recoveries directly from liable third party payers through our vendor, Health Management Services (HMS). This approach to “pay and chase” leaves the provider unencumbered by the recovery process.

AmeriHealth Mercy sends a monthly file containing eligibility, claim, provider and TPL information to HMS via secure electronic files. HMS identifies TPL-related overpayments and is able to generate and transmit secure billing files to responsible third party payers. These payers process the billing files and submit payments to a plan-specific lockbox. HMS reconciles lockbox deposits, but does not have access to the deposited refunds. Lockbox deposits are routinely monitored by AmeriHealth Mercy's Finance Department. HMS also provides AmeriHealth Mercy with detailed billing and posting files to ensure we are informed of all claims for which a recovery was attempted and for which a recovery was realized.

Subrogation

AmeriHealth Mercy will manage all subrogation-related activities for Louisiana through ACS Recovery Services (ACS), similar to the processes it uses today for its other Medicaid agreements. AmeriHealth Mercy forwards a claim file each month containing information related to paid claims and enrollment data. ACS utilizes sophisticated data mining tool to identify potential accident-related claims. The analysis focuses on third party liability, automobile medical related coverage, and no fault workers' compensation.

ACS is one of the nation's largest subrogation vendors. Through years of subrogating claims, it has designed criteria and developed queries and algorithms to successfully mine paid claim data and identify potential recoveries. Claim data is processed to identify recovery potential using an algorithm which takes into account a number of detection variables including diagnosis codes, procedure codes and external cause codes found in the claims information. ACS's data mining criteria include:

- An automated analysis of claim data based on review of ICD-9-CM diagnosis codes as well as the cost of treatment, demographics associated with an individual, and any related claim matters
- Review of claim and enrollment information to determine potential overpayment as it relates to Medicare entitlement due to age, ESRD, and disability
- Review of membership eligibility information using a variety of tools and logic such as mandatory section 111 reports, and the use of real-time commercial eligibility through a proprietary ACS EDI Gateway clearinghouse to proactively divert claims.

Based on the resulting claims identified, ACS may open a subrogation case. ACS will mail a letter and questionnaire to the member to determine if the incident was accident-related. Three attempts are made to contact the member. If the member does not respond to the mail inquiries, additional resources is conducted using ISO ClaimSearch, court dockets and other online research sources to further investigate whether a subrogation claim exists. Additionally, cases may be opened manually by an investigator when a member, provider, or attorney, provides the incident information required to open and investigate a case.

When a case is verified and opened, ACS communicates with members on an "as needed" basis, communicates regularly with attorneys, coordinates with AmeriHealth Mercy on litigation options and settlement negotiations, and follows the case through to closure. AmeriHealth Mercy receives regular status reports on open and closed cases.

All cases with claims in the aggregate equal to or exceeding $500 are pursued. AmeriHealth Mercy will consider pursuing those claims with an aggregate value of less than $500. For all settlement cases in excess of $25,000, AmeriHealth Mercy will obtain DHH approval.

Coordination of Benefits

AmeriHealth Mercy 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.

After the TPL data is loaded, it is immediately available to all Facets® (eligibility and claim system) users, including Claim examiners, Customer Service Representatives, Provider Service Representatives, Enrollment employees, Medical Management employees, and Recovery employees. This information supports specific reporting requirements and enables the Claim Department to process Coordination of Benefits (COB) claims appropriately by using "flags" established within the Facets system. The flags assure that TPL information is considered prior to finalizing claim adjudication.

In 2010, more than $67.7 million was generated in cost-avoidance savings for our affiliate plans. In addition, AmeriHealth Mercy realized Coordination of Benefits savings in excess of $207 million.

Our claims processing system automatically routes all claims containing EOBs from other insurance carriers to claim examiners for further examination. A claim examiner reviews the EOB and claim image information captured during claim submission. The COB module in Facets captures and displays line-level data of AmeriHealth Mercy's and the alternate insurer(s)'s allowed amounts. This information is fully available for use in reporting cost-avoided dollars and provider-reported savings to DHH.

In the event the TPL information on the EOB does not match the TPL information documented in the system, the claim is routed via an automated workflow process to the Recovery Department. The Recovery Department verifies TPL data from the carrier and updates the member's information in the system, and returns the claim to the Claim Examiner for coordination of benefits and payment.

Use of Subcontractor and the Subcontractor's Responsibilities

AmeriHealth Mercy uses two subcontractors for the implementation of our third party liability responsibilities - ACS (ACS Recovery Services) and Health Management Services (HMS). Rather than build this type of expertise in-house, we strategically elected to utilize vendors who are experts in the field and have a proven track record of execution across the continuum of claims payment integrity functions with many plans across the nation. As discussed above, all subrogation-related activities are managed through ACS. ACS receives paid claim and enrollment data on a regular basis and utilizes sophisticated data mining tools to identify potential accident-related claims.

In addition to assisting us with our Pay and Chase efforts described above, HMS also supports the identification and validation of additional TPL data. HMS maintains a proprietary national database containing TPL information for many of the major commercial carriers, as well as government program information. AmeriHealth Mercy sends eligibility information to HMS on a monthly basis. This information is compared to HMS's national data sources to determine if other insurance exists for the member. Any information previously unknown to AmeriHealth Mercy is routed back to AmeriHealth Mercy. This additional TPL information is automatically compared to existing data and, as appropriate, loaded into the claims processing system via an automated file load process. Any updated information is included in the information sent to the State on the 15th day of each month.

Enrollment Data Testing, Updating, and Validation

The following systems/business processes are employed to test, update and validate TPL data:

- Edit Rules: AmeriHealth Mercy's enhanced TPL file load process includes a series of edits that work to validate TPL data by comparing incoming data against State, Plan and/or business-specific rules in advance of being loaded to Facets. Any records deemed incomplete (because key data is missing) or that contain erroneous data (such as non-alphanumeric characters) are excluded from Facets by the automated process.
- Monitoring: The final disposition of every record contained within TPL files is presented in reports that are monitored by Cost Containment and Third Party Liability analysts and supervisors. These reports show every record and corresponding disposition codes. Records

carrying specific disposition codes are manually researched and appropriate follow up and/or error corrections are made to update the Facets system with the new validated records.

- Updates and Verification through Phone Contacts: Each time a member contact is made through the Contact Center, Customer Service Representatives validate third party liability information contained in the Facets system. All Customer Service Representatives have real-time access to members' TPL information, and ask members to verify that the information on file is current.
- External Validation: On a monthly basis, all TPL information is sent to HMS. HMS validates this information against multiple national data sources and returns updated TPL information. The TPL system is updated with this information via automated file loads.

Section Q – Claims Management

AmeriHealth Mercy currently has a robust electronic claims management system that supports five distinct Medicaid plans which service almost 1 million members and almost 20,000 providers. AmeriHealth Mercy has been using the Trizetto Facets® Healthcare system for central claims processing functions and supporting services for more than 10 years. Facets is an enterprise-wide, core administration solution for consumer-directed, managed Medicaid health care organizations. As detailed below, this system meets and/or exceeds all Louisiana requirements for a claims management system and currently processes over 18 million claims in a timely and accurate manner each year.

Q.1: Claims Management System Capabilities

Q1. Describe the capabilities of your claims management systems as it relates to each of the requirements as specified in Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section. In your response explain whether and how your systems meet (or exceed) each of these requirements. Cite at least three examples from similar contracts.

AmeriHealth Mercy meets or exceeds each of the requirements as specified in the Electronic Claims Management Functionality and the Adherence to Key Claims Management Standards by administering claims through Facets. As detailed below, this system meets and/or exceeds all Louisiana requirements for a claims management system and currently processes over 18 million claims in a timely and accurate manner each year.

Specific examples of our capabilities are:

- AMFC has the capability to collect claims data electronically for all of our contracts. Indeed, of the 18 million claims we receive annually across our family of companies, over 80 percent are electronically submitted. All contracts allow for and provide the capability to submit non-electronic claims all of which are scanned and processed within the same timeframes and quality standards as those sent electronically. In addition, our providers can elect to be paid through use of electronic fund transfer (EFT) and as well as receive their claims remittance advice electronically. (Section 17.1.3.6, 17.1.4 and 17.1.7)
- In all current businesses, at minimum, we process provider payments once week on a standard schedule. However for one affiliated plans, two payment cycles are processed each week to meet providers' needs. (Section 17.1.1.17)
- AmeriHealth Mercy currently partners with NaviNet to support a Provider Portal through which providers can check their claim status, be alerted to member's gaps in care and other innovative functionality to enhance the coordination of care for our members, such as access to real time medication and comprehensive member visit histories. NaviNet is the largest multi-payer provider portal vendor reaching over 700,000 providers nationally. (Section 11.7.1.6)

Electronic Claims Management Functionality

Complex benefit structures and pricing schedules of all types can be configured in Facets to be in accordance with all state and/or contracting requirements. During the various stages of the adjudication process, Facets interacts with membership eligibility, product benefit parameters, provider pricing agreements, medical management requirements and clinical editing information to provide accurate and highly automated adjudication of claim and/or encounter submissions. Claims processing utilizes diagnosis codes and procedure codes to read service-based rules, and includes parameters for handling benefit limitations, deductibles, co-pays and coordination of benefit (COB) situations.

Facets has the following highlighted capabilities with respect to the requirements defined in the Electronic Claims Management Functionality Section and the Adherence to Key Claims Management Standards Section:

- Use of the industry standard ASC X12 Claims Submission (837 Transaction Set) format, the system is able to uniquely identify the attending and billing provider for each service.
- A comprehensive claims tracking capability that identifies the date of receipt of the claim and encounter information, real-time accurate history with appropriate dates of adjudication results, relevant pended claim or appeals information, and payment transaction data.
- Ability to support electronic funds transfer (EFT) as well as send claims remittance advice for providers that elect that payment option. The system also allows for generation of checks to individual providers or combined checks at a group or IPA level as well as capture and reporting of 1099 tax information.
- Flexibility to be configured to include all the data elements as required by DHH for encounter data submission.

Facets offers a full integration of member eligibility, including Third Party Liability, Provider Network and Prior Authorization information to support accurate claims processing. The Facets system is the primary source of all member eligibility and provider network information which is transmitted daily via interfaces to the Medical Management applications in support of the prior authorization functions.

Claims Submission

Facets also supports a variety of functionalities to manage the electronic submission and exchange of data. While medical, vision and hospital claims can be submitted via paper, the system also supports claims submission either online or electronically. We consistently achieve a strong encounter acceptance rate, averaging 98 percent on 30 million encounters annually. Claims are processed in an automated fashion, with full support for highly productive electronic adjudication. Facets can also send paper and/or electronic remittance transactions to the trading partners in the HIPAA compliant 835 transaction set standard format. Providers also have the ability to check claim status via the web or Interactive Voice Recognition system (IVR) or may speak directly with a Customer Service Representative.

Of the 18 million claims we receive annually across our family of companies, over 80 percent are electronically submitted.

Providers receive claim billing instructions on where to send their claims and all billing requirements for both paper and electronic claims. Paper claims are scanned via Optical Character Recognition (OCR) and the data, both the image and date, is converted into a proprietary flat file and loaded into the Facets system. Claims are only accepted in an approved format. If a claim does not pass OCR, the paper claim is manually keyed. Numerous edits alert the claims entry associate to any inconsistencies during entry. These predefined system warning messages result in increased accuracy and productivity. Claims can also be entered online or electronically via a proprietary format or the industry standard ASC X12 Claims Submission (837 Transaction Set) format.

Claims Tracking

Throughout the process, Facets records and tracks the status of every claim from receipt to encounter submission to DHH. Facets records the date received, provider billing information, date of each pend status reason, date of payment, check numbers and payment type. All claims submitted receive a Facets generated unique claim number and are date stamped.

All claims that pend for additional review are tracked in the EXP/MACESS system. This system is an imaging-based operations management, workflow management and enterprise content management solution. EXP tracks 100 percent of all pended claims and manages the flow of the claim through

resolution. By using the Doc-Flow component of the system, pended claims are circulated in a queue-based workflow distribution, which ensure timely resolution of the claims per established metrics.

If a clean claim is denied because the provider did not submit required information or documentation with the claim, then the remittance communication will identify all missing information and documentation. The resubmission of a claim with further information and/or documentation does not constitute a new claim for purposes of establishing the timeframe for timely filing.

In addition to Facets, AmeriHealth Mercy currently partners with NaviNet to support a Provider Portal through which providers can check their claim status, be alerted to member's gaps in care and other innovative functionality to enhance the coordination of care for our members, such as access to real time medication and comprehensive member visit histories. NaviNet is the largest multi-payer provider portal vendor reaching over 700,000 providers nationally. Additional information on our robust provider portal functionality can be found in Section G. A view of the claim detail screen in the NaviNet portal appears below.

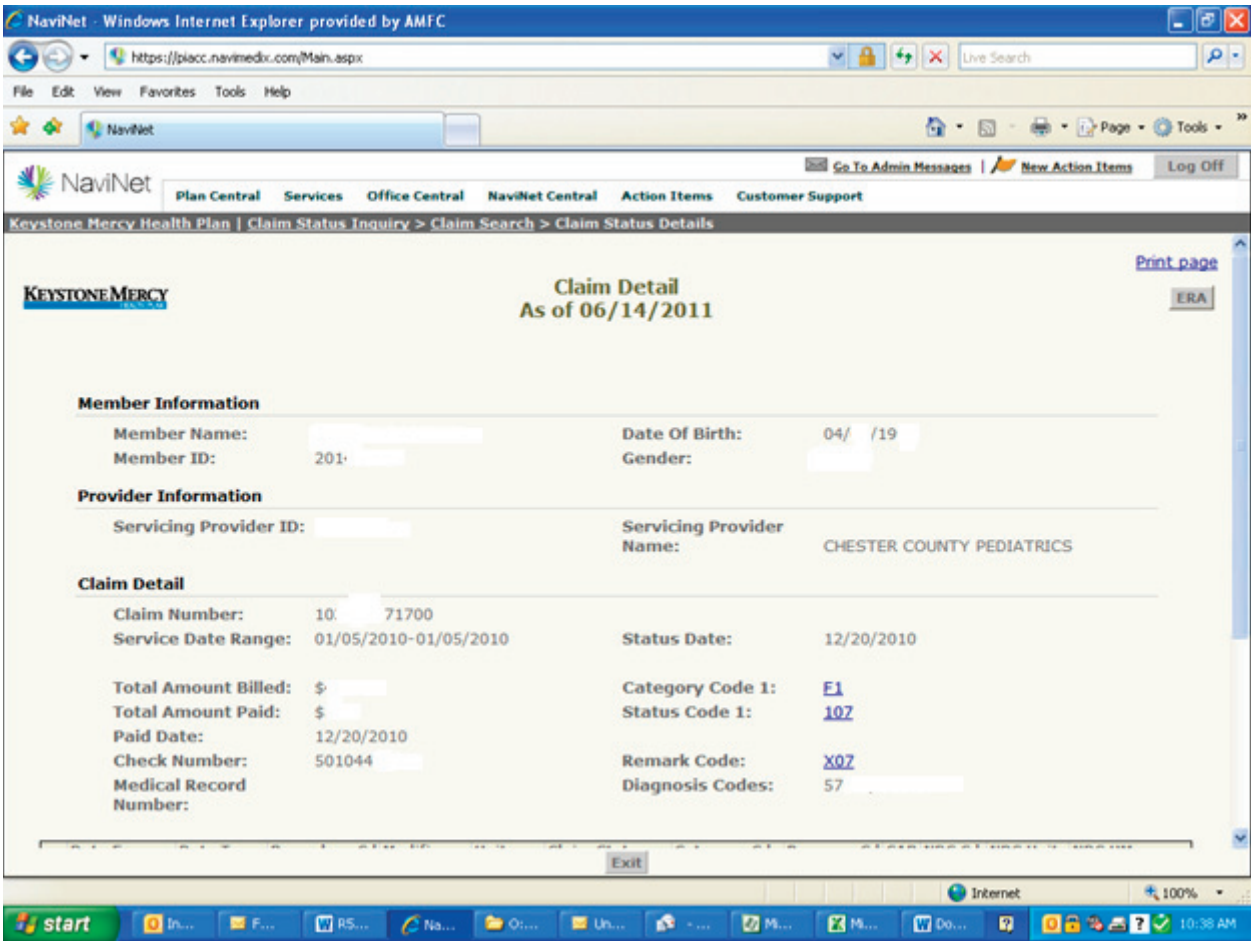


Figure 1: View of NaviNet Portal

Batch Claims

Claims can be adjudicated in batch mode for all medical and hospital claims that are submitted electronically. The batch mode capability allows us to automatically process a large amount of claims at one time and online edits reduce errors prior to batch submission. Manual operations are substantially reduced and claim processors can focus their attention on claims that require experienced judgment.

All claims that are electronically adjudicated go through a detailed series of edits before processing to ensure that claims with data entry errors, or incorrect or missing information, are not processed in the batch cycle. The system indicates the nature of the submission error(s) and provides access to the claim on a line item basis so that errors can be easily corrected. Once corrected, the claim can be resubmitted in the next batch for completion of the adjudication process.

If for any reason a batch is rejected the following data is provided:

- Batch received date
- Date of rejection
- Provider Name and identification
- Reason for why the batch was rejected

Key Claims Management Standards

AmeriHealth Mercy will comply with the Adherence to Key Claims Management Standards and currently meets and exceeds the time to pay requirements of our affiliates. For example, for Select Health, our Medicaid plan in South Carolina, the time to pay requirement is to pay 90 percent of all clean claims within 30 days of the date of receipt and 99 percent of all clean claims within 90 days of the date of receipt. As indicated below, AmeriHealth Mercy exceeds the contractual requirements for timely claim payment.

Table 1: Clean Claim Payment Results

Time to Pay Requirement for Select Health *90% of Clean Claims in 30 days*											
Jun-10	**Jul-10**	**Aug-10**	**Sept-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**
99.8%	99.8%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.8%	99.9%
Time to Pay Requirement for Select Health *99% of Clean Claims in 90 days (Note: The actual percentage provided is for All Claims)*											
Jun-10	**Jul-10**	**Aug-10**	**Sept-10**	**Oct-10**	**Nov-10**	**Dec-10**	**Jan-11**	**Feb-11**	**Mar-11**	**Apr-11**	**May-11**
99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	99.9%	100%	99.9%

The Facets system allows users to review all aspects of the claim, including status, payments, provider, and accumulators (calculated amounts when indicated), for each member. This flexible and powerful tool allows users to find required information quickly. Employees can use either an abbreviated inquiry approach for quick access when fewer specific details about the claim are available or a more comprehensive inquiry approach when there is more information needed about the claim.

In all current businesses, at minimum, we process provider payments once a week on a standard schedule. For our Kentucky plan, two payment cycles are processed each week to meet providers' needs.

AmeriHealth Mercy will adhere to the established standards for financial and administrative accuracy and for timeliness of processing:

- Payment of 90 percent of all clean claims for must be paid within 15 business days of receipt
- Payment of 99 percent of all clean paper claims in a given month within 30 calendar days of receipt

Adherence is achieved through daily monitoring of the claims inventory by the claims management team. Specifically, on a daily basis the managers review the Daily Inventory Report which provides an aging of all pended claims. Based on this report, work load can be appropriately distributed to ensure claims meet the established metric. Managers also review the weekly Claims Timely Report as well as the weekly metric scorecard to ensure all contractual metrics are met. Figure 2 presents a Claims Daily Inventory Report for one of the AmeriHealth Family of Companies' affiliates.

Open Workflow Items Aging Report _Document Detail- Claim Regions

Workflow Region Status Queue Name Document ID /Age	Totals	00 to 05		06 to 10		11 to 15		16 to 20		21 to 25	
Select Health Claimflo System	8372	4986	60%	3125	37%	219	3%	38	0%	4	0%
New	8109	4982	61%	3098	38%	26	0%	2	0%	1	0%
Catch-All	379	237	63%	142	37%	0	0%	0	0%	0	0%
Hospital Claims w/ $100K or More	11	9	82%	1	9%	1	9%	0	0%	0	0%
LOB 2400 $0.00 Charges Billed	1160	715	62%	445	38%	0	0%	0	0%	0	0%
LOB 2400 Clin Edit 2nd Modifie	13	6	46%	7	54%	0	0%	0	0%	0	0%
LOB 2400 COB Hospital	249	117	47%	132	53%	0	0%	0	0%	0	0%
LOB 2400 COB Medical	1081	326	30%	755	70%	0	0%	0	0%	0	0%
LOB 2400 Errors Hospital	259	116	45%	143	55%	0	0%	0	0%	0	0%

Figure 2: Claims Daily Inventory Report

Q.2: Claims Payment Accuracy

Q.2 Describe your methodology for ensuring that claims payment accuracy standards will be achieved per, Adherence to Key Claims Management Standards Section. At a minimum address the following in your response:

- *The process for auditing a sample of claims as described in Key Claims Management Standards Section;*
- *The sampling methodology itself;*
- *Documentation of the results of these audits; and*
- *The processes for implementing any necessary corrective actions resulting from an audit.*

AmeriHealth Mercy's claims management strategy focuses on promoting efficiency and accuracy in processing by using state-of-the-art technology, well-trained employees and a rigorous quality assurance process.

Our system has the flexibility to be configured to automate nearly all payment scenarios and requirements, including unique requirements of state-sponsored programs, such as state fee schedules, DRG methodologies, and EPSDT claims, among others. It has been customized to support the unique requirements of a Medicaid program.

The system enables us to:

- Deliver provider table driven edits of claims ICD9; CPT4; category of service; provider type; revenue code; member type; authorization requirements; bill type; and place of service
- Determine appropriate co-payments based on Third Party Liability, Coordination of Benefits, or other insurance and adjudicate claims accordingly

- Provide detailed explanations of benefits and remittance advice
- Track timeliness of claim payments
- Track claims pended for additional information
- Provide detailed reporting for current inventory, aging inventory and pended claims

Auditing Programs and Sampling Methodologies

AmeriHealth Mercy has a number of programs in place to ensure a fair, expedient and efficient process for the Quality Auditing department to perform reviews of adjudicated claims for procedural, financial and payment accuracy.

Stratified Health Plan Audit Program

On a monthly basis, the selection for this audit consists of a random sample, by payment strata, of at least 384 claims processed in the previous month (The strata is adjusted depending on claims volume).

The sample is divided into three payment strata, a fourth stratum for adjusted claims and fifth stratum for zero paid claims. Payment stratum parameters for each line of business (LOB) are based off of the LOB's previous year's historical data.

Claims pulled for stratified audits consist of manually adjudicated, Rational Robot, and system adjudicated claims. Rational Robot is a claims testing tool that we utilize to process routine claims that fall outside of our auto adjudication process.

The quality scores achieved for each plan serve as the official score. The scores include financial, procedural and payment accuracy percentages.

Manually Adjudicated Audit Program

On a daily basis, the selection for this audit consists of a random sample of at least three percent of each claim examiner's processed work.

Audits are performed on a pre or post-disbursement basis.

The quality scores achieved for each claim examiner serve as a performance management tool for the Claims Operations management team.

If it is determined that a claims representative needs further assistance, the claims management team will direct the auditor to pull, a higher percentage of the individual's processed claims are pulled for an agreed upon period of time.

Rational Robot Audit Program

On a daily basis, the selection for this audit consists of a random sample of at least one percent of Rational Robot claims. The Rational Robot team processes both production jobs (original claims) and claims from projects (adjusted claims.)

Claims selected from projects are audited against the project documentation and the plan's processing rules.

The quality results are utilized by the Rational Robot team to identify process improvement opportunities. The Rational Robot team will be responsible for remediation of identified errors.

Cost Containment/Claim Reconciliation Recovery Unit (CRRU) Audit Program

On a daily basis, the selection for this audit consists of a random sample of at least 10 percent of monthly claims adjusted by the Claim Reconciliation Recovery Unit (CRRU) and at least three percent of monthly claims adjusted by the Cost Containment team.

Audits are performed on a pre- or post-disbursement basis.

The quality scores achieved for each examiner serve as a performance management tool for the Cost Containment and CRRU management teams.

Upon request from the CRRU/Cost Containment management teams, and based on Quality Auditors (QA) capacity, a higher percentage of an individual's processed claims are pulled and audited for an agreed upon period of time.

New Hire Quality On-Boarding Audit Program

The selection for this audit consists of a random sample between five and 30 percent of the daily number of claims processed for each new employee to allow for early identification of performance gaps. The training program is broken into three modules to allow new employees to learn to process one type of claim and gain experience in that claim type, before moving on to another type of claim. Modules exist for: Medical, Hospital and Coordination of Benefits claims. As each module of the training program concludes, the employee begins processing that claim type in the production environment and the auditing periods begin. The audit period following medical claim processing training, the first module, is three weeks, with a two-week period following the hospital and COB modules. Based on capacity, the Quality Auditors review any errors with the employees two to three times per week and with the Trainer/Supervisor at least once per week.

The quality scores achieved for each employee serve as a performance management tool for the trainer and the claims management team.

Upon completion of the "new hire" claims training and audit period, the employee is monitored through the Manually Adjudicated Audit Program.

System Adjudicated Target Audit Program

The sample criteria for this audit is based on claims management team requests, which may include previously identified quality auditing errors, recent configuration changes to the claim system (Facets), provider request, etc.. The sample is focused on high-risk auto adjudicated claims and calculated to meet a minimum of a 95 percent confidence level and +/- five percent precision level.

Target audits are performed on a pre- or post-disbursement basis as requested by the claims management team.

Errors assessed during the target audit are sent by the QA department to the Configuration and Claims Operations management teams for review.

Documentation and Reporting of Audit Results

The documentation of the audit results rests in a dedicated database. Errors identified during the audit are recorded in the database and provided as feedback via reporting. Audit points for stratified and manually adjudicated claims are based on COB, clinical editing, configuration, duplicates, input, timely filing, authorization/referral and processing rules and procedures. Audit points for Rational Robot, Cost Containment and CRRU claims are based on the process rules for the specific project. Audit points for auto adjudicated claims are based on the target audit criteria for an error. For example, the criteria may state that the claim should be denied if there is no matching authorization, and the audit would check to see whether a valid authorization was available at the time the claim was processed.

Once the results are compiled, the Claims Operations teams access the results through a self-service reporting application. Reports are available on a real-time basis and include the following:

- Claim detail report by individual
- Line of Business (health plan) summary report
- Supervisor summary report

Audit results are reviewed by the management staff of each claims team for analysis and action. Results for each line of business and any associated action plans are reported to the individual plan's Quality of Service Committee and to the executive management team responsible for the plan.

Necessary Corrective Action Processes

Claims Management Supervisors are responsible for reviewing the audit reports and determining if the errors are charged appropriately. If there is a discrepancy, the Supervisor/Team Leader follows a formal appeal process to have the audit result reviewed. The Team Supervisors/Team Leaders develop an action plan to address any areas that do not meet goal. Action plans are reviewed by the plan's Quality of Service Committee (QSC). As the plan is implemented, the QSC monitors ongoing progress and associated measurements indicating performance improvement.

Team Leads/Supervisors work with individuals with poor audit scores through coaching and retraining. Employees with repeated poor audit performance are placed on a formal Performance Improvement Program. Continued poor performance will result in termination of employment. Audit results are also uses as part of the development plan process for individual employees. An internal credibility audit is performed monthly to validate the accuracy of auditing statistics.

Q.3: Claims Processing Methodology

Q.3 Describe your methodology for ensuring that the claims processing, including adherence to all service authorization procedures, are met.

AmeriHealth Mercy will use its robust procedures and systems, including the core claims processing system (Facets) and workflow management system (SunGard EXP Macess) to ensure that all claims are processed according to the requirements of Section 17 of the CCN-P Request for Proposals. The combination of these two applications, coupled with AmeriHealth Mercy's experience, will provide the flexibility to meet DHH's claim processing requirements. The claims processing components and associated methodology that support the Louisiana business are described below.

SunGard EXP Macess - Document Management/Workflow Solutions

SunGard EXP Macess is an imaging-based operations management, workflow management, enterprise content management and customer service solution that has been standardized for managed healthcare organizations. The EXP Macess module facilitates scanning and data entry for incoming paper documents (claim forms, member data). Once entered, these documents are sent to the host system (Facets) for adjudication, and the associated data and images are stored in the centralized document management system.

EXP Macess helps track and manage the flow of data, documents, and business processes through our organization. EXP's tools for capturing, centralizing and archiving data and documents help ensure that all of our operations are standardized and integrated. Reporting tools monitor workflow, helping managers identify bottlenecks and increase efficiency. EXP Macess offers solutions for document management, content management and business process management that help organizations automate workflow and improve productivity. Some of the documents we capture include:

- Incoming correspondence from members or providers
- Claims
- Prior Authorization records
- Letters of medical necessity (electronic and scanned images)
- Outgoing correspondence to a member or provider. (e.g., letters to request additional information, notice of Action, notice of appeal resolution.)
- Electronic documents e.g., is the data associated with the check number created when Facets pays a claim.)

EXP's Doc Flow module enables records/documents to be processed into work queues for efficient work assignment and management. The Doc-Flow module of EXP Macess enables queue-based work distribution. Users can use a graphical design component to create electronic workflow and c routing flows to match a predefined workflow process. The system will perform automatic searches for supporting documents, in order to complete tasks in the queue. Time sensitive documents trigger alerts. Users can flag certain documents for dual review. Active X scripting enables integration of Doc Flow with other applications, such as Facets, Argus used to administer pharmacy benefits), TopDown Client Letter, Jiva (our care management information system), and the Data Warehouse.

Facets Claims Adjudication

The robust capabilities within the Facets system allow it to access numerous edits and processing routines during the claim adjudications, process based on the claim's data elements. These processes and edits allow Facets to take different actions based on Eligibility: Provider/PCP/Network: authorization and referral requirements: and pricing agreements. These determinations will be coded to meet AmeriHealth Mercy's provider contracts and Louisiana specific payment guidelines. These processes are part of the core functionality within Facets and ensure the accuracy of the claims processing and payment.

- **Eligibility** - During claims adjudication, Facets eligibility logic will check for valid eligibility and the benefits associated with the member.
- **Provider/PCP/Network Determination** - Facets will determine whether the servicing provider on a claim is the member's PCP and whether the provider participates in AmeriHealth Mercy's network.
- **Service Definition** - Facets will obtain the Service Definition which is linked to the specific provider agreement and determines the price. The "provider agreements" in Facets are based on the payment schedule in each of the executed provider contracts.
- **Duplicate Editing/Claims History Check** - Rules are used to define what constitutes a definite or possible duplicate claim. Numerous groups of claim parameters are configured and linked together to run, against the member's claim history to determine whether the current claim is a duplicate of a prior submission. Facets performs a duplicate check for each claim line.
- **Managed Care Edits** - Edits are configured and applied based on the claims processing guideline, benefit coverage and limits, clinical authorization requirements and referral requirements for each plan. including edits for valid dates of service that coincide with membership eligibility span.
- **Service Authorization Procedures** –Utilization Management employees enter service authorization into the Jiva care management application which supports prior authorization functions. Prior authorization information is transmitted into the Facets claim processing system daily via interfaces. During the adjudication process, Facets editing keys on procedure type and location to determine if the service requires an authorization. For service/location combinations that require authorization, Facets searches the authorization data for a match. If the system identifies an authorization for the service, the authorization is attached to the claim and the claim adjudicates according to the provider agreement and any other applicable edits.

If the system cannot find an authorization the claim pends to a queue for a Claims Examiner to process manually. The Claims Examiner searches the Utilization Match dataset in Facets to validate that there is no authorization on file for the service. If an authorization is found, the Claims Examiner manually attaches the authorization to the claim and adjudicates the claim for payment. If the authorization is not found the Claims Examiner contacts to the Utilization Management (UM) Department to verify the absence of an authorization on file. If the authorization is on file in the Medical Management system the UM nurse will authorize the claim for payment and send an alert to transmit the authorization to Facets system in the nightly batch update.

The Claims and Utilization Management Departments have very specific processes and procedures for handling authorization discrepancies. Dedicated system support staff in the Utilization Management Department review all authorizations that do not cross to Facets and perform root cause analysis. The system support staff provide feedback to the UM Supervisors and Trainers who provide additional coaching and training as needed. System support staff also work with the Information Solutions Healthcare Applications team to make any needed changes to the configuration of the Utilization Management Interface between Jiva and Facets. AmeriHealth Mercy will make these processes and procedures available during the readiness review evaluation.

- **Clinical Editing** – Facets comes with basic clinical edits already configured in the system. Facets also has the capability to create custom edits and to have select services bypass edits. AmeriHealth Mercy also contracts with a vendor, iHealth Technologies (iHT), to enhance the clinical editing capabilities in Facets. During the implementation process and through our provider meetings, AmeriHealth Mercy will determine which edits will be applied to claims. At a minimum, AmeriHealth Mercy will apply standard edits to prevent claim overpayments.
- **Pricing** - Facets will uses all of the appropriate codes on the claim (Procedure codes, Revenue codes, CPT codes, ICD-9 codes and Place of Service codes) to determine the appropriate reimbursement according to the provider agreement.
- **Service Rules** - Service rules allow Facets to adjudicate payment based on multiple parameters. A Service Rule establishes the calculation method for the service, the claims processing edits to be applied, penalty types and amounts, and service tiers. For example, medical claims be priced based on reasonable and customary (R&C) rates, Fee Schedules, Per Diem/Per Case, DRG or percentage of charges. Facets has the flexibility to handle any pricing methodology.
- **Benefit Limits** - Benefit limit rules are used to define each benefit limitation if applicable. Each limit rule can be applied to selected benefit types, based on amounts paid or allowed, or based on the number of services paid. The rule can also be applied during a plan year or over the member's lifetime. A limit is a dollar amount or number of counters that, once reached, will not permit further reimbursement. Limits can be established to apply to all services or only to selected services or related diagnoses. Limits can be at the member level or the family level. Limits can be based on a dollar amount or a number of counters.
- **Penalties** - Facets can be configured to establish service penalties for application during claims processing. For example a penalty can be configured to apply when UM guidelines were not followed or an out-of-network provider was used without authorization. Penalties can be applied as a flat amount or a percentage; can be set to apply to the allowable or paid amount; and can include a maximum dollar limit.
- **Overrides** - During claims processing, users are able to override co-pays and coinsurance on each line item. This becomes an issue when multiple tiers are accessed.
- **Coordination of Benefits (COB)**– Facets will be configured to meet the specific COB payment guidelines for Louisiana
- **Accumulator Update-** Accumulators can be set in Facets to do the following:
  - Track benefits by either dollar amount or number of visits (counter)
  - Track benefits at the member or family level
  - Identify accumulator buckets for all members of a specific product
  - Track accumulations by a specified amount of time (yearly or by lifetime)
  - Track the amount of money spent or saved through Coordination of Benefits (COB)

AmeriHealth Mercy affiliates have an 80 percent auto-adjudication rate. These high rates have been achieved by utilizing standard provider agreements and pricing methodology (percentage of the fee schedule and DRGs). The agreements have been modified over the years based on our experience,

working with providers to improve payment accuracy, region specific preferred payment methodologies and ease of doing business. The processing rules will be available for DHH to review during the readiness review.

Section R – Information Systems

R.1: Information Systems Implementation

R1. Describe your approach for implementing information systems in support of this RFP, including:

- *Capability and capacity assessment to determine if new or upgraded systems, enhanced systems functionality and/or additional systems capacity are required to meet contract requirements;*
- *Configuration of systems (e.g., business rules, valid values for critical data, data exchanges/interfaces) to accommodate contract requirements;*
- *System setup for intake, processing and acceptance of one-time data feeds from the State and other sources, e.g., initial set of CCN enrollees, claims/service utilization history for the initial set of CCN enrollees, active/open service authorizations for the initial set CCN enrollees, etc.; and*
- *Internal and joint (CCN and DHH) testing of one-time and ongoing exchanges of eligibility/enrollment, provider network, claims/encounters and other data.*
- *Provide a Louisiana Medicaid CCN-Program-specific work plan that captures:*
  - *Key activities and timeframes*
  - *Projected resource requirements from your organization for implementing information systems in support of this contract.*
- *Describe your historical data process including but not limited to:*
  - *Number of years retained;*
  - *How the data is stored and*
  - *How accessible is it.*

The work plan should cover activities from contract award to the start date of operations.

Key Differentiators for Implementation

AmeriHealth Mercy has a long history of implementing and supporting Medicaid programs beginning as early as 1983 and including the development and implementation of interfaces with the Medicaid agencies and agents of Pennsylvania, South Carolina, Indiana, Kentucky, and New Jersey. AmeriHealth Mercy is not only familiar with various state management information system requirements through our current business, we are in compliance with all of the information system requirements for each of the state programs we support, including eligibility/enrollment, member data management, third party liability, provider data management, reference data, encounter/claims processing, financial data and utilization/quality improvement. We are positioned to expeditiously and efficiently expand our current capabilities to Louisiana:

Our Technology, Process and People will deliver and execute a sound information system implementation plan through:

- Industry-proven applications and infrastructure (Technology)
- Consistent and repeatable methodologies and best-practices for implementing state Medicaid programs (Process)
- A technically deep resource team, with an average of 10+ years of Medicaid healthcare industry experience working with healthcare systems and business environments (People)

This implementation plan is supported by AmeriHealth Mercy's Enterprise Information Systems Architecture. This architecture is built based on our core business needs, providing the foundation to support key health plan functions: Medical Management, Healthcare Benefits Administration and Provider Network Management depicted in Figure 1. Our core platforms are industry leading, highly

configurable applications allowing us to tailor functionality for each market and leverage repeatable, best practices across all of the health plans we support.

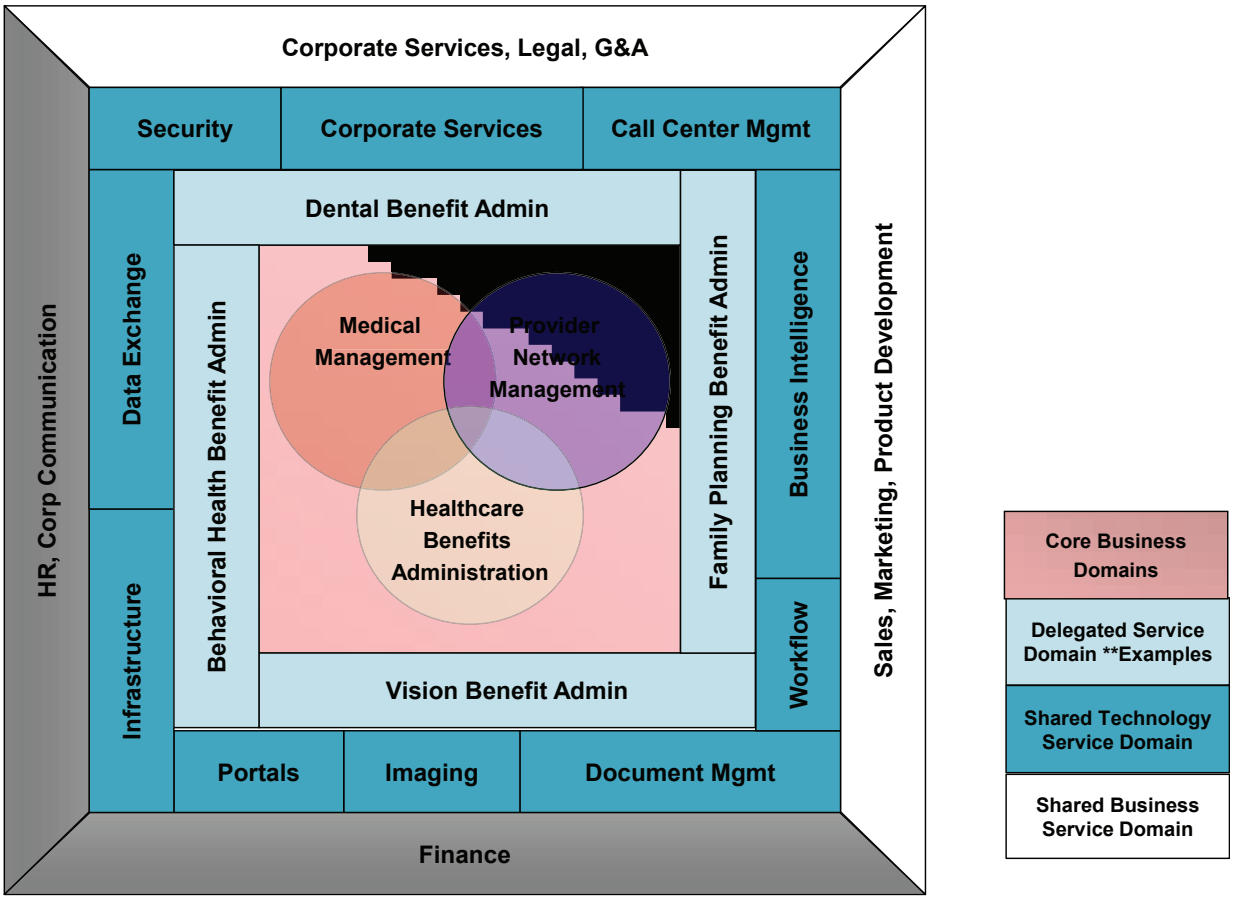


Figure 1- Information Systems Overview

Over the past five years, AmeriHealth Mercy has almost doubled the number of Medicaid Managed Care members we serve through the addition of new contracts and organic growth. We will bring our experience in implementing new contracts, while ensuring we maintain excellent service for existing state clients, by seamlessly scaling our operations and technology to support our Louisiana business.

We use a proven delivery model for business activation, based on our years of experience, incorporating key lessons learned. During the implementation phase, and in conjunction with our Enterprise Program Management Office, IS will engage subject matter experts (SMEs) from our affiliates who have extensive experience building and managing the information system infrastructure necessary to implement and operate a comprehensive managed Medicaid program. Our delivery model, with detailed policies and procedures specific to Medicaid Managed Care, includes:

- Experienced implementation team
- Subject matter experts (SMEs)
- Proven implementation strategy and approach
- Detailed internal system readiness plan and testing strategy
- Scalable IT infrastructure
- Enterprise commitment of resources to ensure a smooth implementation

AmeriHealth Mercy utilizes a best practice Systems Development Life Cycle (SDLC) that adheres to a formal methodology for guiding systems implementation. The SDLC considers business processes, functional requirements, and economic and technical feasibility in order to implement a technology solution that fits the business need. The underlying principles driving our SDLC include 1) meet or exceed customer expectations within cost estimates, 2) work effectively and efficiently within the current and planned information technology infrastructure, and 3) ensure the systems are cost effective to maintain and enhance.

Key phases of our iterative system implementation process include Initiation and Planning, Design, Development and Configuration, Testing and Implementation. Well-defined and standardized artifacts are produced during each of these phases. Examples of specific artifacts include Business and Functional Requirements documents, Design documents, Test Plans, Test Scripts and Operation Guidance. Our process also incorporates supporting disciplines such as Configuration, Change Management and Project Management.

Our systems development life cycle is supported by our IT Enterprise Architecture with three core focus areas: Business Architecture, Information Architecture and Technical Architecture. The primary goals of Enterprise Architecture include:

- Ensuring the evolution of the IT fabric in a "non-complex" manner
- Methods to create and communicate key principles and best practices
- Standards that help to achieve business goals based on an efficient, high performing IT infrastructure

Business Architecture

Business Architecture is a business process-centric discipline that drives our enterprise technology architecture. We will apply business architecture principles to the Louisiana CCN-P requirements that will enable us to fully optimize our solutions across all the three core dimensions of the business, namely: people, process and technology. Within the process dimension for example, our objective will be to ensure implementation of highly streamlined and efficient processes designed to optimally support AmeriHealth Mercy and pairing them with the most optimal technical solution and people resources.

Information Architecture

Information Architecture works to optimally map enterprise data to business processes. Our Enterprise Data Architect maintains a refined metadata management practice that drives data interoperability and exchange through standardization of data across business and client domains. We will apply information architecture principles to the Louisiana CCN-P requirements which will enable storage and exchange of high quality data among all of our information systems. As an example, one of the key objectives of our information architecture discipline will be to ensure full traceability of data elements as they move across our systems with a consistent and reusable set of business rules and validations to ensure correctness or quality of data.

Technical Architecture

The principles of integration, flexibility and ability to scale are of highest priority when implementing solutions. AmeriHealth Mercy has realized major business process optimization and cost savings through successful implementation of fully integrated enterprise workflow and healthcare benefit administration solutions. We will apply technology architecture principles to the Louisiana CCN-P requirements which will enable us to configure a high performance, continuously available, scalable system solutions to meet and exceed business requirements.

Overall Systems Implementation Approach

Our systems implementation approach for Louisiana will include:

1. **Initiation & Planning Phase**

- Conduct Capability and Capacity Assessment
- Review state policies, transaction companion guides, service level requirements
- Review provider network and their technology readiness
- Develop an end-to-end strategy that includes:
  - Provider contracting configuration and setup
  - Claim processing configuration
  - EDI and Encounter data exchange setup and development
  - Medical Management setup and configuration

2. **Design, Development& Configuration Phase**
   - Determine best fit design for all of the all the required systems
   - Establish Facets and other core systems Environments for Louisiana
   - Complete configuration of Benefits and Plans
   - Build Data Exchanges to Load Historical Data
   - Configure Processing Schedules for Data Exchanges and Business Services
   - Finalize data architecture and hardware/software environments
   - Develop Enhancements and customizations to base level capabilities
3. **Testing & Implementation Phase**
   - Complete internal testing to ensure system readiness
   - Conduct joint testing with DHH
   - Collaborate with key stakeholders on implementation planning
   - Leverage an array of communication and training tools for communication with stakeholders
   - Monitor and adjust strategy based on feedback from stakeholders

Capability and Capacity Assessment

As a part of the Initiation and Planning phase of our systems development lifecycle, we conducted a review of DHH's requirements and projected volumes in relation to our Information Systems capacity and capabilities. From our initial review of the requirements outlined in the Louisiana CCN-P RFP, we believe that our systems' capabilities and capacity will meet or exceed the requirements of DHH and the State of Louisiana. The following are the key outcomes of our system capacity and capability assessment for Louisiana (additional detail is included in other sections):

- Our existing infrastructure capacity will accommodate Louisiana's business volumes.
- Our technical application portfolio has the capabilities and features to address Louisiana requirements.
- We will leverage resources from a sourcing partner already knowledgeable with our organization and core business applications to quickly move from assessment to readiness and then implementation.
- We have the internal subject matter experts with prior experience of implementing other state Medicaid programs that will be dedicated to Louisiana.
- We will use proven test scripts to facilitate joint testing with DHH and the designated financial intermediary and enrollment broker.
- As a registered customer of EDIFECS services, we will acquire HIPAA certification prior to submitting Encounter files.

Enabling Capacity Through Our Technology Platforms

One of our key differentiators is the capability of our technology platform to scale to support increasing processing volumes and adapt to meet new functionality demands. A combination of industry-proven application systems and hardware infrastructures has allowed AmeriHealth Mercy to successfully expand into new Medicaid markets over the years. A fundamental element of that success is the tight

collaboration and experience we have gained with our technology platform partners. Our core technology partners providing these scalable solutions are described below.

AmeriHealth Mercy will utilize TriZetto's Facets healthcare system as the foundation for healthcare benefits administration functions and supporting services. AmeriHealth Mercy will leverage existing partnerships with industry leaders such as Avaya, Cisco, EMC/VMware, Hewlett Packard (HP), Oracle and PeopleSoft. Our ability to leverage best-in-breed solutions will position AmeriHealth Mercy to easily assume sizable growth.

Facets incorporates batch processing and load balancing models to readily resize and process expanded volumes of claims. That flexible approach to batch processing combined with our highly scalable VMware virtual server environment will be the foundation of managing the scheduled claim processing growth for Louisiana.

AmeriHealth Mercy will continue to incorporate new technologies like dynamic resource on demand from Hewlett Packard for our business-critical systems supporting Facets and our data warehouse solutions. We are also able to configure our systems to address capacity adjustments as needed.

AmeriHealth Mercy will also use iCAP, a Hewlett Packard technology for instant capacity on demand analysis that populates business critical systems at maximum configuration. The agility gained through this system allows for short-term and long-term needs to be easily addressed.

EMC, our storage partner, has worked with our technical teams to develop a solution that incorporates scalability, performance and growth. Our highly available DMX 3 Symmetrix storage solution can scale from the 288 hard drives that we initially sized for Louisiana to 2,000 hard drives at maximum configuration. The agility of the system to manage multiple storage configurations within one enclosure will position AmeriHealth Mercy to run at optimal performance and have scalability for key applications.

We use a comprehensive approach to project capacity based on the number of members we expect to serve. Collaborating with our health plans and business operations department, dedicated staff from our Application, Architecture, Infrastructure and Data Center Operations teams use planning models to evaluate capacity across the IS spectrum including: network, storage, processors, voice communications, applications, desktops, etc. This team continuously monitors system utilization to ensure our baselines and growth projections are within expected ranges. The team also evaluates opportunities to enhance performance and ensure availability of our mission critical systems. Our scalable and agile systems architecture allows us to expand our capacity if volumes or performance exceeds projected thresholds through increased enrollment or new opportunities.

Details explaining how our systems meet or exceed the DHH requirements, and our ability to scale our systems to handle the anticipated volumes associated with the Louisiana program can be found in the subsequent responses to Section R.

Configuration of Systems

As a part of the Design, Development and Configuration phase of our systems development lifecycle, AmeriHealth Mercy will work closely with DHH, the State's fiscal intermediary and the Enrollment Broker to configure and tailor an information system infrastructure to meet the program's needs. As indicated above, and demonstrated throughout our response to the rest of Section R, no substantial changes are required to our information system design and infrastructure to accommodate these requirements.

Configuration of Business Rules and Critical Reference Data

For each key business component: Provider, Eligibility/Enrollment, Encounters, Claims, Medical and Care Management, we have a specific set of reference data, business rules and parameters. Through collaborative working sessions we bring together key inputs, such as a DHH's Systems Companion Guide

and review with the subject matter experts (SMEs) in each discipline. The output of the collaborative working sessions is the requirements and specifications document for configuring each of the systems. Participants in such sessions will include DHH and its agents, as required, to ensure a complete and accurate understanding.

Examples of key inputs for developing business rules for systems configuration include:

- Systems Companion Guide
- System/Healthcare Codes (ICD, CPT, etc.)
- Fee Schedule
- Benefit Matrix
- Claim Pricing Rules
- Provider Agreements
- Third Party Liability Requirements
- Prior Authorization List
- Referral List

Once the business rules are defined, designated experienced staff will use the business rules to configure each system to meet the requirements. Test cases and plans are developed and executed to ensure systems readiness, both internally and externally.

System Set Up for Intake, Processing and Acceptance

As a part of the Design, Development and Configuration phase of our systems development lifecycle, our SMEs will collaborate closely with DHH and its agents, to define requirements for intake, processing and acceptance of one-time data feeds from the state and other sources.

AmeriHealth Mercy will leverage a highly versatile data exchange solution to support Louisiana's data intake requirements. This solution includes functionality for secure inbound and outbound movement of data for point-in-time or real-time transactions. Data exchanges occur through dedicated point-to-point connectivity or secure virtual private networks (VPNs) across the Internet. It supports both one-time and routine data exchanges.

Based on the data exchange requirements specific to Louisiana, this solution will be configured to support a variety of data feeds including:

- Initial set of CCN enrollees
- Claims/service utilization history for initial CCN enrollees
- Active/open service authorizations for initial CCN enrollees
- Claims/encounters including behavioral health, pharmacy, laboratory results, vision, dental and transportation
- Exchange of information with trading partners, including Emdeon, subcontractors, clinical editing vendors, cost containment vendors, banking partners
- Exchange of information with DHH and its agents, including the FI and the Enrollment Broker

The data exchange solution includes two main components:

- Mapping incoming data elements to an AmeriHealth Mercy standard intake format
- Loading the data through the standard intake format to our transactional and reporting databases.

We use our systems development lifecycle discipline to define incoming data with the sender(s) and map the data elements to the standard format. Extract, Transform and Load (ETL) jobs are then built to load the files into our systems. For outgoing files, we work with the receiver(s) to map data elements to their prescribed formats for outgoing data exchange.

The graphic below,(Figure 2), depicts the data exchange solution which will be used for Louisiana.

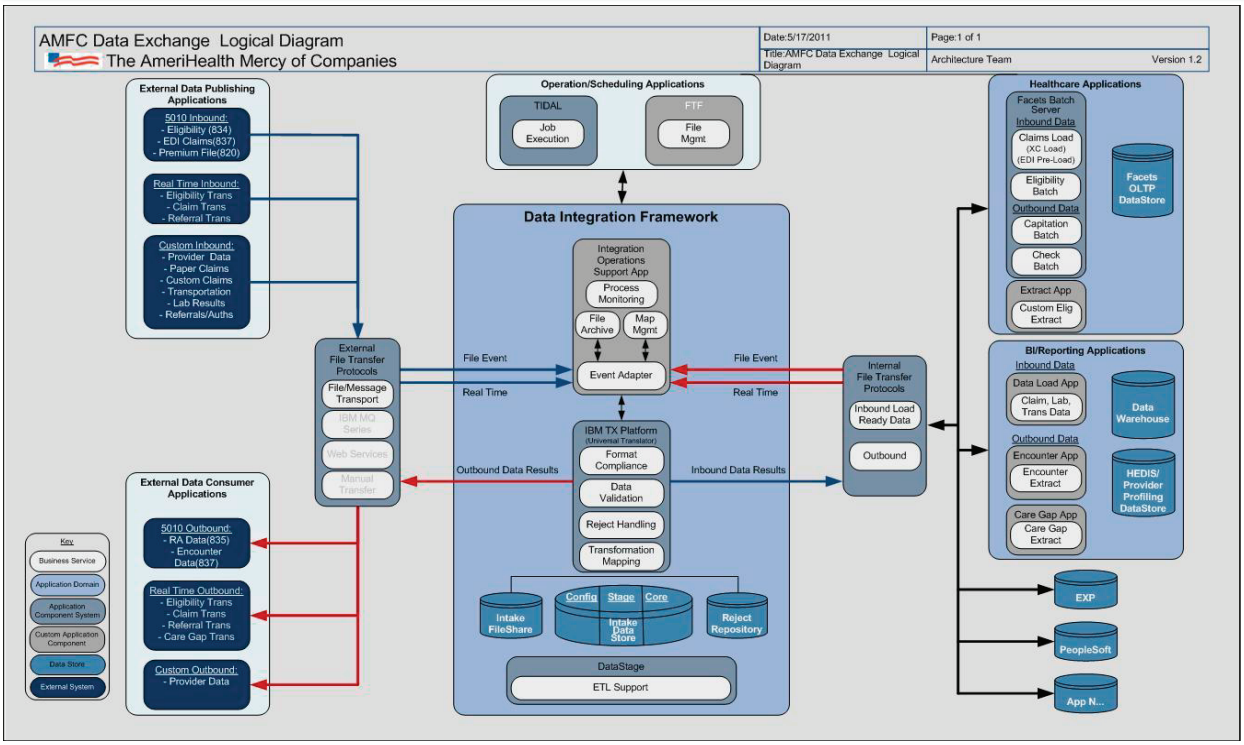


Figure 2: Data Exchange Solution

Internal and Joint Testing

Internal Testing

All of the programmatic software changes/enhancements made across the application environments require QA and Testing support with rare exception of emergency changes. The deliverables from the AmeriHealth Mercy IS QA and Testing Team will be made available to DHH and its agents as requested and dictated by the needs of the Louisiana implementation project. Details on our testing processes and program can be found in Section R7.

Joint Testing

Joint Testing includes data intake and output testing with each trading partner (including enrollment brokers, fiscal intermediaries, clearing houses, subcontractors, and state agencies). The purpose of joint testing is to ensure data requirements needed for Louisiana are accurately met for all data flows between AmeriHealth Mercy and each of the trading partners.

The first level of joint testing involves testing file transfer protocols and processing schedules to ensure transfer utilities are available and secure for sending and receiving data and data files. The second level of testing involves compliance checking of HIPAA and proprietary file formats and associated business rules prior to the loading of data to internal databases. If file or data errors are found, iterative tests are performed between trading partners to resolve issues. The third level of testing involves completeness and accuracy tests on the data content. All of the three levels of testing are performed in accordance with a pre-defined test plan and against pre-scripted test scenarios during systems integration testing with trading partners to ensure all the necessary requirements and service levels for Louisiana are met or exceeded.

Louisiana Medicaid CCN Program Specific Work Plan

AmeriHealth Mercy has developed a CNN program specific work plan that will successfully implement the Louisiana State Medicaid requirements. This work plan, while customized for Louisiana's program,

has been modeled after other work plans used for similar state Medicaid new business. Therefore, with our experience implementing against this work plan for other projects, we are confident that it will not only fit the Louisiana requirements, but it will also deliver these requirements for the January 1, 2012 Go Live.

The following work plan breaks out specifically the *Information Systems* activity for the CCN program. Since the Information Systems work plan was developed as part of the broader work plan, it accounts for dependencies both across the AmeriHealth Mercy organization and with DHH. The estimated technical resource hours by role are displayed in Table 1, below:

Table 1: Estimate of Resource Hours

Role	Estimated Hours
Analyst	8,595
Architect	145
Developer	15,100
Engineer	18,968
Manager	4,012
Tester	3,564

Table 2: Work Plan

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
0	**Louisiana Implementation Schedule**	**Tue 1/11/11**	**Fri 2/1/13**		**177,669.95 hrs**
183	**Project Manager 1**	**Mon 2/7/11**	**Fri 2/1/13**		**85,820 hrs**
184	**MEDICAL MANAGEMENT**	**Wed 6/1/11**	**Fri 2/1/13**		**68,419 hrs**
586	MEDICAL MANAGEMENT IS	Wed 6/15/11	Mon 12/19/11		1,148 hrs
587	**Systems**	**Wed 6/15/11**	**Mon 12/19/11**		**1,148 hrs**
588	**Jiva Application**	**Fri 6/17/11**	**Mon 12/19/11**		**272 hrs**
595	**Member Extract**	**Thu 6/16/11**	**Thu 12/15/11**		**142 hrs**
602	**Provider Extract**	**Thu 6/16/11**	**Thu 12/15/11**		**142 hrs**
609	**UM Load**	**Fri 6/17/11**	**Fri 12/16/11**		**268 hrs**
616	**Clinical Criteria - McKesson**	**Fri 6/17/11**	**Fri 6/17/11**		**4 hrs**
618	**Streamline Application**	**Thu 6/16/11**	**Thu 6/30/11**		**28 hrs**
623	**Visual Cactus Application**	**Wed 6/15/11**	**Thu 12/15/11**		**292 hrs**
646	**REPORTING**	**Wed 6/1/11**	**Fri 3/30/12**		**2,439 hrs**
677	**PROVIDER NETWORK MANAGEMENT**	**Mon 2/7/11**	**Thu 8/9/12**		**13,814 hrs**
773	**Project Manager 2**	**Tue 2/8/11**	**Wed 5/2/12**		**63,017.2 hrs**
774	**Information Services Team**	**Tue 2/8/11**	**Wed 5/2/12**		**63,017.2 hrs**
775	**Data Intake Solution System Implementation**	**Thu 7/28/11**	**Wed 2/1/12**		**4,803 hrs**
776	**Gather Data Requirements**	**Thu 7/28/11**	**Wed 8/24/11**		**160 hrs**
780	**Gap Analyses**	**Mon 8/1/11**	**Sat 10/15/11**		**448 hrs**
784	**Business Rules**	**Mon 10/17/11**	**Wed 10/26/11**		**64 hrs**
787	**Architecture Review**	**Thu 10/27/11**	**Mon 11/7/11**		**64 hrs**

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
790	**Identify Impacted Objects**	**Tue 11/8/11**	**Thu 11/17/11**		**64 hrs**
793	**Documentation Requirements**	**Fri 8/12/11**	**Thu 1/5/12**		**990 hrs**
809	**Unit & System Integration Testing (SIT)**	**Fri 8/12/11**	**Thu 9/29/11**		**1,349 hrs**
821	**Quality Assurance**	**Thu 9/1/11**	**Wed 2/1/12**		**896 hrs**
826	**Production Migration**	**Tue 9/27/11**	**Thu 10/6/11**		**128 hrs**
830	**Historical Loads**	**Fri 9/30/11**	**Tue 1/17/12**		**640 hrs**
836	**HealthCare Applications Support of Louisiana**	**Mon 5/16/11**	**Mon 1/30/12**		**10,729 hrs**
837	Project Oversight	Thu 8/25/11	Fri 12/30/11		740 hrs
838	**Analysis, Functional Specifications, Technical Designs**	**Mon 5/16/11**	**Mon 8/15/11**		**2,104 hrs**
845	Determine Environment Region	Mon 5/30/11	Mon 5/30/11		0 hrs
846	**HealthCare Applications Development**	**Mon 7/11/11**	**Mon 9/12/11**	**838FS-25 days,845**	**5,949 hrs**
847	**Enrollment**	**Mon 7/11/11**	**Fri 7/29/11**	**176FS-14 days**	**1,120 hrs**
858	**Provider Network Management**	**Mon 7/11/11**	**Mon 9/12/11**		**2,046 hrs**
869	**Claims Processing**	**Mon 7/11/11**	**Mon 9/12/11**		**1,570 hrs**
882	**Customer Service**	**Mon 7/11/11**	**Fri 7/22/11**		**201 hrs**
886	**Finance**	**Mon 7/11/11**	**Wed 8/3/11**	**2695FS-4 days**	**810 hrs**
893	Utilization Management	Mon 7/11/11	Mon 8/15/11		202 hrs
894	**System Integration Testing**	**Mon 10/17/11**	**Fri 11/25/11**	**846FS-20 days,997FS-5**	**1,200 hrs**
900	Deploy to QA/UAT	Mon 11/28/11	Tue 11/29/11	894	16 hrs
901	QA/UAT Testing Support	Wed 11/30/11	Mon 1/9/12	900	480 hrs
902	Go Live Preparation & Readiness Resolution	Tue 1/10/12	Mon 1/30/12	901	240 hrs

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
903	**DATA WAREHOUSE**	**Tue 2/8/11**	**Thu 2/9/12**		**2,328 hrs**
904	DWH Manager Oversight/Review	Tue 2/8/11	Fri 7/22/11		192 hrs
905	**Data Warehouse Start-up**	**Fri 7/1/11**	**Fri 7/29/11**		**200 hrs**
918	**User Acceptance Testing (UAT)**	**Mon 8/1/11**	**Tue 9/20/11**		**176 hrs**
929	**Start Readiness Cycle**	**Fri 9/2/11**	**Fri 12/30/11**		**1,168 hrs**
934	**Ready for Go Live**	**Tue 11/1/11**	**Mon 12/12/11**		**352 hrs**
936	**Go Live**	**Sun 1/1/12**	**Thu 2/9/12**		**240 hrs**
938	**ELECTRONIC DATA INTERFACE (EDI)**	**Tue 2/8/11**	**Mon 11/7/11**		**2,301 hrs**
939	Project Oversight	Tue 2/8/11	Mon 3/7/11		160 hrs
940	Amend Emdeon contract to add LA	Wed 6/1/11	Thu 6/2/11		16 hrs
941	State companion guides (834, 820)	Wed 6/1/11	Wed 6/1/11		8 hrs
942	**Requirements Document**	**Tue 2/8/11**	**Tue 8/9/11**		**640 hrs**
952	**Development (EDI maps)**	**Tue 2/15/11**	**Tue 8/16/11**		**500 hrs**
960	**Development (Sybase/NET)**	**Wed 6/29/11**	**Fri 9/2/11**		**608 hrs**
971	**QA / UAT Testing**	**Mon 9/5/11**	**Fri 11/4/11**		**362 hrs**
975	**Production Deployment**	**Mon 11/7/11**	**Mon 11/7/11**	**971**	**7 hrs**
976	Submit Change Request Ticket	Mon 11/7/11	Mon 11/7/11		2 hrs
977	CMB approval	Mon 11/7/11	Mon 11/7/11	976	1 hr
978	Deploy to production	Mon 11/7/11	Mon 11/7/11	977	4 hrs
979	**Facets CONFIGURATION**	**Mon 6/20/11**	**Wed 3/7/12**		**8,035 hrs**
1134	**ENCOUNTERS**	**Tue 2/8/11**	**Mon 3/19/12**		**3,420 hrs**
1135	Manager Oversight	Tue 2/8/11	Mon 3/21/11		240 hrs

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
1136	**Phase 1 - Configuration & Readiness**	**Wed 6/1/11**	**Fri 10/28/11**		**1,580 hrs**
1137	**Configure build process to Submit Encounter File**	**Wed 6/1/11**	**Tue 7/26/11**		**320 hrs**
1142	**Selection criteria**	**Wed 6/15/11**	**Tue 6/21/11**		**40 hrs**
1144	**Config initial and resubmission process for encounters to Louisiana**	**Wed 6/15/11**	**Mon 6/27/11**		**120 hrs**
1147	**Config void & adjustment processes**	**Wed 6/15/11**	**Mon 6/27/11**		**160 hrs**
1150	**Pre-submission process**	**Wed 6/15/11**	**Tue 6/21/11**		**80 hrs**
1153	**Pre-readiness testing**	**Mon 9/5/11**	**Mon 9/26/11**	**923**	**420 hrs**
1158	**Create file tracking & monthly control file**	**Wed 6/15/11**	**Tue 8/9/11**		**240 hrs**
1162	Readiness Test	Mon 9/26/11	Fri 10/28/11	1153	200 hrs
1163	**Phase 2 - Corrections & Production Prep**	**Fri 10/28/11**	**Fri 11/25/11**	**1136**	**1,024 hrs**
1164	Phase 1 Corrections	Thu 9/15/11	Wed 9/28/11		160 hrs
1165	**Configure Audit & Recon tables**	**Fri 10/28/11**	**Fri 11/11/11**		**80 hrs**
1167	**Process rebound file from Louisiana**	**Fri 10/28/11**	**Fri 11/25/11**		**304 hrs**
1175	**Reconciliation process for encounters**	**Fri 10/28/11**	**Fri 11/25/11**		**480 hrs**
1185	**Phase 3 - Final QA**	**Fri 11/25/11**	**Fri 12/2/11**	**1163**	**120 hrs**
1186	Finalize HIPPA certification	Fri 11/25/11	Fri 12/2/11	1163	40 hrs
1187	Systems Integration & Final QA with DHH	Fri 11/25/11	Fri 12/2/11	1163	80 hrs
1188	**Phase 4 - Deployment & Stabilization**	**Thu 1/12/12**	**Mon 3/19/12**	**1185**	**456 hrs**
1189	Deployment & Validation	Thu 1/12/12	Fri 1/13/12		16 hrs
1190	**Production Processing**	**Tue 1/31/12**	**Mon 3/19/12**		**440 hrs**
1196	**Corporate Infrastructure / Hardware**	**Tue 2/8/11**	**Fri 10/7/11**		**3,112 hrs**

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
1197	**Telecomm**	**Fri 7/15/11**	**Fri 10/7/11**		**2,168 hrs**
1203	**Database**	**Tue 2/8/11**	**Mon 4/4/11**		**584 hrs**
1214	**Intel Servers**	**Tue 2/8/11**	**Mon 3/21/11**		**360 hrs**
1219	**LA Care Implementation Test Schedule**	**Mon 8/1/11**	**Fri 8/5/11**		**88 hrs**
1233	**Local Office Infrastructure / Hardware**	**Tue 2/8/11**	**Fri 12/16/11**		**4,904 hrs**
1234	**Network Connectivity**	**Mon 7/4/11**	**Fri 10/14/11**		**1,120 hrs**
1241	**TELECOM**	**Tue 2/8/11**	**Fri 12/16/11**		**3,784 hrs**
1281	**Workflow**	**Tue 6/14/11**	**Fri 12/23/11**		**1,472 hrs**
1282	Identify Business Requirements	Tue 6/14/11	Sun 6/26/11		80 hrs
1283	Draft Workflow requirements	Mon 6/27/11	Wed 7/6/11		65 hrs
1284	Finalize Work Flow	Wed 7/6/11	Tue 7/12/11		80 hrs
1285	Construct New EXP forms	Fri 7/8/11	Thu 7/28/11		210.5 hrs
1286	Unit Test all new EXP forms	Thu 7/21/11	Thu 7/28/11		96 hrs
1287	SIT test EXP Scripts	Fri 7/29/11	Wed 8/3/11	1286	64 hrs
1288	Readiness Testing prep	Fri 8/5/11	Fri 8/26/11		256 hrs
1289	Support Readiness	Mon 8/29/11	Mon 9/12/11		164.5 hrs
1290	Identify additional EXP requirements	Tue 9/20/11	Mon 9/26/11		80 hrs
1291	EXP SIT test	Mon 11/7/11	Wed 11/9/11		40 hrs
1292	EXP QA Test	Mon 11/14/11	Fri 11/18/11		80 hrs
1293	EXP production Install	Fri 12/2/11	Fri 12/23/11		256 hrs
1294	**Information Security**	**Mon 6/6/11**	**Thu 9/29/11**		**1,475 hrs**
1295	Assign and create access privileges for new user network and applications accounts	Thu 7/28/11	Wed 8/31/11		200 hrs

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
1296	Create Data Loss Prevention processes and alerting criteria	Mon 8/29/11	Wed 8/31/11		24 hrs
1297	Create user accounts for mandatory training requirements & communicate to end users	Wed 8/31/11	Wed 8/31/11		8 hrs
1298	Installation and monitoring tools for new infrastructure	Mon 6/6/11	Wed 8/31/11		60 hrs
1299	Encrypt Email communication to new Exchange servers	Wed 8/31/11	Wed 8/31/11		4 hrs
1300	**E-SERVICES**	**Thu 6/16/11**	**Thu 9/29/11**		**1,179 hrs**
1301	**NaviNet (Provider Portal)**	**Fri 6/17/11**	**Thu 9/29/11**		**308 hrs**
1310	**Member Portal**	**Fri 6/17/11**	**Tue 9/27/11**		**188 hrs**
1317	**Online Provider Directory**	**Fri 6/17/11**	**Fri 7/29/11**		**198 hrs**
1324	**IVR**	**Thu 6/16/11**	**Thu 9/22/11**		**201 hrs**
1331	**Clearinghouses (HDX, Emdeon)**	**Fri 6/17/11**	**Thu 9/29/11**		**284 hrs**
1340	**Voice Network Services**	**Thu 6/30/11**	**Thu 12/1/11**		**18,728 hrs**
1341	**Cabling**	**Wed 11/2/11**	**Tue 11/15/11**		**96 hrs**
1344	**Installation of Avaya Survivable Gateway**	**Thu 9/1/11**	**Fri 11/4/11**		**408 hrs**
1349	**VoiceMail Implementation**	**Tue 11/1/11**	**Tue 11/15/11**		**176 hrs**
1352	**Voice Circuits**	**Mon 10/31/11**	**Mon 11/28/11**	**1346**	**480 hrs**
1362	**Call Center Build**	**Mon 8/1/11**	**Tue 11/15/11**		**11,064 hrs**
1431	**Language Services Associates**	**Mon 8/1/11**	**Tue 8/30/11**		**704 hrs**
1436	**eCas**	**Mon 10/31/11**	**Fri 11/11/11**	**1443SS**	**80 hrs**
1438	**Office set-up**	**Mon 10/31/11**	**Wed 11/30/11**	**1346**	**1,064 hrs**
1446	**IP Phones**	**Tue 10/4/11**	**Tue 11/1/11**		**1,232 hrs**
1454	Boot phone--verify DHCP	Wed 11/2/11	Thu 12/1/11	1451	176 hrs
1455	Boot phone--verify Option 242	Wed 11/2/11	Thu 12/1/11	1450	176 hrs

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
1456	Log-in extension	Tue 10/4/11	Tue 11/1/11		176 hrs
1457	Enable ftp backup/retrieve	Tue 10/4/11	Tue 11/1/11		176 hrs
1458	Retrieve labeling and options	Tue 10/4/11	Tue 11/1/11		176 hrs
1459	Verify phones are properly registered and can talk	Tue 10/4/11	Tue 11/1/11		176 hrs
1460	**End User Documentation**	**Tue 11/1/11**	**Fri 11/11/11**		**360 hrs**
1466	**IVR**	**Mon 7/25/11**	**Thu 9/1/11**		**424 hrs**
1492	**Avaya Contact Recorder / Call Logger Build**	**Thu 6/30/11**	**Mon 11/14/11**		**1,056 hrs**
1503	**Video Conferencing**	**Tue 11/1/11**	**Tue 11/15/11**		**528 hrs**
1510	**Test Cycle 1 - Basic processing engine with Paper claims only**	**Thu 9/1/11**	**Mon 10/3/11**		**560.4 hrs**
1511	**Batch 1 - Initial Provider Test - Mocked data**	**Thu 9/1/11**	**Tue 9/20/11**		**183.4 hrs**
1544	**Batch 1a - Provider test with Supplied Data - On Request**	**Thu 9/22/11**	**Wed 9/28/11**		**39.8 hrs**
1573	**Batch 2 - Member Load - Mocked up data**	**Fri 9/2/11**	**Tue 9/27/11**		**67 hrs**
1602	**Batch 2a - Member Load - Supplied data - on request**	**Tue 9/20/11**	**Mon 10/3/11**		**44 hrs**
1632	**Batch 3 -UMI Load Process- Mocked up data**	**Thu 9/1/11**	**Tue 9/27/11**		**63 hrs**
1656	**Batch 4 -Medical Management**	**Tue 9/27/11**	**Fri 9/30/11**	**1518,1575**	**74 hrs**
1687	**Batch 5 - Claims Load process - Mocked up paper claims only**	**Thu 9/1/11**	**Wed 9/28/11**		**87.2 hrs**
1739	**End Test Cycle 1**	**Fri 9/30/11**	**Fri 9/30/11**		**2 hrs**
1742	**Test Cycle 2 - Basic processing engine with EDI, Paper claims and extracts**	**Mon 10/3/11**	**Wed 11/16/11**	**1510**	**1,061.8 hrs**
1743	**Batch 1 - Provider Test 2 - Mocked data**	**Mon 10/3/11**	**Sat 10/15/11**		**92.2 hrs**
1777	**Batch 2 - Member Load - Mocked up data**	**Mon 10/3/11**	**Thu 10/13/11**		**46 hrs**
1807	**Batch 3 -UMI Load Process- Mocked up data**	**Mon 10/3/11**	**Tue 10/11/11**		**63 hrs**

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
1831	Batch 4 -Medical Management	Mon 10/3/11	Thu 10/6/11		74 hrs
1862	Batch 5 - Claims Load process - Mocked up EDI Data and Paper claims from ACS	Mon 10/3/11	Mon 10/31/11		329 hrs
1991	End Test Cycle 2	Tue 11/1/11	Tue 11/1/11		1 hr
1994	Test Cycle3	Tue 11/1/11	Wed 11/16/11	1993	456.6 hrs
1995	Change Management and QA Migration	Tue 11/1/11	Thu 11/3/11		16 hrs
1998	Batch 1 - Provider Test 3	Thu 11/3/11	Wed 11/9/11		45.8 hrs
2031	Batch 2 - Member Load	Fri 11/4/11	Wed 11/9/11		46.8 hrs
2063	Batch 3 -UMI Load Process- Mocked up data	Tue 11/1/11	Mon 11/7/11		49 hrs
2087	Batch 4 - Claims Load process - EDI and Paper	Tue 11/1/11	Wed 11/16/11		299 hrs
2222	Project Manager 3	Mon 4/11/11	Wed 5/2/12		17,675.12 hrs
2539	Project Manager 4	Tue 1/11/11	Mon 12/12/11		2,385.63 hrs
2540	Legal Affairs	Tue 4/12/11	Fri 7/15/11		20 hrs
2544	POLICIES AND PROCEDURES CREATION	Mon 5/16/11	Fri 8/5/11		120 hrs
2547	HUMAN RESOURCES	Mon 5/2/11	Fri 12/30/11		1,016 hrs
2586	PEOPLESOFT HUMAN RESOURCES SET-UP	Tue 5/31/11	Wed 8/31/11		428.63 hrs
2587	Definition	Wed 6/1/11	Tue 6/14/11		34.63 hrs
2593	Analysis, Architecture and Design	Tue 5/31/11	Wed 8/31/11		44 hrs
2609	Development	Thu 7/7/11	Fri 7/29/11		108 hrs
2621	Test and Quality Assurance	Mon 8/1/11	Wed 8/31/11		184 hrs
2626	Transition/Roll-out	Fri 7/1/11	Fri 7/15/11		50 hrs

ID	Task Name	Start	Finish	Predecessors	Estimated Work Effort
2630	**Production**	**Wed 7/13/11**	**Wed 8/31/11**		**8 hrs**
2635	**Compliance & Plan Oversight**	**Mon 5/2/11**	**Fri 7/1/11**		**544 hrs**
2648	**FINANCE**	**Tue 5/10/11**	**Wed 7/27/11**		**0 hrs**
2672	**PEOPLESOFT FINANCIAL SERVICES SET-UP**	**Tue 5/31/11**	**Thu 7/28/11**		**257 hrs**
2673	**Pre-Implementation Phase**	**Tue 5/31/11**	**Mon 6/6/11**		**48 hrs**
2679	**Analysis, Architecture and Design**	**Mon 6/6/11**	**Mon 6/6/11**		**0 hrs**
2693	**Development**	**Mon 6/6/11**	**Thu 6/9/11**		**92 hrs**
2708	**Test and Quality Assurance**	**Mon 6/6/11**	**Mon 6/20/11**		**80 hrs**
2711	**Transition/Roll-out**	**Fri 7/15/11**	**Wed 7/20/11**		**26 hrs**
2715	**Production**	**Tue 7/26/11**	**Thu 7/28/11**		**11 hrs**

Historical Data Process

AmeriHealth Mercy will fully comply with all record retention guidelines and regulations as described in the Louisiana CCN-RFP. Our retention processes are customizable based on specific needs of individual customers, while maintaining compliance with applicable state and federal regulations. Our standard data retention practices and policies vary based on the data domain/type. Our standard data retention and management practices are listed below:

- **Claims**: AmeriHealth Mercy retains claims for 36 months in our production system where they are available in real time online, and accessible through our Facets claims system. Claim data older than 36 months are archived and can easily be restored as needed, either individually or in batch back into our production Facets database. Our data warehouse stores all historical claims for up to 10 years. Data warehouse claim data is primarily utilized for informatics and analytical needs. Claims are archived using Facets' archival system to an archive database.
- **Membership and Provider Data**: AmeriHealth Mercy retains membership and provider data permanently in our Facets system. Our data warehouse also retains a complete history of all membership and provider data.
- **Billing and Capitation Data**: AmeriHealth Mercy retains Billing and Capitation data in our Facets claims system for 6-18 months depending on state requirements. Our data warehouse retains all billing and capitation data for 10 years. Billing and capitation data is archived using Facets archival system to an archive database.

The graphic below, (Figure 3), depicts the AmeriHealth Mercy historical data process including number of years retained; how the data is stored; and data accessibility.

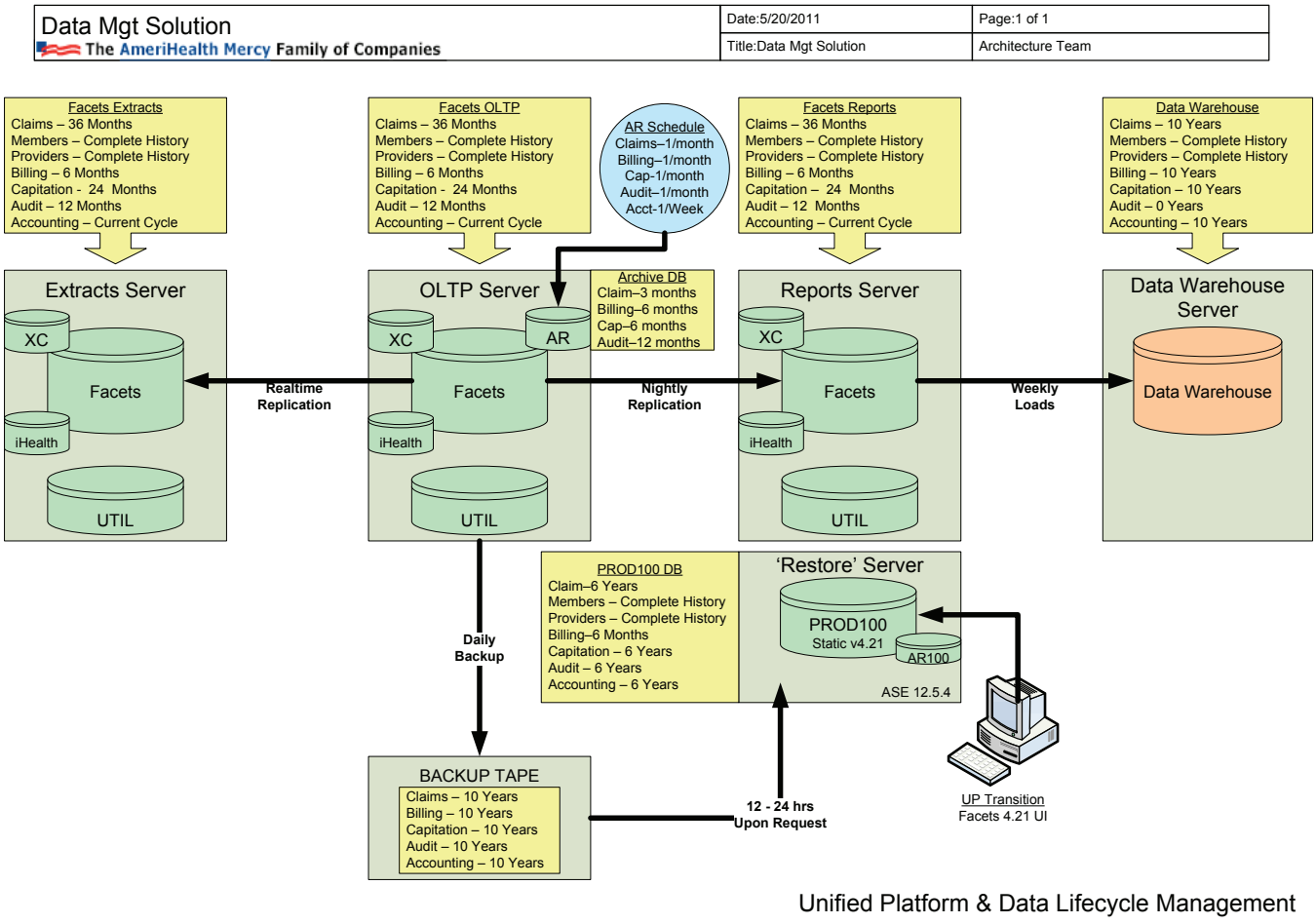


Figure 4: Historical Data Process

R.2: Ensuring Information Integrity, Validity and Completeness

R.2 Describe your processes, including procedural and systems-based internal controls, for ensuring the integrity, validity and completeness of all information you provide to DHH and the Enrollment Broker. In your description, address separately the encounter data-specific requirements in, Encounter Data Section of the RFP as well as how you will reconcile encounter data to payments according to your payment cycle, including but not limited to reconciliation of gross and net amounts and handing of payment adjustments, denials and pend processes. Additionally, describe how you will accommodate DHH-initiated data integrity, validity and provide independent completeness audits.

Integrity, Validity and Completeness of Information Exchange

AmeriHealth Mercy leverages a versatile data exchange solution to support the processing of eligibility/enrollment, provider and encounter data to and from DHH and its agents. For Louisiana, we will establish the required historical, daily, weekly and monthly data exchanges to obtain/share updates to/from the State and the fiscal intermediary and to effectively support the Healthcare Benefits and Claims Administration services. AmeriHealth Mercy's exchange of data across the enterprise is depicted in *Figure 5: Data Exchange Paths*.

The data exchanges between the State, fiscal intermediary, Enrollment Broker, AmeriHealth Mercy and our delegated service providers are supported by a multi-faceted approach to manage the integrity, validity and completeness of these data exchanges as well as ensure the timeliness and accuracy of data.

Our approach includes a strict adherence to scheduled processing times, routine error handling/reporting and associated processes to address discrepancies, reconciliation of data between parties, and audits. The audits include operational quality assurance audits, internal audits, and/or third party audits, including state and regulatory audits. Each of these system and procedural controls are detailed in the following pages.

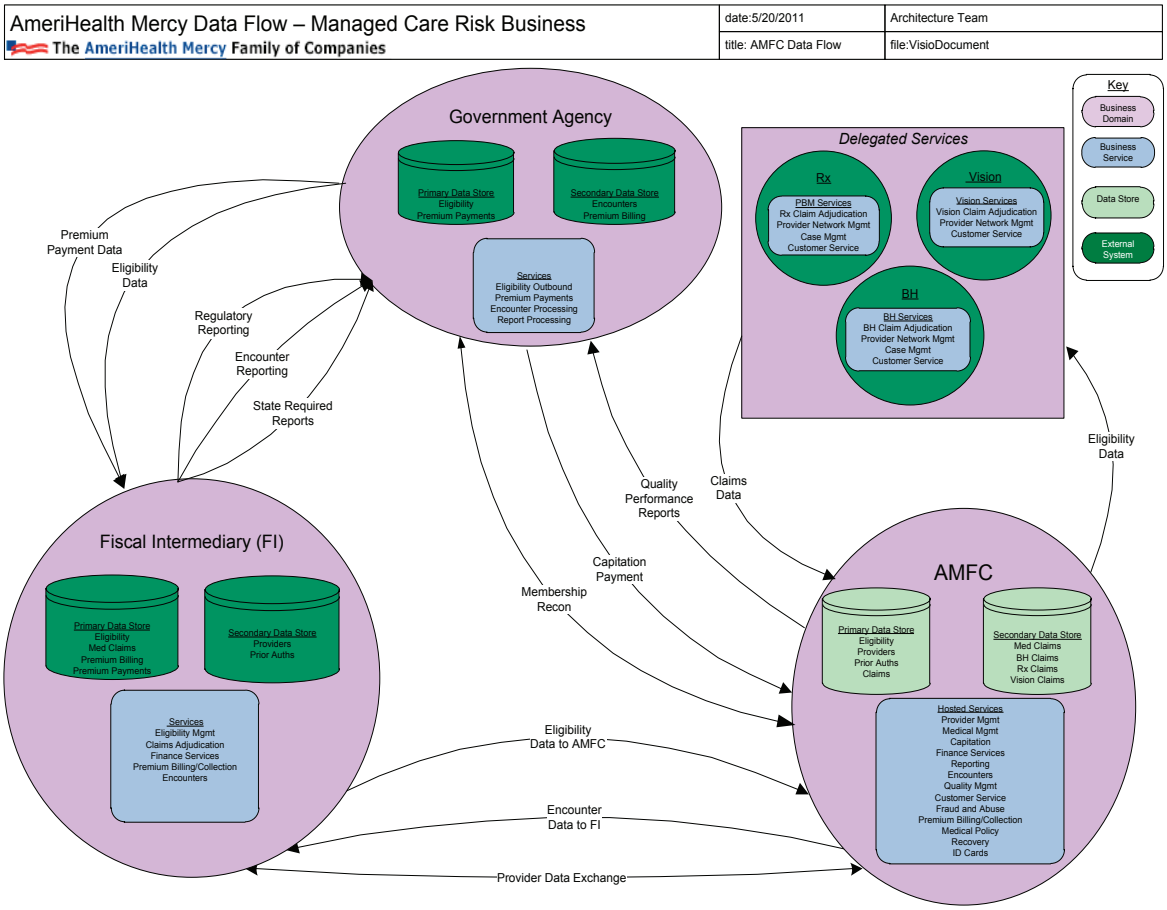


Figure 5: Data Exchange Paths

Scheduled and Secure Processes

AmeriHealth Mercy employs the TriZetto Facets Healthcare system for enterprise-wide delivery of Healthcare Benefits Administration functionality and services. To provide predictable and reliable processing, CISCO's Tidal Enterprise Scheduler is used to manage sending and receiving files between AmeriHealth Mercy and the State and its agents. It is also used to facilitate the execution of related Facets processes/services. The predetermined schedules allow for alerts to be signaled in the event a file is not received or sent when expected, if the file transfer is not successful, or in the event any processing step fails. These alerts are monitored (24x7x365) and appropriate steps taken dependent upon the circumstances.

All file transfers are conducted via a secure inbound and outbound movement of data for point-in-time or real-time transactions using dedicated point-to-point connectivity or secure virtual private networks across the Internet. The lock step method executed with each data movement ensures all received and outbound exchanges are archived and logged for future reference or processing, if needed.

Processing, Reconciliation, and Operational Quality Audits

Enrollment Data

Enrollment updates are received using the HIPAA 834 transaction into our Healthcare Benefits Administration system to update member's records with DHH and its agents most current data for existing members, member terminations, re-enrollment and new enrollees that become eligible. When received, the HIPAA 997 Acknowledgement is returned to the sender.

In order to effectively manage the accuracy of our membership data, files are processed in the order in which they are received and records are processed in chronological order for each member. Eligibility transactions are compared to our existing member records and updated or added as necessary.

Membership data that does not meet our standard edits defaults to an error report. Designated Enrollment Department employees will review and reconcile the errors with the Louisiana State System. They will update the Facets system to match the Louisiana State System data and reconcile all error reports within 24 hours of receipt. Some common discrepancies include address changes, name spelling errors, or different email addresses.

As we receive updated member information through member phone calls or correspondence, changes such as address or telephone numbers are entered into the Facets system to ensure member contact information is kept current. These changes will be sent to DHH and its agents for use in updating state enrollment data.

AmeriHealth Mercy maintains a single unique member ID number that is used to identify a distinct Medicaid member across multiple populations and systems. We also employ a robust duplicate records process to ensure member data accuracy and ultimately claim payment accuracy. We have procedures and interfaces in place to communicate identified duplicates to DHH and resolve duplicate records within all of our integrated systems.

In addition to the automated identification of enrollment discrepancies, five percent of the work performed manually by the Enrollment Unit is audited for quality. The records are randomly selected from the work of all employees who complete enrollment functions. Detailed quality reports that document overall accuracy and error trends are provided to the manager on a monthly basis. This information is used for training and performance monitoring purposes.

Provider Data

Similar to enrollment data, provider data is critical to accurate, cost-effective and timely service delivery. AmeriHealth Mercy will coordinate all provider contracting, credentialing and enrollment processes to ensure that provider information is accurate and complete and facilitate ongoing data updates and quality audit reviews. The provider directory data is sent to the Enrollment Broker to be used for primary care physician (PCP) assignments and for the Enrollment Assistance Coordinators. Additionally, provider data is important in fulfilling HIPAA 837 transaction requirements and in managing the quality of care and the network.

The Credentialing Department will gather and verify provider demographic data, including the provider's current state license, Federal and Louisiana identification numbers, and any additional information requested by the state. We will verify the data provided to ensure compliance with applicable state laws and regulations, ensure that providers are eligible to participate in Louisiana, and have appropriate policies of malpractice insurance as may be required.

AmeriHealth Mercy written policies and procedures will govern the processes for verification of provider credentials and insurance and the periodic review of provider performance. Louisiana Standard Credentialing Applications for new providers will be received in the AmeriHealth Mercy Provider Network Management area for completeness review prior to being sent to the Credentialing Department.

AmeriHealth Mercy will have a number of procedures in place to periodically review, verify and perform quality audits on the integrity of provider data. Automated comparisons identify discrepancies in the provider data and these discrepancies are distributed for investigation and correction, as necessary. Some of the key areas reviewed monthly include:

- Invalid/duplicate office hours
- Practitioner/group address/phone number disconnect
- Missing parish on service site
- Missing or invalid phone number
- CRNPs listed as having Board Certification
- Missing or invalid Gender Code
- Directory Print Conflict within group
- Invalid Panel Restrictions

Other means to verify and maintain the integrity of the provider data include:

- Provider office visits at least once a year (and in some cases quarterly) by the Provider Network Management representatives to verify demographic data.
- Receipt of claims and/or demographic change requests that require changes and updates to provider data.
- Other requests for verification from providers about their information, updating any incorrect information and submission of any changes to AmeriHealth Mercy.
- Review by appropriate staff of changes documented and attested to on roster validation forms with subsequent updates made in the Facets database as necessary

Should changes be required, the Provider Change Form and process is used to document changes to provider information in the Facets system. Additionally, Provider Data Maintenance quality audits are performed daily on five provider information change transactions per employee**.**

Encounter Data

Through collaboration with each state we have achieved consistent initial encounter acceptance rates of 95-99 percent on an annual basis. Critical to this achievement is our well-defined encounter processes and related reconciliation and operational quality reviews. These processes are described below and summarized in Figure 2: Encounters Processing Lifecycle.

1. Provider Claims Reconciled Upon Receipt

Claims/encounters are submitted by Providers via electronic data interface (EDI) methods or on a paper claim form, which is converted to electronic format, through a clearinghouse. The clearinghouse edits specific claim data to set business rules and returns claims that do not meet editing rules back to the provider. Clean claims are processed through Facets, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. Claim acknowledgements are returned to providers via the clearing house. A control process ensures all claims received are acknowledged. Discrepancies are identified, researched and corrected.

2. Adjudication Claims Pended, Paid, Denied are Reconciled to Remittance Advices

The claims processing system sets the claim to a status of Pend, Deny, or Pay. Pended claims are claims that require a manual review before adjudication can be finalized. Pended claims are routed to claims examiners via an automated workflow system. The workflow system tracks each pended claim until adjudication is finalized. Denied claims are claims with missing or inaccurate information, such as no authorization, or invalid procedure code. Denied claims are given a denial reason code which is identified on the Remittance Advice (RA). For most Louisiana affiliates, providers receive one RA each week. The RA includes information on all claims paid,

denied, and adjusted in that week. The associated payment to the provider is the net of all debits and credits.

3. Claims Reconciled to Encounters

Paid and denied claims, along with provider and member demographic information, are loaded and reconciled into the data warehouse weekly for reporting purposes. Claim counts and payment amounts are validated between the claims processing system and the data warehouse system. For Louisiana, encounter files will be prepared from the data warehouse monthly for submission to DHH's Fiscal Intermediary (DHH/FI) as specified by DHH/FI processing schedules. Encounter files will be checked for completeness and accuracy prior to submission to DHH/FI. This includes verification on claim counts, and key claim/encounter data, as well as HIPAA compliance validation. All encounter files and claim/encounter records are logged to an audit file.

Following encounter processing by the DHH/FI, the 997 and 835 files received from the DHH/FI will be reconciled to the encounter audit file to determine disposition. Should AmeriHealth Mercy not receive a 997/835, disposition will be resolved in collaboration with DHH/FI.

4. Quality & Independent Audits

Internal Quality audits are performed frequently and discrepancies are investigated promptly. Quality and independent audits are conducted by sampling claims and encounters processed by AmeriHealth Mercy systems. Queries are written and pre-approved by an auditor. Specific data elements may be requested (i.e., provider NPI, procedure, diagnosis codes, bill amount, payment amount, etc.) Query results are provided to the auditor to verify the samples against AmeriHealth Mercy internal systems, and will be provided for verification with encounter data residing in DHH/FI databases.

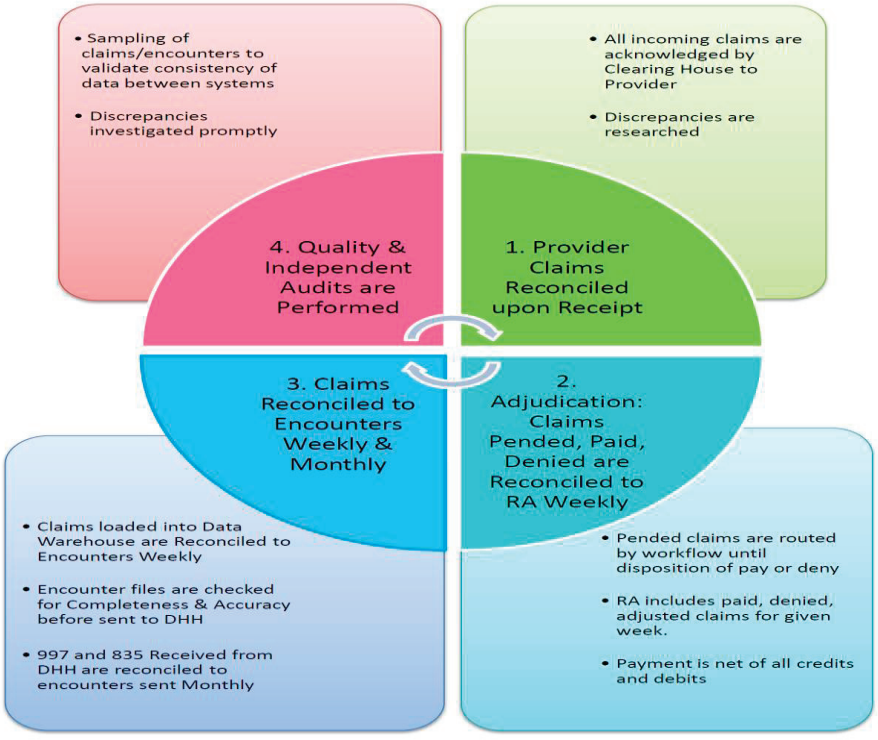


Figure 6: Encounters Processing Lifecycle

Audit and Compliance

The Internal Audit (IA) department assists AmeriHealth Mercy to accomplish its goal of delivering high-quality service to members, providers and state customers by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, internal control, and governance processes. The IA department performs financial, compliance, operational and information technology audits for the organization. In addition, AmeriHealth Mercy uses a third party auditor to perform a SAS 70 (now called a SSAE 16) audit to assess and test the design and effectiveness of internal controls. Lastly, in situations where new processes/systems and/or major process/system enhancements are planned, IA resources are involved at the outset of the initiative to ensure proper controls are implemented from the start.

In support of all DHH and regulatory audits, the Internal Audit department coordinates activities across AmeriHealth Mercy. This provides the state auditor(s) a single point of contact to assist with identification of subject matter experts (SMEs), requests for documentation and meetings, and review of findings. This also ensures a standard methodology and framework are used throughout the audit period.

AmeriHealth Mercy will participate in any audit required by DHH and will address any and all access or documentation requests within prescribed timeframes and any subsequent follow-up or suggested actions will be agreed upon and executed.

R.3: Ensuring Compliance with Required Systems Standards

R.3 Describe in detail how your organization will ensure that the availability of its systems will, at a minimum, be equal to the standards set forth in the RFP. At a minimum your description should encompass: information and telecommunications systems architecture; business continuity/disaster recovery strategies; availability and/or recovery time objectives by major system; monitoring tools and resources; continuous testing of all applicable system functions, and periodic and ad-hoc testing of your business continuity/disaster recovery plan.

Identify the timing of implementation of the mix of technologies and management strategies (policies and procedures) described in your response to (a), or indicate whether these technologies and management strategies are already in place.

Elaborate, if applicable, on how you have successfully implemented the aforementioned mix of technologies and management strategies with other clients.

AmeriHealth Mercy leverages state-of-the-art technologies and processes to ensure availability and resiliency of all our information and telecommunications systems. The design and architecture provides an economy of scale resulting in system availability exceeding the standards set forth in the RFP.

AmeriHealth Mercy has successfully implemented high-availability technologies and strategies to assure 24 X 7 systems availability for all our clients. Across our client base, we have consistently achieved an Uptime Service Level Agreement (SLA) greater than 99.9 percent across all our Information and Telecommunication systems. Uptime SLA is measured monthly and does not include any pre-scheduled downtime for regular system maintenance. Where applicable, we have adopted “Warm-standby” architecture design pattern to support system maintenance activities without impacting end user experience.

Information System Availability

Our storage and server computing systems are comprised of enterprise class, high capacity EMC DMX 3 Symmetrix Storage Solution, high performance HP Itanium Servers, Superdome2 and Blade servers.

The following diagram depicts the key components of our Information Systems architecture.

Information Systems Architecture

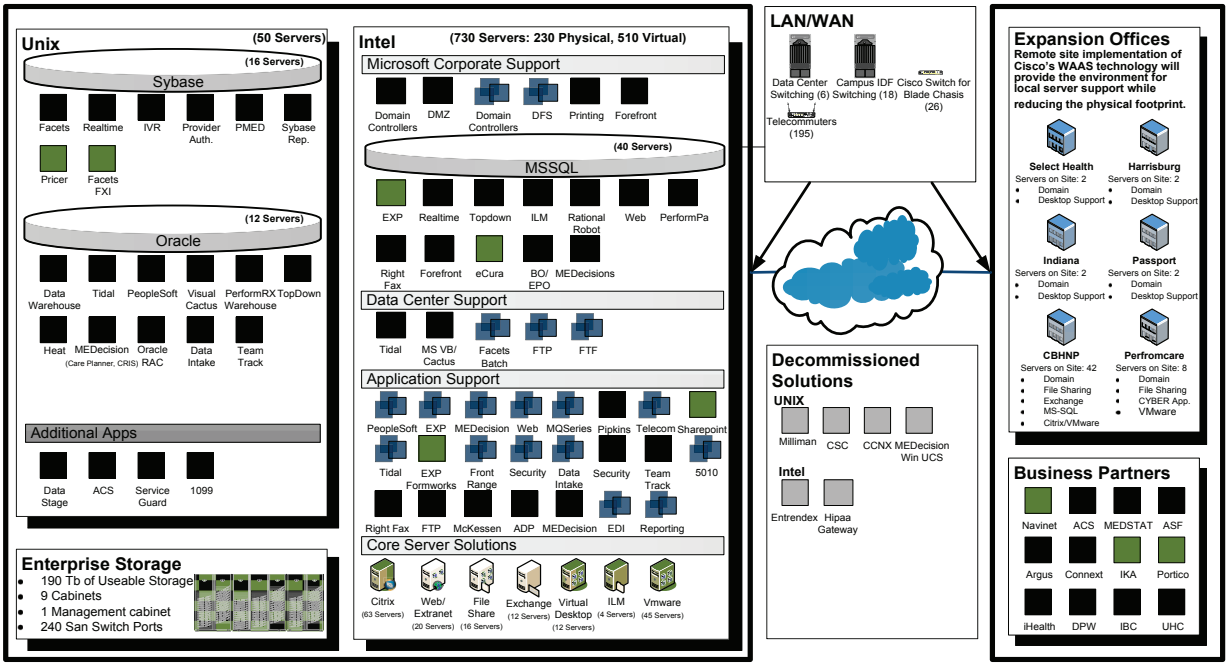


Figure 7: Information Systems Architecture

AmeriHealth Mercy's approach to high-availability infrastructure design includes collaboration with experts from our infrastructure and applications teams working with our business users and customers. This ensures that the various technologies work together to provide an integrated, secure and reliable technology environment to support our business. The following technologies are used to ensure high availability of our systems:

- **EMC** – Redundancy and RAID level fault protection
- **Service Guard Clustering** – Server based failover and fault tolerance
- **HP ICAP** – Instant capacity
- **Virtualization** – Expandability and failover
- **Microsoft clustering** – Rapid failover and fault tolerance

EMC

EMC technology provides redundant and fault tolerant storage to all of our servers. If a storage attached to a server fails for any reason, this technology provides a seamless transition to a redundant high performance storage disk. It supports storage configuration in a highly tolerant Mirror or Raid level of protection, capable of absorbing physical disk failures. The multipath approach of cache holding data in memory engineered by EMC provides not only data protection but improves storage performance.

Service Guard Clustering

We employ HP Serviceguard Solutions to ensure high availability of the HP Integrity servers running all our Critical Business Systems such as Facets, Integrated Care Management and our data warehouses. HP Serviceguard is designed to protect mission-critical applications from a wide variety of hardware and software failures. It provides support for multiple nodes, which are organized into an HA enterprise cluster that delivers highly available application services. If a particular server (node) on the cluster fails, it enables us to transfer the applications supported by the failed server to a secondary server (node) designated as a backup server.

HP ICAP

Incorporated in our HP-UX Superdome2 environments, HP's Instant Capacity (ICAP) technology allows dynamic allocation of system resources to address increased load on servers in the event of a failover supported by the Serviceguard technology. If a particular primary Server in our environment fails, this technology will allow us to allocate additional CPU & Memory resources to the secondary server to support maintaining the desired level of application performance on that server.

Virtualization

Virtualized servers can easily be relocated from one physical machine to another as needed. Because of this easy relocation, virtualization allows us to rapidly recover in case of any physical server faults or a site failure event. AmeriHealth Mercy partners with VMware's proven server and datacenter virtualization solutions built on VMware vSphere. Virtualization also allows us to provision servers faster with the use of this technology, while meeting enterprise application SLAs with a more resilient solution. We also leverage HP UNIX Business Critical Solutions for a similar virtualization and failover technology on our HP SuperDome2.

In addition to the server virtualization technologies listed above, we also utilize VMware Virtual desktop technology, which provides a stateless workspace available from anywhere and at any time. This provides rapid recovery from desktop software corruption by allowing us to provision a brand new user desktop from a pre-defined image. Owing to speed of provisioning new images, this technology helps reduce desktop maintenance cost and greatly reduces the time required to setup and provision new users.

Microsoft clustering

For those applications that are not part of our virtualized server farm, we leverage Microsoft Clustering technology. Clustering addresses the impact to a physical server failure by utilizing active-passive or active-active clustering. When any active server in the cluster goes down due to any failure, the secondary server in the cluster takes over the operations of the failed server. This technology allows the nodes of the cluster to monitor health of the servers across the entire cluster and leverages predefined failover rules in any failure event.

Security Monitoring System Availability

AmeriHealth Mercy's Intrusion Prevention System (IPS) is based on "inline" technology, protected by a pair of Zero Power High Availability (ZPHA) devices. These devices were developed to specifically address the need of organizations to retain constant connectivity and monitoring capability. The ZPHA device automatically detects loss of power to the Intrusion Prevention System (IPS) and immediately provides redundant network connectivity, preventing any network downtime that can affect business operations.

The architectural foundation of our critical security infrastructures like Intrusion Detection (IDS) and Intrusion Prevention System (IPS) is to "fail open" in the event of a hardware failure. This eliminates any impedance on network traffic related to the appliance failure.

Aladdin, our two-factor authentication solution, leverages multiple Microsoft server nodes configured in an active/passive cluster. The model ensures continued support for external access to the AmeriHealth Mercy network.

Telecommunications System Availability

Our framework for telecommunication system availability consists of four major functional areas:

- Fault management — enables the early detection, isolation, and correction of any abnormal operation of the telecom/data network and its associated environment.

- Configuration management — controls, configures, identifies, and collects data from the various network elements, such as routers, switches etc. and provides this information to the network management system.
- Performance management — evaluates and reports on the individual behavior of the data/telecommunication equipment and network facilities. This includes the ability to map behavior to SLA metrics and to track quality of service metrics.
- Security management — provides the protection and detection of improper access and usage of network resources and related services as well as their containment and recovery. It also monitors operator access to network management control consoles and logs configuration changes.

Site-to-Site Connectivity

Key components of high availability: Multiple diverse carriers (Sprint, Verizon, Level 3) and Redundant circuit paths.

Every office in AmeriHealth Mercy is designed with redundant network connectivity utilizing diverse carriers of various sizes that connect the affiliates with the parent company. Our use of diverse carriers protects us from any outages specific to a particular carrier. We intend to replicate this same, highly resilient setup for our Louisiana office. The corporate office of the parent company, AmeriHealth Mercy, is connected to its Tier IV data center by multiple, 10Gbps diverse paths of private dedicated optical fiber circuit (dark fiber). The diverse, multiple paths provide a full redundancy against any failure of a particular fiber path. Supporting the Data Center itself is a design based on a dual core network architecture that includes multiple enterprise class Cisco Catalyst 6500 series switches with dual supervisor engines and dual power supplies. Enterprise monitoring assures up time and proactive response to network events.

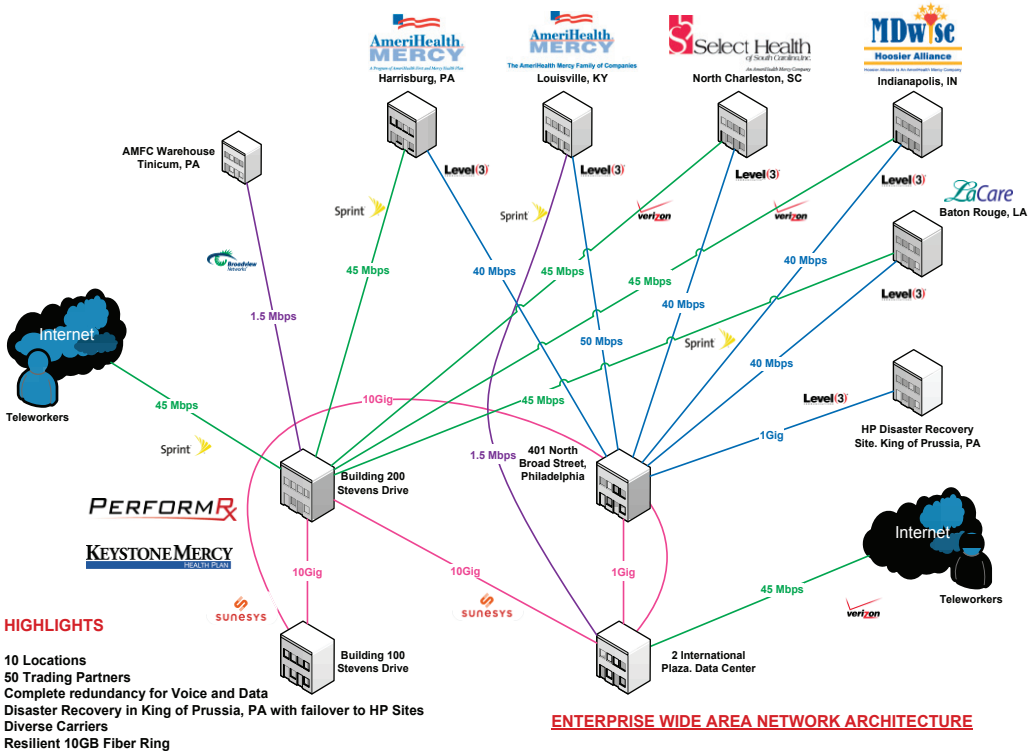


Figure 8: Network Architecture

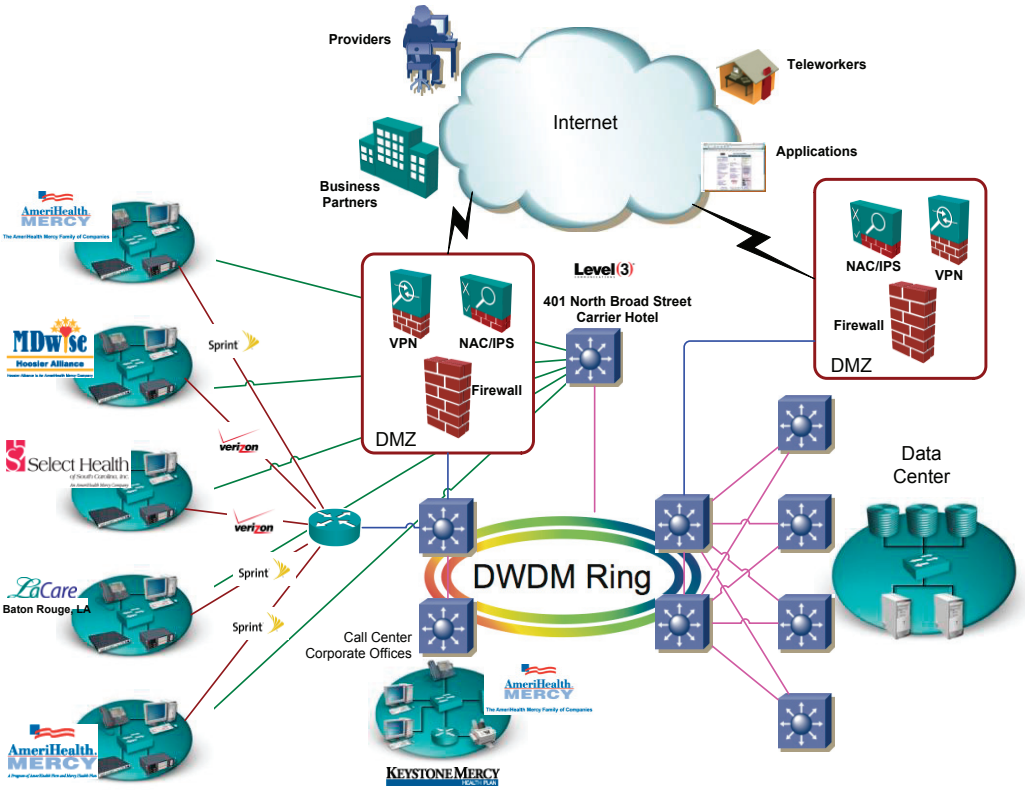


Figure 9: External Connectivity

Key components of high availability: Multiple redundant enterprise class networking hardware including concentrators, switches, firewalls and routers

AmeriHealth Mercy supports a number of secured HIPAA compliant connectivity solutions through the Internet, or through private connectivity with participating business partners. We utilize industry standard VPN client-to-site, or site-to-site VPN technologies to protect our data as we further integrate with our partners. We also leverage a dual layer DMZ topology to assure additional security, and to separate public Internet connectivity with private business partner's connectivity. The Internet DMZ is serviced by redundant Cisco VPN ASA5520 concentrators, and cryptographic service routers, and secured with Cisco ASA5500 firewalls. Our Extranet for private connectivity with business partners is serviced by redundant Cisco ASA5550 firewalls, and redundant Cisco ACE4710 load balancers and reversed proxy servers. Additionally, our Internet facing DMZ can support secured FTP connections with support for SFTP, FTPS, HTTPS/S, & SCP2 and FIPS 140-2 validated cryptography. Authentication is handled by Cisco AAA CSACS01121 security appliances.

Telephony Services

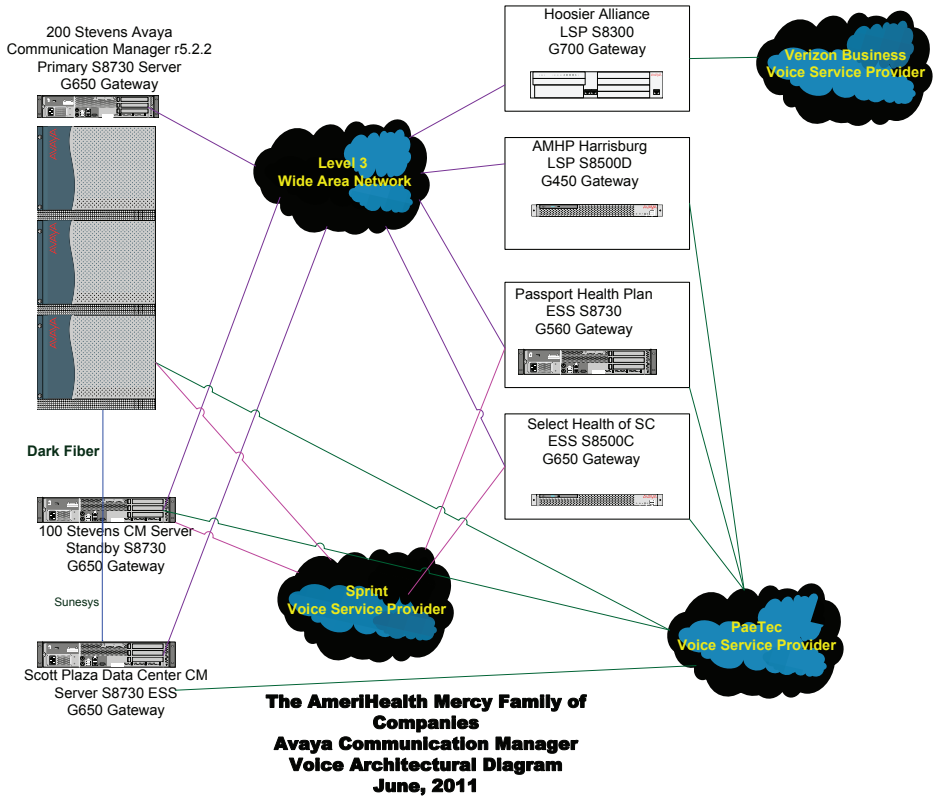


Figure10: Voice Architectural Diagram

Key components of high availability: Diverse carriers (PAETEC, Sprint), Distributed PBX setup

Voice Network Services ensures the highest level of support and availability of telephonic and contact center services for AmeriHealth Mercy. 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 PAETEC and Sprint. If connectivity to the enterprise hub at our corporate Philadelphia campus is interrupted, the local passive PBX will engage and 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 routed to the parent company or another affiliate. This ensures the continued service of our members in the event of a crisis.

Periodic and ad-hoc testing of our business continuity/disaster recovery plan.

We formally test the Disaster Recovery Plan at an alternate site annually. This is achieved in partnership with our vendor, Hewlett-Packard. During each disaster test, we fully restore production environments based on testing requirements and maintain detailed reports, which continually refine the processes used during the time period of the tests. Our Disaster Recovery (DR) services with HP include:

Planning:

- Planning and resource coordination; communication
- Physical inventory of Servers, Routers, Cabling, Applications etc.
- Test planning; risk and contingency analysis: mitigation strategies
- Assembly of DR cans with required documentation and materials

Control:

- SharePoint document repository
- Playbook
- Annual document review
- Quarterly contract, inventory and technical recovery review
- Biannual DR can content review

Construction:

- Hot site including data center and seats (King of Prussia, PA)
- Network installation
- Rack for pre-staging equipment

Execution:

- HP supported hot site capable of supporting 300+ seats
- Playbook execution
- Timed activities in sequence
- Measure time duration
- Schedule exercises

In addition to this comprehensive plan, all of our facilities have extensive contingency plans for weather emergencies, building evacuation, and any other type of disaster. Utilizing advanced routing features through vector programming within our Voice Platforms, or simply logging on with a specific agent log-on ID, voice and fax calls from any of our offices can be rerouted instantaneously to a predetermined alternate location.

Continuous testing of all applicable system functions

AmeriHealth Mercy leverages a number of monitoring tools and technologies, described in the next section, to continuously monitor and test the health of all our information and telecommunications systems. The primary goal of this testing is to ensure that all systems are working as expected, specifically measuring for response times and optimal workload capacity.

Systems Monitoring Tools

EMC Service Processor

The DMX Symmetrix, our enterprise storage solution, is monitored and supported by the EMC Service Processor. This system monitors all components in the storage frame, predicts failures and contacts EMC support to initiate a service call in the event of a failure. The same system also manages the micro code and storage configuration for the Symmetrix.

HP System Insight Manager

System Insight Manager oversees the health of our Microsoft and HP-UNIX server platforms. Environment maps are automatically built and maintained by the solution. It leverages a centrally managed model where the monitoring capability of the solution alerts employees of predicted failures, while providing a method to capture utilization and performance metrics. Another facet of the solution is the inventory management capabilities that assist in maintaining the warranties of the technology we utilize.

Security Monitoring

Technologies embedded in the Information Security infrastructure like IDS, IPS, Websense and EventTracker continuously monitor our public facing entry points and devices residing on our network. These solutions are configured to alert key personnel when any change to a system, environment and/or logical configuration occurs within our local and extended networks.

Additionally, Information Security contracts with a trusted third party vendor to provide four (4) unannounced penetration tests each year to ensure the our wide area Security design is hardened and up-to-date relative to the evolving threats. These tests probe the InfoSec protection architecture by utilizing external hacking methods. This ensures AmeriHealth Mercy that the current security technology and systems deployed to protect and manage our data and electronic assets are working as expected. They assist in refining and tuning the threshold configurations that provide intelligent responses to activities as they occur.

Network Monitoring

AmeriHealth Mercy utilizes Orion, a robust tool for comprehensive monitoring of LAN/WAN, Infrastructure and Teleworkers. Orion Network Performance Monitor (NPM) delivers detailed network performance monitoring. Orion makes it easy to quickly detect, diagnose, and resolve performance issues within our ever-changing corporate or data center environments. NPM delivers real-time views and dashboards that allow us to visually track network performance at a glance. Leveraging dynamic network topology functionality and automated network discovery features, we can maintain our agility with the evolving network needs of the organization.

Orion resides on a virtual server with a backend SQL database that captures and stores data for trending, bench marking and data analysis. Our license allows for an unlimited number of network nodes, VM Enclosures, UNIX servers, and Intel servers to be monitored. In addition, we also own unlimited licenses for all of the Orion NPM modules with the exception of the SAN Storage module.

- Orion NetFlow Traffic Analyzer: Orion NetFlow Traffic Analyzer (NTA) enables us to capture flow data from continuous streams of network traffic and convert those raw numbers into easy-to-interpret charts and tables that quantify exactly how the corporate network is being used, by whom, and for what purpose – enabling us to identify and close down instances of abnormally high bandwidth use.
- Orion IP (Internet Protocol) SLA (Service Level Agreement) Manager: Orion IP SLA Manager identifies site-specific or WAN-related network performance issues and allows for focused monitoring of our remote sites to ensure we are meeting agreed upon service levels. The network team monitors applications traversing the WAN by monitoring the performance of underlying network protocols, including DNS lookups, FTP, HTTP, TCP connect, and UDP jitter, while continuing to monitor Voice-over-IP call paths.
- Orion Application Performance Monitor: Orion Application Performance Monitor (APM) provides visibility into the performance of our applications and underlying operating systems with servers they run on. It monitors, alerts, and reporting based on established thresholds by application.
- Orion Internet Protocol Address Monitor: Orion IP Address Monitor (IPAM) automatically scans the network for IP address changes and maintains a dynamic list of IP addresses, ensuring there is no downtime caused by address conflicts. The network team utilizes the web interface to view and manage our Internet Protocol (IP) addresses across all sites.

Management Strategies for Ensuring High Availability of Information and Telecommunication Systems

AmeriHealth Mercy has addressed the increased demand for availability, performance, and reliability from information and telecommunication systems by developing comprehensive Service Level Agreement (SLA), policies and procedures and has core competency groups who maintain the guaranteed service levels. By doing so, AmeriHealth Mercy ensures benefits such as:

- Critical application service levels are tracked and maintained. A competency center is staffed with skilled technical staff that selects, maintains, and upgrades the infrastructure to provide

constant vigilance across the network. This results in improved levels of availability, performance, and reliability.

- Network and Systems SLA performance is accurately tracked. A key task of the competency center is to ensure appropriate tools are available to detect these problems and protect the enterprise from mediocre service provider performance.
- Obtain desired levels of customer satisfaction. User requirements are identified and planned across network and systems management. An annual support plan identifies new business application requirements and user expectations.

AmeriHealth Mercy has successfully implemented all of the above high-availability technologies and strategies to assure 24 X 7 systems availability for all of our clients. We intend to fully leverage these technologies and management strategies to ensure that we exceed all of the availability and business continuity/disaster recovery standards set forth in the RFP.

R.4: Key Production Systems

R.4 Describe in detail:

- *How your key production systems are designed to interoperate. In your response address all of the following:*
  - *How identical or closely related data elements in different systems are named, formatted and maintained:*
    - *Are the data elements named consistently;*
    - *Are the data elements formatted similarly (# of characters, type-text, numeric, etc.);*
    - *Are the data elements updated/refreshed with the same frequency or in similar cycles; and*
    - *Are the data elements updated/refreshed in the same manner (manual input, data exchange, automated function, etc.)*
  - *All exchanges of data between key production systems.*
    - *How each data exchange is triggered: a manually initiated process, an automated process, etc.*
    - *The frequency/periodicity of each data exchange: "real-time" (through a live point to-point interface or an interface "engine"), daily/nightly as triggered by a system processing job, biweekly, monthly, etc.*
- *As part of your response, provide diagrams that illustrate:*
  - *point-to-point interfaces,*
  - *information flows,*
  - *internal controls and*
  - *the networking arrangement (AKA "network diagram") associated with the information systems profiled.*

These diagrams should provide insight into how your Systems will be organized and interact with DHH systems for the purposes of exchanging Information and automating and/or facilitating specific functions associated with the Louisiana Medicaid CCN Program.

Interoperation of Key Production Systems

AmeriHealth Mercy has developed a robust architecture of Management Information Systems (MIS) to support our enterprise business processes and clients. We leverage best practices for the development and implementation of flexible, resilient and powerful applications to meet the complexities of the Medicaid business. Our architecture promotes standardization, controls, and automation to support effective system interoperability and ensure data quality.

Metadata Management – Data Element Naming and Formatting

Consistency of Data Element Names

AmeriHealth Mercy utilizes robust tools to ensure data elements are named consistently across systems. We employ an industry leading data modeling suite, CA Erwin Data Modeler, to maintain, store and generate Data Definition Language (DDL) scripts, report metadata and synchronize database objects across all online transaction processing (OLTP) databases and relational data warehouses. The relational database management system (RDBMS) for the OLTP application is Sybase and the data warehouse RDBMS is Oracle.

The CA Erwin tool contains a glossary that empowers a data modeler to consistently name elements across data models and databases. For example: The suffix "ID" is consistently utilized to refer to an "Identifier." There are standard naming conventions that we leverage for our OLTP Systems in-line with our core claims administration system (Facets.) We also have a distinct set of naming conventions for our data warehouse systems that are more business friendly and help enhance the data warehouse user experience.

Please refer to the following physical data models below. These illustrate an example of our naming conventions for both our OLTP and our data warehouse systems.

OLTP Physical Data Model Example

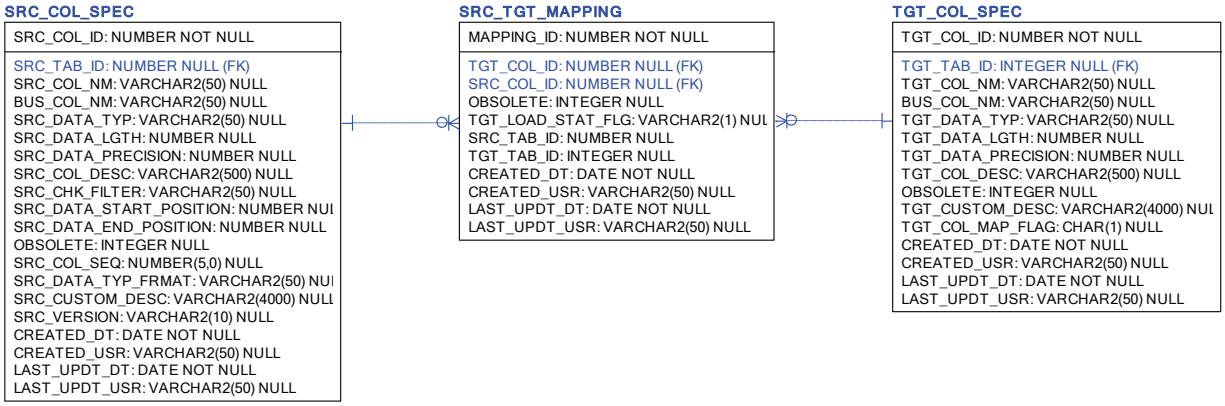


Figure 11: OLTP Physical Data Model Example

Data Warehouse Physical Data Model Example

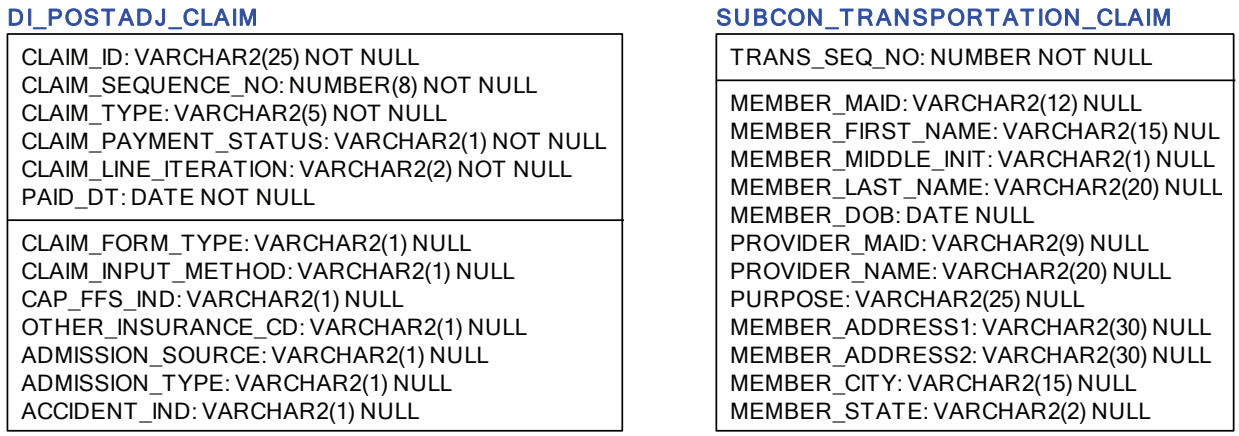


Figure12: Data Warehouse Physical Data Model Example

Consistency of Data Element Formats:

All data exchanges that occur between various systems such as the OLTP and data warehouse are performed using the IBM Data Stage ETL tool. Data Stage ensures data elements format consistency across databases. Also, CA Erwin utilizes domains to ensure data type consistency across data models and databases.

Frequency and Manner of Data Element Updates:

Data elements are updated/refreshed through regularly scheduled batch processing and also through daily real-time on-line transaction processing. Employing our enterprise scheduler system, Tidal Enterprise Scheduler (Tidal), data is batch loaded to the OLTP and data warehouse according to pre-defined schedules. Data warehouse data is updated weekly from the OLTP and other sources using our Tidal and Data Stage ETL tools.

Overall, across various systems, data elements are updated using consistent processes according to pre-defined schedules. They can either be real-time, daily, weekly or monthly. Other data exchanges are handled via established ETL data exchanges or using AmeriHealth Mercy's state-of-the-art data intake system described in our Unified Data Intake Layer.

Metadata Repository

The primary goal of our Metadata Repository is to document and publish information about our enterprise data artifacts. Within the Metadata Repository, the following information is available to employees and contractors online: a robust metadata dictionary for the OLTP and data warehouse environments, data models, source-to-target data maps and high level process flow diagrams. In some cases, the process flow diagrams and data dictionary are integrated to maximize a user's experience. The Metadata Repository includes information such as data type, data format, business rules, ownership and definitions for every data element.

Data Exchanges between Key Production Systems

AmeriHealth Mercy supports total data and data flow integration in the most secure and controlled manner. The diagram below outlines the Data Integration Architecture including interfaces and the flow of data between integrated systems and the frequency of the data flow. Key production systems, as well as data sources and targets are identified. All point–to-point interfaces between internal and external production systems are included. The integration methods, frequency and internal quality controls for each interface are also provided.

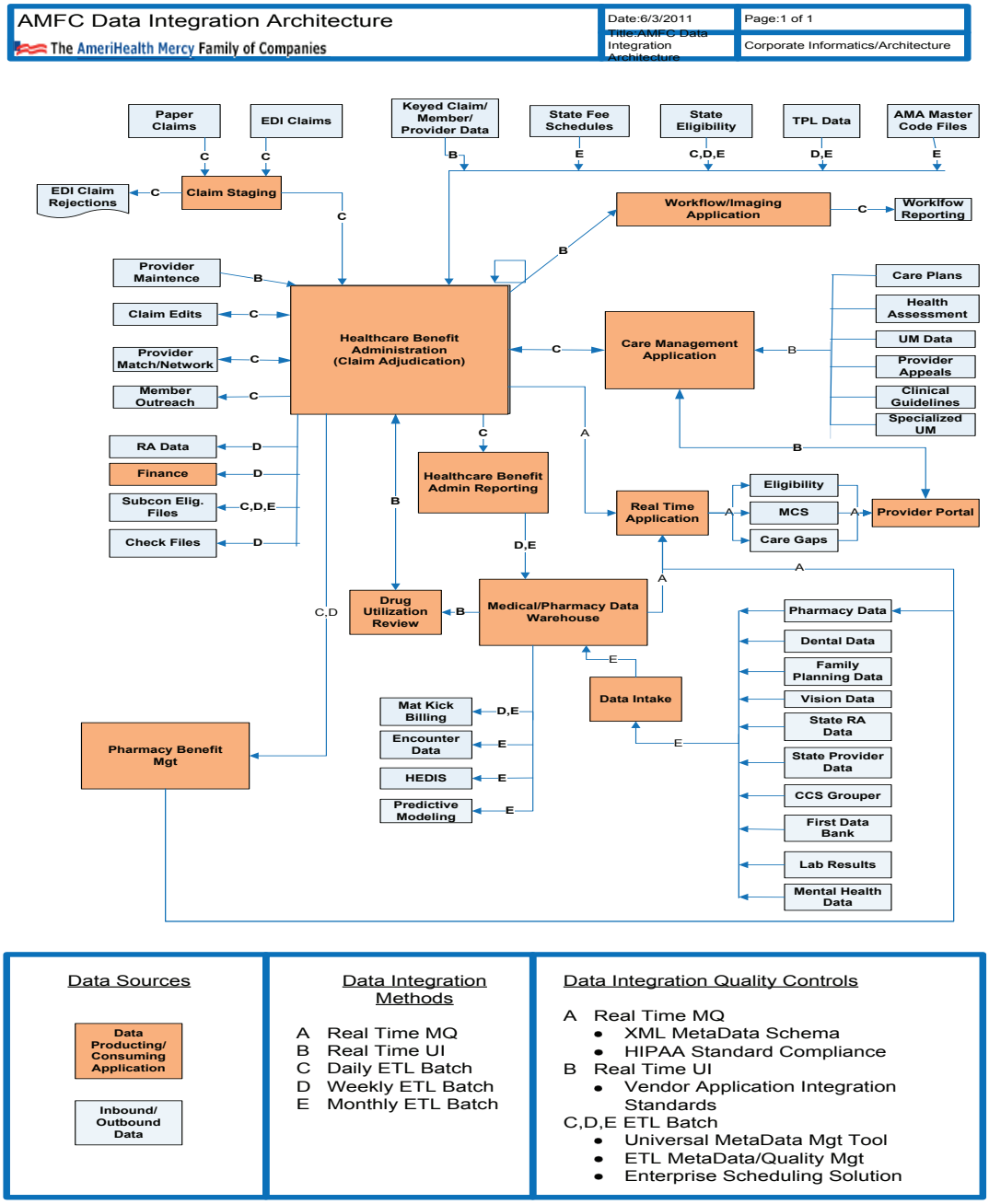


Figure 13: Data Integration Architecture

The data replication diagram illustrated below depicts an example of the data and information flow between various OLTP, Batch and Reporting environments. We leverage Sybase Replication technology which provides a robust, high performance mechanism to exchange data among systems.

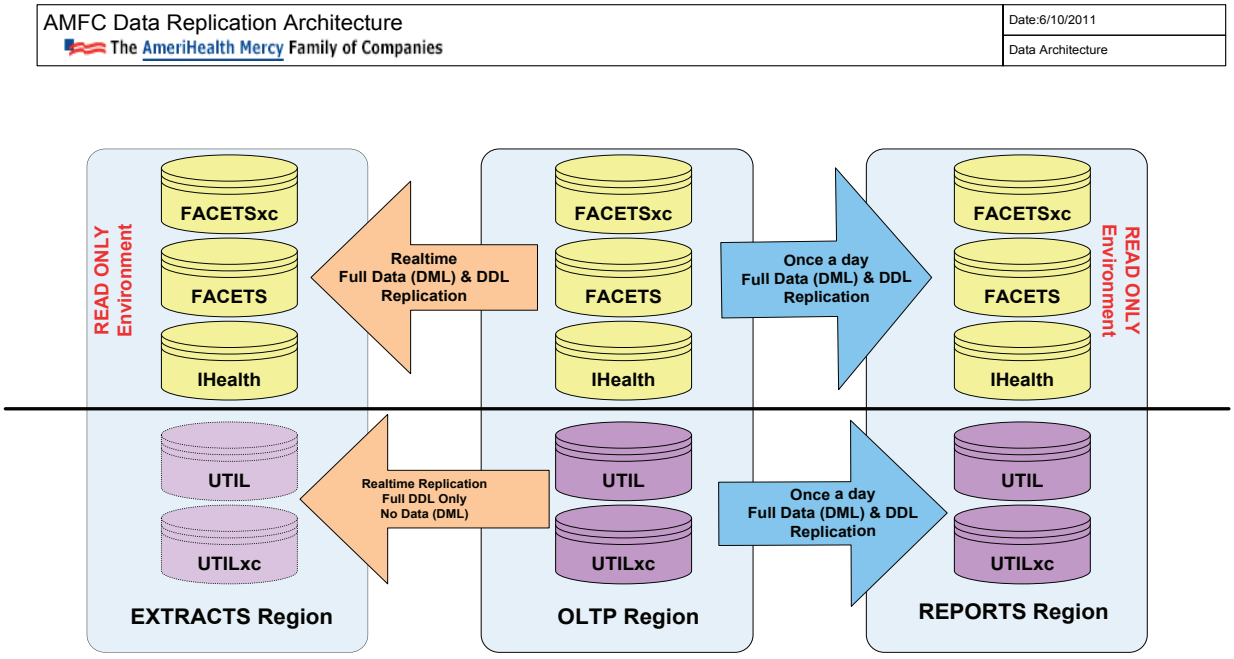


Figure 14: Data Replication Architecture

Data Exchange with DHH

Our unified data intake layer utilizes state-of-the-art tools such as IBM Web sphere Transformation Extender (WTX), UNIX and Data Stage (ETL) to perform high-speed data transformation. These systems significantly reduce our "time-to-market" for setting up new data exchanges using standard or custom formats, and will be used to establish data exchanges processes with DHH and its agents. The Data Intake process consists of four integrated engines that drive the data intake process (source file management, configuration, standardization and publication.)

The Source File Management Engine uses IBM WTX to validate the data files and prepare the source file for processing. The Configuration Engine stores the file mapping, business and validation rules related to the source file. In this portion of the process, business and validation rules are identified and controlled by business users. This process has established a data exchange competency that is unparalleled. The Standardization Engine validates and standardizes the input data and loads it to the target database using Data Stage. During this stage, business and validation rules are enforced on the inbound data set. The Publication Engine performs further data transformations that are required for downstream processing. The entire Data Intake process sits on a high performance/high transaction server and ensures high quality for data in AmeriHealth Mercy data stores. The process is illustrated in the diagram below.

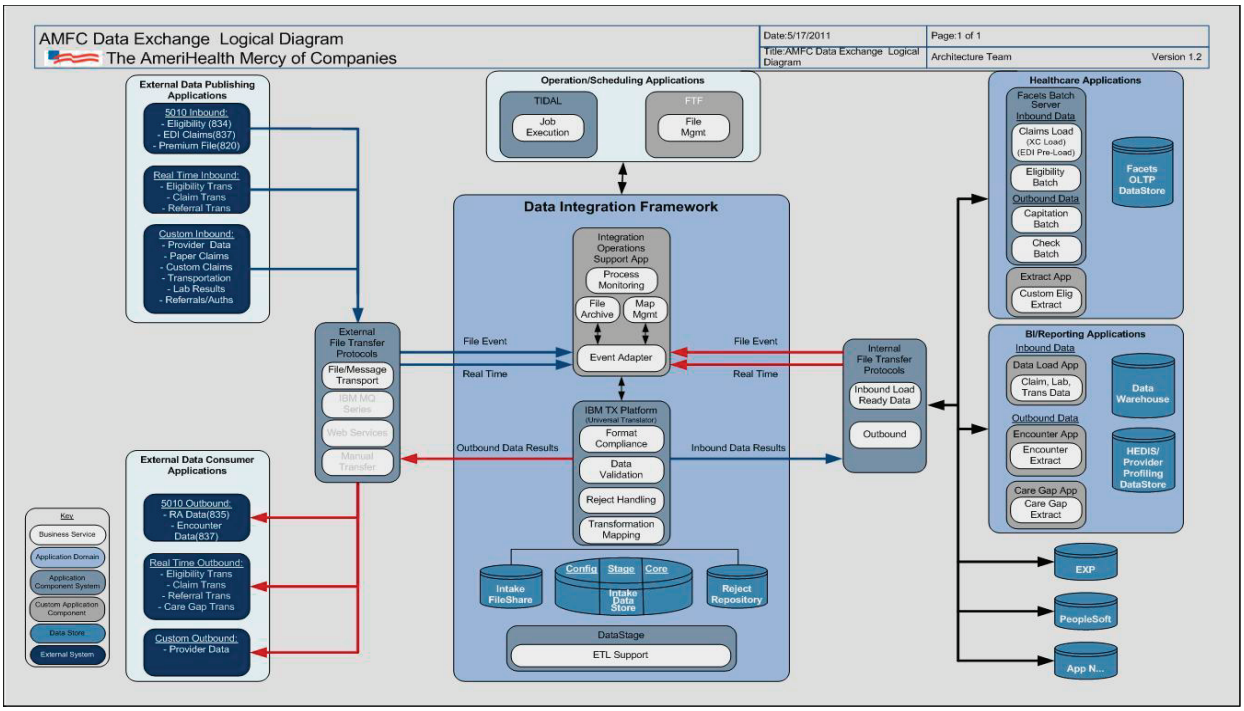


Figure 25: Data Exchange Process on High Performance/High Transaction Server

The following are specific examples of the types of transactions supported in the above Data Exchange platform.

Table 2: EDI Transaction Types Supported by AmeriHealth Mercy

X12 Transactions Batch	Type	Source	In/Out	Frequency
820	Premium Payments	State/FI	Inbound	Daily/Monthly
834	Enrollment	State/FI	Inbound	Daily/Weekly
835	Payment/Remittance	Health Plan	Outbound	Weekly
835	Inbound (Maternity Kick)	State/FI	Inbound	Weekly
837I	Institutional Claims	Emdeon	Inbound	Daily
837I	Institutional Claims	State/FI	Inbound	Daily
837P	Professional Claims	Emdeon	Inbound	Daily
837P	Professional Claims	State/FI	Inbound	Daily
837	Outbound (Maternity Kick)	State/FI	Inbound	Weekly

X12 Transactions Real Time	Type	Source	In/Out	Frequency
270	Eligibility Inquiry	Provider to NaviNet	Inbound	RT 24/7
271	Eligibility Response	Provider to NaviNet	Outbound	RT 24/7
276	Claims Status Inquiry	Provider to NaviNet	Inbound	RT 24/7
277	Claims Status Response	Provider to NaviNet	Outbound	RT 24/7
278	Referrals Submissions	Provider to NaviNet	In/Out	RT 24/7
278	Referral Inquiry	Provider to NaviNet	In/Out	RT 24/7
997	File Level Acknowledgement	Health Plan	Outbound	RT 24/7

AmeriHealth Mercy Network Integration

The enterprise network overview diagram, below, depicts the communication channels and connection points supporting the systems described above.

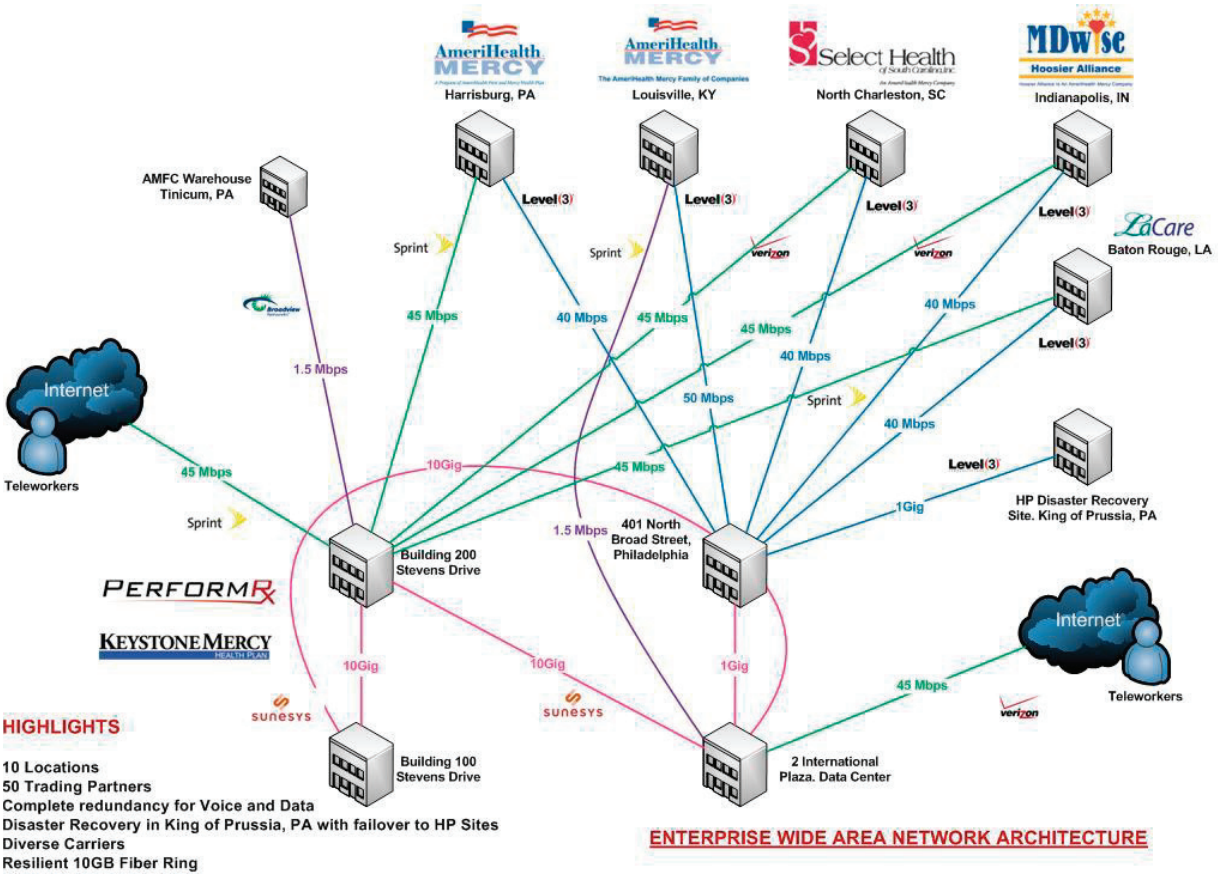


Figure 36: Enterprise Network Overview

Service Domain Integration

AmeriHealth Mercy will leverage the above network infrastructure to support the required connectivity to for the functions associated with Louisiana. These services will be provided on the consolidated service domain architecture depicted below.

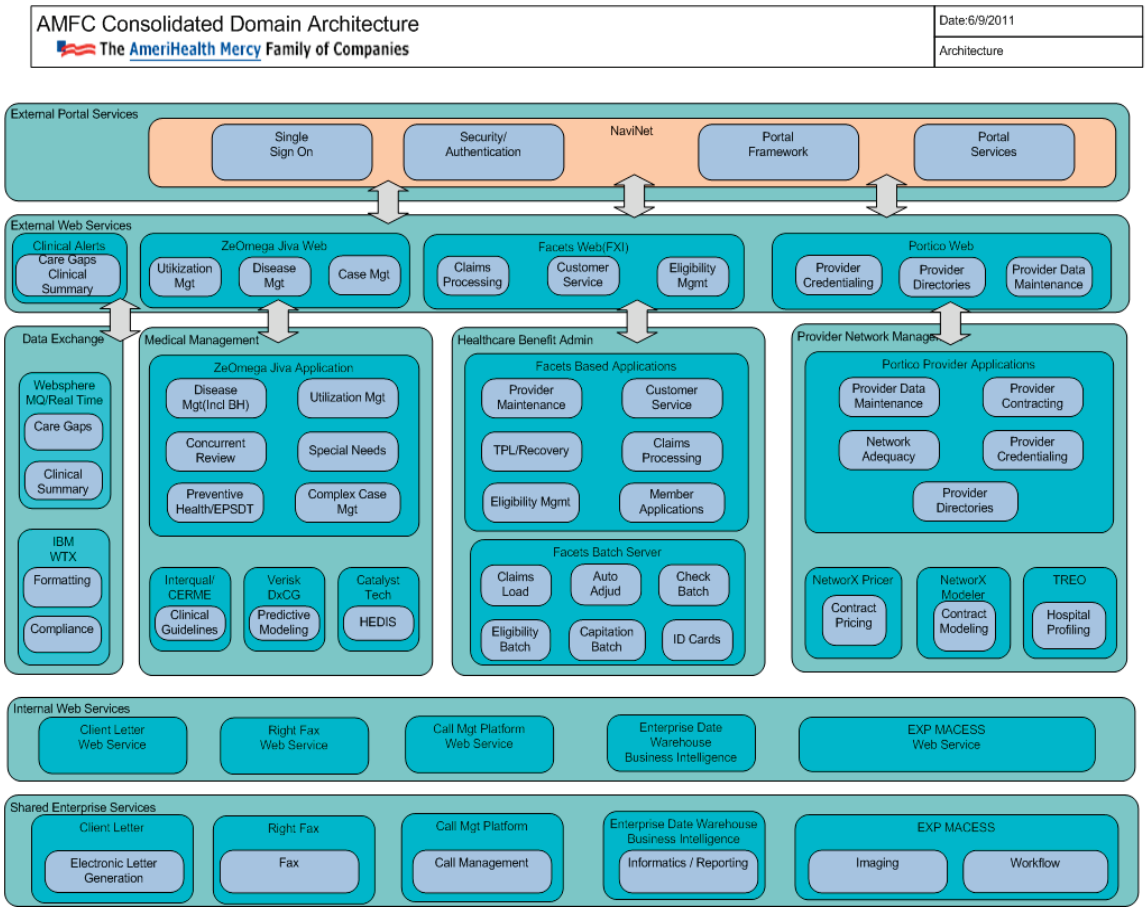


Figure 17: Consolidated Domain Architecture

R.5: Provide and Store Encounter Data

R5. Describe your ability to provide and store encounter data in accordance with the requirements in this RFP. In your response:

- *Explain whether and how your systems meet (or exceed) each of these requirements.*
- *Cite at least three currently-live instances where you are successfully providing encounter data in accordance with DHH coding, data exchange format and transmission standards and specifications or similar standards and specifications, with at least two of these instances involving the provision of encounter information from providers with whom you have capitation arrangements. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.*
- *If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*
- *Identify challenges and "lessons learned" from your implementation and operations experience in other states and describe how you will apply these lessons to this contract.*

Encounter System Capabilities

AmeriHealth Mercy has successfully submitted encounters to multiple state Medicaid programs for many years. Through collaboration with each state, we have achieved consistent initial acceptance rates of 95-99 percent on an annual basis and developed an extensive systems process covering all state requirements. Our encounter processing system is comprised of multiple applications that produce and submit 837 ANSI X12 provider-to-payer-to-payer coordination of benefits (COB) format, and National Council Prescription Drug Programs (NCPDP) compliant files, as well as, proprietary encounters files through a secure file transfer process according to submission timing requirements and as specified in companion guides provided by state Medicaid offices. Using this expertise, AmeriHealth Mercy will meet and exceed DHH requirements as outlined in the CCN-P RFP.

Encounter system components are regularly updated with new state and federal requirements as well as updated editions of CPT, HCPCS, ICD-9 and other code sets in compliance with HIPAA standards. HCPCS Level II and Category II CPT codes are also supported.

The encounter system consists of the following key components:

- Selection of new encounters in accordance with state requirements
- Submission of paper encounters converted to electronic format and EDI-received encounters
- Submission of fee-for-service and capitated encounters with equivalent level of detail, as well as encounters involving coordination of benefits
- Submission of delegated service (e.g., vision, dental subcontractor) encounters
- Submission of one encounter file aggregating all relevant data
- Pre-editing of encounters for completeness, consistency and compliance with all state specific requirements
- Submission of voids/cancellations and replacements
- Formatting of encounter data into 837 professional, institutional, and dental, or NCPDP format for Pharmacy encounters
- HIPAA compliance checking of all 837 files prior to submission to the state
- Logging of all files submitted to the state as well as individual encounters along with the disposition (accepted, rejected, translator error, etc.)
- Processing of all “incoming” files from the state including 997, interchange level and multiple response files (HIPAA 835 or 277)
- Resubmission of denied encounters using various selection methods (error codes, paid dates, manual selection, etc.)
- Data Certification including business owner review of encounter data for completeness prior to submission
- Reconciliation and reporting process to validate the integrity of the encounter data and overall system

Figure 18, on the next page, outlines our encounter processing flow.

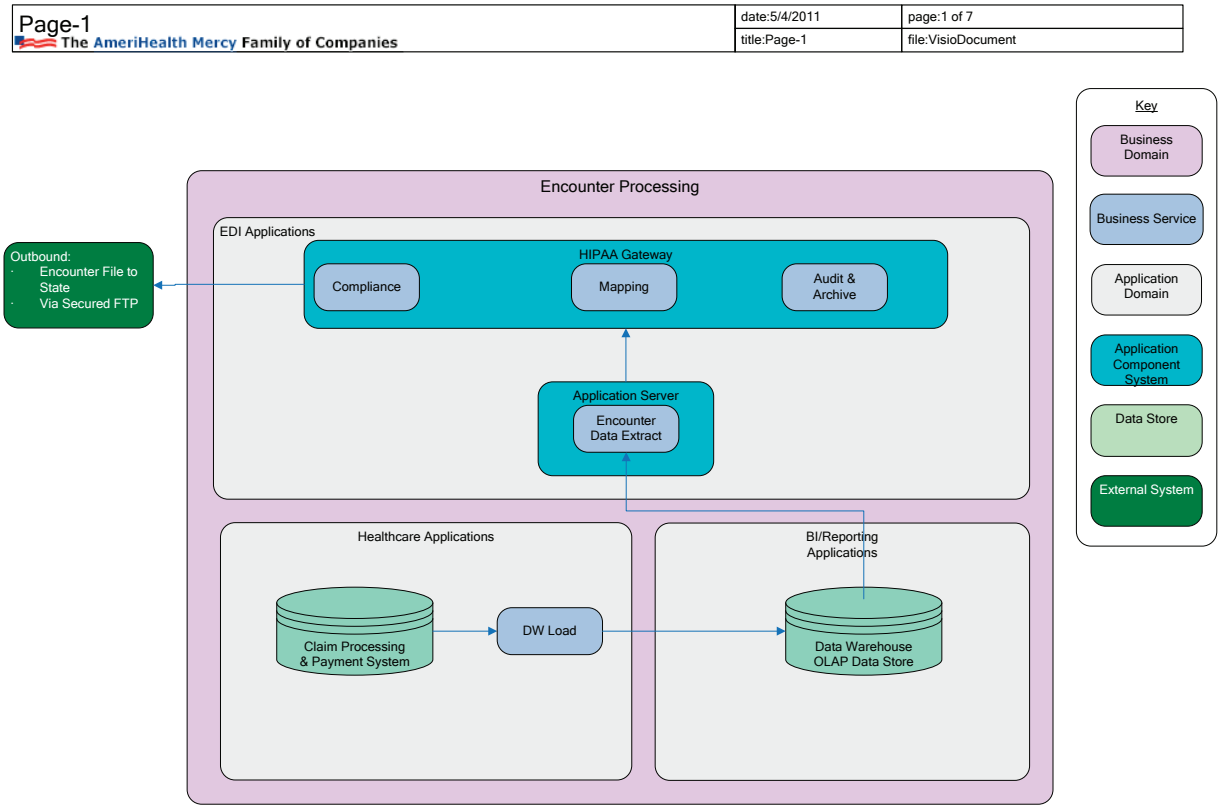


Figure 18: Encounter Processing Flow

Subcontractors

We will require all subcontractor files to pass HIPAA compliance checking for all 837 files prior to submission to the state. If any file fails this compliance check, the subcontractor is required to return a corrected encounter file to us within four business days. This process is undertaken every time files are received from subcontractors, which is typically once a month. To support subcontractors' efforts to meet performance expectations, we provide regular updates of the state's procedure codes, diagnosis codes, and provider data reference files. Also, AmeriHealth Mercy's Quality of Service Committee will be responsible for monitoring subcontractors' encounter data performance.

AmeriHealth Mercy will submit one encounter file to the state each month containing internally processed claims and claims processed by subcontractors. An initial file is submitted once a month, then throughout the month adjustments and corrections will be submitted as needed.

Ensuring Completeness

AmeriHealth Mercy has an extensive data completeness monitoring plan to assure that claims and encounters submitted by our providers and subcontractors are accurate and timely. This ensures that our submissions to the state are, likewise, accurate and timely. Our completeness controls include selection of paid claims from our claims processing system for a given date range to identify encounters that may not have been previously submitted. Results are reviewed on a weekly basis by encounter analysts and appropriate action is taken to assure 100 percent completeness.

AmeriHealth Mercy also has sound procedures to ensure that rejected encounters are resolved and resubmitted promptly and accurately. We routinely audit and track our performance and the performance of our subcontractors and providers. Our monitoring program assures compliance with state encounter

data reporting requirements, and highlights when follow up is required to resolve issues regarding encounter reporting by subcontractors or providers.

Ensuring Accuracy

Encounters are submitted on a claim form and then processed through the claims processing system, which verifies the completeness and accuracy of provider numbers, member ID numbers, diagnosis codes, and procedure codes. The claims processing system rejects claims with missing or inaccurate information and rejected claims are returned to the providers for correction.

The claims processing system utilizes claim clinical editing functions based on use of valid Current Procedure Terminology, ICD-9 and HCPCS codes, and National Correct Coding Initiative standards. When encounter data is loaded from the claims processing system into the encounter database, from which we prepare encounter data submissions to the state, the data passes through a secondary pre-edit process. This process enables AmeriHealth Mercy to identify, research, and correct significant errors before submitting the encounters to the state in the required formats.

To assure file accuracy, 837 professional and institutional files must pass HIPAA compliance checking prior to submission to the state. In addition, AmeriHealth Mercy uses an encounter audit table for data validation. After encounter files are created from the Data Warehouse, AmeriHealth Mercy posts encounter data to an encounter audit table and audit history table at the claim line level, and marks each encounter with status as "sent to state." When responses from the state are received, the encounter status is updated to "accepted" or "rejected." Also, there is a monthly status report from the encounter audit table that will show claim counts by each status. This report is used to resolve/resubmit encounters, and to identify non-reparable encounters, such as exact duplicates. After update of response files, the acceptance percentage is calculated based on claims sent and accepted by the state.

AmeriHealth Mercy's goal is to achieve the highest possible initial acceptance rate for the encounter data that is submitted to the state, and meet or exceed DHH requirements. When data errors occur, the encounter team, with analysts trained in both claims and enrollment, is responsible for coordinating corrections with other functional areas, and subsequently resubmitting rejected encounters. Encounter analysts are very familiar with standard state edit and exception codes and processing rules for the purpose of correcting and resubmitting rejected/denied encounters. Analysts monitor the rejections on each error file received from the state, and also refer to cumulative error reports to identify error trends. Some errors, such as synchronizing edits between internal and state systems, can be corrected through programming within the Encounter Department. Other errors, for example terminated Medical Assistance identification numbers, are referred to the appropriate department within AmeriHealth Mercy for resolution.

Claims Adjudicated in	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV
Percent Accepted to Date	99.69%	99.66%	99.74%	99.66%	99.65%	99.71%	99.73%	99.65%	99.75%	99.71%	99.71%
Total Sent	120,453	133,916	137,610	163,837	136,185	133,763	165,723	141,425	162,973	225,900	166,951
Total Accepted	120,080	133,464	137,246	163,280	135,713	133,370	165,274	140,927	162,561	225,255	166,464
Total Rejected	373	452	364	557	472	393	449	498	412	645	487

Figure 19: Sample Acceptance Rate Report

Successfully Providing Encounter Data

Using the encounter systems capabilities previously described, AmeriHealth Mercy successfully provides encounter data to the states of: Pennsylvania, Indiana, South Carolina, and New Jersey. All of these states include providers with capitation arrangements. We consistently achieve a 95-99 percent initial acceptance rate for encounters submissions. Below is a table outlining DHH encounter requirements in relation to AmeriHealth Mercy's experience, as outlined in Section 17.

Table 4: Encounter Requirements

DHH Encounter Requirements	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4. Encounter Data				
17.5.4.1. The CCN's system shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.	Yes, via secure FTP	Yes, via secure FTP	Yes, via direct VPN tunnel	Yes, via secure FTP
17.5.4.2. Within sixty (60) days of operation in the applicable geographic service area, the CCN's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The CCN must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the ***CCN-P Systems Companion Guide.***	Certified ClarEDI	Not certified (State-required proprietary format)	Not certified (State-required proprietary format)	Certified by ClarEDI
	AmeriHealth Mercy is a registered customer of EDIFECS services and will acquire certification prior to submitting Encounter files in Louisiana.			
All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.	HIPAA format	State-required Proprietary Format	State-required Proprietary Format	HIPAA format
17.5.4.3. The CCN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.	2010 Average initial acceptance rate (30 days) 98.4%	2010 Average initial acceptance rate (30 days) 99.1 %	2010 Average initial acceptance rate (30 days) 99.7%	2010 Average initial acceptance rate (30 days) 95%
17.5.4.4. The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.	Updates to code tables made quarterly	Updates to code tables made quarterly	Updates to code tables made quarterly	Updates to code tables made quarterly

DHH Encounter Requirements	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.5. In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the CCN and DHH to evaluate performance measures.	Yes	Yes	Yes	Yes
17.5.4.6. The CCN shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.	Yes, in HIPAA format to FI	Yes, in State-required Proprietary format to FI	Yes, in State-required Proprietary format to FI	Yes, in HIPAA format to FI
17.5.4.7. The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the CCN. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.	Yes, invalid encounters identified by 277, fatal errors by 997	Yes	Yes	Yes, invalid encounters identified by 835, fatal errors by 997
17.5.4.8. DHH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny." Encounter denial codes shall be deemed "repairable" or "non-repairable." An example of a repairable encounter is "provider invalid for date of service." An example of a non-repairable encounter is "exact duplicate." The CCN is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.	Yes, all types	Yes, all types	Yes, all types	Yes, all types

DHH Encounter Requirements	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.9. As specified in the ***CCN-P Systems Companion Guide***, denials for the following reasons will be of particular interest to DHH: • Denied for Medical Necessity including lack of documentation to support necessity; • Member has other insurance that must be billed first; • Prior authorization not on file; • Claim submitted after filing deadline; and • Service not covered by CCN.	State requires denials for timely filing, no authorization, non-covered services, and denials for COB are sent	Yes, all claim denials sent	State requires all claim denials except no authorization or member ineligible are sent	Yes, all claim denials sent
17.5.4.10. The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The CCN shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.	Yes	Yes	Yes	Yes
17.5.4.11. Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90 percent) of reported repairable errors are addressed within thirty (30) calendar and	2010 Avg Initial acceptance rates (30 days) 98.4 percent	2010 Avg Initial acceptance rates (30 days) 99.1 percent	2010 Avg Initial acceptance rates (30 days) 99.7 percent	2010 Avg Initial acceptance rates (30 days) 95 percent
99 percent of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.	90 days Currently no state requires 60 days (See Table 5 below)	180 days Currently no state requires 60 days (See Table 5 below)	90 days Currently no state requires 60 days (See Table 5 below)	90 days Currently no state requires 60 days (See Table 5 below)

DHH Encounter Requirements	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.12. For encounter data submissions, the CCN shall submit 95 percent of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the CCN has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.	Minimum 95 percent Monthly by 10th of the month	Minimum 95 percent Weekly each Friday	Minimum 95 percent Monthly by 25th of Month	Minimum 95 percent Bi-Weekly every other Wednesday
17.5.4.13. The CCN shall ensure that all encounter data from a contractor is incorporated into a single file from the CCN. The CCN shall not submit separate encounter files from CCN contractors.	State requirement is for multiple files	Single file submitted	Single file submitted	State requirement is for multiple files
17.5.4.14. The CCN shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CCN has a capitation arrangement.	Yes	Yes	Yes	Yes
17.5.4.15. The CCN shall ensure the level of detail associated with encounters from providers with whom the CCN has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CCN received and settled a fee-for-service claim.	Yes	Yes	Yes	Yes

DHH Encounter Requirements	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.16. The CCN shall adhere to federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH across all CCNs.	Yes	Yes	Yes	Yes
17.5.4.17. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CCNs applicable reimbursement methodology for that service.	Yes	Yes	Yes	Yes

In situations where AmeriHealth Mercy is not presently providing services in a manner that meets Louisiana's state requirements and/or our services are performed on a more limited basis than required, AmeriHealth Mercy is committed to addressing these needs as follows:

Table 5: Compliance with DHH Encounter Requirements

DHH Encounter Processing Requirement	AmeriHealth Mercy's Ability to Comply
17.5.4.2. Within sixty (60) days of operation in the applicable geographic service area, the CCN's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The CCN must incur all costs associated with certifying HIPAA transactions readiness through a third-party, EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the CCN-P Systems Companion Guide. All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.	AmeriHealth Mercy uses third-party compliance checking software to ensure that its HIPAA transactions are fully compliant. Compliance is checked in our production environment before sending for outgoing transaction and after receipt for incoming transactions. For example, all encounters submissions are checked for compliance before being submitted to our state clients. Compliance checking tools are also used by programmers for testing as they develop and update our EDI applications. AmeriHealth Mercy uses ClarEDI for much of our compliance checking and has registered as a customer with EDIFECS and will become certified as required by DHH.
17.5.4.11. Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be ninety percent (90 percent) of reported repairable errors are addressed within thirty (30) calendar and 99 percent of reported repairable errors within sixty	Given our high initial 30 day acceptance rate of 95-99% for current clients, we do not anticipate issues meeting this requirement. We will evaluate encounter resources and processes to ensure these requirements are met.

DHH Encounter Processing Requirement	AmeriHealth Mercy's Ability to Comply
(60) calendar days or within a negotiated timeframe approved by DHH. Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.	

Challenges and Lessons Learned

Over the many years of processing encounters, AmeriHealth Mercy has experienced a variety of challenges and lessons learned. We have incorporated this experience into our process and technology platform for encounters to ensure quality, timeliness and flexibility for current and new state customers. The table below describes key challenges and Lessons Learned and how we have incorporated the lessons learned into our systems and processes.

Table 6: Lessons Learned - Encounters

Challenges and Lessons Learned	How this will apply to Louisiana
Challenge: Inaccurate provider submission of NPI information on claims creates encounter rejections. **Lesson Learned:** Our experience processing National Provider Identification (NPI) numbers on claim/encounter records submitted by providers has shown that providers do not always submit complete NPI information, and when they do, at times, the NPI information does not match information registered with the state.	We have improved claim and encounter processing by validating NPI information submitted on claims by providers. Our systems have the flexibility to reference state NPI crosswalks to ensure accuracy of NPI information to prevent downstream errors. AmeriHealth Mercy will have this capability day one in Louisiana.
Challenge: Each state will have specific requirements for encounters processing over and above what may be documented or maintained in companion guides. For example, reparable encounters are required to be submitted in a variety of ways, which we have incorporated into our encounters system. **Lesson Learned:** We work closely with each State to ensure that our encounter system is configured to each requirement in the companion guide, and we maintain our encounter system to be consistent with on-going requirements.	We will work with DHH to do extensive testing both upfront on the initial implementation and ongoing as changes are made to ensure that all DHH requirements are met. We have done this very successfully for many years in close collaboration with states we currently do business with, and we will leverage this experience to meet Louisiana's on-going encounter reporting requirements.

R.6: Receive, Process and Update Data

R.6 Describe your ability to receive, process, and update eligibility/enrollment, provider data, and encounter data to and from the Department and its agents. In your response:

- *Explain whether and how your systems meet (or exceed) each of these requirements.*
- *Cite at least three currently-live instances where you are successfully receiving, processing and updating eligibility/enrollment data in accordance with DHH coding, data exchange format*

and transmission standards and specifications or similar standards and specifications. In elaborating on these instances, address all of the requirements in Section 17. Also, explain how that experience will apply to the Louisiana Medicaid CCN Program.

- *If you are not able at present to meet a particular requirement contained in the aforementioned sections, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.*
- *Identify challenges and "lessons learned" from implementation in other states and describe how you will apply these lessons to this contract.*

AmeriHealth Mercy leverages a versatile data exchange solution to support the data lifecycle of processing eligibility/enrollment, provider and encounter data to and from our customers and their agents. The data exchange solution, as demonstrated in the sections below, includes:

- The ability to transmit, receive, process, update and send replies in HIPAA-compliant and/or proprietary formats;
- The ability to exchange data through secure file transfer protocol (FTP) over a secure virtual private network (VPN);
- The ability to exchange data for a point in time (e.g., daily, weekly, monthly) or for a real-time transaction;
- And, the logging and archiving of all data exchanges for future reference, if needed.

This solution, in combination with our applications and systems, allows us to meet or exceed all DHH requirements for receiving, processing and updating eligibility/enrollment, provider data and encounter data to and from DHH and its agents. Using these capabilities, AmeriHealth Mercy will work with DHH to ensure appropriate understanding and interpretation of all requirements including the systems companion guide. We will also set up a rigorous testing process with DHH as part of our implementation plan.

The diagram below depicts the data exchanges between DHH and its agents and AmeriHealth Mercy.

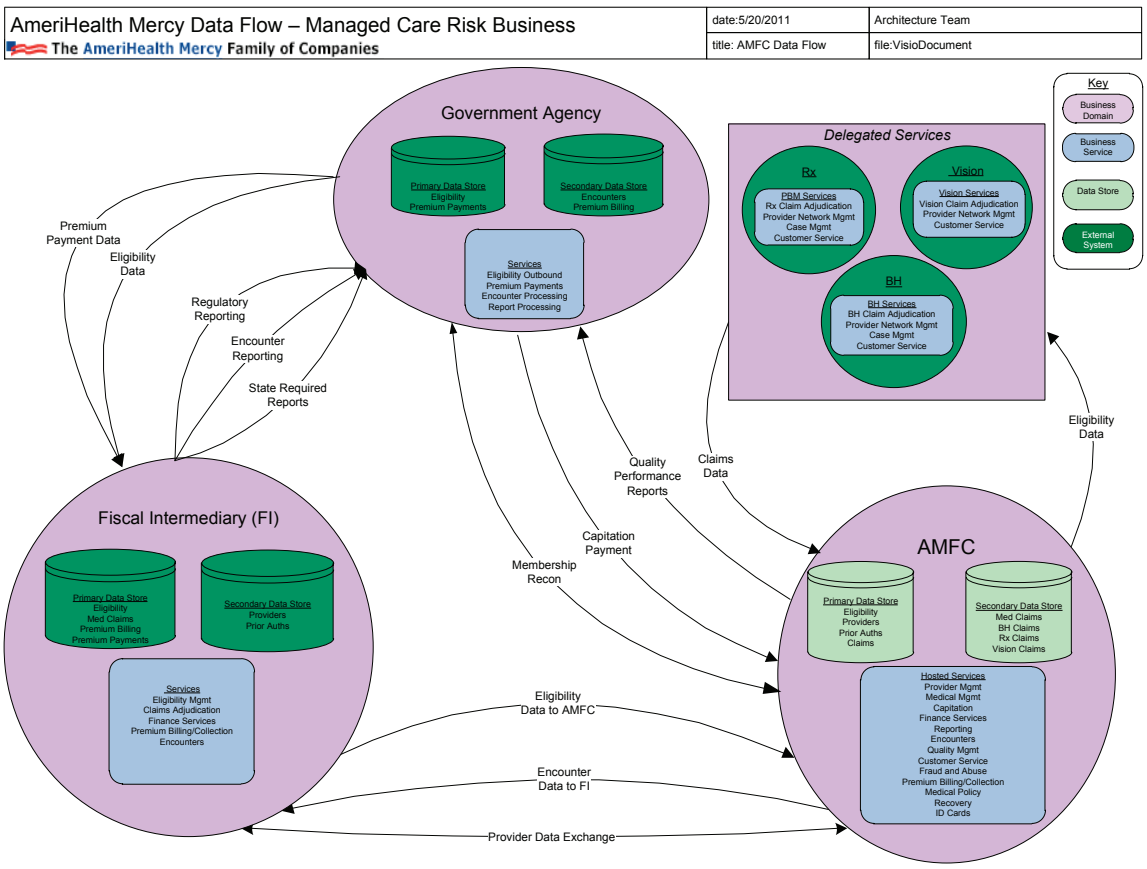


Figure 20: AmeriHealth Mercy Data Exchange

Eligibility/Enrollment

Receive, Process and Update Data

Enrollment updates are received in the Facets system using a HIPAA 834 transaction. New records are used to update member records with the most current data from DHH and its agents, add termination dates to an eligibility span, create new eligibility spans for re-enrolled members and add records for new enrollees. Upon receipt of a HIPAA 834 transaction, a HIPAA 997 acknowledgement is returned to the sender.

In order to effectively manage the accuracy of our membership data, files are processed in the order in which they are received and records are processed in chronological order for each member. Eligibility transactions are compared to our existing member records and updated or added as necessary.

Membership data that does not meet our standard edits defaults to an error report. Designated Enrollment Department employees will review and reconcile the errors with the Louisiana State System. They will update the Facets system to match the Louisiana State System data and reconcile all error reports within 24 hours of receipt. Some common discrepancies include address changes, name spelling errors, or differences in email addresses.

As we receive updated member information through member phone calls or correspondence, changes such as addresses or telephone numbers are entered into the Facets system to ensure member contact information is kept current. These changes are sent daily to the state for use in updating state enrollment data.

Enrollment data from Facets is used with all other systems and processes, including care management; PCP selection or auto assignment; generation of member materials including ID cards; EPSDT tracking; member services; contact center; claims processing; and provider relations applications. The information is available to our providers for eligibility verification through the IVR system and/or Web-based provider portal.

In addition to the core processing available in Facets, AmeriHealth Mercy has developed capabilities specifically to address the unique needs of State Medicaid plans based on our many years of experience in serving these programs.

Health Equities

As an early adopter of NCQA's Multicultural Healthcare (MHC) program, AmeriHealth Mercy developed the ability to collect, store, audit and report on both state- and manually-collected race, ethnicity and language (REL) data. Collection of more detailed data than that available through the state allows us to identify opportunities and design programs to provide the most appropriate care to our members. This supplemental capability is fully integrated with Facets and our Integrated Care Management (ICM) systems. Further details on these capabilities can be found in Section R7: System and Technical Requirements.

Newborn Processing

Through our ICM programs, we often learn of births to our pregnant members prior to the receipt of the State eligibility data for the newborn. We track newborn information on our database to ensure accurate and timely newborn enrollment and claims handling once eligibility is determined. AmeriHealth Mercy will work with DHH to determine the most efficient process for use of this valuable data in newborn eligibility determination.

Third Party Liability

Facets is enhanced to accommodate expanded sources of third party liability (TPL) data which may be received from the State, discovered through claims processing, obtained through a member interaction in our Contact Center, or obtained through other sources. The use of this data is integrated into our core claims adjudication processes. For example, in the event a primary carrier for a billed service is identified, this information is communicated back to the provider on the remittance advice to ensure appropriate billing by the provider.

Retrospective Eligibility

Many State plans permit a retrospective eligibility period for members or for a specific population of members. Facets was adapted to address this need and has the ability to handle retrospective eligibility for varying durations, ranging from three months to 10+ years to meet state requirements, and for specific populations, such as, newborns.

Table 7: Eligibility and Enrollment Requirements

DHH Eligibility/Enrollment Requirement	AmeriHealth Mercy's Ability to Comply
16.8.1 Receive, process and update enrollment files sent daily by the Enrollment Broker.	Yes, via daily, weekly, and monthly files Acknowledgement sent to State and/or Enrollment Broker
Send and Receive in HIPAA Compliant format	HIPAA and Proprietary files supported

DHH Eligibility/Enrollment Requirement	AmeriHealth Mercy's Ability to Comply
16.8.2 Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files	Yes
16.8.3 Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes	Yes
16.8.4 Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control	Yes, members can be uniquely identified within Louisiana, members are given their own unique Medicaid ID that is populated for use in Facets and restricted to Louisiana processing. Additionally, Facets provides an auto-generated Subscriber ID which is a unique value representing an individual member.
16.8.5 Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.	Yes, the inbound eligibility process utilizes a hierarchy of member searches in Facets to identify a duplicate member record. When a duplicate is identified, it will be researched with DHH. Enrollment employees, upon confirmation from DHH, will merge the service utilization record and the customer interaction histories into one single member file through a systematic process.

Provider Data

Receive, Process and Update Data

Similar to eligibility/enrollment data, provider data is critical to accurate, cost-effective and timely service delivery. AmeriHealth Mercy will coordinate all provider contracting, credentialing and enrollment processes to ensure that provider information is accurate and complete and facilitate ongoing data updates and quality audit reviews. Provider data is key in fulfilling HIPAA 837 transaction requirements, assigning primary care physicians, establishing provider directories, improving quality of care and network management. The high-level Provider Data flow is described below and in the following sections.

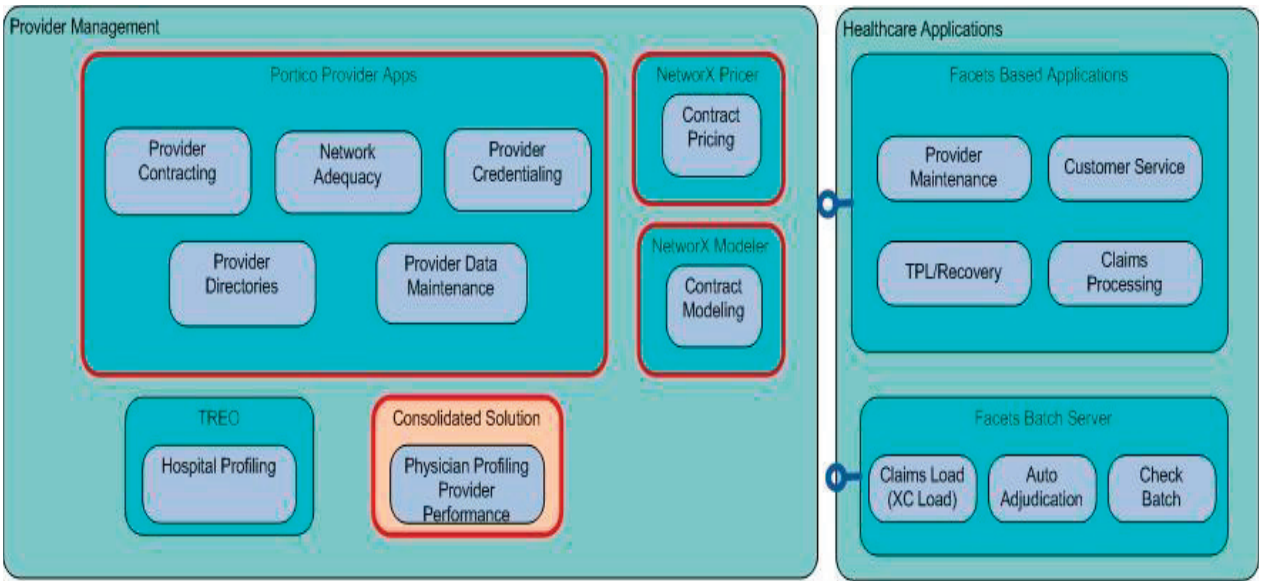


Figure 21: Provider Data Flow

Recognizing the importance of the provider data and given our commitment to continuously improve our capabilities, AmeriHealth Mercy invested in Portico Systems, Visual CACTUS and TriZetto Facets NetworX products to expand our functionality and improve efficiencies related to management of provider data.

Portico Systems and Visual CACTUS facilitate provider contracting and credentialing, respectively, while the Facets NetworX module accommodates more complex contract pricing, to improve data and payment accuracy. These capabilities position us to model the financial implications of changes during provider negotiations and those driven by regulatory changes, such as the ICD10 implementation.

Provider directory data is sent to the Enrollment Broker to be used for primary care physician (PCP) assignments and for use by Enrollment Assistance Coordinators. The Credentialing Department will gather and verify provider demographic data, including the provider's current state license, Federal and Louisiana identification numbers, and any additional information requested by the state. We will verify the data received from the provider and gathered through our primary verification systems to ensure compliance with applicable state law and regulations, ensure that providers are eligible to participate in Louisiana and have appropriate policies of malpractice insurance as may be required.

AmeriHealth Mercy written policies and procedures will govern the processes for verification of provider credentials and insurance and the periodic review of provider performance. Louisiana Standard Credentialing Applications for new providers will be received in the Provider Network Management Department for completeness review prior to being sent to the Credentialing Department.

We will also offer our providers the option of using the Council for Affordable Quality Healthcare (CAQH) application for credentialing. CAQH provides administrative ease to the providers and allowing them to update and maintain one source of information that can be accessed by multiple entities. Its Universal Credentialing DataSource simplifies and streamlines the data collection process for credentialing and re-credentialing. Providers submit just one standard application to a single confidential database either online or by fax. Providers can easily update their information at any time in a manner more convenient than contacting every payer. Providers are asked to verify the accuracy of completion of the information on file with CAQH quarterly, thus providing an additional mechanism to assure provider data integrity. Through CAQH, we have access to credentialing information at any time and can use this as a source to validate, update and maintain our provider database.

At the conclusion of the verification process (through paper or CAQH), the Credentialing Department will create a provider profile containing a full set of provider information, including name, address(es), phone, fax, E-mail, ID numbers (state and NPI), license numbers, board certifications, languages spoken, office hours, group names and tax identification numbers, linkages of individual providers to groups and site review information such as handicap accessibility.

AmeriHealth Mercy will allow providers to review the information submitted in support of their credentialing application and will notify a provider of any information obtained during the credentialing process that varies substantially from the information submitted by the provider. Providers are allowed to correct erroneous information prior to the final credentialing determination. Information on AmeriHealth Mercy's confidentiality policies are given to Providers to ensure they understand that all information obtained in the credentialing process is confidential except as otherwise provided by law

Provider Maintenance Oversight

All providers will receive an AmeriHealth Mercy provider identification number after the credentialing process is complete. AmeriHealth Mercy will enter the participating status and attach the provider data to the agreement associated with the appropriate participating contract. The data contained on the application is compared against the system to ensure accuracy after entry into the Facets database.

Periodic Integrity Review and Updating of Provider Data

AmeriHealth Mercy will use a number of procedures to periodically review, verify and perform quality audits on the integrity of provider data. Automated comparisons identify discrepancies in the provider data and these discrepancies are distributed for investigation and correction, as necessary. Some of the key areas reviewed monthly include:

- Invalid/duplicate office hours
- Practitioner/group address/phone number disconnects
- Missing parish on service site
- Missing or invalid phone number
- CRNPs listed as having Board certification
- Missing or invalid gender code
- Directory print conflict within group
- Invalid panel restrictions

Other means to verify and maintain the integrity of the provider data include:

- Provider Network Management representatives conduct office visits at least once a year (and in some cases quarterly) during which they verify demographic data.
- Receipt of claims and/or demographic change requests that require changes and updates to provider data.
- Other requests from providers for verification of their information, updating any incorrect information and submission of any changes to AmeriHealth Mercy.
- Review by appropriate employees of changes documented and attested to on the form with subsequent updates made in the Facets database as necessary.

Should changes be required, the Provider Change Form and process is used to document the request and actions taken to modify provider information in the Facets system. Additionally, Provider Data Maintenance Quality audits of five data modification transactions are performed daily for each provider maintenance employee.

Table 8: Provider Data Requirements

DHH Provider Data Requirement	AmeriHealth Mercy's Ability to Comply
16.9. Provider Enrollment At the onset of the CCN Contract and periodically as changes are necessary, DHH shall publish at the url: www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. The CCN shall utilize these codes within their provider enrollment system. The objective is to coordinate the provider enrollment records of the CCN with the same provider type, specialty and subspecialty codes as those used by DHH and the Enrollment Broker.	AmeriHealth Mercy has reviewed the Louisiana codes referenced and shall utilize the current codes. These codes will be configured in the Facets system. Additionally, we will monitor the www.lamedicaid.com site for updates to the code list and make any changes in our systems.
16.9.1. Provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy and payment information;	This information is recorded and maintained by AmeriHealth Mercy in our Facets system.
16.9.2. All relevant provider ownership information as prescribed by DHH, federal or state laws; and	This information is recorded and maintained by AmeriHealth Mercy in our provider data management systems.
16.9.3. Performance of all federal or state mandated exclusion background checks on all providers (owners and managers.) The providers shall perform the same for all their employees at least annually.	AmeriHealth Mercy Credentialing employees monitor the Office of the Inspector General (OIG) web site and updates from the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank (NPDB/HIPDB) to collect information concerning sanctions, adverse actions and fraud and abuse in health care delivery that may indicate preclusion from participating in the Medicaid program. Our procurement area monitors the Excluded Parties List System to identify individuals excluded from participation with Federal Government Agencies. The requirement to perform these activities for employees is communicated to providers through the provider's manual.
16.9.4. Provider enrollment systems shall include, at minimum, the following functionality: • Audit trail and history of changes made to the provider file; • Automated interfaces with all licensing and medical boards; • Automated alerts when provider licenses are nearing expiration; • Retention of NPI requirements; • System generated letters to providers when their licenses are nearing expiration; • Linkages of individual providers to groups; • Credentialing information; • Provider office hours; and • Provider languages spoken.	AmeriHealth Mercy provider enrollment and maintenance capabilities will meet the outlined requirements through our Visual CACTUS credentialing software.

Encounter Data

AmeriHealth Mercy has successfully submitted encounter data to multiple state Medicaid programs for many years. This expertise will enable AmeriHealth Mercy to meet and exceed the DHH's requirements.

Through collaboration with each state we have achieved consistent initial acceptance rates of 95-99 percent on an annual basis, and developed an extensive systems process covering all state requirements for plans in Pennsylvania, New Jersey, Indiana, and South Carolina. Below is a table outlining the requirements in Section 17 and how AmeriHealth Mercy fulfills them in the states we currently support.

Table 9: Claim Processing Requirements

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.1 Electronic Claims Management (ECM) Functionality				
17.1.1 The CCN shall annually comply with DHH's Electronic Claims Data Interchange policies for certification of electronically submitted claims.	Yes	Yes	Yes	Yes
17.1.2 To the extent that the CCN compensates providers on a fee-for-service or other basis requiring the submission of claims as a condition of payment, the CCN shall process the provider's claims for covered services provided to members, consistent with applicable CCN policies and procedures and the terms of the Contract and the Systems Guide, including, but not limited to, timely filing, and compliance with all applicable state and federal laws, rules and regulations.	Yes	Yes	Yes	Yes
17.1.3 The CCN shall maintain an electronic claims management system that will:				
17.1.3.1 Uniquely identify the attending and billing provider of each service	Yes	Yes	Yes	Yes
17.1.3.2 Identify the date of receipt of the claim (the date the CCN receives the claim and encounter information)	Yes	Yes	Yes	Yes
17.1.3.3 Identify real-time accurate history with dates of adjudication results of each claim such as paid, denied, suspended, appealed, etc., and follow up information on appeals	Yes	Yes	Yes	Yes
17.1.3.4 Identify the date of payment, the date and number of the check or other form of payment such as electronic funds transfer (EFT)	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.1.3.5 Identify all data elements are required by DHH for encounter data submission as stipulated in this Section of the RFP and the Systems Guide; and	Yes	Yes	Yes	Yes
17.1.3.6 Allow submission of non-electronic and electronic claims by contracted providers	Yes – Paper claims through ACS, EDI X12 Emdeon; Blue Cross claims through Blue Squared (ITS) BC proprietary file	Yes – Paper claims through ACS and EDI X12 Emdeon	Yes – Paper claims through ACS and EDI X12 Emdeon	Yes – Paper claims through ACS, EDI X12 Emdeon; Blue Cross claims through Blue Squared (ITS) BC proprietary file
17.1.4 The CCN shall ensure that an electronic claims management (ECM) capability that accepts and processes claims submitted electronically is in place	Yes	Yes	Yes	Yes
17.1.5 The CCN shall ensure the ECM system shall function in accordance with information exchange and data management requirements as specified in this Section of the RFP and the Systems Guide.	Yes	Yes	Yes	Yes
17.1.6 The CCN shall ensure that as part of the ECM function it can provide online and phone-based capabilities to obtain processing status information	Yes – online via Provider Portal; Phone-based capabilities will be added	Yes – online via Provider Portal; Phone-based capabilities will be added	Yes – online via Provider Portal; Phone-based capabilities will be added	Yes – online via Provider Portal; Phone-based capabilities will be added
17.1.7 The CCN shall support an automated clearinghouse (ACH) mechanism that allows providers to request and receive electronic funds transfer (EFT) of claims payments	Yes - Emdeon	Yes - Emdeon	Yes - Emdeon	Yes - Emdeon

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.1.8 The CCN shall not derive financial gain from a provider's use of electronic claims filing functionality and/or services offered by the CCN or a third party. However, this provision shall not be construed to imply that providers may not be responsible for payment of applicable transaction fees and/or charges.	Yes	Yes	Yes	Yes
17.1.9 The CCN shall require that their providers comply at all times with standardized billing forms and formats, and all future updates for Professional claims (CMS 1500) and Institutional claims (UB 04).	Yes	Yes	Yes	Yes
17.1.10 The CCN must comply with requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010, regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.	Yes	Yes	Yes	Yes
17.1.11 The CCN agrees that at such time that DHH presents recommendations concerning claims billing and processing that are consistent with industry norms, the CCN shall comply with said recommendations within ninety (90) calendar days from notice by DHH	As per State guidelines	As per State guidelines	As per State guidelines	As per State guidelines
17.1.12 The CCN shall have procedures approved by DHH, available to providers in written and web form for the acceptance of claim submissions which include:	Yes	Yes	Yes	Yes
17.1.12 .1 The process for documenting the date of actual receipt of non-electronic claims and date and time of electronic claims	Yes – Paper, ITS and EDI claims	Yes – Paper and EDI claims	Yes – Paper and EDI claims	Yes – Paper, ITS and EDI claims
17.1.12.2 The process for reviewing claims for accuracy and acceptability.	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.1.12.3 The process for prevention of loss of such claims, and	Yes	Yes	Yes	Yes
17.1.12.4 The processing for reviewing claims for determination as to whether claims are accepted as clean claims.	Yes	Yes	Yes	Yes
17.1.13 The CCN shall have a procedure approved by DHH available to providers in written and web form for notifying providers of batch rejections. The report, at a minimum, should contain the following information:	Yes – Emdeon and operations billing guide	Yes – Emdeon and operations billing guide	Yes – Emdeon and operations billing guide	Yes – Emdeon and operations billing guide
17.1.13.1 Data batch was received by the CCN;	Yes	Yes	Yes	Yes
17.1.13.2 Date of rejection report;	Yes	Yes	Yes	Yes
17.1.13.3 Name or identification number of CCN issuing batch rejection report	Yes	Yes	Yes	Yes
17.1.13.4. Batch submitters name or identification number; and	Yes	Yes	Yes	Yes
17.1.13.5 Reason batch is rejected.	Yes	Yes	Yes	Yes
17.1.14 The CCN shall assume all costs associated with claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the CCN or to the design of systems within the CCN's span of control	Yes	Yes	Yes	Yes
17.1.15 The CCN shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH.	N - Not a state requirement	N - Not a state requirement	N - Not a state requirement	N - Not a state requirement
17.1.16 For purposes of network management, the CCN shall notify all contracted providers to file claims associated with covered services directly with the CCN, or its contractors, on behalf of Louisiana Medicaid members.	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.1.17At a minimum, the CCN shall run one (1) provider payment cycle per week, on the same day each week, as determined by the CCN and approved by DHH.	Yes – Weekly	Yes – Weekly	Yes – Weekly	Yes – Weekly
17.2 Claims Processing Methodology Requirement The CCN shall perform system edits, including, but not limited to:	Yes	Yes	Yes	Yes
17.2.1 Confirming eligibility on each member as claims are submitted on the basis of the eligibility information provided by DHH and the Enrollment Broker that applies to the period during which the charges were incurred;	Yes – Facets adjudication	Yes – Facets adjudication	Yes – Facets adjudication	Yes – Facets adjudication
17.2.2-17.2.6 A review of the entire claim within five (5) working days of receipt of an electronic claim, to determine that the claim is not a clean claim and issue an exception report to the provider indicating all defects or reasons known at that time that the claim is not a clean claim. The exception report shall contain at a minimum the following information: • Member name; • Provider claim number, patient account number, or unique member identification number; • Date of service; • Total billed charges; • CCN's name; and • The date the report was generated	Yes – Emdeon edits and HIPAA compliance validations	Yes – Emdeon edits and HIPAA compliance validations	Yes – Emdeon edits and HIPAA compliance validations	Yes – Emdeon edits and HIPAA compliance validations
17.2.3. Medical necessity;	Yes	Yes	Yes	Yes
17.2.4 Prior Approval – The system shall determine whether a covered service required prior approval and if so, whether the CCN granted such approval	Yes – Facets	Yes – Facets	Yes – Facets	Yes – Facets

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.2.5 Duplicate Claims – The system shall in an automated manner, flag a claim as being exactly the same as a previously submitted claim or a possible duplicate and either deny or pend the claim as needed;	Yes – Facets	Yes – Facets	Yes – Facets	Yes – Facets
17.2.6 Covered Services - Ensure that the system verify that a service is a covered service and is eligible for payment;	Yes – Facets	Yes – Facets	Yes – Facets	Yes – Facets
17.2.7 Provider Validation - Ensure that the system shall approve for payment only those claims received from providers eligible to render service for which the claim was submitted	Yes – Facets	Yes – Facets	Yes – Facets	Yes – Facets
17.2.8 Quantity of Service - Ensure that the system shall evaluate claims for services provided to members to ensure that any applicable benefit limits are applied	Yes – Facets	Yes – Facets	Yes – Facets	Yes – Facets
17.2.9 Perform system edits for valid dates of service, and assure that dates of services are valid dates such as not in the future or outside of a member's Medicaid eligibility span	Yes – Facets adjudication	Yes – Facets adjudication	Yes – Facets adjudication	Yes – Facets adjudication
17.2.10 Perform post-payment review on a sample of claims to ensure services provided were medically necessary; and	Yes Post payment reviews performed on limited basis for investigative purposes and targeted services	Yes Post payment reviews performed on limited basis for investigative purposes	Yes Post payment reviews performed on limited basis for investigative purposes	N/A – not required in our contract
17.2.11 Have a staff of qualified, medically trained and appropriately licensed personnel, consistent with NCQA accreditation standards, whose primary duties are to assist in evaluating claims for medical necessity.	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.3. Explanation of Benefits (EOBs)				
17.3.1 The CCN shall within forty-five (45) days of payment of claims, provide individual notices to a sample group of the members who received services. The required notice must specify:	N – Not a state requirement	N – Not a state requirement	N – Not a state requirement	Yes – Produce member EOB/ Remittance advices.
17.3.1.1.1. The service furnished	N/A	N/A	N/A	Yes
17.3.1.1.2 The name of the provider furnishing the service	N/A	N/A	N/A	Yes
17.3.1.1.3 The date on which the service was furnished; and	N/A	N/A	N/A	Yes
17.3.1.1.4 The amount of the payment made for the service.	N/A	N/A	N/A	Yes
17.4 Remittance Advices – In conjunction with its payment cycles, the CCN shall provide:				
17.4.1 Each remittance advice generated by the CCN to a provider shall, if known at that time, clearly identify for each claim, the following information				
17.4.1.1-17.4.1.9 • The name of the member • Unique member identification number • Patient claim number or patient account number • Date of service • Total provider charges • Member liability, specifying any co-insurance, deductible, co-payment, or non-covered amount • Amount paid by the CCN • Amount denied and the reason for denial; • In accordance with 42 CFR §§ 455.18 and 455.19, the following statement shall be included on each remittance advice sent to providers: " I understand that payment and satisfaction of this claim will be from federal and state funds, and that any false claims, statements, documents, or concealment of a material fact, may be prosecuted under applicable federal and/or state laws."	Yes – current Paper Remittance Advice and HIPAA 835	Yes – current Paper Remittance Advice and HIPAA 835	Yes – current Paper Remittance Advice and HIPAA 835	Yes – current Paper Remittance Advice and HIPAA 835

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5. Adherence to Key Claims Management Standards				
17.5.1. Prompt Payment to Providers				
17.5.1.1. The CCN shall ensure that 90 percent of all clean claims for payment of services delivered to a member are paid by the CCN to the provider within fifteen (15) business days of the receipt of such claims.	N - State requirement is 30 days	N - State requirement is 30 days	N - State requirement is 30 days	N - State requirement is 25 days
17.5.1.2. The CCN shall process and, if appropriate, pay within thirty (30) calendar days, 99 percent of all clean claims to providers for covered services delivered to a member.	Yes	Yes	Yes	Yes
17.5.1.3. If a clean claim is denied on the basis the provider did not submit required information or documentation with the claim, then the remittance advice shall specifically identify all such information and documentation. Resubmission of a claim with further information and/or documentation shall not constitute a new claim for purposes of establishing the timeframe for timely filing.	Yes	Yes – For ER claims only	N - Not a state requirement	N - Not a state requirement
17.5.1.4. To the extent that the provider contract requires compensation of a provider on a capitation basis or on any other basis that does not require the submission of a claim as a condition to payment, such payment shall be made to the provider by no later than: o The time period specified in the provider contract between the provider and the CCN, or if a time period is not specified in the contract: o The tenth (10th) day of the calendar month if the payment is to be made by a contractor, or o If the CCN is required to compensate the provider directly, within five (5) calendar days after receipt of the capitated payment and supporting member roster information from DHH.	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.1.5. The CCN shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third-party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.	N - Not a state requirement	N - Not a state requirement	N - Not a state requirement	N - Not a state requirement
17.5.1.6. The CCN shall not pay any claim submitted by a provider who is excluded from participation in Medicare, Medicaid, or CHIP program pursuant to Section 1128 or 1156 of the Social Security Act or is otherwise not in good standing with DHH.	Yes	Yes	Yes	Yes
17.5.2. Claims Dispute Management				
17.5.2.1. The CCN shall have an internal claims dispute procedure that shall be submitted to DHH within thirty (30) days of the date the Contract is signed by the CCN, which will be reviewed and approved by DHH.	Yes	Yes	Yes	Yes
17.5.2.2. The CCN shall contract with independent reviewers to review disputed claims.	Yes	Yes	Yes	N/A – not a state requirement
17.5.2.3. The CCN shall systematically capture the status and resolution of all claim disputes as well as all associated documentation.	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.3. Claims Payment Accuracy Report				
17.5.3.1. On a monthly basis, the CCN shall submit a claims payment accuracy percentage report to DHH. The report shall be based on an audit conducted by the CCN. The audit shall be conducted by an entity or staff independent of claims management as specified in this Section of the RFP, and shall utilize a randomly selected sample of all processed and paid claims upon initial submission in each month. A minimum sample consisting of two hundred (200) to two hundred-fifty (250) claims per year, based on financial stratification, shall be selected from the entire population of electronic and paper claims processed or paid upon initial submission.	Yes – Use BCBSA MTM Member Touch Point Measures Methodology	Yes – Use BCBSA MTM Member Touch Point Measures Methodology	Yes – Use BCBSA MTM Member Touch Point Measures Methodology	Yes – Use BCBSA MTM Member Touch Point Measures Methodology
17.5.3.2. The minimum attributes to be tested for each claim selected shall include: • Claim data correctly entered into the claims processing system; • Claim is associated with the correct provider; • Proper authorization was obtained for the service; • Member eligibility at processing date correctly applied; • Allowed payment amount agrees with contracted rate; • Duplicate payment of the same claim has not occurred; • Denial reason applied appropriately; • Co-payment application considered and applied, if applicable; • Effect of modifier codes correctly applied; and • Proper coding.	Yes	Yes	Yes	Yes

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.3.3. The results of testing at a minimum should be documented to include: • Results for each attribute tested for each claim selected; • Amount of overpayment or underpayment for each claim processed or paid in error; • Explanation of the erroneous processing for each claim processed or paid in error; • Determination if the error is the result of a keying error or the result of error in the configuration or table maintenance of the claims processing system; and • Claims processed or paid in error have been corrected.	Yes	Yes	Yes	Yes
17.5.3.4. If the CCN contracted for the provision of any covered services, and the CCN's contractor is responsible for processing claims, then the CCN shall submit a claims payment accuracy percentage report for the claims processed by the contractor.	Yes	Yes	Yes	Yes
17.5.4. Encounter Data				
17.5.4.1. The CCN's system shall be able to transmit to and receive encounter data from the DHH FI's system as required for the appropriate submission of encounter data.	Yes – via secure FTP	Yes – via secure FTP	Yes – via direct VPN tunnel	Yes – via secure FTP
17.5.4.2. Within sixty (60) days of operation in the applicable geographic service area, the CCN's system shall be ready to submit encounter data to the FI in a provider-to-payer-to-payer COB format. The CCN must incur all costs associated with certifying HIPAA transactions readiness through a third-party,	Certified ClarEDI	Not certified (proprietary format)	Not certified (proprietary format)	Certified by ClarEDI

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
EDIFECS, prior to submitting encounter data to the FI. Data elements and reporting requirements are provided in the *CCN-P Systems Companion Guide.*	***AmeriHealth Mercy is a registered customer of EDIFECS services and will acquire certification prior to submitting Encounter files in Louisiana.***			
All encounters shall be submitted electronically in the standard HIPAA transaction formats, specifically the ANSI X12N 837 provider-to-payer-to-payer COB Transaction formats (P - Professional, and I - Institutional). Compliance with all applicable HIPAA, federal and state mandates, both current and future is required.	HIPAA format	Proprietary Format	Proprietary Format	HIPAA format
17.5.4.3. The CCN shall provide the FI with complete and accurate encounter data for all levels of healthcare services provided.	Yes	Yes	Yes	Yes
17.5.4.4. The CCN shall have the ability to update CPT/HCPCS, ICD-9-CM, and other codes based on HIPAA standards and move to future versions as required.	Updates to code tables are made quarterly	Updates to code tables are made quarterly	Updates to code tables are made quarterly	Updates to code tables are made quarterly
17.5.4.5. In addition to CPT, ICD-9-CM and other national coding standards, the use of applicable HCPCS Level II and Category II CPT codes are mandatory, aiding both the CCN and DHH to evaluate performance measures.	Yes	Yes	Yes	Yes
17.5.4.6. The CCN shall have the capability to convert all information that enters its claims system via hard copy paper claims to electronic encounter data, to be submitted in the appropriate HIPAA compliant formats to DHH's FI.	Yes – in HIPAA format to FI	Yes – in Proprietary format to FI	Yes – in Proprietary format to FI	Yes – in HIPAA format to FI

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.7. The FI encounter process shall utilize a DHH-approved version of the claims processing system (edits and adjudication) to identify valid and invalid encounter records from a batch submission by the CCN. Any submission which contains fatal errors that prevent processing, or that does not satisfy defined threshold error rates, will be rejected and returned to the CCN for immediate correction.	Yes – invalid encounters identified by HIPAA 277, fatal errors by HIPAA 997	Yes	Yes	Yes – invalid encounters identified by HIPAA 835, fatal errors by HIPAA 997
17.5.4.8. DHH and its FI shall determine which claims processing edits are appropriate for encounters and shall set encounter edits to "pay" or "deny." Encounter denial codes shall be deemed "repairable" or "non-repairable." An example of a repairable encounter is "provider invalid for date of service." An example of a non-repairable encounter is "exact duplicate". The CCN is required to be familiar with the FI exception codes and dispositions for the purpose of repairing denied encounters.	Yes – all types	Yes – all types	Yes – all types	Yes – all types
17.5.4.9. As specified in the *CCN-P Systems Companion Guide*, denials for the following reasons will be of particular interest to DHH: • Denied for Medical Necessity including lack of documentation to support necessity; • Member has other insurance that must be billed first; • Prior authorization not on file; • Claim submitted after filing deadline; and • Service not covered by CCN.	State requires denials for timely filing, no authorization, non-covered services, and denials for COB are sent	Yes – all claim denials sent	State requires all claim denials except no authorization or member ineligible denials	Yes – all claim denials sent

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.10. The CCN shall utilize DHH provider billing manuals and become familiar with the claims data elements that must be included in encounters. The CCN shall retain all required data elements in claims history for the purpose of creating encounters that are compatible with DHH and its FI's billing requirements.	Yes	Yes	Yes	Yes
17.5.4.11. Due to the need for timely data and to maintain integrity of processing sequence, the CCN shall address any issues that prevent processing of an encounter; acceptable standards shall be 90 percent of reported repairable errors are addressed within thirty (30) calendar	2010 Avg. Initial acceptance rate (30 days) 98.4 percent	2010 Avg. Initial acceptance rate (30 days) 99.1 percent	2010 Avg. Initial acceptance rate (30 days) 99.7 percent	2010 Avg. Initial acceptance rate (30 days) 95 percent
99 percent of reported repairable errors within sixty (60) calendar days or within a negotiated timeframe approved by DHH. . Failure to promptly research and address reported errors, including submission of and compliance with an acceptable corrective action plan may result in monetary penalties.	90 days Currently no state requires 60 days	180 days Currently no state requires 60 days	90 days Currently no state requires 60 days	90 days Currently no state requires 60 days
17.5.4.12. For encounter data submissions, the CCN shall submit 95 percent of its encounter data at least monthly due no later than the twenty-fifth (25th) calendar day of the month following the month in which they were processed and approved/paid, including encounters reflecting a zero dollar amount ($0.00) and encounters in which the CCN has a capitation arrangement with a provider. The CCN CEO or CFO shall attest to the truthfulness, accuracy, and completeness of all encounter data submitted.	Minimum 95 percent Monthly by 10th of the month	Minimum 95 percent Weekly each Friday	Minimum 95 percent Monthly by 25th of Month	Minimum 95 percent Bi-Weekly every other Wednesday

DHH Claim Processing Requirement	Pennsylvania	Indiana	South Carolina	New Jersey
17.5.4.13.The CCN shall ensure that all encounter data from a contractor is incorporated into a single file from the CCN. The CCN shall not submit separate encounter files from CCN contractors	State requirement is for multiple files	Single file submitted	Single file submitted	State requirement is for multiple files
17.5.4.14.The CCN shall ensure that files contain settled claims and claim adjustments or voids, including but not limited to, adjustments necessitated by payment errors, processed during that payment cycle, as well as encounters processed during that payment cycle from providers with whom the CCN has a capitation arrangement.	Yes	Yes	Yes	Yes
17.5.4.15.The CCN shall ensure the level of detail associated with encounters from providers with whom the CCN has a capitation arrangement shall be equivalent to the level of detail associated with encounters for which the CCN received and settled a fee-for-service claim.	Yes	Yes	Yes	Yes
17.5.4.16.The CCN shall adhere to federal and/or department payment rules in the definition and treatment of certain data elements, such as units of service that are a standard field in the encounter data submissions and will be treated similarly by DHH across all CCNs	Yes	Yes	Yes	Yes
17.5.4.17. Encounter records shall be submitted such that payment for discrete services which may have been submitted in a single claim can be ascertained in accordance with the CCNs applicable reimbursement methodology for that service.	Yes	Yes	Yes	Yes

In situations where AmeriHealth Mercy is not presently providing services in a manner that meets Louisiana's state requirements and/or our services are performed on a more limited basis than required, AmeriHealth Mercy is committed to addressing these needs as follows:

Table 10: Compliance with Claim Processing Requirements

DHH Claims Processing Requirements	AmeriHealth Mercy's Ability to Comply for Louisiana
17.1.15 The CCN shall not employ off-system or gross adjustments when processing correction to payment error, unless it requests and receives prior written authorization from DHH.	AmeriHealth Mercy will not employ off-system or gross adjustments when processing correction to a payment error unless prior written authorization is granted from DHH. (This statement pertains to claim settlements.)
17.2.10. Perform post-payment review on a sample of claims to ensure services provided were medically necessary; and	AmeriHealth Mercy will pull a random sample of claims (Paid or denied for no authorization) to determine if the services rendered were medically necessary and paid or denied appropriately. The audit results will be logged and trended. The analysis will determine the following: • Clinical Authorization Criteria applied appropriately – Audit results will be used to determine if the Utilization Review staff are applying the Medical necessity criteria based on the approved guidelines. • Potential fraudulent billing – The audit results will be sent to the Corporate and Financial Investigation unit for further investigation. In addition, the Network Management department will be informed of on the results of the investigation and will take the appropriate action to address the issue with the Provider. All cases of Fraud will be reported based on DHH requirements. • Claim payment processing error – All error will follow AmeriHealth Mercy's internal quality Auditing and reporting process. Potential outcomes: Additional staff training, updating payment processing guideline, etc. AmeriHealth Mercy will also perform this service on claims that are forwarded by the Provider to dispute claim payments.
17.5.1.1 The CCN shall ensure that 90 percent of all clean claims for payment of services delivered to a member are paid by the CCN to the provider within 15 business days of the receipt of such claims	AmeriHealth Mercy will ensure that payment to the provider will be made within 15 business days of the receipt of such claim though system configuration changes and additional staffing, where needed.
17.5.1.5. The CCN shall not deny provider claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case the provider is pursuing payment from a third party. In situations of third-party benefits, the timeframes for filing a claim shall begin on the date that the third party completes resolution of the claim.	AmeriHealth Mercy will implement systems configuration criteria and processes to ensure the timeframes for filing a claim begin on the date that the third party completes resolution of the claim.

DHH Claims Processing Requirements	AmeriHealth Mercy's Ability to Comply for Louisiana
17.5.4.11 99% of reported repairable errors within 60 calendar days or within negotiated timeframe approved by DHH.	Given our high initial acceptance rate, we do not anticipate issues meeting this requirement. We will evaluate encounter resources and processes to ensure these requirements are met.

Challenges and Lessons Learned

Through our many years of serving Medicaid plans in other states, we have continuously improved our processes to better serve our customers. AmeriHealth Mercy will benefit from its multi-state experience. Below are some examples:

Table 11: Lessons Learned – Claims Processing

Challenges and Lessons Learned	How this will apply to Louisiana
Challenge: Inconsistent technology platforms and business processes across supported plans made it difficult to readily identify what could be reused as a new plan was on boarded. **Lesson Learned:** Build and leverage an enterprise technology platform and business processes	AmeriHealth Mercy has transformed the IS architecture and platforms to a business–service delivery model which has a significant degree of reusability. All of our plans are currently supported by this unified platform which can provide the benefits of uniformity while also allowing for the ability to configure unique state requirements. This capability provides a strong foundation and will be used for Louisiana.
Challenge: Unexpected growth resulting in system capacity issues. **Lesson Learned:** Use scenario planning approach to plan for systems resource needs and implement technologies that allow for additional "capacity on demand".	Based on our review of the current enrollment scenario projections and available "on demand" capacity, we can accommodate the "best possible" enrollment outcome for Louisiana within our existing infrastructure.
Challenge: Adequately setting expectations and timelines for delivery with all parties. **Lesson Learned:** Collaborative implementation planning and execution with DHH and the Enrollment Broker are critical to identify and manage implementation risks which will ensure a successful launch and ongoing business relationship	AmeriHealth Mercy will work with the DHH and its agents to validate the state requirements and the associated technology impacts and agree on a joint testing approach, including data, test scripts and timely processing.
Challenge: Delayed receipt and incomplete test files that resulted in less than sufficient testing and conditions that did not meet state requirements. **Lesson Learned:** Importance of early receipt and representative test data sample for enrollment files from DHH and the Enrollment Broker.	AmeriHealth Mercy will work with DHH and its agents to ensure testing requirements are well-defined and agreed upon upfront. This will mutually benefit DHH and AmeriHealth Mercy to ensure a successful implementation and ongoing quality processes.

R.7: Systems and Technical Requirements

R.7 Describe the ability within your systems to meet (or exceed) each of the requirements in Section §16. Address each requirement. If you are not able at present to meet a particular requirement contained in the aforementioned section, identify the applicable requirement and discuss the effort and time you will need to meet said requirement.

16.0 SYSTEMS AND TECHNICAL REQUIREMENTS

16.1. General Requirements

16.1.1. The CCN shall maintain an automated Management Information System (MIS), hereafter referred to as System, which accepts and processes provider claims, verifies eligibility, collects and reports encounter data and validates prior authorization and pre-certification that complies with DHH and federal reporting requirements. The CCN shall ensure that its System meets the requirements of the Contract, state issued Guides (See CCN-P Systems Guide) and all applicable state and federal laws, rules and regulations, including Medicaid confidentiality and HIPAA and American Recovery and Reinvestment Act (ARRA) privacy and security requirements.

AmeriHealth Mercy's Management Information Systems (MIS) meets or exceeds the requirements in Section §16 thru the development and configuration of flexible, scalable and resilient applications which meet the complexities of the Medicaid business. The MIS meets the requirements of the Systems Guide and all applicable laws and HIPAA privacy, confidentiality and security requirements.

16.1.2. The CCN's application systems foundation shall employ the relational data model in its database architecture, which would entail the utilization of a relational database management system (RDBMS) such as Oracle®, DB2®, or SQL Server®. It is important that the CCN's application systems support query access using Structured Query Language (SQL). Other standard connector technologies, such as Open Database Connectivity (ODBC) and/or Object Linking and Embedding (OLE), are desirable.

AmeriHealth Mercy's foundational application systems use both Sybase and Oracle RDBMS for its core OLTP and Data Warehouse processing. Our analytical and reporting environments employ best of breed reporting tools such as: SAP Crystal Reports, MS Access, SAP Business Objects Web Intelligence, SAS, SSRS, SQL Developer, Toad and Rapid SQL. A variety of highly regarded analytical tools are also used: TREO, VIPS, DST Care Analyzer and ManagedCare.com. For most of the tools and applications, we connect to Oracle or Sybase using an ODBC connection. For our .NET applications, Oracle connectivity is achieved via Oracle Data Provider for .NET (ODP.NET).

16.1.3. All the CCN's applications, operating software, middleware, and networking hardware and software shall be able to interoperate as needed with DHH's systems and shall conform to applicable standards and specifications set by DHH.

AmeriHealth Mercy's applications, operating software, middleware, networking hardware and software will be able to interoperate as required with DHH's systems and conform to appropriate standards and specifications set by DHH. AmeriHealth Mercy utilizes best practices as outlined by the respective vendor for each platform from application development to hardware and network component selection and configuration.

16.1.4. The CCN's System shall have, and maintain, capacity sufficient to handle the workload projected for the begin date of operations and shall be scalable and flexible so that it can be adapted as needed, within negotiated timeframes, in response to changes in the Contract requirements.

Using our business activation delivery model, we conducted a detailed review of the DHH requirements, projected volumes, and Louisiana specified requirements in relation to our Information System capabilities. From our initial review of the requirements outlined in the RFP, we have determined that our systems capabilities and capacity will meet or exceed the requirements of the State of Louisiana and can be adapted as needed in response to changes in the contract requirements.

16.2 HIPAA Standards and Code Sets

16.2.1. The System shall be able to transmit, receive and process data in current HIPAA-compliant or DHH specific formats and/or methods, including, but not limited to, secure File Transfer Protocol (FTP) over a secure connection such as a Virtual Private Network (VPN), that are in use at the start of Systems readiness review activities. Data elements and file format requirements may be found in the CCNP Systems Companion Guide.

We have reviewed the required data elements and file formats in the CCNP Systems Companion Guide and AmeriHealth Mercy will be able to transmit, receive and process data in current HIPAA-compliant DHH specified formats and methods. AmeriHealth Mercy will use HIPAA compliant connectivity solutions through the Internet, or through private connectivity with business partners. We utilize industry standard VPN client to site, or site to site connectivity to protect our data and that of our members. We also use a dual layer DMZ topology to assure additional security, and to separate public Internet connectivity with private business partner's connectivity.

The Internet DMZ is serviced by redundant Cisco VPN ASA5520 concentrators, and cryptographic service routers, and secured with Cisco ASA5500 firewalls. Our Extranet for private connectivity with our business partners is serviced by redundant Cisco ASA5550 firewalls, redundant Cisco ACE4710 load balancers and reversed proxy servers. Additionally, our Internet facing DMZ can support secured FTP connections with support for SFTP, FTPS, HTTPS/S, & SCP2 and FIPS 140-2 validated cryptography. Authentication is handled by Cisco AAA CSACS01121 security appliances.16.2.2. All HIPAA-conforming exchanges of data between DHH and the CCN shall be subjected to the highest level of compliance as measured using an industry-standard HIPAA compliance checker. The HIPAA Business Associate Agreement (Appendix C) shall become a part of the contract.

AmeriHealth Mercy currently uses the Ingenix ClarEDI HIPAA compliance checker to ensure HIPAA compliance of our transactions. We are a registered customer of EDIFECS and will ensure compliance through this tool prior to transmitting data to DHH. It is our standard practice to have the HIPAA Business Associate Agreement as part of our state contracts.

16.2.3. The System shall conform to the following HIPAA-compliant standards for information exchange. Batch transaction types include, but are not limited to, the following:

- **16.2.3.1. ASC X12N 834 Benefit Enrollment and Maintenance;**
- **16.2.3.2. ASC X12N 835 Claims Payment Remittance Advice Transaction;**
- **16.2.3.3. ASC X12N 837I Institutional Claim/Encounter Transaction;**
- **16.2.3.4. ASC X12N 837P Professional Claim/Encounter Transaction;**
- **16.2.3.5. ASC X12N 270/271 Eligibility/Benefit Inquiry/Response;**
- **16.2.3.6. ASC X12N 276 Claims Status Inquiry;**
- **16.2.3.7. ASC X12N 277 Claims Status Response;**
- **16.2.3.8. ASC X12N 278/279 Utilization Review Inquiry/Response; and**
- **16.2.3.9. ASC X12N 820 Payroll Deducted and Other Group Premium Payment for Insurance Products.**

AmeriHealth Mercy uses HIPAA compliant standards for information exchange and can support the transaction types listed and required by DHH. We comply with all applicable federal and HIPAA standards and regulations.

16.2.4. The CCN shall not revise or modify the standardized forms or formats.

AmeriHealth Mercy adheres to the HIPAA compliant standard forms/formats, and does not revise or modify them.

16.2.5. Transaction types are subject to change and the CCN shall comply with applicable federal and HIPAA standards and regulations as they occur.

AmeriHealth Mercy has a disciplined process to monitor applicable federal and HIPAA standards and regulations for changes in order to keep our systems compliant. Any needed changes to our systems or coding as a result of changes to HIPAA standards or regulations are automatically assigned a high priority in our change management and workload prioritization processes. Additional information on these processes can be found in Section R8.

16.2.6. The CCN shall adhere to national standards and standardized instructions and definitions that are consistent with industry norms that are developed jointly with DHH. These shall include, but not be limited to, HIPAA based standards, federal safeguard requirements including signature requirements described in the CMS State Medicaid Manual.

AmeriHealth Mercy will adhere to national standards and instructions, consistent with industry norms that are developed jointly with DHH.

16.3. Connectivity

16.3.1. DHH is requiring that the CCN interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker (EB) and its trading partners. The CCN must have capacity for real time connectivity to all DHH approved systems.

AmeriHealth Mercy has the capability to interface with DHH, the Medicaid Fiscal Intermediary (FI), the Enrollment Broker and its trading partners. We will have the capacity for real-time connectivity to all DHH approved systems.

The diagram below depicts an overview of our current connectivity with various states and their agents.

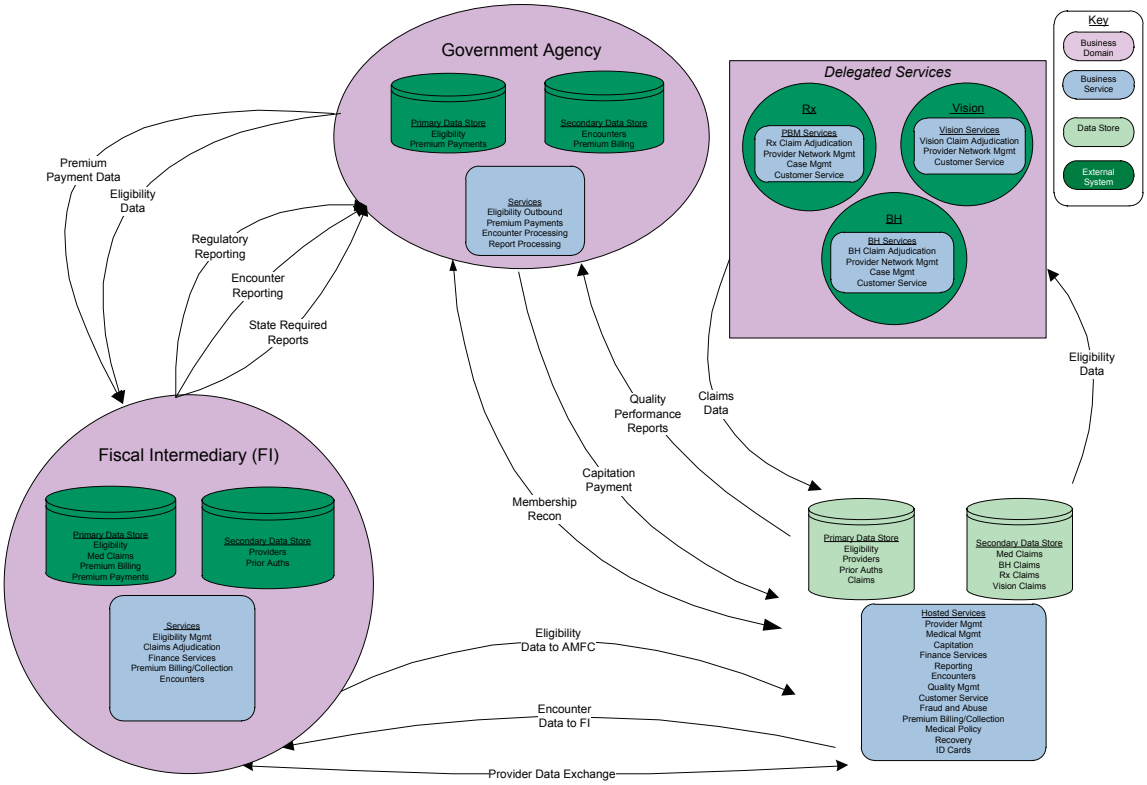


Figure 22: Overview of Current Connectivity with States and their Agents

16.3.2. The System shall conform and adhere to the data and document management standards of DHH and its FI, inclusive of standard transaction code sets.

AmeriHealth Mercy will conform and adhere to the data and document management standards as specified by DHH and its Fiscal Intermediary.

16.3.3. The CCN's Systems shall utilize mailing address standards in accordance with the United States Postal Service.

AmeriHealth Mercy's systems utilize USPS mailing address standards.

16.3.4. At such time that DHH requires, the CCN shall participate and cooperate with DHH to implement, within a reasonable timeframe, a secure, web-accessible health record for members, such as Personal Health Record (PHR) or Electronic Health Records (EHR).

AmeriHealth Mercy will participate with DHH to implement a secure, web-accessible health record for members, such as a Personal Health Record (PHR) or Electronic Health Records (EHR), in a reasonable timeframe at such time that DHH requires.

16.3.5. At such time that DHH requires, the CCN shall participate in statewide efforts to incorporate all hospital, physician, and other provider information into a statewide health information exchange.

AmeriHealth Mercy has extensive experience in working with health information exchanges and will support statewide efforts to incorporate hospital, physician and other provider information into a statewide health information exchange as DHH requires.

AmeriHealth Mercy subject matter experts will offer the network current industry intelligence on the form and direction of Federal HIT initiatives. Joe Miller, Director of E-Business for AmeriHealth Mercy regularly attends industry stakeholder meetings in Washington around health information exchange, 5010 and ICD-10 and has testified before the National Committee on Vital and Health Statistics on Federal IT initiatives. He speaks regularly in national and local forums to provider networks on HIT topics.

16.3.6. The CCN shall meet, as requested by DHH, with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.

AmeriHealth Mercy will meet with work groups or committees to coordinate activities and develop system strategies that actively reinforce the healthcare reform initiative.

16.3.7. All information, whether data or documentation and reports that contain or references to that information involving or arising out of the Contract is owned by DHH. The CCN is expressly prohibited from sharing or publishing DHH's information and reports without the prior written consent of DHH. In the event of a dispute regarding the sharing or publishing of information and reports, DHH's decision on this matter shall be final.

AmeriHealth Mercy will conform and adhere to this specification.

16.3.8. The Medicaid Management Information System (MMIS) processes claims and payments for covered Medicaid services. DHH's current MMIS contract expired December 31, 2010. DHH exercised its right to extend all or part of a five year extension to its current FI. DHH shall require the CCN to comply with transitional requirements as necessary should DHH contract with a new FI during the Contract at no cost to DHH or its FI.

AmeriHealth Mercy will support DHH's current and potential future MMIS contractors.

16.3.9. The CCN shall be responsible for all initial and recurring costs required for access to DHH system(s), as well as DHH access to the CCN's system(s). These costs include, but are not limited to, hardware, software, licensing, and authority/permission to utilize any patents, annual maintenance, support, and connectivity with DHH, the Fiscal Intermediary (FI) and the Enrollment Broker.

AmeriHealth Mercy will adhere to this specification.

16.3.10. The CCN shall complete an Information Systems Capabilities Assessment (ISCA), which will be provided by DHH. The ISCA shall be completed and returned to DHH no later than thirty (30) days from the date the CCN signs the Contract with DHH.

AmeriHealth Mercy will adhere to this specification.

16.3.11. Hardware and Software. The CCN must maintain hardware and software compatible with current DHH requirements which are as follows:

16.3.11.1. Desktop Workstation Hardware:

Table 11: Desktop Hardware

DHH Hardware Requirement	Meet or Exceed DHH Standard	AmeriHealth Mercy Desktop Standard
IMB-compatible PD using at least a Dual Core Processor (2.66 GHz, 6MB cache, 1333 MHz FSB)	✔	• Intel Core i5-2400 Processor 3.10 GHz, 6M cache, 4 cores/4 threads • 1333 MHz FSB
At least 4 GB (gigabites) of RAM	✔	4 GB of RAM
At least 250 GB HDD	✔	160 GB HDD Additional storage is provisioned on a storage area network, (EMC), which expands capacity beyond the 250GB per employee requirement. Our Security policy prevents saving of files on the local hard drives. All files are saved, backed up and archived on our network.
256 MB discrete video memory	✔	1GB of discrete video Memory
A color monitor of LCD capable of at least 800 x 640 screen resolution	✔	19-inch Color LCD Monitor Native Resolution 1280 x 1024
A DVD +/- RW and CD-ROM drive capable of reading and writing to both media	✔	• DVD/CD Rom (Standard) • DVD/CD Writer (With approval from Corporate Security based on Policy 145.012)
1 gigabyte Ethernet card;	✔	• Integrated Intel 82579LM Gigabyte Ethernet • Intel Pro 1000 CT Gigabyte • 802.11 b/g/n wireless
Enough spare USB ports to accommodate thumb drives, etc.; and,	✔	10 USB Ports (Corporate Security Policy 145.003 prohibits the use of USB Drives without approval)
Printer compatible with hardware and software required.	✔	All Desktops are configured to use: • Canon Printers/Copiers (Network Printing) • HP LaserJet printers (Direct Connection)

16.3.11.2. Desktop Workstation Software:

Table 12: Desktop Software

DHH Software Requirement	Meet or Exceed DHH Standard	AmeriHealth Mercy Desktop Standard
Operating system should be Microsoft Windows XP SP3 or later,	✔	Microsoft Windows XP SP3

DHH Software Requirement	Meet or Exceed DHH Standard	AmeriHealth Mercy Desktop Standard
Web browser that is equal to or surpasses Microsoft Internet Explorer v7.0 and is capable of resolving JavaScript and ActiveX scripts;	✔	• Microsoft Internet Explorer v7.0 • Capable of resolving JavaScript, ActiveX scripts, Silverlight and Flash
An e-mail application that is compatible with Microsoft Outlook;	✔	Microsoft Exchange 2010
An office productivity suite such as Microsoft Office that is compatible with Microsoft Office 2007 or later;	✔	Microsoft Office 2010 Professional
Each workstation should have access to high speed Internet;	✔	All workstations have access to two high speed Internet access points
Each workstation connected to the Internet should have anti-virus, anti-spam, and anti-malware software. Regular and frequent updates of the virus definitions and security parameters of these software applications should be established and administered;	✔	• Microsoft Forefront Endpoint Protection (Antivirus, Malware); Configured to check for definitions at minimum once a day • Axway Tumbleweed (SPAM Protection, Secure Mail)
A desktop compression/encryption application that is compatible with WinZip v11.0;	✔	• Zip Encryption supported through WinZip v11.0
All workstations, laptops and portable communication devices shall be installed with full disk encryption software; and	✔	• Checkpoint Encryption for Removable Media Devices • Pointsec Encryption for Laptops
Compliant with industry-standard physical and procedural safeguards for confidential information (NIST 800-53A, ISO 17788, etc.).	✔	Corporate Security Policies 145.002 and 145.017 enforce policies to control access and management of confidential information.

16.3.11.3. Network and Back-up Capabilities

- Establish a local area network or networks as needed to connect all appropriate workstation personal desktop computers (PCs);
- Establish appropriate hardware firewalls, routers, and other security measures so that the CCN's computer network is not able to be reached by an external entity;
- Establish appropriate back-up processes that ensure the back-up, archival, and ready retrieval of network server data and desktop workstation data;
- Ensure that network hardware is protected from electrical surges, power fluctuations, and power outages by using the appropriate uninterruptible power system (UPS) and surge protection devices; and.
- The CCN shall establish independent generator back-up power capable of supplying necessary power for four (4) days.

AmeriHealth Mercy will establish a scalable local area network to connect all workstations and devices in support of our business in Louisiana. We will utilize local and wide area networking industry standard technologies to ensure a secure high-performing network is available from the local AmeriHealth Mercy office to the enterprise data center.

Enterprise Network Overview

The primary goal of our Network team is to design, develop, and support the Local Area and Wide Area Networks. Network team services include:

- Deliver a secure remote access solution into the network
- Telecommuter support
- VPN solutions for business partners and employees
- Provide wireless connectivity in the local office
- Maintain and support a secure state of the art, highly available network for 24x7 operations
- Provide Internet access for employees
- Support video conferencing as part of corporate solution linking the our expansions and partners

The graphic below depicts an overview of the current enterprise network of AmeriHealth Mercy, which will be expanded to include Louisiana.

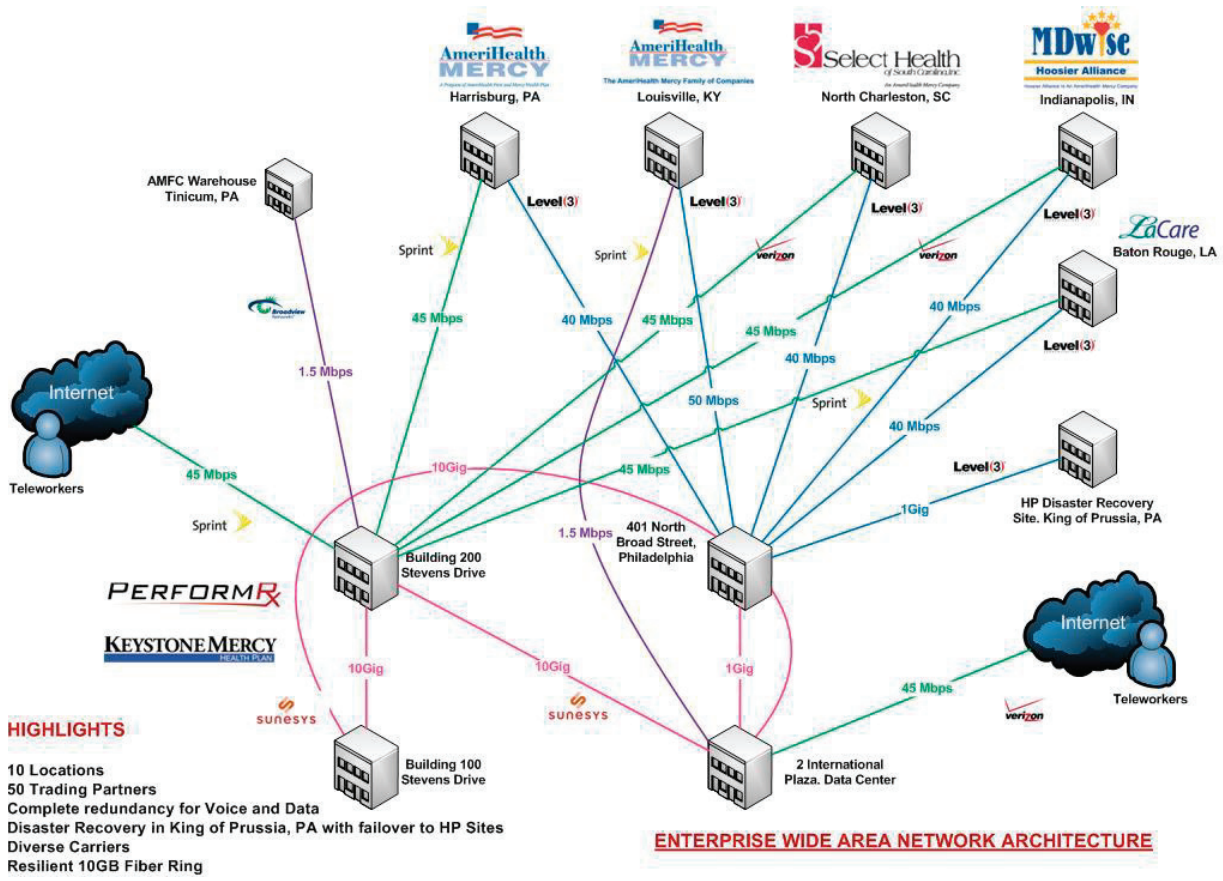


Figure 23: Enterprise Network Overview

Hardware firewalls, Routers, and Other Security Measures

External access to/from our network is accomplished only through the hardened network facilities at AmeriHealth Mercy. To ensure a secure environment from external entities, we utilize a dual layer DMZ topology model where public Internet connectivity is separated from private business partner's connectivity. The Internet DMZ is serviced by redundant Cisco VPN ASA5520 concentrators, cryptographic service routers, and secured with two Cisco ASA5500 firewalls. Secured FTP sessions are supported for SFTP, FTPS, HTTPS/S, & SCP2 and FIPS 140-2 validated cryptography. Authentication for the Internet DMZ is accomplished through the use of two Cisco AAA CSACS01121 security

appliances. AmeriHealth Mercy's Extranet solution, providing private connectivity with business partners, is serviced by redundant Cisco ASA5550 firewalls, Cisco ACE4710 load balancers and reversed proxy servers.

AmeriHealth Mercy has a defined process that allows external entities to securely access the AmeriHealth Mercy electronic environments and ensures security throughout the lifecycle of the connection. These sessions are fully auditable and are monitored on a 24-hour-a-day, 7-day-a-week, 365–days-a-year basis by the Information Security Team.

Network System Monitoring

AmeriHealth Mercy utilizes Orion, a robust tool for comprehensive monitoring of LAN/WAN Infrastructure Orion Network Performance Monitor (NPM) delivers detailed network performance monitoring. Orion makes it easy to quickly detect, diagnose, and resolve performance issues within our ever-changing corporate and data center environments. NPM delivers real-time views and dashboards that enable us to visually track network performance at a glance. Leveraging dynamic network topology functionality and automated network discovery features, we can maintain our agility with the evolving network needs of the organization.

Security Monitoring

Technologies embedded in the Information Security infrastructure like IDS, IPS, Websense and EventTracker continuously monitor our entry points and devices residing on our network. These solutions are configured to alert key personnel when any change to a system, environment and or logical configuration occurs within our local and extended networks.

Remote Data Back-up and Archival

Remote Backups will be employed to protect all data utilized to support AmeriHealth Mercy operations including network server and desktop workstation data. Retention and archiving of data will follow established policies and procedures. All media will be stored at a vault with Vital Records, Inc. (VRI), our contracted off-site record storage facility. Retrial of stored media can be accomplished in two hours.

Power Protection

All deployed network and server technology will be maintained with conditioned protected power provided from appropriate-sized uninterruptible power supply UPS solutions and surge protection in each server cabinet's power distribution. All required computing technology and facility lighting will be protected by an electrical generator with a fuel capacity to provide power for four days as maximum load.

16.4. Resource Availability and Systems Changes

16.4.1. Resource Availability. The CCN shall provide Systems Help Desk services to DHH, its FI, and Enrollment Broker staff that have direct access to the data in the CCN's Systems.

16.4.1.1. The Systems Help Desk shall:

- Be available via local and toll-free telephone service, and via e-mail from 7:00 a.m. to 7:00 p.m., Central Time, Monday through Friday, with the exception of DHH designated holidays. Upon request by DHH, the CCN shall be required to staff the Systems Help Desk on a state holiday, Saturday, or Sunday;
- Answer questions regarding the CCN's System functions and capabilities; report recurring programmatic and operation problems to appropriate staff for follow-up; redirect problems or queries that are not supported by the Systems Help Desk, as appropriate, via a telephone transfer

or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate DHH staff;

- Ensure individuals who place calls after hours are have the option to leave a message. The CCN's staff shall respond to messages left between the hours of 7p.m. and 7a.m. by noon that next business day;
- Ensure recurring problems not specific to Systems unavailability identified by the Systems Help Desk shall be documented and reported to CCN management within one (1) business day of recognition so that deficiencies are promptly corrected; and
- Have an IS service management system that provides an automated method to record, track and report all questions and/or problems reported to the Systems Help Desk.

The AmeriHealth Mercy Service Desk is the central point of contact for reporting, tracking, resolving and escalating technology issues and requests. As currently operating, our Service Desk meets the requirements outlined by DHH. The AmeriHealth Mercy Service Desk is staffed from our corporate office and is available via toll free telephone number and email 24-hours a day, 7-days a week. On-Call Service Desk support receives calls directly and responds to voice mail messages received after hours (7p.m. and 7a.m.) by noon the next business day.

The Service Desk functions include:

- Single Point of Contact for all incidents, requests and problems
- Recording, routing, escalating and tracking incidents, requests and problems through resolution
- Coordinating second and third line support
- Resetting passwords
- Keeping customers informed on request status and progress
- Making an initial assessment of all incidents, requests and problems
- Monitoring and escalation procedures relative to the appropriate service level agreements (SLAs)
- Notification of customers when incidents, requests and problems are resolved
- Facilitating root cause analysis to ensure resolution of recurring incidents and problems

AmeriHealth Mercy will adjust the staffing of the Service Desk to accommodate for any differences between our and DHH's holiday schedules and for weekend days or holidays where help desk staffing is requested by DHH.

The AmeriHealth Mercy Service Desk leverages the FrontRange incident management system, HEAT for logging all Service Desk contacts for incidents and requests, tracking all details for resolving incidents and requests, generating and tracking assignments for ticket resolution, creating reports to status, monitor and track all incidents, requests and problems. The process of tracking and monitoring all reported requests and issues ensures that recurring problems not specific to Systems unavailability identified by the Service Desk are documented and reported to CCN management within one (1) business day of recognition so that deficiencies are promptly corrected.

16.4.2. Information Systems Documentation Requirements

16.4.2.1. The CCN shall ensure that written Systems process and procedure manuals document and describe all manual and automated system procedures for its information management processes and information systems.

AmeriHealth Mercy maintains documentation of all manual and automated system procedures for its information management processes and information systems as a standard practice.

16.4.2.2. The CCN shall develop, prepare, print, maintain, produce, and distribute to DHH distinct Systems design and management manuals, user manuals and quick reference Guides, and any updates.

AmeriHealth Mercy agrees to provide to DHH the aforementioned manuals and Guides along with updates.

16.4.2.3. The CCN shall ensure the Systems user manuals contain information about, and instruction for, using applicable Systems functions and accessing applicable system data.

AmeriHealth Mercy agrees documentation shall include information and instruction for applicable Systems functions and data access.

16.4.2.4. The CCN shall ensure when a System change is subject to DHH prior written approval, the CCN will submit revision to the appropriate manuals before implementing said Systems changes.

AmeriHealth Mercy agrees that for all changes subject to DHH prior written approval, updated manuals shall be provided prior to implementing said Systems changes.

16.4.2.5. The CCN shall ensure all aforementioned manuals and reference Guides are available in printed form and on-line; and

AmeriHealth Mercy agrees to make documentation available both printed and on-line.

16.4.2.6. The CCN shall update the electronic version of these manuals immediately, and update printed versions within ten (10) business days of the update taking effect.

AmeriHealth Mercy agrees to the timeline for provision of updated documentation.

16.4.2.7. The CCN shall provide to DHH documentation describing its Systems Quality Assurance Plan.

The AmeriHealth Mercy System Quality Assurance plan outlines the scope, approach, assumptions, risks, roles, responsibilities, and schedule, among other items relative to the Louisiana's implementation and ongoing operations. The System Quality Assurance plan provides a framework to ensure that the system performs as expected and provides business continuity, as needed.

An outline of the AmeriHealth Mercy Systems Quality Assurance Plan is included below. A full copy of the plan will be provided to DHH upon request.

Table 13: Outline of Systems Quality Assurance Plan

1) INTRODUCTION ▪ Overview ▪ Terminology and Definitions ▪ Reference Documents ***2) SCOPE*** ▪ Provider Network Management ▪ Eligibility and Enrollment ▪ Claims ▪ Medical Management ▪ Finance ▪ Contact Center ▪ Encounters ▪ Statutory Reporting / Informatics ▪ Corporate Communications ▪ Facilities ▪ Infrastructure ▪ UAT ▪ Out of Scope ***3) ASSUMPTIONS*** ***4) PRE-REQUISITES***	***5) DEPENDENCIES*** ***6) TEST METHODOLOGY*** ***7) TEST LEVEL CRITERIA*** a) Entry Level Criteria b) Exit Criteria ***8) TEST RESOURCES*** a) Personnel b) Environments c) Test Tools ***9) APPLICATIONS TESTED*** ***10) TEST DATA*** ***11) TEST PLANNING RISK ASSESSMENT/Details*** ***12) TASKS AND RESPONSIBILITIES*** ***13) ROLES AND DESCRIPTIONS*** ***14) TEST SCENARIOS*** ***15) DEFECT MANAGEMENT*** ***16) DEFECT SEVERITY DEFINITIONS*** ***17) DEFECT STATUS***

16.4.3. Systems Changes

16.4.3.1. The CCN's Systems shall conform to future federal and/or DHH specific standards for encounter data exchange within one hundred twenty (120) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH.

AmeriHealth Mercy agrees to conform to future federal and/or DHH specific standards for encounter data exchange within one hundred twenty (120) calendar days prior to the standard's effective date or earlier, as directed by CMS or DHH, provided reasonably sufficient notice and definition around the changes.

16.4.3.2. If a system update and/or change are necessary, the CCN shall draft appropriate revisions for the documentation or manuals, and present to DHH thirty (30) days prior to implementation, for DHH review and approval. Documentation revisions shall be accomplished electronically and shall be made available for Department review in an easily accessible, near real-time method. Printed manual revisions shall occur within ten (10) business days of the actual revision.

AmeriHealth Mercy agrees to provide changes to our documentation within the timelines specified.

16.4.3.3. The CCN shall notify DHH staff of the following changes to its System within its span of control at least ninety (90) calendar days prior to the projected date of the change:

AmeriHealth Mercy agrees to provide notification of system changes at least ninety (90) days prior to the projected date of the change for the types of changes outlined in section 16.4.3.4.

16.4.3.4. Major changes, upgrades, modification or updates to application or operating software associated with the following core production System:

- ***Claims processing;***
- ***Eligibility and enrollment processing;***
- ***Service authorization management;***
- ***Provider enrollment and data management; and***
- ***Conversions of core transaction management Systems.***

AmeriHealth Mercy agrees to provide notification of system changes at least ninety (90) days prior to the projected date of the change for the types of changes outlined in section 16.4.3.4.

16.4.3.5. The CCN shall respond to DHH notification of System problems not resulting in System unavailability according to the following timeframes:

- ***Within five (5) calendar days of receiving notification from DHH, the CCN shall respond in writing to notices of system problems.***
  AmeriHealth Mercy agrees to respond within the timelines specified.
- ***Within fifteen (15) calendar days, the correction shall be made or a requirements analysis and specifications document will be due.***
  AmeriHealth Mercy agrees to respond within the timelines specified.
- ***The CCN shall correct the deficiency by an effective date to be determined by DHH.***
  AmeriHealth Mercy will work with DHH to determine a mutually agreed upon timeframe to correct a deficiency based on the scope of the system problem.
- ***The CCN's Systems shall have a system-inherent mechanism for recording any change to a software module or subsystem.***
  AmeriHealth Mercy utilizes TeamTrack to initiate and approve changes. All system changes are traceable through deployment tools and/or the operating system.
- ***The CCN shall put in place procedures and measures for safeguarding against unauthorized modification to the CCN's Systems.***
  Only Change Control Board authorized changes are permitted to be implemented in production and only specific authorized roles within the organization have system privileges to update production systems.

16.4.3.6. Unless otherwise agreed to in advance by DHH, the CCN shall not schedule Systems unavailability to perform system maintenance, repair and/or upgrade activities to take place during hours that can compromise or prevent critical business operations.

AmeriHealth Mercy will not schedule system unavailability to perform system maintenance, repair and or upgrade activities during hours that would compromise or interrupt critical business operations. Scheduled maintenance activities occur during the second weekend of the month. Documentation of affected systems and windows of potential interruption are provided in advance of the scheduled maintenance. The design of our critical systems minimizes the impact of application unavailability due to maintenance or repair.

16.4.3.7. The CCN shall work with DHH pertaining to any testing initiative as required by DHH and shall provide sufficient system access to allow testing by DHH and/or its FI of the CCN's System.

The AmeriHealth Mercy IS QA & Testing Team will work with designated DHH/FI personnel to provide the appropriate level of access to testing environments, as dictated by project needs. At AmeriHealth Mercy, programmatic software changes/enhancements made to the System require QA & Testing support with the rare exception of emergency changes. The same testing process is followed for all projects and maintenance and includes four major phases: Test Planning, Test Development, Execution and

Summarization the details of which are outlined below. The deliverables from the AmeriHealth Mercy IS QA & Testing Team will be made available to DHH/FI as the project need dictates.

The Test Planning phase includes one major deliverable, but it is the most critical--the Test Plan. The Test Plan is drafted by the Test Lead, reviewed and approved by key stakeholders and serves as the document of record for the scope of testing. We use a number of different approaches to testing based on the needs of the project. For example, projects with tight timelines may use more of a risk-based approach others may use a more traditional approach. The types of testing will be decided during this phase (e.g. System & Integration, UAT, Regression, etc.) as along with testing environments and roles and responsibilities. The intent of the Test Planning phase is to gain consensus of all parties as to the Who, What, How, When, and Where for the test effort.

The Test Development phase includes deliverables such as, identification of test scenarios/cases and development of test scripts. We maintain a library of test scenarios and scripts in our test management tool, HP Quality Center. The tool enables us to manage and re-use test scripts from prior test efforts, mitigating the need to "re-invent the wheel" each time a software change arises. This is a time saver especially when it comes to the identification of regression testing needs.

The Test Execution phase includes the execution of test scripts identified in the Test Development phase, tracking defects from identification through resolution, re-test and closure, leveraging HP Quality Center. We track and report the status of testing, pass/fail and defect volumes and severity levels weekly and hold defect tracking meetings.

Finally, the Summarization phase includes one major deliverable, the Test Summary document. The Test Summary document is designed to serve two-purposes: 1) Summarize testing facts as it pertains to results, defects, pass/fail metrics, outstanding defects; identify outstanding issues; and provide risk areas in the deployment to production; 2) Facilitate approval for production deployment. The Testing Summary can be presented in both a formal and informal manner, typically dictated by project size and scope. The larger the project effort, the more formal the presentation of the Test Summary document.

16.5. Systems Refresh Plan

16.5.1. The CCN shall provide to DHH an annual Systems Refresh Plan. The plan shall outline how Systems within the CCN's span of control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors.

We maintain a three year refresh schedule for our key platforms supporting our enterprise storage solutions, HP-UNIX solutions and Cisco environments. Our Microsoft Server platform is positioned to replace one third of the environment each year. As part of the Microsoft server replacement process, all candidates are considered for virtualization. We prefer to refresh Microsoft server solutions with our VMware platform to reduce the physical footprint required in our data center, while providing a more highly available solution that uses fewer consumed resources. The corporate desktop employs a similar schedule with respect to refreshing desktops, laptops and peripherals, refreshing one-third of the devices each year.

16.5.2. The systems refresh plan shall also indicate how the CCN will ensure that the version and/or release level of all of its Systems components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF), or a third party authorized by the OEM and/or SDF to support the Systems component.

Operating systems and application versioning are maintained based on individual application product schedules. AmeriHealth Mercy stays within two service packs or updates as relevant to our use of the product. The exception to this approach is the release of security patches from Microsoft and anti-virus updates. Anti-virus signature updates are applied as they are released by our vendor; security patches are applied after initial testing.

Maintenance and warranty schedules of our key technologies are maintained with our strategic partners, as part of our refresh process. Those schedules are generally prepaid for the life of the.

16.6. Other Electronic Data Exchange

16.6.1. The CCN's system shall house indexed electronic images of documents to be used by members and providers to transact with the CCN and that are reposed in appropriate database(s) and document management systems (i.e., Master Patient Index) as to maintain the logical relationships to certain key data such as member identification, provider identification numbers and claim identification numbers. The CCN shall ensure that records associated with a common event, transaction or customer service issue have a common index that will facilitate search, retrieval and analysis of related activities, such as interactions with a particular member about a reported problem

AmeriHealth Mercy utilizes SunGard EXP MACESS™ system to house indexed electronic images of documents that are used by members and providers to transact with AmeriHealth Mercy. This system is also utilized by AmeriHealth Mercy's operations and care management staff to support automation of various internal processes. The EXP System utilizes a SQL Server Database to store logical relationships between key data elements such as Member Identification Numbers, Provider Identification Numbers and claim identification numbers. These relationships are utilized for search, record retrieval, updates and other functions by the EXP System. Our EXP System also utilizes common indexes that facilitate high performance search functions across all records pertaining to Members and Providers, associated with a common event, transaction or customer service issue related to a particular reported problem.

In addition, EXP MACESS helps track and manage the flow of data, documents, and business processes throughout AmeriHealth Mercy corporate offices and affiliates. EXP's tools for capturing, centralizing, and archiving data and documents help ensure that all of our organization's operations are standardized and integrated. Reporting tools monitor workflow, helping mangers identify bottlenecks and increase efficiency.

SunGard EXP MACESS™ is a state-of-the-art imaging-based operations management, workflow management, enterprise content management and customer service solution that has been standardized specifically for managed healthcare organizations.

16.6.2. The CCN shall implement Optical Character Recognition (OCR) technology that minimizes manual indexing and automates the retrieval of scanned documents.

AmeriHealth Mercy 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.

16.7. Electronic Messaging

16.7.1. The CCN shall provide a continuously available electronic mail communication link (e-mail system) to facilitate communication with DHH. This e-mail system shall be capable of attaching and sending documents created using software compatible with DHH's installed version of Microsoft Office (currently 2007) and any subsequent upgrades as adopted.

AmeriHealth Mercy leverages Microsoft Exchange as its e-mail solution. Our implementation of MS-Exchange has been configured for high availability and scalability. We are currently completing an upgrade from Microsoft Exchange 2007 to Microsoft Exchange 2010, which will be complete by the end of the year. Users access MS Exchange using Microsoft Office 2010 which is compatible with DHH's version of Microsoft Office 2007.

16.7.2. As needed, the CCN shall be able to communicate with DHH over a secure Virtual Private Network (VPN).

AmeriHealth Mercy utilizes industry standard Cisco VPN for client-to-site, or site-to-site VPN connectivity to protect our data and communicate remotely.

16.7.3. The CCN shall comply with national standards for submitting public health information (PHI) electronically and shall set up a secure emailing system with that is password protected for both sending and receiving any personal health information.

AmeriHealth Mercy complies with national standards when submitting PHI electronically. We use Tumbleweed as the standard for secure email communications. Tumbleweed requires unique user account information to login and retrieve (download) messages sent to a recipient and the file transfer occurs over an encrypted SSL (Secure Socket Layer) session.

16.8. Eligibility and Enrollment Data Exchange

The CCN shall:

16.8.1. Receive, process and update enrollment files sent daily by the Enrollment Broker;

AmeriHealth Mercy will process enrollment files daily with an Enrollment Broker.

16.8.2. Update its eligibility and enrollment databases within twenty-four (24) hours of receipt of said files;

AmeriHealth Mercy will update enrollment files within 24 hours of receipt.

16.8.3. Transmit to DHH, in the formats and methods specified by DHH, member address changes and telephone number changes;

AmeriHealth Mercy will process member address and telephone number changes and transmit to DHH per DHH's definition of format and method.

16.8.4. Be capable of uniquely identifying (i.e., Master Patient Index) a distinct Medicaid member across multiple populations and Systems within its span of control; and

Members are assigned a unique member ID that is used across all of our Systems.

16.8.5. Be able to identify potential duplicate records for a single member and, upon confirmation of said duplicate record by DHH, resolve the duplication such that the enrollment, service utilization, and customer interaction histories of the duplicate records are linked or merged.

Duplicate member records are identified and resolved through our in-bound eligibility process through exception reporting and collaboration with DHH and meet the requirements above.

16.9. Provider Enrollment

At the onset of the CCN Contract and periodically as changes are necessary, DHH shall publish at the url: www.lamedicaid.com the list of Louisiana Medicaid provider types, specialty, and sub-specialty codes. The CCN shall utilize these codes within their provider enrollment system. The objective is to coordinate the provider enrollment records of the CCN with the same provider type, specialty and subspecialty codes as those used by DHH and the Enrollment Broker. The CCN shall provide the following:

16.9.1. Provider name, address, licensing information, Tax ID, National Provider Identifier (NPI), taxonomy and payment information;

16.9.2. All relevant provider ownership information as prescribed by DHH, federal or state laws; and

16.9.3. Performance of all federal or state mandated exclusion background checks on all providers (owners and managers). The providers shall perform the same for all their employees at least annually.

AmeriHealth Mercy's system will use the specified codes within our provider enrollment system as published at www.lamedicaid.com. Our provider enrollment process will capture and store the data elements above and our credentialing process will ensure appropriate background checks are conducted.

16.9.4. Provider enrollment systems shall include, at minimum, the following functionality:

- Audit trail and history of changes made to the provider file;
- Automated interfaces with all licensing and medical boards;
- Automated alerts when provider licenses are nearing expiration;
- Retention of NPI requirements;
- System generated letters to providers when their licenses are nearing expiration;
- Linkages of individual providers to groups;
- Credentialing information;
- Provider office hours; and
- Provider languages spoken.
- Automated interfaces with all licensing and medical boards

AmeriHealth Mercy provider enrollment and maintenance capabilities will meet the requirements outlined above. The requirements below will be met assuming the licensing board has the capability for automated interfaces.

16.10. Information Systems Availability

CCN Shall:

16.10.1. Not be responsible for the availability and performance of systems and IT infrastructure technologies outside of the CCN's span of control;

16.10.2. Allow DHH personnel, agents of the Louisiana Attorney General's Office or individuals authorized by DHH or the Louisiana Attorney General's Office direct access to its data for the purpose of data mining and review;

16.10.3. Ensure that critical member and provider Internet and/or telephone-based IVR functions and information functions are available to the applicable System users twenty-four (24) hours a day, seven (7) days a week except during periods of scheduled System unavailability agreed upon by DHH and the CCN. Unavailability caused by events outside of the CCN's span of control is outside of the scope of this requirement;

16.10.4. Ensure that at a minimum all other System functions and information are available to the applicable system users between the hours of 7a.m. and 7p.m., Central Time, Monday through Friday;

16.10.5. Ensure that the systems and processes within its span of control associated with its data exchanges with DHH's FI and/or Enrollment Broker and its contractors are available and operational;

AmeriHealth Mercy will meet all of the above-stated availability and access requirements within our span of control.

AmeriHealth Mercy has successfully implemented high-availability technologies and strategies to assure 24 X 7 system availability for all of our customers. Across our customer base, we have consistently achieved Uptime service levels of at least 99.9 percent for all of our Information and Telecommunication systems. The Uptime service level is measured monthly and does not include any pre-scheduled downtime for regular system maintenance. Any downtime schedule will be pre-determined and agreed upon by DHH and CCN.

16.10.6.Ensure that in the event of a declared major failure or disaster, the CCN's core eligibility/enrollment and claims processing system shall be back on line within seventy-two (72) hours of the failure's or disaster's occurrence;

The recovery time objective for our core eligibility / enrollment & claims processing systems is 24 hours, which exceeds the Louisiana CCN-P RFP requirement of 72 hours set forth in this section.

Recovery Time Objectives for our major systems exceed those required by the DHH and are outlined below. (Major disaster event)

Table 14: Recovery Time Objectives

Major System / Application	Recovery Time Objective
Care Management Platform – ZeOmega Jiva System	24 hours
Core Eligibility / Enrollment Claims Processing – TriZetto Facets	24 hours
Workflow – SunGard EXP	36 hours
Emails - Microsoft Exchange Server	24 hours
Network File Server	24 hours
Operations Call Center	12 hours

16.10.7. Notify designated DHH staff via phone, fax and/or electronic mail within sixty (60) minutes upon discovery of a problem within or outside the CCN's span of control that may jeopardize or is jeopardizing availability and performance of critical systems functions and the availability of critical information as defined in this Section, including any problems impacting scheduled exchanges of data between the CCN and DHH or DHH's FI. In its notification, the CCN shall explain in detail the impact to critical path processes such as enrollment management and encounter submission processes;

16.10.8.Notify designated DHH staff via phone, fax, and/or electronic mail within fifteen (15) minutes upon discovery of a problem that results in delays in report distribution or problems in on-line access to critical systems functions and information during a business day, in order for the applicable work activities to be rescheduled or handled based on System unavailability protocol;

16.10.9. Provide information on System unavailability events, as well as status updates on problem resolution, to appropriate DHH staff. At a minimum these updates shall be provided on an hourly basis and made available via phone and/or electronic mail, and;

16.10.10. Resolve and implement system restoration within sixty (60) minutes of official declaration of unscheduled System unavailability of critical functions caused by the failure of system and telecommunications technologies within the CCN's span of control. Unscheduled System unavailability to all other System functions caused by system and telecommunications technologies within the CCN's span of control shall be resolved, and the restoration of services implemented, within eight (8) hours of the official declaration of System unavailability.

16.10.10.1. Cumulative Systems unavailability caused by systems and/or IS infrastructure technologies within the CCN's span of control shall not exceed twelve (12) hours during any continuous twenty (20) business day period; and

16.10.11. Within five (5) business days of the occurrence of a problem with system availability, the CCN shall provide DHH with full written documentation that includes a corrective action plan describing how the CCN will prevent the problem from reoccurring.

AmeriHealth Mercy will comply with all problem notification and resolution requirements stated in Sections 16.10.7 through 16.10.11, above, using our Incident and Problem Management processes. Additional information on our procedures for incident and problem management can be found below.

16.11. Contingency Plan

16.11.1.The CCN, regardless of the architecture of its Systems, shall develop and be continually ready to invoke, a contingency plan to protect the availability, integrity, and security of data during unexpected failures or disasters, (either natural or man-made) to continue essential application or system functions during or immediately following failures or disasters.

16.11.2. Contingency plans shall include a disaster recovery plan (DRP) and a business continuity plan (BCP). A DRP is designed to recover systems, networks, workstations, applications, etc. in the event of a disaster. A BCP shall focus on restoring the operational function of the organization in the event of a disaster and includes items related to IT, as well as operational items such as employee notification processes and the procurement of office supplies needed to do business in the emergency mode operation environment. The practice of including both the DRP and the BCP in the contingency planning process is a best practice.

AmeriHealth Mercy has an active business continuity program that seeks to minimize the impact of technology- or facility-related emergencies or external events on employees, members or providers. AmeriHealth Mercy's Business Continuity Program sponsors are responsible for oversight of the company's business continuity program. The Business Continuity Program Management Office manages the four key program components which are updated at least annually:

- Crisis Management
- Business Continuity
- Disaster Recovery
- Pandemic

Figure 24: Business Continuity

AmeriHealth Mercy's Business Continuity Program is designed to:

- Prepare employees to respond to a crisis in a safe manner;
- Help management control risks and exposures;
- Provide preventative measures, where appropriate;
- Provide the ability to take proactive management control of business or technology interruptions;
- To resume critical business operations
- To limit lost operational times and costs
- To minimize decision-making during an interruption/disaster
- Prepare the company to continue to deliver critical business functions if the employee population is impacted due to influenza or other infectious diseases;
- Provide protection of corporate assets; and
- Ensure the continuity and survival of the business.

AmeriHealth Mercy's Business Continuity program is designed to provide immediate response and subsequent recovery from any unplanned technology service interruption, such as loss of utility services, building evacuation or a catastrophic event such as a major fire or hurricane.

Types of Disasters covered by the plan

Minor: 24 hours or less

A minor disaster is an operational disruption that generally does not require the activation of the declaration process. However, it does require initiating our incident management process and engagement of the Business Continuity team.

A minor disaster usually involves an outage or disruption with a duration anticipated to be one day or less. Damage due to a minor disaster is not extensive. It may consist of component failure or minor damage to hardware, software or supporting electrical equipment. Examples include:

- Partial or total loss of hardware for a period of several hours
- Recoverable loss of critical data; full recoverability in less than 24 hours
- Loss of an important computer application
- Temporary loss of or HVAC, electrical or access to the facility
- Temporary loss of internal or external networks

Major: 24 hours to 7 days

A major disaster is an operational disruption greater than 24 hours and less than 7 days that generally requires the activation of the declaration process. It also requires the Business Continuity team to assume oversight of the incident. The Incident Management team will transition their engagement as the lead while continuing to assist in support of the incident.

Damage from a major disaster is more severe than that associated with a minor disaster and operations can be restored within one week. Examples include:

- Damage to hardware resulting in downtime of more than 24 hours
- Recoverable loss of critical data; full recoverability taking more than 24 hours
- Loss of an important computer application for more than 24 hours
- Loss of service HVAC, electrical, water or access to the facility for more than 24 hours
- Loss of network caused by severe weather or interruption of service caused by 3rd party carriers

Catastrophic: greater than 7 days

A catastrophic disaster is one where the outage is anticipated to be more than seven days. Activation of the declaration process is required. The Business Continuity team is responsible for providing oversight of the incident. The Incident Management Team assists in supporting the incident where needed.

Damage related to a catastrophic disaster is usually severe and could involve total destruction of the Data Center requiring major replacement of equipment and/or major renovation of the Data Center. Examples include:

- Serious damage or total destruction of the Data Center facilities
- Unrecoverable loss of critical data
- Loss of access to facilities preventing staff from performing their jobs
- Loss of the operations center staff due to uncontrollable factors (outbreak of epidemic disease)
- Major telecommunications failure
- Regional incident: weather, terrorism or chemical

Disaster Recovery Plan Objectives

The objectives of our Disaster Recovery Plan are to recover time-sensitive infrastructure and business applications in a timely and organized fashion in order to minimize impact to the organization, its business partners, and its clients.

The primary objectives of the plan are:

- Provide a rehearsed/exercised recovery plan that, when executed, will provide for efficient/timely response, recovery, restoration/resumption of infrastructure and applications
- Ensure compliance with regulatory requirements for each supported Plan
- Minimize inconvenience and disruption to members, providers, business partners, and vendors
- Minimize the impact to public and industry image and maintain confidence in our organization and services
- Reduce the operational impacts of a disaster for time-sensitive business apps.
- Minimize the following:
  - Number and frequency of ad -hoc decisions following a disruption
  - Dependence on participation of any specific individuals
  - Confusion, errors, omissions, and unnecessary duplication of effort
  - Extent of losses associated with disruption and recovery
  - Total elapsed time required for recovery and restoration

Table 15: Recovery Time Objectives

Major System / Application	Recovery Time Objective
Care Management Platform – ZeOmega Jiva System	24 hours
Core Eligibility / Enrollment & Claims Processing – TriZetto Facets	24 hours
Workflow – SunGard EXP	36 hours
Emails - Microsoft Exchange Server	24 hours
Network File Server	24 hours
Operations Call Center	12 hours

Recovery Time Objective for our core eligibility / enrollment & claims processing systems is 24 hours, which exceeds the requirement of 72 hours set forth in Section 16.10.6 of the Louisiana CCN-P RFP.

Periodic and ad-hoc testing of our business continuity/disaster recovery plan.

We formally test the Disaster Recovery Plan at an alternate site annually. This is achieved in partnership with our vendor, Hewlett-Packard. During each disaster test, we fully restore production environments based on testing requirements and maintain detailed reports, which are used to continually refine the processes used during the time period of the tests. Our Disaster Recovery (DR) services with HP include:

Planning:

- Planning and resource coordination; communication
- Physical inventory of Servers, Routers, Cabling, Applications etc.
- Test planning; risk and contingency analysis: mitigation strategies
- Assembly of DR cans with required documentation and materials

Control:

- SharePoint document repository
- Playbook
- Annual document review
- Quarterly contract, inventory and technical recovery review
- Biannual DR can content review

Construction:

- King of Prussia hot site including data center and seats
- Network installation
- Rack for pre-staging equipment

Execution:

- HP supported hot site capable of supporting 300+ seats
- Playbook execution
- Timed activities in sequence
- Measure time duration
- Schedule exercises

In addition to this comprehensive plan, all of our facilities have extensive contingency plans for weather emergencies, building evacuation, and any other type of disaster. Utilizing advanced routing features through vector programming within our Voice Platforms, or simply logging on with a specific agent log-on ID, voice and fax calls from any or our offices can be rerouted instantaneously to a predetermined alternate location.

16.12. Off Site Storage and Remote Back-up

16.12.1. The CCN shall provide for off-site storage and a remote back-up of operating instructions, procedures, reference files, system documentation, and operational files.

All AmeriHealth Mercy Production environments, including operating instructions, procedures, reference files, system documentation and operational files are backed up daily and the backup tapes are sent offsite the same day. We ensure full protection of information through the retention of backup data in secure offsite locations.

16.12.2. The data back-up policy and procedures shall include, but not be limited to:
16.12.2.1. Descriptions of the controls for back-up processing, including how frequently back-ups occur;

The current records retention policy (168.114), identifies the requirements, backup frequency and schedule to retain pertinent AmeriHealth Mercy data and information in recognition of the need for the systematic identification, control, maintenance, storage, retention and destruction of the records. It also addresses the roles of employees with regards to the responsibilities and escalation.

The Infrastructure Delivery Backup policy (144.007), establishes the requirements for the recalling of tapes and media and the length of tape retention by type of backup (Full Weekly or Monthly and Daily Differential). It states what is included in the backup of each server supporting our enterprise class Data Center and the expected windows of execution for the backup process.

16.12.2.2. Documented back-up procedures;

Operational documentation of how to back up a server, recall tapes and the execution of a restore are maintained in the team's disaster recovery container. The container like our tapes and media are housed at offsite at VRI and is recalled minimally twice a year for updates. Changes to the process due to technology enhancements are reflected in updates to the Infrastructure Delivery Backup policy.

AmeriHealth Mercy performs audits twice a year to ensure that all tapes and media expected to be securely housed are accounted for. The audit is performed by AmeriHealth Mercy employees.

16.12.2.3. The location of data that has been backed up (off-site and on-site, as applicable);

All Production environments, including operating instructions, procedures, reference files, system documentation and operational files of AmeriHealth Mercy are backed up daily and the backup tapes are sent offsite the same day. We ensure full protection of information through the retention of backup data in secure offsite locations.

AmeriHealth Mercy employs the services of Vital Records Inc. (VRI) to house all tape and media supporting our systems. Our enterprise backup solution is based on leveraging NetBackup and HP's ESL712e tape library. Tapes are encrypted as part of the process to ensure that they are only able to be used as prescribed. Backup tapes and media are securely removed and transported by VRI daily based on a defined schedule. Transportation of tapes and media is performed using locked secured containers that follows an exchange process requiring the signatures of identified AmeriHealth Mercy employees and VRI personnel. VRI delivers tapes and media that are part of our differential protection process with the intent that the media will be reused.

Emergency delivery of tapes or media requires authorized AmeriHealth Mercy personnel to call VRI to initiate the process; VRI will have the requested media onsite within two hours.

Remote Management of offsite tapes is accomplished through NetBackup. We utilize VRI's extranet to report on the tapes housed at VRI.

16.12.2.4. Identification and description of what is being backed up as part of the back-up plan; and

Our Infrastructure Delivery Backup policy (144.007) establishes the requirements for the recalling of tapes and media, the length of tape retention by type of backup (Full Weekly or Monthly and Daily Differential). It states what is included in the backup of each server supporting our enterprise class Data Center and the expected windows of execution for the backup process.

Operational documentation detailing the process used to back up a server, recall tapes and execute a restore are maintained in the team's disaster recovery container. The container, like our tapes and media, are housed at VRI and are recalled minimally twice a year for updates.

16.12.2.5. Any change in back-up procedures in relation to the CCN's technology changes.

The current Record Retention policy (168.114) identifies the requirements, backup frequency and schedule to retain pertinent AmeriHealth Mercy data and information in recognition of the need for the systematic identification, control, maintenance, storage, retention and destruction of records. It also addresses the roles of employees with regards to the responsibilities and escalation.

Changes to the process due to technology enhancements are reflected in updates to the Infrastructure Delivery Backup policy.

16.12.3. DHH shall be provided with a list of all back-up files to be stored at remote locations and the frequency with which these files are updated.

AmeriHealth Mercy will provide DHH with the required information.

16.13. Records Retention

16.13.1. The CCN shall have online retrieval and access to documents and files for six (6) years in live systems for audit and reporting purposes, ten (10) years in archival systems. Services which have a once in a life-time indicator (i.e., appendix removal, hysterectomy) are denoted on DHH's procedure formulary file and claims shall remain in the current/active claims history that is used in claims editing and are not to be archived or purged. Online access to claims processing data shall be by the Medicaid recipient ID, provider ID and/or ICN (internal control number) to include pertinent claims data and claims status. The CCN shall provide forty-eight (48) hour turnaround or better on requests for access to information that is six (6) years old, and seventy-two (72) hour turnaround or better on requests for access to information in machine readable form, that is between six (6) to ten (10) years old. If an audit or administrative, civil or criminal investigation or prosecution is in progress or audit findings or administrative, civil or criminal investigations or prosecutions are unresolved, information shall be kept in electronic form until all tasks or proceedings are completed.

AmeriHealth Mercy has the facility to fully comply with all record retention guidelines and regulations as described in the above requirements.

16.13.2. The historical encounter data submission shall be retained for a period not less than six (6) years, following generally accepted retention guidelines.

AmeriHealth Mercy will fully comply with encounter data retention specifications, as described.

16.13.3. Audit Trails shall be maintained online for no less than six (6) years; additional history shall be retained for no less than ten (10) years and shall be provide forty-eight (48) hour turnaround or better on request for access to information in machine readable form, that is between six (6) to ten (10) years old.

AmeriHealth Mercy fully complies with the requirement for audit trails. Audit trails are maintained for a period of ten years and the retention policies can be enhanced to suit additional requirements. Audit trail history can be made available in machine readable form within forty-eight (48) hours of a request. AmeriHealth Mercy is confident all requirements will be satisfied for records and data retention. A pictorial summary of the current records retention policy is shown below.

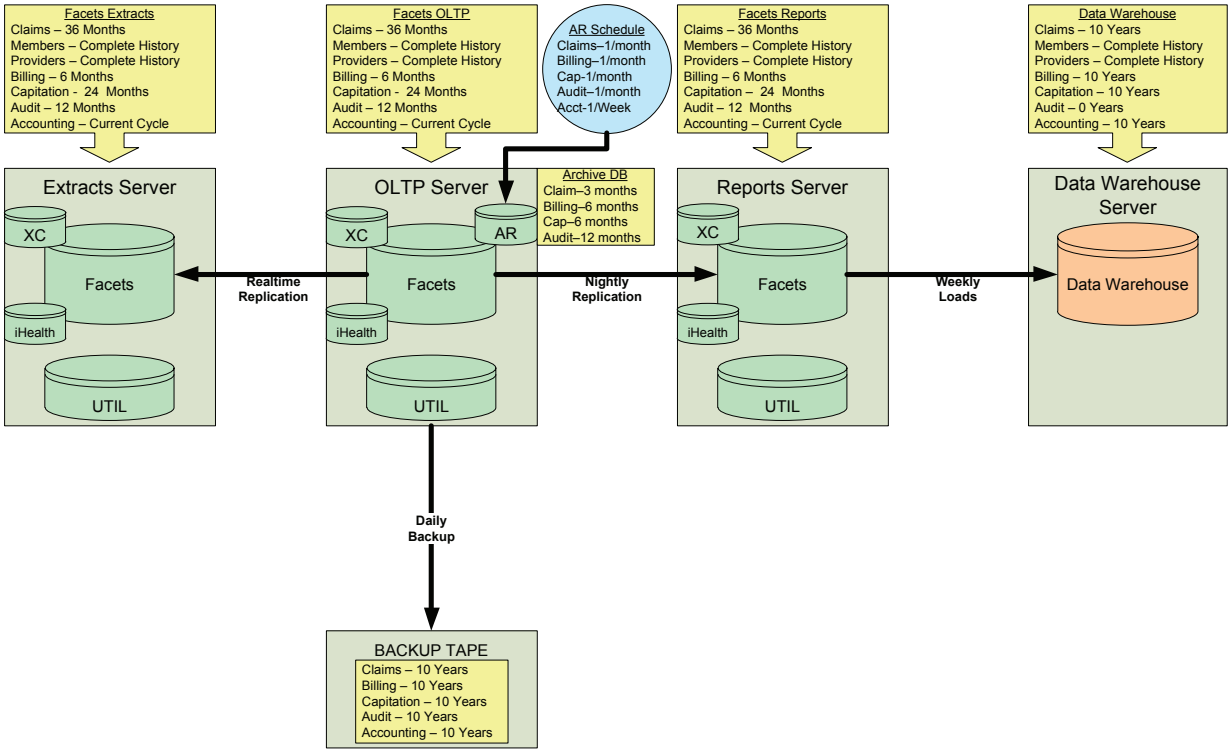


Figure 25: Record Retention Overview

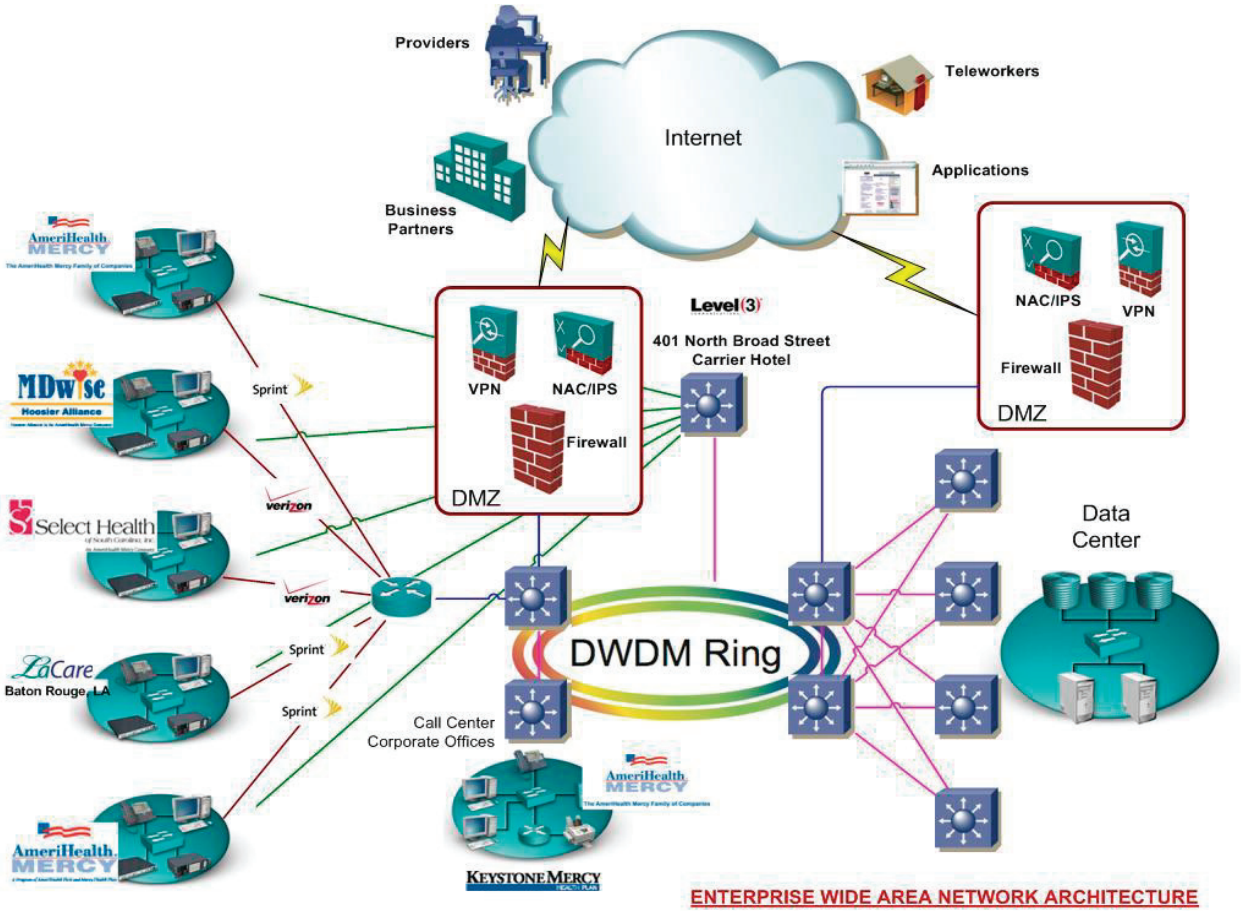


Figure 26: High Level Information Security Diagram

16.14. Information Security and Access Management

The CCN's system shall:

16.14.1. Employ an access management function that restricts access to varying hierarchical levels of system functionality and information. The access management function shall:

AmeriHealth Mercy maintains rigorous policies and procedures to protect health care management data. It is our policy that no data is to be shared without prior written permission that outlines the specific data elements and entities with which it is to be shared. AmeriHealth Mercy uses technology to restrict access to data through the use of data access profiles and follows a hierarchical model for privilege assignments. Access profiles include a detailed description of which types of data, pertaining to specific types of patients, that workforce members in a given job class are permitted to access. These profiles are managed through a rigorous process and overseen by a committee. Access profiles are sufficiently restricted to afford patients' information as much privacy and security as possible, but access to information must not

be so restricted as to interfere with the efficiency of operations or the quality of services provided by AmeriHealth Mercy.

To prevent unauthorized access, individual user accounts for the health care management system are disabled after a predetermined number of failed access attempts. System administrators are required to unlock an account once disabled. System accounts are also disabled after a period of pre-determined time (45 days) for non-use. Enterprise-wide syslog (network and security event logging) collection ensures all system access is reviewed and any anomalies (such as three failed password attempts) are investigated immediately upon notification (notification occurs through automated channels as thresholds are reached).

16.14.1.1. Restrict access to information on a "least privilege" basis, such as users permitted inquiry privileges only, will not be permitted to modify information;

AmeriHealth Mercy complies with the concept of "least privilege" by utilizing *role-based* security principles. Granting access to any system goes through a process that includes an initial request from members of management, and approval by the Information Security Team (after a thorough vetting process to ensure the access requested is appropriate for the role), and assignment of rights based on the user's role within the organization. Access is continuously monitored 24 hours a day, 7 days a week, 365 days a year to ensure compliance with company policies and procedures. In addition to vetting requests for access when they are initially received, comprehensive audits are performed on an annual basis to ensure access levels (group rights, users within a group and database permissions) are still appropriate. Changes and modifications to access follow a similar process to ensure accountability and integrity across all applications and electronic assets..

16.14.1.2. Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions shall be restricted to specified staff jointly agreed to by DHH and the CCN; and

Access to any AmeriHealth Mercy managed system is based on user profiles and roles within the organization. Additionally, Administrative rights (or "global access") to the Facets system is tightly controlled and all access is monitored and reviewed. The listing of administratively enabled users (and associated justification for access) is available for review and agreement.

Users can have a "view only" or "update" capability assigned as appropriate for their job functions. All access assigned to each user and profile created is documented and available on the AmeriHealth Mercy intranet site for review.

System information is available through a variety of, mechanisms, including direct "view only" access to specific datasets or generated activity reports.

16.14.1.3. Restrict unsuccessful attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

AmeriHealth Mercy records and reviews both successful and unsuccessful login attempts. All access attempts (successful or otherwise) are logged and reviewed on a daily basis through automated reporting tools. Any alerted action is investigated by the Information Security team working closely with AmeriHealth Mercy's Corporate Compliance and Corporate Auditing departments. Automated alerting capabilities are triggered after three (3) failed login attempts across the enterprise and the login account is disabled.

16.14.2. Make System information available to duly authorized representatives of DHH and other state and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

AmeriHealth Mercy regularly complies with such requests and is positioned to create the appropriate access for reporting and auditing entities at the request of DHH. Furthermore, AmeriHealth Mercy will ensure this access is created within prescribed timeframes.

16.14.3. Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed by the CCN and DHH.

Information and system integrity is assured and verified through a combination of programmatic and manual controls, administered across the organization, to ensure appropriate controls are in place and functioning as expected. These controls are audited throughout the year by various state and other auditing entities, including annual SSAE 16 or SAS 70 TYPE II audits performed by third parties. Our controls are available for inspection and auditing as needed.

16.14.4. Ensure that audit trails be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

AmeriHealth Mercy ensures audit trails of user and administrative activity are logged through native and third party programs which are monitored and reviewed daily. These functions include database and host level auditing, application firewalls "in front" of the relevant production systems and databases which audit access and program touch points and provide detailed reports (real-time and scheduled) for action or auditing purposes.

16.14.4.1. Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

AmeriHealth Mercy collects and reviews all system generated time stamps, which include; the user account name, the originating IP address, the action that was performed (or attempted) and the date and time of origination and the source of the event initiation, such as job-name in the case of a process or batch script or an Associate ID.

16.14.4.2. Have the date and identification "stamp" displayed on any on-line inquiry;

All actions or attempted actions (including inline queries) in any system of record (such as the Facets claims payment and processing system) or networked asset is recorded on both the system of origination as well as stored in a secondary system (such as Event Tracker or Guardium) to prevent log manipulation and ensure successful recording and monitoring of events.

16.14.4.3. Have the ability to trace data from the final place of recording back to its source data file and/or document;

AmeriHealth Mercy has the ability to trace data and all events back to point of origination. AmeriHealth Mercy's event logs are stored in two places and all actions going to or from networked systems (such as Facets) are recorded and monitored throughout each process performed.

16.14.4.4. Be supported by listings, transaction reports, update reports, transaction logs, or error logs; and

Transaction logs, event logs and reports are generated on a daily, ad-hoc, weekly and monthly basis and are available for auditing and review at any time. A robust team of Information Security professionals

review log data and investigate any suspect activity. The AmeriHealth Mercy Internal Audit and Fraud and Abuse teams also review log data to ensure data accuracy and completeness.

16.14.4.5. Facilitate auditing of individual records as well as batch audits.

AmeriHealth Mercy maintains systems and processes to fully audit all individual account records as well as process and batch server transactions on a daily, weekly, monthly and ad-hoc basis.

Audit trails contain the specific user account, IP address, and unique workstation name as well as the action performed (successful or otherwise) and a date and timestamp of the occurrence. This data is maintained in separate places (both on and off the system of record that generated the action) and is available for investigative or audit purposes.

Data Loss Prevention (DLP) is installed in the AmeriHealth Mercy network and facilitates the audit and policy enforcement actions of ePHI, and tracks (or restricts) data movement by employee, location and transportation method and specific data contents.

16.14.5. Have inherent functionality that prevents the alteration of finalized records;

AmeriHealth Mercy has the functionality to prevent the alteration of finalized records through a combination of automatic, programmatic and manual safeguards in place to ensure data comparisons and data integrity are assured throughout the lifecycle of a claim. These processes include dedicated staff to monitor and conduct audits, programmatic checks to compare data at different points of the claim payment and processing steps and "after the fact" fraud and abuse investigative team that ensures proper accounting is maintained and investigated.

16.14.6. Provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The CCN shall provide DHH with access to data facilities upon request. The physical security provisions shall be in effect for the life of the Contract;

AmeriHealth Mercy provides various physical safeguards of our data facilities such as; strict and very limited badge access (via card key) to all data processing areas (audited on a monthly basis); live camera (both plain-sight and hidden) feeds to a manned security station 24 hours a day, 7 days a week, 365 days a year; fully audited visitor logs (with the policy for admittance strictly enforced and known "beforehand"); as well as use of photo identification prior to any access given or received.

16.14.7. Restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access;

Perimeter access restrictions are in place for AmeriHealth Mercy data processing facilities. Card key access is required for all sensitive areas of the AmeriHealth Mercy facilities, with even more strict controls on data processing centers. All card key access is reviewed in real time by a staff of physical security team members and monitored in various locations (real time). An auditable trail of access is generated each day and reviewed by both the Physical Security Manager as well as the Data Center Manager, as required. Visitor logs are audited, maintained and reviewed daily.

16.14.8. Include physical security features designed to safeguard processor sites through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel;

To promote physical security, AmeriHealth Mercy maintains exhaustive security practices related to our facilities. For example:

- Security employees monitors the building around the clock and remote cameras continually survey the building, inside and outside

- All employees are issued a photo identification badge, and badge information is maintained in a computer system (C-Cure 800) that is updated real-time to enforce physical access policies.
- The security system records all activities on all identification cards
- Upon entering the building, each employee's photo is checked to match the individual entering the building, and entrance to the building is restricted to the front doors
- Guest passes are restricted, and all guests must be verified and accompanied by an employee
- Employees without a business need are not permitted into the building after 6:00 p.m. unless they are escorted by security

The AmeriHealth Mercy data processing centers are protected by a variety of additional mechanisms, including fire suppression chemicals (FM2000), on site fire extinguishers and temperature-specific capped water lines. Uninterruptable Power Supply (UPS) backup and on-site generators are primed, fueled and tested on a monthly basis. Electrical, smoke and fire alarms are monitored 24 hours a day, 7 days a week, 365 days a year and configured to alert personnel in the event of an incident. All system health and temperature readings, as well as physical and environmental controls, are configured to alert as necessary and are continuously monitored.

16.14.9. Put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a CCN's span of control. This includes, but is not limited to, any provider or member service applications that are directly accessible over the Internet, shall be appropriately isolated to ensure appropriate access;

AmeriHealth Mercy has many procedures, measures and technical safeguards to prohibit unauthorized access to data communication facilities and applications. As an example, any AmeriHealth Mercy managed system that is accessible from the public Internet must go through a rigorous third party code review and ethical hacking exercise (performed by a trusted third party) prior to being available on the Internet. In this fashion, any security weaknesses and coding issues are identified prior to the system going "live" over the Internet.

Additionally, AmeriHealth Mercy employees accessing the Internet are subject to the following "high level" controls:

- Enterprise wide syslog and system monitoring
- URL Filtering (to ensure malicious websites are blocked prior to session initiation)
- Intrusion Prevention Systems (IPS) and Intrusion Detection System (IDS) monitoring and alerting
- Data Loss Prevention (DLP) to ensure policy compliance and enforce standards
- Network segments are portioned (VLANs) and monitored with various IDS monitoring sensors

Internet Security

All Internet traffic is secured using SSL Encryption. SSL technology is used to secure web pages and transactions by means of public key cryptography. A digitally secure communication channel is established between the server and the client, after which all data is encrypted. Message integrity is provided by the use of digital signatures, and trust in an individual or a web site is ascertained by using digital certificates which are signed by a Certificate Authority acting as a "trusted third party." AmeriHealth Mercy uses a minimum encryption standard of 128 bit key lengths.

All Internet access points are monitored and reviewed continuously for malicious activities (including simple misuse and designed intrusions) by a tiered architecture of Intrusion Prevention Systems (IPS) and network and host-based intrusion detection systems (IDS) deployed to interrogate all Internet access points and any hosts available to the public Internet. These systems are monitored 24 hours a day, 7 days a week, 365 days a year by a dedicated team of Information Security professionals.

Electronic and Clinical Transaction Security

All communication access to AmeriHealth Mercy from an open network requires strong authentication. Communication protocols that are used when transmitting to and from the AmeriHealth Mercy and our affiliates include integrity and authenticity of the information network perimeter controls. Strong encryption and decryption controls are used for all electronic and clinical transactions. Digital signatures and message digest hashing are used to ensure the data is from the sending entity and has not been modified.

Data Loss Prevention (DLP) is deployed throughout the AmeriHealth Mercy network to maintain, enforce and audit access to electronic Protected Health Information (ePHI). This is accomplished through implementation of a sophisticated policy that dictates encryption, as necessary, enforcement of policy and access auditing for all AmeriHealth Mercy managed devices and data types. These are automated to ensure compliance with all applicable policy, including automatically generated responses to end users and management, as necessary.

Perimeter security includes;

- Intrusion Prevention Systems at access points to all Internet gateways
- Access Control Lists (ACLs) on Cisco firewall pairs
- WebSense URL and malicious link protection
- 2-Factor authentication for all VPN or remote connections
- Dedicated VPN tunneling or SSL SFTP connection termination
- Cisco Network Access Control (NAC).

Internal security controls include;

- Intrusion Detection Systems (different vendor from IPS) installed on all production VLANS and network core.
- Data Loss Prevention software that restricts access to ePHI and enforces policy to ensure proper transmission of data occurs.
- Alert correlation management and aggregation console.
- CheckPoint Media Encryption (CPME) for all removable media (limited to authorized users only – default behavior is DENY WRITE").
- PointSec full disk encryption.
- Tumbleweed (Axway) Secure Email and Anti-SPAM engines.
- Full monthly (and on-demand) network scanning for vulnerability analysis by Nessus applications.

These tools are all supported and monitored 24 hours a day, 7 days a week, 365 days a year by the AmeriHealth Mercy Information Security team.

All Internet-facing applications go through a penetration test and code review (performed by a trusted third party) prior to publication to the Internet. Additionally, the AmeriHealth Mercy Information Security Team participates in four (4) unannounced penetration tests performed by a third party every year and undergoes recertification for HIPAA compliance (with an emphasis on Security controls) every two years.

16.14.10. Ensure that remote access users of its Systems can only access said Systems through two-factor user authentication and via methods such as Virtual Private Network (VPN), which must be prior approved by DHH no later than fifteen (15) calendar days after the Contract award; and

AmeriHealth Mercy complies with the above requested methodologies. Remote access to any AmeriHealth Mercy system can only be accomplished through 2-factor authentication tokens. In addition, each user must go through a NAC (Network Access Control) system to verify compliance with

policy. Remote access is achieved through Citrix gateways and is secured through a mandated Cisco VPN tunnel (IPSEC or SSL). Additionally, all access is monitored through IDS and Syslog on a 24 hours a day, 7 days a week and 365 days a year basis. We will submit our protocols for DHH approval within fifteen (15) calendar days of the award.

16.14.11. Comply with recognized industry standards governing security of state and federal automated data processing systems and information processing. As a minimum, the CCN shall conduct a security risk assessment and communicate the results in an information security plan provided no later than fifteen (15) calendar days after the Contract award. The risk assessment shall also be made available to appropriate federal agencies.

AmeriHealth Mercy welcomes any and all efforts to audit and assure the viability and security of our Information Security practices. To this end, AmeriHealth Mercy contracts with a trusted third party vendor to provide four (4) unannounced security/ethical hacking exercises each year and conducts a thorough HIPAA Security assessment (called TrustCheck) via a third party every two years. This HIPAA audit has been conducted every two years for the past six (6) years . It acts as a measuring stick for HIPAA compliance and security best practices and is a nationally recognized service based on various industry standards and scoring matrices.

16.15. Audit Requirements

16.15.1. The CCN shall ensure that their Systems facilitate the auditing of individual claims. Adequate audit trails shall be provided throughout the Systems. To facilitate claims auditing, the CCN shall ensure that the Systems follows, at a minimum, the guidelines and objectives of the American Institute of Certified Public Accountants (AICPA) Audit and Account Guide, The Auditor's Study and Evaluation of Internal Control in Electronic Data Processing (EDP) Systems.

All AmeriHealth Mercy audit trails are in full compliance with American Institute of Certified Public Accountants (AICPA) Audit and Account guidelines. Additionally, AmeriHealth Mercy participates in a SAS 70 Type II (also known as a SSAE 16) audit every year.

16.15.2. The CCN shall maintain and adhere to an internal EDP Policy and Procedures manual available for DHH review upon request, which at a minimum shall contain and assure all accessible screens used throughout the system adhere to the same Graphical User Interface (GUI) standards, and that all programmers shall adhere to the highest industry standards for coding, testing, executing and documenting all system activities. The manual is subject to yearly audit, by both state and independent auditors.

Our EDP Policy and Procedures include our application development standards as well as IS operational activity standards and policies. The majority of our core applications are industry leading COTS – Commercial Off The Shelf – software and our development is primarily the integration of these COTS applications as well as interfaces for secure data exchange with external entities. Through our internal policies and standards, our IS Architecture group ensures that all applications adhere to the same standards. We follow Information Technology Infrastructure Library ITIL) standards for IS operational processes such as Change and Release Management. All standards documentation is maintained in an online library for access by our employees. These standards and policies will be available for DHH, state and independent auditors review upon request.

16.16. State Audits

16.16.1. The CCN shall provide to state auditors (including legislative auditors), upon written request, files for any specified accounting period that a valid Contract exists in a

file format or audit defined media, magnetic tapes, CD or other media compatible with DHH and/or state auditor's facilities. The CCN shall provide information necessary to assist the state auditor in processing or utilizing the files.

AmeriHealth Mercy will participate in third party and state sponsored audits and will provide files and documentation in whichever format is necessary to facilitate a successful audit session. AmeriHealth Mercy is well versed in supporting and responding to state-sponsored (and third party) audits.

16.16.2. If the auditor's findings point to discrepancies or errors, the CCN shall provide a written corrective action plan to DHH within ten (10) business days of receipt of the audit report.

AmeriHealth Mercy will comply with any requests for corrective action within prescribed timeframes.

16.16.3. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the state auditors. These findings shall be reviewed by DHH and integrated into the CCN's EDP manual.

AmeriHealth Mercy will update the electronic data processing (EDP) manuals in accordance with audit findings and recommendations.

16.17. Independent Audit

16.17.1. The CCN shall be required to contract with an independent firm, subject to the written approval of DHH, which has experience in conducting EDP and compliance audits in accordance with applicable federal and state auditing standards for applications comparable with the scope of the Contract's Systems application. The independent firm shall:

16.17.1.1. Perform limited scope EDP audits on an ongoing and annual basis using DHH's audit program specifications at the conclusion of the first twelve (12) month operation period and each twelve (12) month period thereafter, while the Contract is in force with DHH and at the conclusion of the Contract; and

16.17.1.2. Perform a comprehensive audit on an annual basis to determine the CCN's compliance with the obligations specified in the Contract and the Systems Guide.

16.17.2. The auditing firm shall deliver to the CCN and to DHH a report of findings and recommendations within thirty (30) calendar days of the close of each audit. The report shall be prepared in accordance with generally accepted auditing standards for EDP application reviews.

16.17.3. DHH shall use the findings and recommendations of each report as part of its monitoring process.

16.17.4. The CCN shall deliver to DHH a corrective action plan to address deficiencies identified during the audit within ten (10) business days of receipt of the audit report. At the conclusion of the audit, an exit interview is conducted and a yearly written report of all findings and recommendations is provided by the independent auditing firm. These findings are reviewed by DHH and shall become a part of the CCN's EDP manual.

16.17.5. Audits shall include a scope necessary to fully comply with AICPA Professional Standards for Reporting on the Processing of Transactions by Service Organizations (SAS-70 Report).

AmeriHealth Mercy contracts for self-audits by third-party vendors, to conduct SAS 70 Type II (also known as a SSAE 16) and HIPAA-compliance audits. We will comply with the above requirements through a contract with a DHH-approved independent firm to conduct limited scope and annual EDP

audits using DHH's audit program specifications for the audit timeframes specified above. The contract will require the audit firm to deliver a report of audit findings and recommendations, prepared in accordance with generally accepted auditing standards for EDP application reviews, within thirty (30) calendar days of the close of the audit. We will deliver to DHH a corrective action plan to address any deficiencies identified during the audit within ten (10) business days of receipt of the audit report. Any required changes will be made to our EDP policies and procedures.

We will participate in any audit required by DHH and will fully comply with requests for information and associated requirements as outlined above in 16.17.1.1-5.

R.8: Information Systems Change Management and Version Control

R.8 Describe your information systems change management and version control processes. In your description address your production control operations.

The AmeriHealth Mercy IS Change Management process facilitates implementation of both planned and unplanned changes across the IS application and infrastructure environment. The primary goal of this process is to minimize business impact and risk from system changes in an efficient and cost effective manner. This process is managed and executed by the Change and Release Management organization within IS.

Ensuring effective Change Management practices for all AmeriHealth Mercy IS environments is critical to maintaining stability and high quality processing. Adherence to these practices, using Information Technology Infrastructure Library (ITIL) change management principles, enables us to maintain SAS 70 compliance as well as low occurrences of production turnover defects. AmeriHealth Mercy will use this tested and well-managed process. The diagram below depicts a high-level overview of the IS Change Management process:

Change Management Process

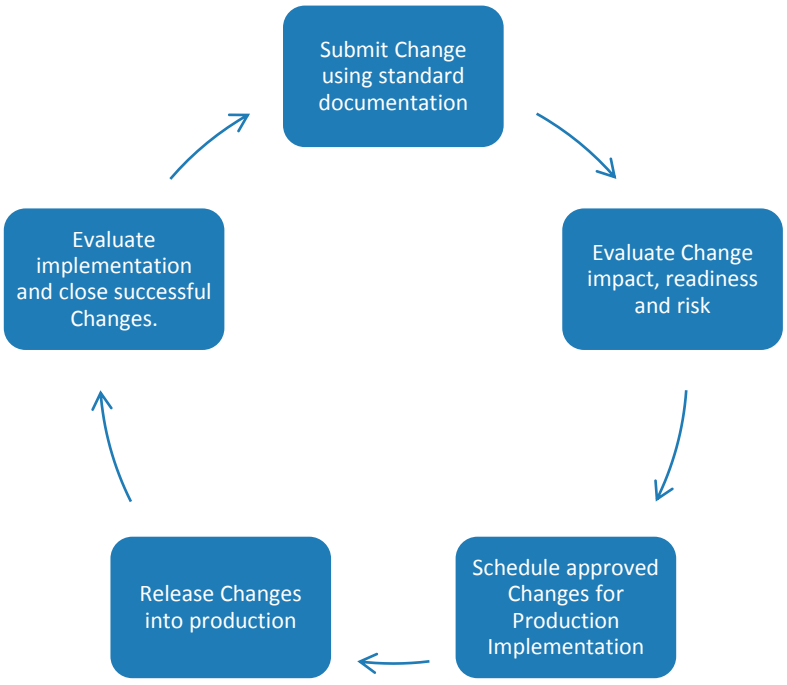


Figure 27: IS Change Management Process

Our Change Management Board (CMB), consisting of key IS stakeholders representing all Facets of our IS environment, meets weekly to review and evaluate submitted changes. Change request submitters and associated implementers present their changes to the board for review and approval. The board has the opportunity to review the change before the meeting and ask clarifying questions to the submitters at the meeting. They also review each change in the context of other changes requested to ensure proper sequencing and prioritization. Approved changes are scheduled for release to production through our Production Control team. Standard changes are released weekly. Once the change is successfully implemented in production, the change request is closed. The change activity lifecycle is maintained and tracked through an automated system called TeamTrack. TeamTrack provides a single system of record for changes across the organization.

Key components of the AmeriHealth Mercy Change Management program include:

- Accurate Documentation and Testing – Ensuring the relevant information for each change is submitted and reviewed, including quality testing outcomes, a critical factor for error free implementations
- Continuous Oversight – Using a disciplined process of evaluating changes to balance the demands of change while evaluating and managing risk to the production environments
- Formal, Defined Approval Process – Following an established, multi-level approval process to ensure all changes are completed as expeditiously as possible, while ensuring complex, high impact changes receive the oversight necessary to guarantee success

Depicted below are the three types of Change Management Requests. Each follows the defined change management process; however, non-standard changes require accelerated and elevated review and additional approvals. Our change management discipline enables us to maintain a stable IS environment. In 2010, we implemented 1,498 changes with a success rate of 94 percent. Continuous improvement is a key part of our discipline. We update processes and procedures to improve our success rate using the lessons learned from prior implementations.

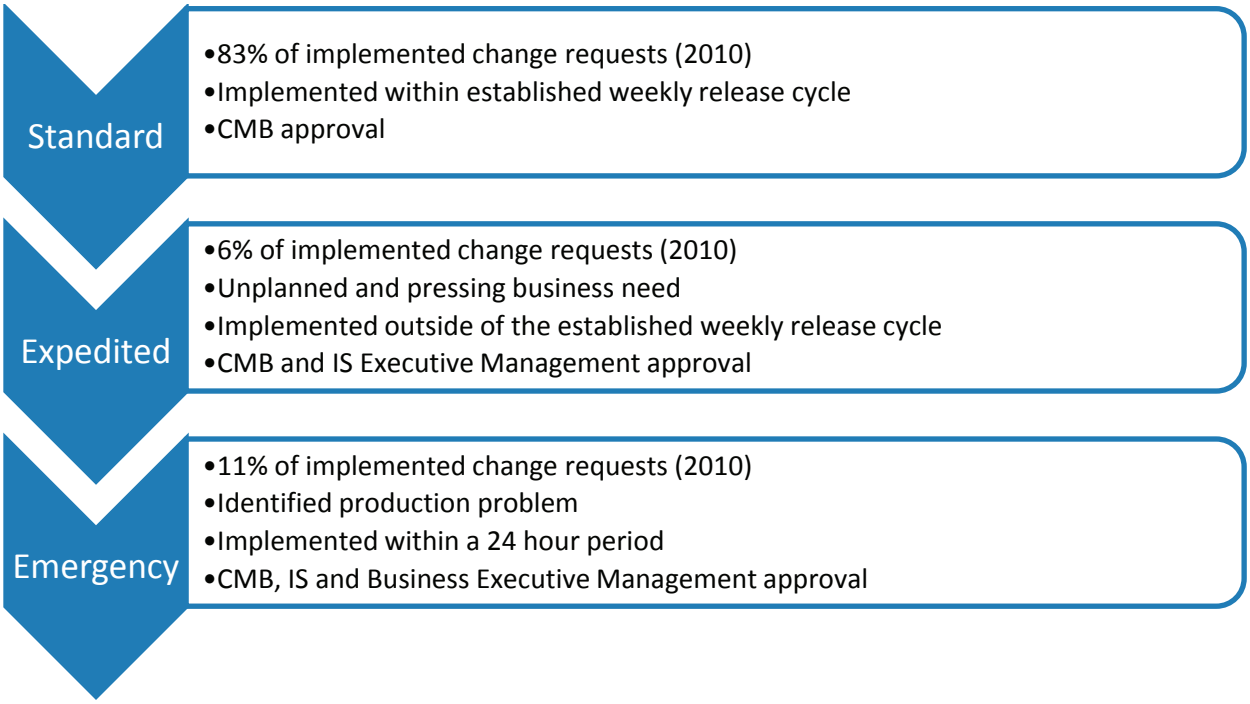


Figure 28: Change Management Requests

Version Control

Version Control is a series of processes and corresponding tools that ensures uniformity and "correctness" of the components in an implementation package. An implementation package consists of source code, object code, deployment plans, and operations execution instructions and back out procedures. Through our version control tool, all of these components can be centrally accessed and managed. These processes and tools also give us the ability to retain each version of an implementation package, allowing us to access any previous version of the package, as required.

AmeriHealth Mercy utilizes Microsoft Visual SourceSafe (VSS) as its version control tool. It provides the "Check-in / Check-out" versioning and audit log functionality essential to support a robust version control process. Our version control process is tightly coupled with our Change Management process. A high level process flow is shown here.

Production Control Operations

Our Production Control team is tightly integrated with our Change Management function. Production Control administers and monitors operational and production processing standards for all AmeriHealth Mercy enterprise operations, ensuring all production cycle requirements are in accordance with company standards and state and customer requirements.

Production Control employees provide technical support services 24 hours a day, seven days a week, 365 days a year. Production Control is responsible for over 3,700 jobs executed on a daily basis in production. These processes are triggered by predetermined calendars, file events, e-mail events and job events and by operator interaction.

Production Control Tool: Tidal Enterprise Scheduler

AmeriHealth Mercy utilizes the Tidal Enterprise Scheduler to leverage job scheduling and automation to facilitate job execution and file transfers across the organization and all application platforms. This scheduler allows us to develop and process data across multiple application platforms within our domain. Our scheduler allows for complex, interdependent job flows to support processing 24 hours a day, seven days a week, 365 days a year. The architecture of this solution is highly resilient and robust and includes 4 Tidal Masters, 70 Window Servers and 30 Unix Servers connected by Tidal Agents across our DEV, SIT, UAT and Production environments. This configuration allows us to create, test and implement new processes with little risk to the primary environment. The current integration model we support is fully scalable to accommodate any additional required integration and our job repository has no limitation on growth.

The diagram on the next page provides a high level overview of our TIDAL Production Control Tool:

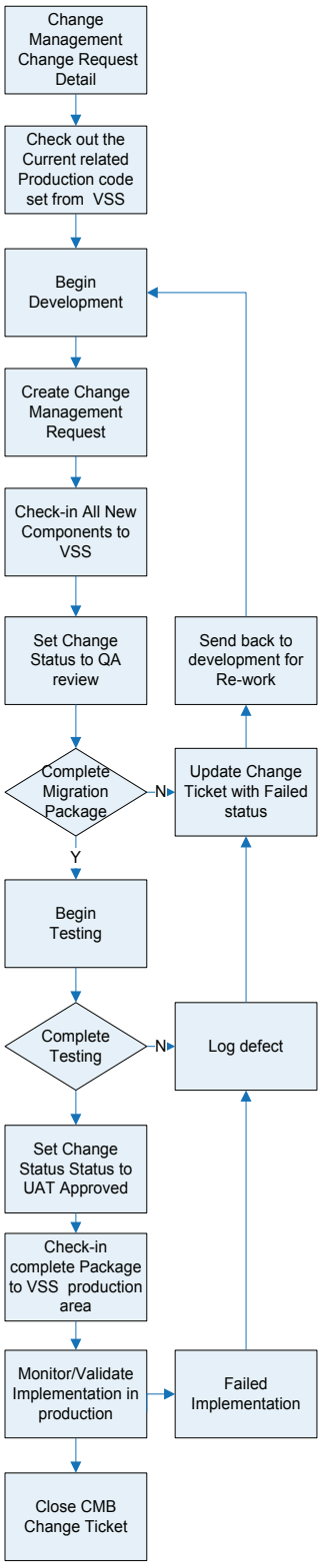


Figure 29: Version Control Process

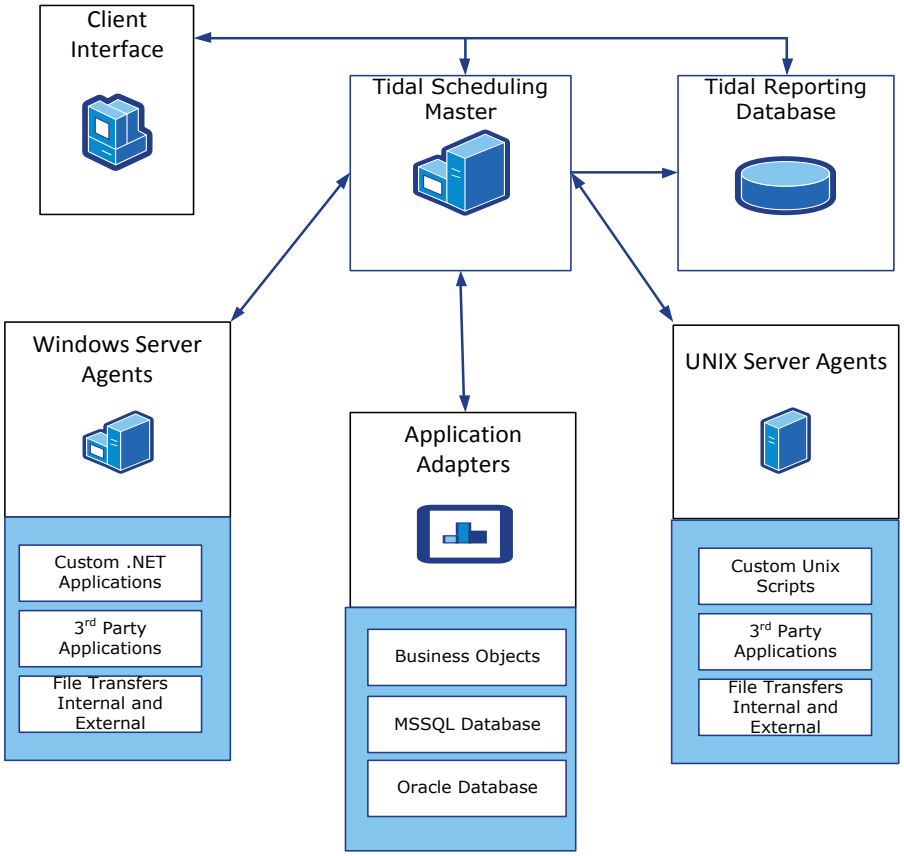


Figure 30: Production Control Tool

R.9: System Readiness

R.9 Describe your approach to demonstrating the readiness of your information systems to DHH prior to the start date of operations. At a minimum your description must address:

- *provider contract loads and associated business rules;*
- *eligibility/enrollment data loads and associated business rules;*
- *claims processing and adjudication logic; and*
- *encounter generation and validation prior to submission to DHH.*

AmeriHealth Mercy has extensive experience in system readiness based on many years of bringing up Medicaid managed care operations in several states. We have developed a detailed system readiness strategy which is a critical component of our implementation plan. This process has proven to be very valuable in limiting the number of system defects that occur and require remediation prior to go live.

AmeriHealth Mercy will provide documentation on systems and facility security and provide evidence that of HIPAA compliance, as specified in the Information Security and Access Management section and as otherwise stated in the Louisiana CCN-P RFP.

The AmeriHealth Mercy Readiness Review Strategy contains the following components:

- **System Development Lifecycle (SDLC) –** AmeriHealth Mercy follows a disciplined SDLC that incorporates a rigorous testing component. All DHH requirements and AmeriHealth Mercy plan requirements will be mapped for traceability through system development, configuration and testing.
- **Execution of broad and deep test scripts –** AmeriHealth Mercy has a library of over 2,200 test scripts that codifies our extensive experience. If needed, additional test scripts will be written to address Louisiana specific requirements not found in our library. Appropriate scripts will be executed to test system functionality and to ensure all of the requirements are met.
- **Internal Readiness Assessment –** Our implementation process requires us to conduct our own table top assessment for all functional areas including information systems.
- **Validate policies and workflows with live system demonstration –** All appropriate polices and workflows will be exercised to demonstrate that all requirements are met.
- **Validation of system interfaces and batch cycles** – AmeriHealth Mercy will validate all interfaces and batch cycles by reviewing system output. The process owner will validate the system output against the expected output (for example the production of provider checks and payments is validated against the expected payment amounts and payees).
- **Infrastructure Testing** – We will test connectivity with all external parties including DHH, the Enrollment Broker, Financial Intermediaries and telecommunications lines.

As part of the overall implementation process, AmeriHealth Mercy will develop specific test plans consistent with the higher-level testing approach described below:

Provider Contract Loads and Associated Business Rules

- Pull a sample of provider contract, pricing templates and configuration documentation
- Adjudicate a sample claim batch
- Validate the provider was paid correctly against the provider's contract and pricing template
- Validate that the provider appears on the outbound provider file

Eligibility/Enrollment Data loads and Associated Business Rules

- Load "test" eligibility file or files
- Produce all reconciliation reports
- Pull a sample of members from the test file and validate that all of the appropriate data elements were loaded successfully and/or appeared on the discrepancy report
- Validate that the PCP was appropriately assigned from the test file and/or assigned through the PCP auto assignment process
- Validate that the member appears on the ID card production batch file
- Review policies and procedures and business workflows related to the Eligibility file process
- Demonstrate the capability to support a Master Patient Index as outlined in 16.8.4
- Demonstrate the duplicate member process as outlined in 16.8.5

Claims Processing and Adjudication Logic

- Load "test" claims with specific test conditions to ensure that we capture all claim types. The specific test conditions will match the adjudication logic
- Adjudicate "test" claims in Facets utilizing the appropriate processing rules

- Review of test adjudication output to validate and show that appropriate adjudication logic and claim edits were applied (i.e. Claim paid, denied or pended appropriately with the correct reason code applied)
- Claim appears on the Provider Payment batch file

Encounter Generation and Validation (produce an encounter file)

- Produce a single encounter file that includes paid claims, adjustments and voids demonstrating both fee-for-service and capitated arrangements, as applicable, per section 17.5.4.
- Produce an encounter error file and corresponding correction file.

System Readiness Review Matrix

The System Readiness Review Matrix is used in conjunction with the various levels of testing – unit, system and integration, across applications. The matrix provides a comprehensive and systematic method of assuring that requirements are met and tested and that they operate across systems. The following chart outlines the tool used to identify tasks for the System Readiness Review.

Table 15: System Readiness Review Matrix

Business Service Domain	Business Service Group	Business Services	Primary Application Component System	Test Script #	System Readiness Date	Comment
Medical Management	Utilization Management	Utilization Management (authorization, referral processing)	Jiva			
		On Line Utilization Management	Jiva			
		Clinical Guidelines	Interqual			
	Integrated Care Management	Disease Management	Jiva			
		Case Management	Jiva			
		Preventive Health(EPDST)	Jiva			
		Predictive Modeling	DxCG			
		Clinical Alert Rules	Clinical Alert System			
		Real Time Care Gaps	Clinical Alert System			
		HEDIS reporting	Quality Spectrum/ IKA			
		Provider Profiling	TREO			
		Performance Reporting	TREO			
		CAPHS(Member Survey) Extract	TBD			
Provider Network Management	Provider Maintenance	Inbound Provider file processing	Facets Batch			
		Outbound Provider file processing	Facets Batch			
		Provider maintenance	EXP			

Business Service Domain	Business Service Group	Business Services	Primary Application Component System	Test Script #	System Readiness Date	Comment
	Provider Contracting	Provider Credentialing	Visual CACTUS			
		Network Adequacy	GeoAccess			
		Provider contracting	Choreo			
		Provider Complaints/ Grievance	Custom			
		Pay For Performance	Facets/ Custom			
	Provider Self Service	On Line Provider Directory	Custom via NaviNet			
		Real Time Claim Status	Custom via NaviNet			
		Real Time Eligibility	Custom via NaviNet			
	Provider Corresp.	Provider manual	Fulfillment Vendor			
		Provider directory	Facets Batch/ Ingenix Applications (Geo Networks)			
		Custom provider correspondence	Client Letter/EXP			
		Panel roster	Facets Batch/ Emdeon			
		Capitation roster	Facets Batch/ Emdeon			
		Claim remittance advice	Facets Batch/ Emdeon			
Healthcare Benefit Administration	Enrollment	EDI Eligibility(834) acceptance	HIPAA Gateway			
		Enrollment file processing(Broker/ Fiscal Intermediary)	Facets Batch			
		Manual enrollment processing	Facets Client Application			
		PCP assignments	Facets Batch/ Ingenix Applications (GeoCoder)			
		Inbound TPL	Facets Batch			
		Outbound TPL	Facets Batch			
		Maintenance of TPL information	Facets Client Application/ TPL Extension			
		PCP Capitation processing	Facets Batch			

Business Service Domain	Business Service Group	Business Services	Primary Application Component System	Test Script #	System Readiness Date	Comment
		Global Subcon Capitation processing	Facets Batch			
		Outbound Eligibility	Facets Batch			
		Member ID cards	Facets Batch			
		Member handbooks (welcome packet)	Fulfillment Vendor			
		Custom member correspondence	EXP			
	Claims Processing	EDI Claims Inbound (837)	HIPAA Gateway			
		Paper Claims inbound	Facets Batch/ ACS – Claims intake/MS VB/C# applications			
		Medicare Crossover	Facets Batch/ACS – Claims intake/MS VB/C# applications			
		Clinical Editing	iHealth			
		Claims adjudication	Facets Batch/Facets Client Application			
		EOB	Facets Batch			
		COB processing	Facets Client Application/ COB Extension			
		Cost Containment	Facets Client Application/ Rational Robot			
		Claims auditing	Facets Client Application/Rational Robot			
		Subrogation	ACS			
		DRG Grouper	IRP/Ingenix			
Shared Corporate Services	Customer Service	Member Call Center	Facets Client Application/ Streamline/ EXP			
		Provider Call Center	Facets Client Application/ Streamline/ EXP			

Business Service Domain	Business Service Group	Business Services	Primary Application Component System	Test Script #	System Readiness Date	Comment
		Provider Claim Services	Facets Client Application/ Streamline/ EXP			
		Interactive Voice Response (IVR)	IVR			
		Member Portal	Web Applications			
	Finance/HR	Fraud and Abuse	VIPS			
		1099 processing	Facets Batch/ Emdeon			
		Member Premium Billing	Facets Batch			
		Produce claims checks	Facets Batch/ Emdeon			
		Produce capitation checks	Business Objects			
		EFT	Emdeon			
		ERA	Emdeon			
		State capitation/ membership reconciliation	MS Access			
		Accounts Payable	PeopleSoft			
		Purchasing	PeopleSoft			
		General Ledger accounting	PeopleSoft			
		Budgeting	PeopleSoft			
		Human Resource Administration	PeopleSoft			
		Employee Benefit Administration	PeopleSoft			
		Payroll Administration	ADP/People Soft			
	Reporting Services	Statutory Reporting	Business Objects/Data Warehouse			
		Informatics Reporting	Business Objects/Data Warehouse			
		Operations Reporting	Business Objects/ Facets			
		Actuarial Reporting	Business Objects/Data Warehouse			
		Report Scheduling/Distribution	Business Objects			
	Workflow/Docu	Document Imaging	EXP			

Business Service Domain	Business Service Group	Business Services	Primary Application Component System	Test Script #	System Readiness Date	Comment
	ment Management	Workflow	EXP			
		Letter Generation	Client Letter/EXP			
		On-Line Help	RoboHelp			
	Data Intake	Custom Member Claim Data	Data Intake Solution			
		Custom Eligibility Data	Data Intake Solution			
Shared Technology Services	Workflow/Document Management	Provider Data	Data Intake Solution			
		Lab Result Data	Data Intake Solution			
		Pharmacy Claim Data	Data Intake Solution			
		Behavioral Health Claim Data	Data Intake Solution			
	Data Intake Encounter Processing System Configuration and Maintenance	Dental Claim Data	Data Intake Solution			
		Vision Claim Data	Data Intake Solution			
		Family Planning Claim Data	Data Intake Solution			
		Transportation Claim Data	Data Intake Solution			
		Submit medical claims	Data Warehouse/ MS VB/C# applications			
		Acknowledgements and corrections	HIPAA Gateway			
		Submission of subcontractor claims	Data Warehouse/ MS VB/C# applications			
		Processing of subcontractor acknowledgements and corrections	HIPAA Gateway			
		Code Maintenance (ICD, CPT, etc.)	Facets/MS Access			
		Fee schedule maintenance	Facets/MS Access			
	Encounter Processing	Benefit Matrix Maintenance	Facets/MS Access			
		Claim Pricing	NetworX Pricer			
		Provider agreement maintenance	NetworX Pricer			
		TPL Configuration	Facets/MS Access			

Business Service Domain	Business Service Group	Business Services	Primary Application Component System	Test Script #	System Readiness Date	Comment
	System Configuration and Maintenance Infrastructure	Prior Authorization List	Facets/MS Access			
		Referral List	Facets/MS Access			
		Connectivity (LAN/WAN)	Cisco			
		Web Services	Microsoft/ Autonomy			
		Disaster Recovery	HP			
		Business Continuity	HP			
		Intel Servers (incl. VM and Citrix)	HP			
		UNIX Servers	HP			
	Infrastructure	File Store	EMC			
		Database Administration	Oracle, MSSQL, Sybase			
		Desktop Management	HP			
		Service Desk	HEAT			
		Call Center	Avaya			
		Data Center Operations	TIDAL Enterprise Scheduler			
		Quality Assurance/ Testing	Mercury Quality Center			
		Security	Account Provisioning			
Delegated Services	Vendor #1	Eligibility	Facets Interface			
		Prior Authorization	UMI Interface			
		Claims Administration	Data Intake Interface			
		Provider Network Management	Facets Interface			
	Vendor #2	Eligibility	Facets Interface			
		Prior Authorization	UMI Interface			
		Claims Administration	Data Intake Interface			
		Provider Network Management	Facets Interface			

R.10: Reporting and Data Analytic Capabilities

R.10 Describe your reporting and data analytic capabilities including:

- *generation and provision to the State of the management reports prescribed in the RFP;*

- *generation and provision to the State of reports on request;*
- *the ability in a secure, inquiry-only environment for authorized DHH staff to create and/or generate reports out of your systems on an ad-hoc basis; and*
- *Reporting back to providers within the network.*

AmeriHealth Mercy understands the importance of timely, accurate and complete reporting, both as a tool for our own management as well as an oversight mechanism for our State Medicaid customers. AmeriHealth Mercy is able to generate and provide the reports requested in the Louisiana CCN-P RFP and will comply with all associated reporting requirements. As a long-standing Medicaid contractor in multiple States, AmeriHealth Mercy brings significant knowledge and expertise to the preparation of all reports required in this RFP ensuring timeliness, accuracy and compliance.

Generation and Provision of Management Reports to the State – Prescribed and On Request

To support the quality and timely delivery of all State management reporting, AmeriHealth Mercy maintains a disciplined enterprise data management strategy along with a best of breed Business Intelligence technology platform. This will enable AmeriHealth Mercy to generate the prescribed management reports as scheduled as well as reports on request for the State.

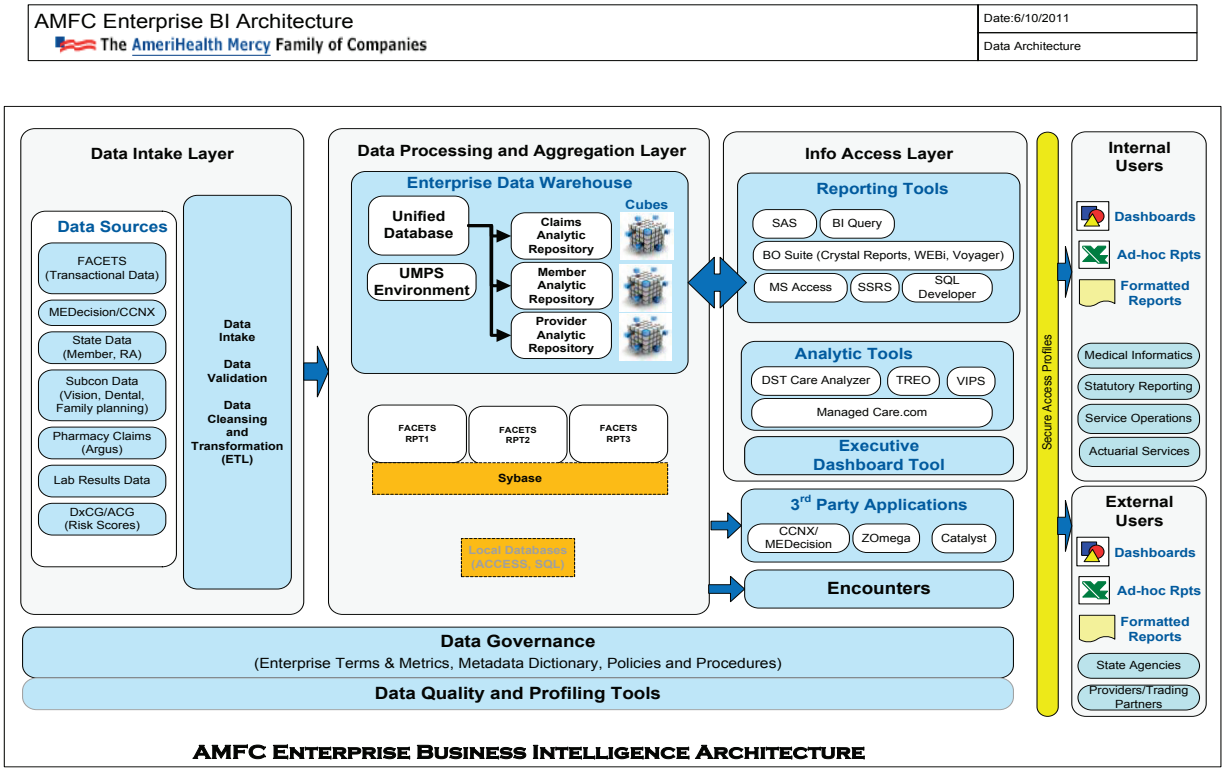


Figure 31: Enterprise BI Architecture

The following tools are leveraged in the production, quality assurance and delivery of reports to meet the complex reporting requirements of our State customers.

DataStage®, by IBM-Ascential Software Inc.™, provides an ETL (extract, transform, and load) function to populate business intelligence data into our data warehouse. Data are extracted from our business systems databases (such as Facets) and loaded to our Oracle data warehouse.

Crystal Reports® is a reporting tool that enables rapid development of flexible, versatile reports against a number of data sources, and integrates them into Web and Windows applications. Crystal Enterprise®, by Business Objects™, is used throughout the organization for reporting from the data warehouse, Facets, our care management system, and other sources. Crystal Reports® is often used for medical management reporting on claims, membership, provider, authorization, and care management data.

SPSS Statistical Reporting® is a Statistical Package for the Social Sciences. It provides data management, analysis, and presentation functions, including statistical analyses and graphical presentation of data. It is used to analyze survey data, utilization data, cost data, record sampling and control group vs. test group sampling.

SAP Business Objects Web Intelligence by SAP utilizes data models, graphical representations of database structures, and powerful reporting features to provide business intelligence to the enterprise.

HEDIS Services - Quality Spectrum® is a Web-enabled service, provided by Catalyst. Source files are loaded monthly into a dedicated data repository used for HEDIS reporting, provider profiling and the generation of "care gap" intelligence. Catalyst is NCQA-certified for HEDIS reporting.

Statutory Reporting Capabilities

AmeriHealth Mercy's Statutory Reporting department ensures that reports are developed, tested and sent as prescribed for each state client. Policies and procedures are in place to ensure that all reports use appropriate specifications for report creation, are quality-reviewed for data integrity and completeness, and are retained in accordance with AmeriHealth Mercy policy and applicable laws and regulations. Dedicated staff in our Statutory Reporting department manages the ongoing reporting process to ensure timely delivery though a quarterly project plan, as specified in 18.7 Report Submission Timeframes.

Secure Inquiry and Reporting Access for DHH Authorized Staff

AmeriHealth Mercy utilizes a secure Provider Web Portal to extend reporting access and services to external entities. The diagram below illustrates the logical architecture by which these services will be delivered to authorized DHH staff.

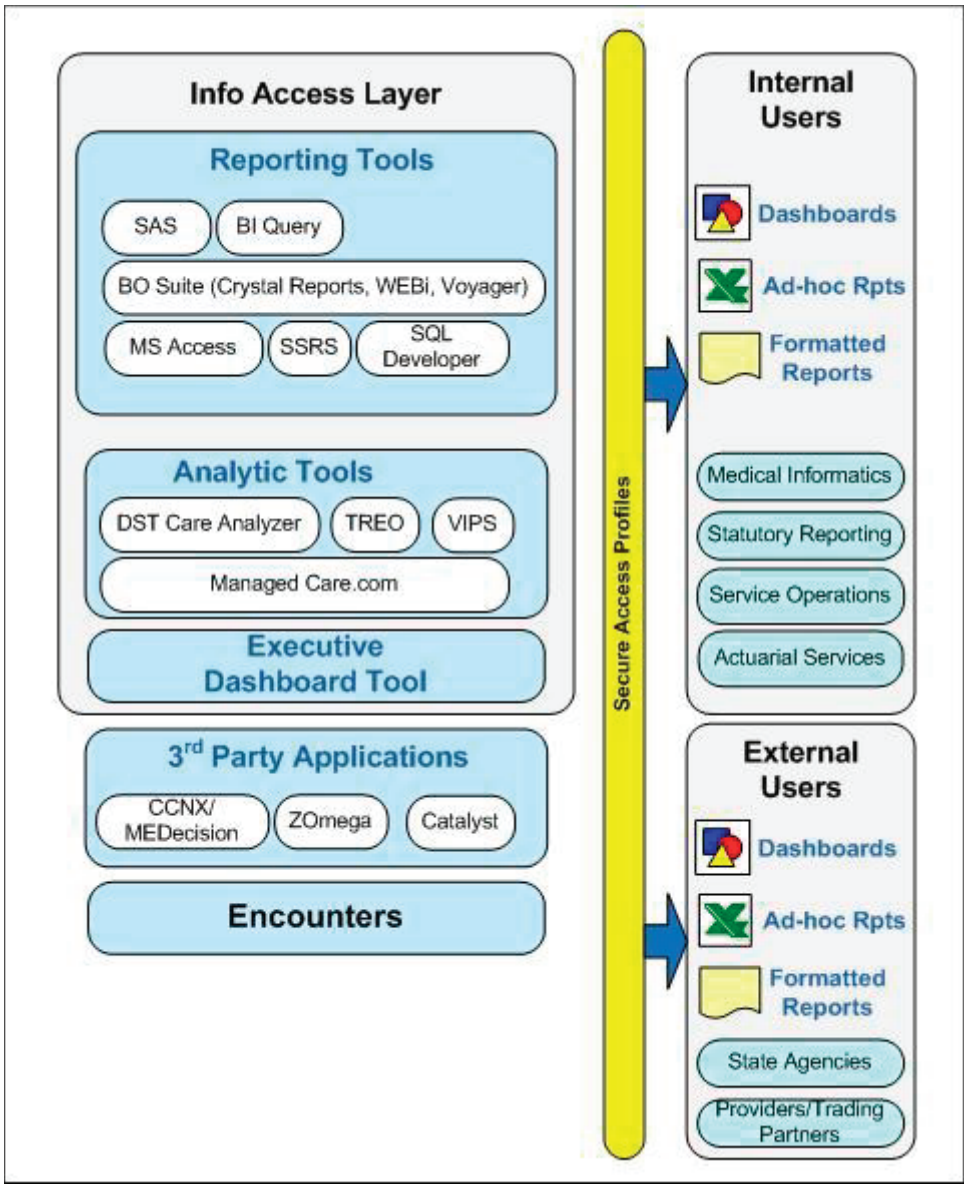


Figure 32: Secure Inquiry Reporting

AmeriHealth Mercy will work with the DHH to establish a safe, secure and efficient approach to enable DHH staff to query program data within agreed-upon parameters. We will employ tools similar to those used to give providers secure access to our systems for the generation and/or creation of ad-hoc reports from AmeriHealth Mercy systems.

Provider Reporting

Providers access reports on-line using AmeriHealth Mercy's secure reporting capability in NaviNet. NaviNet is a multi-payor portal that allows providers to access information for all payors subscribing to this service. NaviNet's flexible and robust reporting components are used extensively by AmeriHealth Mercy's affiliate provider networks. Through NaviNet, providers can access numerous reports in both print-ready and download-compatible formats..

The reporting tool allows providers to customize their reports by setting filters and sorting. Providers can receive the report output in either a printable PDF, or a downloadable Microsoft Excel-compatible or

Continuity of Care (CCD) format. These formats allow providers the flexibility to generate mailing labels, integrate with their electronic medical record (EMR) system or pull the data into other tools for more complex analyses.

Designed as a flexible multi-purpose interface, the reporting tool can pull information from AmeriHealth Mercy's backend systems and new reports can be developed with minimal changes and effort. AmeriHealth Mercy affiliates offer their networks a wide range of reports today including:

- **Population Health Management Reports** – These reports enable providers to proactively manage the health needs of their patients by identifying those with overdue preventive health screenings, members who require disease management interventions (diabetes, asthma, etc.), and members who need adjustments in their medications.
- **Administrative Simplification Reports** – These reports make it easier and simpler for the provider to work with AmeriHealth Mercy. One report in this category is the on-line Panel Roster report that lists all members assigned to a primary care office, along with key demographic and contact information. As with all reports, this report can be downloaded and integrated with the provider's practice management or EMR.
- **Performance Reports** – Reports in this category contain performance results on key metrics, and are used to provide updates on progress and outcomes related to quality initiatives and pay-for-performance programs.
- **Member-Level Clinical Reports** – These reports contain claim-based detail of services and medications at the member level. Described in more detail in Section E, these reports include information on prescriptions filled by the member, clinical conditions found in the member's claim data, care gaps (recommended services for which there is no claim evidence), inpatient admissions, emergency room admissions and office visit. In addition, a separate Care Gap Worksheet is available detailing services recommended for the member and identifying whether the service is up-to-date, missing or overdue, and the date the service was last received. For Louisiana, we will also offer providers an EPSDT Clinical Summary for pediatric members identifying immunizations and screening services the member received.

This flexible reporting tool will allow AmeriHealth Mercy to leverage many of the reports already developed by other affiliates as well as implement customized reports that address the unique needs of the Louisiana provider network.

Reporting Accomplishments

AmeriHealth Mercy's reporting and analytical capabilities and leadership are nationally recognized:

- Presenter, 2010 National Predictive Modeling Congress
- Quality Profiles, The Leadership Series, 2009, NCQA
- Winner, 2009 Thomson Reuters Healthcare Advantage Award
- Presenter, 2009 Thomson Reuters Healthcare Conference
- Poster Presentation, 2008 Society of General Internal Medicine
- Winner, 2007 Thomson Innovator Award
- Presenter, 2006 Thomson Annual Conference
- Finalist, 2006 Thomson Innovator Award
- Poster Presentation, 2006 AHIP Meeting
- Poster Presentation, 2005 Pennsylvania Public Health Association

In addition to the above presentation and awards, members of our Information Solutions Reporting teams serve in the following capabilities:

- Board member, Pennsylvania Public Health Association
- Member, American Medical Informatics Association

- Reviewer of papers for the AMIA
- Member, American Health Information Management Association
- Member, The Data Warehouse Institute
- Member, Healthcare Financial Management Association
- Member, NCQA HEDIS Policy Panel .

Report Samples

Samples of a few of the reports identified as "TBD" in Section 18.8 of the Louisiana CCN-P RFP are enclosed for consideration by DHH. Samples and/or templates of all DHH-required reports will be provided in compliance with the Readiness Review.

Table 16: Enclosed Sample Reports

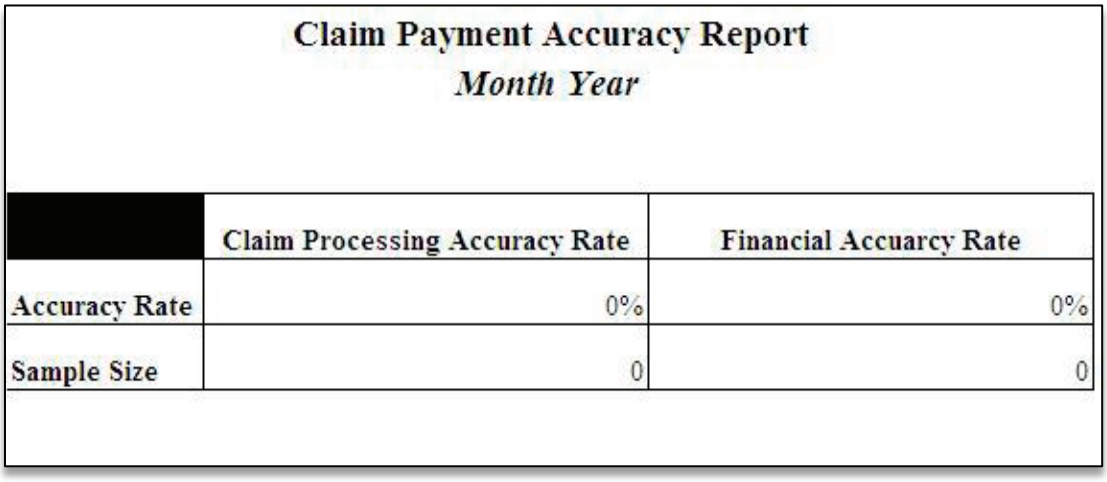
Louisiana DHH Report Name		AmeriHealth Mercy Report Name	Frequency
Annual Medical Loss Ratio Report		Plan Wide Indicator Report	Monthly
CCMP – A. Reports		QCCP Profile Report	Quarterly
Claims Payment Accuracy Report		Claims Payment Accuracy	Quarterly
Claims Summary Report		Claims Processing Summary	Monthly
Member Services Call Center		Member Call Center Report	Monthly
Prior Authorization and Pre-Certification Summary		Prior Authorization Report	Monthly
Provider Network Directory		LOB 100 Combined Directory	Weekly

Figure 33: Sample Annual Medical Loss Ratio Report (AM01– Plan Wide Indicator Report)

Plan Wide Indicators
Trend Analysis Report - 20XX
XXX Health Plan

Indicator	Budget or Goal	Jan	Feb	Mar
Financial				
Membership				
Revenue PMPM				
Medical Loss PMPM				
Medical Loss Ratio				
General & Administrative Expense PMPM				
General & Administrative Expense Ratio				
Income PMPM				
Income Ratio				

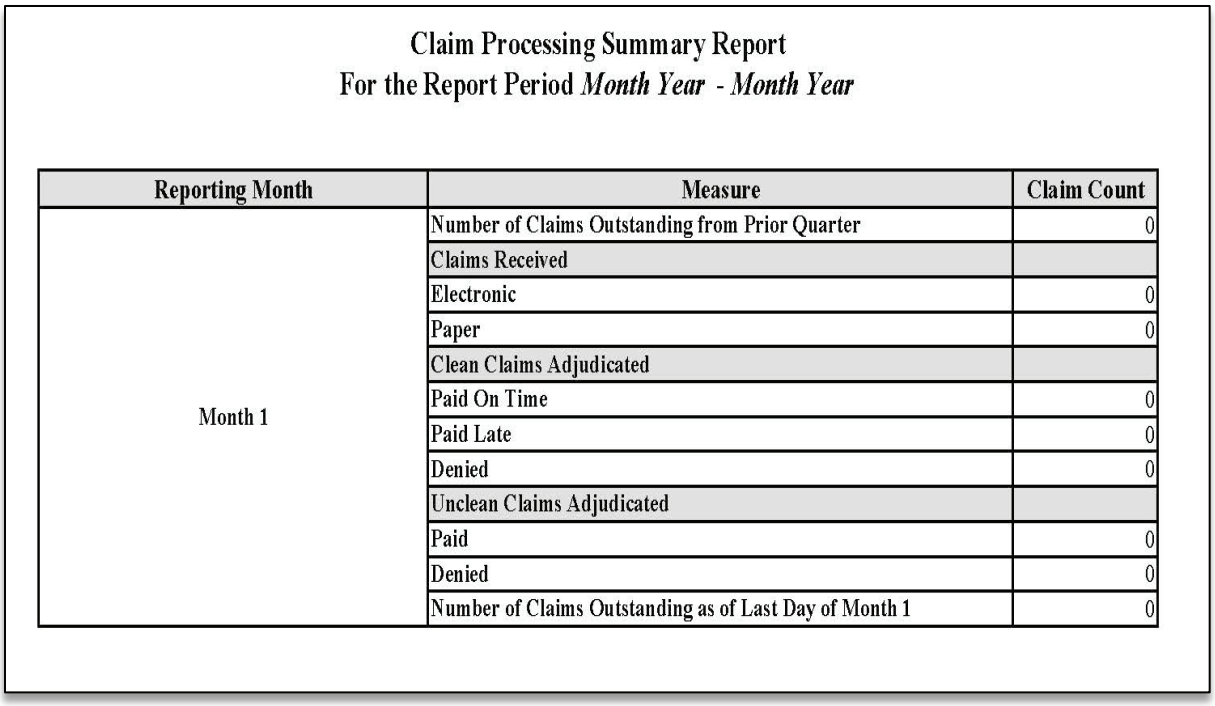
Figure 34: Sample Claims Payment Accuracy Report (AM06 – Claims Payment Accuracy)



Claim Payment Accuracy Report
Month Year

	Claim Processing Accuracy Rate	Financial Accuarcy Rate
Accuracy Rate	0%	0%
Sample Size	0	0

Figure 35: Sample Claims Summary Report (AM07 – Claims Processing Summary)



Claim Processing Summary Report
For the Report Period *Month Year* - *Month Year*

Reporting Month	Measure	Claim Count
Month 1	Number of Claims Outstanding from Prior Quarter	0
	Claims Received	
	Electronic	0
	Paper	0
	Clean Claims Adjudicated	
	Paid On Time	0
	Paid Late	0
	Denied	0
	Unclean Claims Adjudicated	
	Paid	0
	Denied	0
	Number of Claims Outstanding as of Last Day of Month 1	0

Figure 36: Sample Member Service Call Center (AM16 – Member Call Center Report)

Member Services Call Center
Report Period Ended *Month Year*

Calls	January	February	March	Year to Date
Total Call Volume	0	0	0	0
Calls Abandoned	0	0	0	0
Calls Answered within __ Seconds	0	0	0	0
Percent Abandoned	0	0	0	0
Percent Answered within __ Seconds	0	0	0	0

Figure 37: Sample Prior Authorization and Pre-Certification Summary (AM19 – Prior Authorization Report)

May Outpatient Utilization Summary

	May-11	May-10	variance	% chg	Ytd 2011	Ytd 2010	variance	% chg	May-11	May-10	variance	% chg	Ytd 2011	Ytd 2010	variance	% chg
	Plan A								Plan B							
Total Budget SPT	TBD								TBD							
Approved SPT																
Requested SPT																
Approval Rate																
Facility																
Non-Facility																
Chiro																
DME																
Home																
Home Infusion																
Imaging																
Medical																
Obstetrics																
Observation 23 hrs																
Psychiatric																
Rehab																
Surgical																
Therapies																
Transplant																
Transportation																

Figure 38: Sample Provider Network Directory (AM21 – LOB 100 Combined Directory)

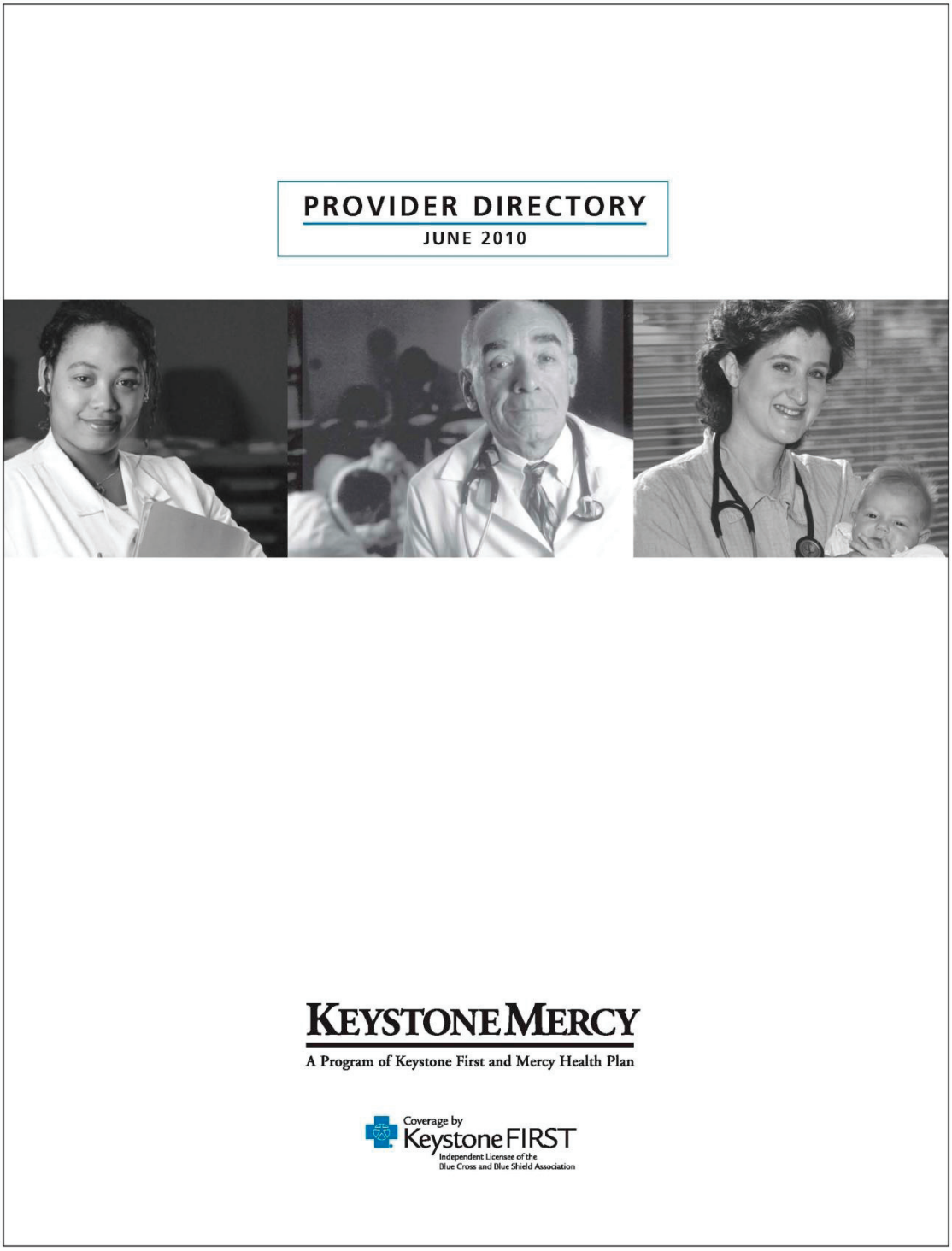


TABLE OF CONTENTS

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PHILADELPHIA (CONTINUED)

DREXEL INTERNAL MEDICINE HUH
1005191

1427 VINE ST 6TH FL
PHILADELPHIA, PA 19102
215-762-6500
♿
ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 5:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
SATURDAY
9:00 AM - 5:00 PM
ADAMOV, ELENA, MD
BABALOLA, ADENIYI, MD◆
BERLINGER III, WILLIAM, MD◆
CHOU, EDGAR, MD◆
DHAR, SUNIL, MD◆
DHOND, ABHAY, MD◆
DUKE, PAMELA, MD◆
GHALI, SHERIN, MD◆
GUTT, POONAM, MD◆
HAIST, STEVEN, MD◆
HASNI, SYED, MD◆
KUZMA, MARY ANN, MD◆
MAY, NATHALIE, MD◆
MORGENSTERN, DIANA, MD◆
NAIR, SHAILAJA, MD◆
NOVACK, DENNIS, MD◆
NUNEZ, ANA, MD◆
PALUZZI, RICHARD, MD◆
PETRICONE JR, WILLIAM, MD◆
RUSSELL, STEVEN, MD◆
RYAN, KATHLEEN, MD◆
SALDIVAR, MADELAINE, MD◆
VARJAVAND, NIELUFAR, MD◆
VESBIANU, CARMAN, MD
VESBIANU, DRAGOS, MD◆
VOGEL, ERIC, MD◆

LANGUAGE(S):
ARABIC,ENGLISH,FRENCH,HINDI,MALAYALAM,SPANISH

HOSPITALS
ABINGTON MEMORIAL HOSPITAL
HAHNEMANN UNIVERSITY HOSPITAL
MEDICAL COLLEGE OF PA
MERCY FITZGERALD HOSPITAL
MERCY PHILADELPHIA HOSPITAL
METHODIST HOSP
TEMPLE UNIVERSITY CHILDRENS MEDICAL CENTER
TEMPLE UNIVERSITY HOSPITAL

DREXEL PARTNERSHIP CLINIC
1047782

1427 VINE ST 3RD FL
PHILADELPHIA, PA 19102
215-762-2530
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NOT ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 5:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
BAMFORD, LAURA, MD◆
BELL, JOANNA, MD◆
BRUNO, CHRISTOPHER, MD◆
GARDINER, DAVID, MD◆
JACOBSON, JEFFREY, MD◆
KAPLAN, SUSAN, MD◆
PALERMO, BRANDON, MD◆
SCHLECHT, HANS, MD◆
SKLAR, PETER, MD◆
SOLARI, PAOLA, MD◆
VIELEMEYER, OLE, MD◆
WEIKERT, BLAIR, MD◆

LANGUAGE(S):
ENGLISH,SPANISH

HOSPITALS
HAHNEMANN HOSP
HAHNEMANN UNIVERSITY HOSPITAL
MAIN LINE HOSPITALS INC-LANKENAU HOSP
MAIN LINE HOSPITALS INC - PAOLI MEMORIAL HOSP
MAIN LINE HOSPITALS INC-BRYN MAWR HOSP
PRESBYTERIAN MEDICAL CENTER

19103

DREXEL CENTER FOR WOMENS HEALTH
30064929

255 S 17TH ST 3RD FL
PHILADELPHIA, PA 19103
215-735-8504
♿
ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 5:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM

THE FOUNTAINS
2 FRANKLIN TOWN BLVD
5TH FL
PHILADELPHIA, PA 19103
215-563-1800
♿
ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 5:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
NAIR, SHAILAJA, MD◆
SHERIF, KATHERINE, MD◆
SOUTENDIJK, CHRISTINE, MD◆

LANGUAGE(S):
ENGLISH,HINDI,MALAYALAM

HOSPITALS
HAHNEMANN UNIVERSITY HOSPITAL

DREXEL INTERNAL MEDICINE HUH
30027098

255 S 17TH ST
PHILADELPHIA, PA 19103
215-735-3363
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ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 5:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
RYAN, KATHLEEN, MD◆

LANGUAGE(S): ENGLISH

HOSPITALS
HAHNEMANN UNIVERSITY HOSPITAL

GAY, ROY N.
30033471

2116 CHESTNUT ST 1ST FL
PHILADELPHIA, PA 19103
215-988-0508
♿
ACCEPTING NEW PATIENTS
MONDAY
9:00 AM - 7:00 PM
WEDNESDAY
9:00 AM - 7:00 PM
FRIDAY
9:00 AM - 5:00 PM
GAY, ROY, MD◆

LANGUAGE(S): ENGLISH

HOSPITALS
MERCY PHILADELPHIA HOSPITAL
PRESBYTERIAN MEDICAL CENTER

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MULLOY, WILLIAM P.
10017

255 S 17TH ST STE 605
PHILADELPHIA, PA 19103
215-963-9202
♿
ACCEPTING NEW PATIENTS
MONDAY
3:00 PM - 8:00 PM
TUESDAY
9:00 AM - 2:00 PM
WEDNESDAY
3:00 PM - 8:00 PM
THURSDAY
9:00 AM - 2:00 PM
FRIDAY
9:00 AM - 8:00 PM
MULLOY, WILLIAM, MD◆

LANGUAGE(S): ENGLISH,FRENCH,SPANISH

HOSPITALS
METHODIST HOSP
NEUMANN MEDICAL CENTER

SIDNEY HILLMAN MEDICAL ASSOCIATES
1026829

2116 CHESTNUT ST 2ND FL
PHILADELPHIA, PA 19103
215-568-4080
♿
NOT ACCEPTING NEW PATIENTS
MONDAY
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TUESDAY
8:30 AM - 6:00 PM
WEDNESDAY
7:30 AM - 5:30 PM
THURSDAY
9:00 AM - 5:30 PM
FRIDAY
7:30 AM - 2:00 PM
SATURDAY
8:30 AM - 12:30 PM
KEAGLE, DOUGLAS, DO◆

LANGUAGE(S): ENGLISH

HOSPITALS
MEDICAL COLLEGE OF PA
MERCY FITZGERALD HOSPITAL

19104

BUNYA, VATHANA O.
30041249

110 S 43RD ST
PHILADELPHIA, PA 19104
215-225-6222
♿
ACCEPTING NEW PATIENTS
BUNYA, VATHANA, MD

LANGUAGE(S): ENGLISH

HOSPITALS
THOMAS JEFFERSON UNIV HOSP

CHOP CARE CENTER MARKET STREET
100358

3550 MARKET ST 5TH FL
PHILADELPHIA, PA 19104
215-590-3000
♿
ACCEPTING NEW PATIENTS
MONDAY
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TUESDAY
8:30 AM - 8:00 PM
WEDNESDAY
8:30 AM - 8:00 PM
THURSDAY
8:30 AM - 8:00 PM
FRIDAY
8:30 AM - 5:00 PM
SATURDAY
9:00 AM - 3:00 PM
CAREY, WILLIAM, MD◆

LANGUAGE(S): ENGLISH

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CHOP CARE CENTER UNIVERSITY
100321

39TH AND CHESTNUT STS
STE 110
PHILADELPHIA, PA 19104
215-590-5090
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ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 8:00 PM
TUESDAY
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WEDNESDAY
8:30 AM - 8:00 PM
THURSDAY
8:30 AM - 8:00 PM
FRIDAY
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SATURDAY
9:00 AM - 3:00 PM
CAREY, WILLIAM, MD◆

LANGUAGE(S): ENGLISH

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CHILDRENS HOSPITAL OF PHILADELPHIA

CPUP PENN FAMILY CARE
1043286

51 N 39TH ST 7TH FL MUTCH BLDG
PHILADELPHIA, PA 19104
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THURSDAY
8:30 AM - 5:00 PM
FRIDAY
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ARONOWITZ, ROBERT, MD◆
BAYLSON, MARGARET, MD◆
BENNETT, IAN, MD
BOGNER, HILLARY, MD◆
BOWMAN, MARJORIE, MD◆
BREAM, KENT D, MD◆
CRONHOLM, PETER, MD◆
DUVALL, MONICA, MD◆
ERICKSON, LEE, MD◆
GALLO, JOSEPH, MD◆
GOLDBERG, DAPHNE, MD◆
GRAHAM, JOSEPH, MD◆
HOFMANN, LAURA, MD◆
HONG, SEUNG, MD◆
KAPUR, RAHUL, MD◆
LIPSON, SUSAN, MD◆
MAO, JUN, MD◆
MARGO, KATHERINE, MD◆
MARTIN, LAURA, MD◆
MCFILLIN- PETROLONGO, TERRI, DO
NEILL, RICHARD, MD◆
NGUYEN, GIANG, MD
NICHOLSON, JAMES, MD◆
NICKLIN, DAVID, MD◆
OPPENHEIM, LAURA, MD
REED, ELAINE, MD◆
SABERI, POUNE, MD◆
SHABAZZ, SAFIYYA, MD◆
STRATON, JOSEPH, MD◆
VANBERCKELEAR, ANJE, MD◆
WEBNER, DAVID, MD◆
WITTINK, MARSHA, MD◆

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CROZER-CHESTER MEDICAL CENTER
HOSP OF THE UNIV OF PA
PENNSYLVANIA HOSPITAL
PRESBYTERIAN MEDICAL CENTER

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30049434

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215-387-1022
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MONDAY
9:00 AM - 4:30 PM
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9:00 AM - 4:30 PM
WEDNESDAY
9:00 AM - 4:30 PM
THURSDAY
9:00 AM - 4:30 PM
FRIDAY
9:00 AM - 4:30 PM
SATURDAY
9:00 AM - 12:00 PM
STRICKLAN, DAVID, MD

LANGUAGE(S): ENGLISH

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THE LANKENAU HOSPITAL

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FINKEL, DAVID M.
1011166

51 N 39TH ST
MOB STE 280
PHILADELPHIA, PA 19104
215-662-8874
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NOT ACCEPTING NEW PATIENTS
MONDAY
9:00 AM - 3:00 PM
TUESDAY
9:00 AM - 3:00 PM
WEDNESDAY
9:00 AM - 3:00 PM
THURSDAY
9:00 AM - 3:00 PM
FINKEL, DAVID, MD◆

LANGUAGE(S): ENGLISH

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PRESBYTERIAN MEDICAL CENTER

GERIATRIC MEDICINE DIVISION CLINICAL PRACTICE OF UNIV O
1020221

3615 CHESTNUT ST
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PHILADELPHIA, PA 19104
215-662-2746
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THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
BRUZA, JOHN, MD◆
JOHNSON, JERRY, MD◆
KINOSIAN, BRUCE, MD◆

LANGUAGE(S): ENGLISH

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HOSP OF THE UNIV OF PA

GRISKA MED ASSOCIATES PENNCARE MCKEE & SHEPARD
1004606

3801 FILBERT ST MAB STE 212
PHILADELPHIA, PA 19104
215-662-8978
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MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 7:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
GRISKA, JOEL, MD◆
PUJOLS-MCKEE, ANA, MD◆
RATH, MANASIJA, MD◆
REIS, EDWARD GERALD A, MD◆
SHEPARD, JAMES, MD◆

LANGUAGE(S): ENGLISH

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HEALTH CARE CENTER #3
100083

555 S 43RD ST
PHILADELPHIA, PA 19104
215-685-7504
♿
ACCEPTING NEW PATIENTS
MONDAY
8:00 AM - 4:30 PM
TUESDAY
8:00 AM - 5:00 PM
WEDNESDAY
8:00 AM - 5:00 PM
THURSDAY
8:00 AM - 4:30 PM
FRIDAY
8:00 AM - 5:00 PM
CHEESEMAN, LESLIE, MD◆
DEAN, JAMES, MD◆
FINE, MANETTE, DO◆
GOHEL, MIRA, MD◆
KWAKWA, HELENA, MD◆
SALAM, HASEEDA, MD◆
SMITH, JAMES, MD
VAIDYA, KALPANA, MD◆

LANGUAGE(S):
ARABIC,ASSYRIAN,ENGLISH,FRENCH,GERMAN,GUIARATI,HINDI,MALAYALAM,MARATHI,PHILLIPINO

HOSPITALS
ALBERT EINSTEIN MEDICAL CENTER
HOSP OF THE UNIV OF PA
MERCY FITZGERALD HOSPITAL
MERCY PHILADELPHIA HOSPITAL
TEMPLE EPISCOPAL DIVISION
TEMPLE UNIVERSITY HOSPITAL
THOMAS JEFFERSON UNIV HOSP

HEALTH CARE CENTER #4
100084

4400 HAVERFORD AVE
PHILADELPHIA, PA 19104
215-685-7601
♿
ACCEPTING NEW PATIENTS
MONDAY
8:30 AM - 5:00 PM
TUESDAY
8:30 AM - 5:00 PM
WEDNESDAY
8:30 AM - 5:00 PM
THURSDAY
8:30 AM - 5:00 PM
FRIDAY
8:30 AM - 5:00 PM
AHMED, FATEMA, MD
DIVAKER, SHASHI, MD◆
HACKNEY, JANEL, MD
KATZ, JANICE, MD◆
KWAKWA, HELENA, MD◆
LIU, AARON, MD◆
MARSHALL JR, VIRGIL, MD◆
STOREY, THOMAS, MD
VAIDYA, KALPANA, MD◆
VENEGAS, CYNTHIA, MD

LANGUAGE(S):
ARABIC,ASSYRIAN,BENGALI,ENGLISH,FRENCH,GERMAN,GUIARATI,HINDI,MALAYALAM,MANDARIN,MARATHI,PHILLIPINO,SPANISH,TAGALOG,URDU

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MERCY FITZGERALD HOSPITAL
MERCY HOSPITAL
MERCY PHILADELPHIA HOSPITAL
NORTH PHILA HEALTH SYSTEM-GIRARD MEDICAL CENTER
PRESBYTERIAN MEDICAL CENTER
TEMPLE UNIVERSITY HOSPITAL

R.11: Profile of Key Information Systems

R.11 Provide a detailed profile of the key information systems within your span of control.

Information Systems Profile Overview

AmeriHealth Mercy's enterprise Information Systems architecture is built based on our core business needs, providing the foundation to support our key health plan functions: Medical Management, Healthcare Benefits Management and Provider Management depicted in the below diagram. Leveraging our fully integrated technology model, AmeriHealth Mercy will have the capabilities and capacity to meet the contract requirements and ever changing needs of the Louisiana Medicaid population.

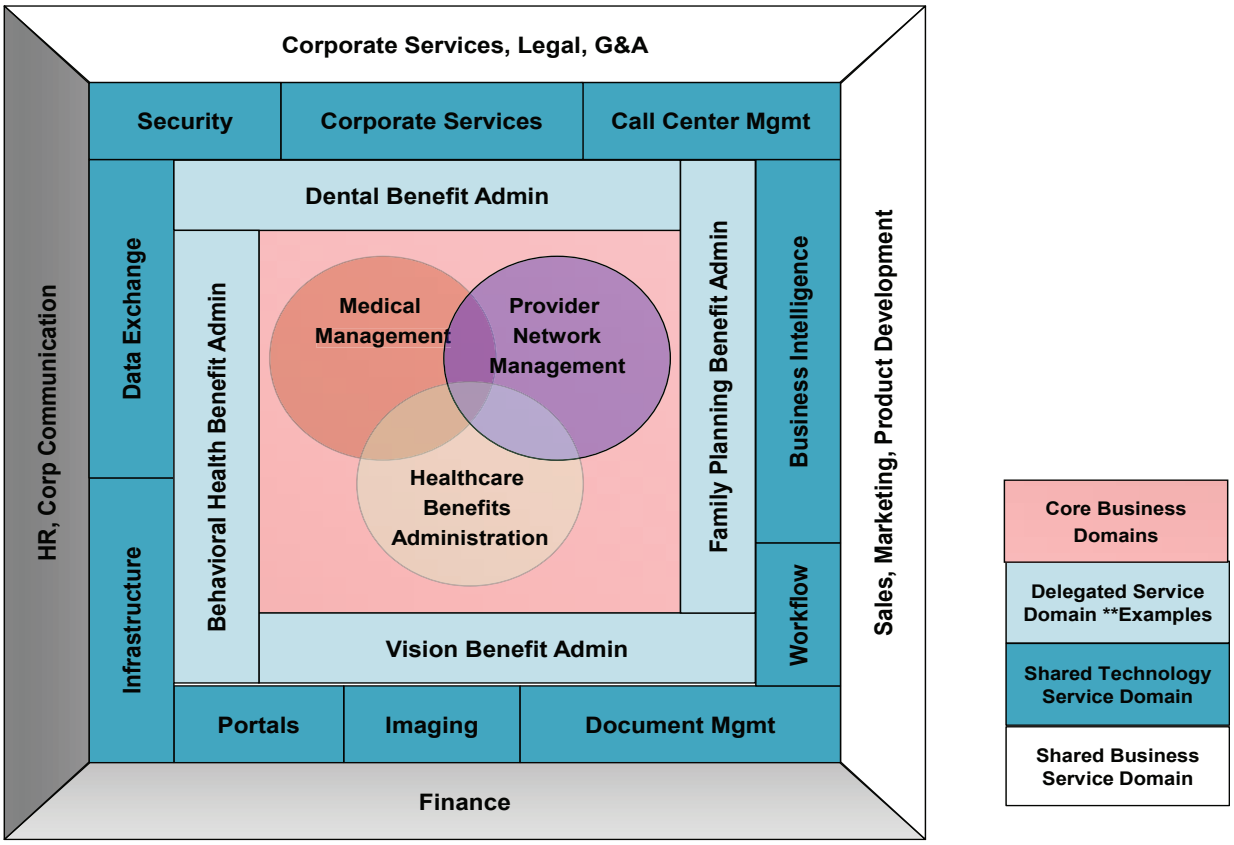

Figure 39: Information Systems Overview

The following is a profile of the key information systems that will be used to support AmeriHealth Mercy in Louisiana.

Medical Management

AmeriHealth Mercy maintains a flexible suite of Care Management and e-Health solutions that deliver valuable clinical services and information including:

- Integrated utilization, case, disease and quality management
- Preventive health / EPSDT services
- Clinical guidelines
- Integration with Health Information Exchanges and provider EHRs
- Access to real-time member summaries including medications and encounters
- Alerts for gaps in care and medication risks
- Interactive member portal with health education resources
- Population management reports
- Multi-payer provider portal
- EHR and e-Prescribing capabilities

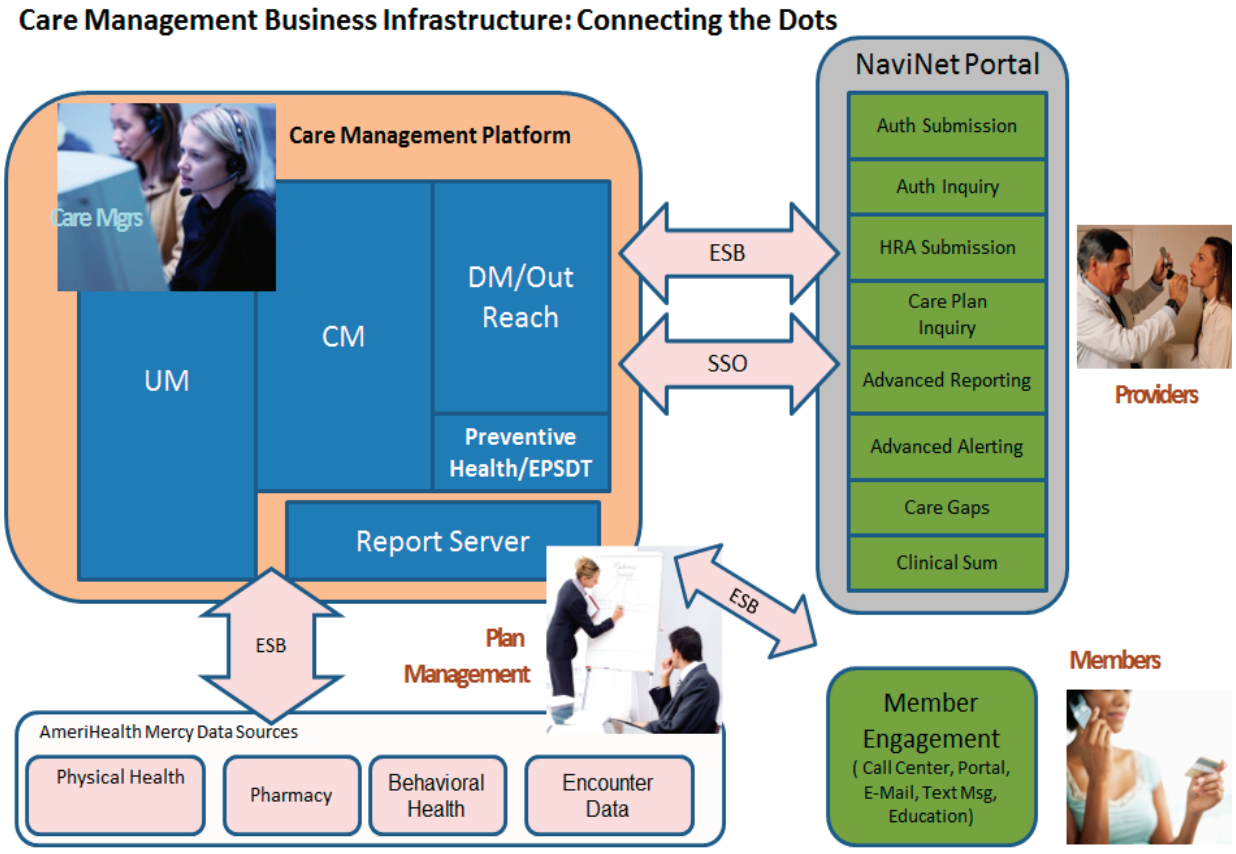

Figure 40: Business Infrastructure

Medical Management Technology

AmeriHealth Mercy recognizes that the care management industry is going through unprecedented change. In response to the need for continuous innovation, AmeriHealth Mercy conducted an extensive search and selection process for the most robust and integrated care management solution. Early 2011, AmeriHealth Mercy selected ZeOmega's Jiva solution to support the needs of this emerging market.

ZeOmega's Jiva is a fully integrated, rules-driven care management platform that addresses current and emerging needs of care management. Jiva's integrated care management solution is licensed with a base

platform containing over 20 different functions and optional modules. This flexibility allows AmeriHealth Mercy to select care management services (UM, CM, DM, MM, and outreach modules), advanced tools (data mining and reporting, configuring rules and assessments), content (clinical protocols, clinical data codes), provider and member engagement services (appeals, call tracking, inquires, and portals), data exchange services (integration for claims, clinical data, eligibility, HRA, referrals, authorizations, guidelines and criteria) and administrative services (billing and invoicing) based on specific business requirements. AmeriHealth Mercy is scheduled to implement this new care management platform in the fourth quarter of 2011.

We are taking several steps to minimize any risk to the Louisiana implementation from the Jiva implementation. Our contract with ZeOmega contains performance guarantees and penalties designed to ensure on-time completion of configuration and installation for all system components. We structured our implementation timeline to ensure that staff who will be directly servicing or assisting Louisiana members and providers during the start-up phase are the first to receive training. Our South Carolina affiliate, serviced by many of the staff who will serve as seasoned support for Louisiana will be the first health plan to transition to Jiva. This will allow staff and systems to be fine-tuned prior to Louisiana's launch. Additionally, our Jiva training environments will be available in September, ensuring that all staff hired for Louisiana can receive training on the systems and tools they will use for the program.

Integrated Care Management

ZeOmega

ZeOmega is an emerging provider of collaborative health care management solutions. The system offers health care payers simplified, smart and state-of-the-art technologies that allow them to more easily collaborate on patient care, both internally and externally with other care team members, physicians, hospitals, laboratories, and patients. This collaborative approach helps payers improve the quality and affordability of health care, maintain costs, optimize operational efficiencies and strengthen relationships with other health care stakeholders. ZeOmega is an up-and-coming health information technology innovator, with a rapidly growing customer base.

The Jiva Care Management application is a collaborative health care management platform for case and disease management, preventive health (EPSDT) and utilization management. Jiva serves as the core system of our Integrated Care Management program. Jiva's extensive capabilities, coupled with our robust analytic and data mining capabilities, form a comprehensive Medical Management Information System. Highlights of our system capabilities include:

- Defined business rules that automatically evaluate care requests to determine whether the request should be approved or pended for further review
- Clinical rules, based on evidence-based medicine, reference materials, industry-standard best practices and physician expertise, for clinical consistency in care management processes
- Identification and stratification of target patients and populations to set appropriate levels of intervention and improvements for a member's care
- Integrated access to medical, pharmacy, lab, and behavioral health data to provide a 360 degree view of the member
- A series of care management clinical pathways that enable the efficient implementation of our holistic approach to the management of chronic conditions, pregnancy, pediatric preventive care and quality management initiatives that reduce costs and improve the health outcomes
- Comprehensive outreach pathways that incorporate current member needs, health reminders and missed service strategies
- Integrated correspondence that allows automatic generation of customized faxes, letters and email based on approved letter templates
- Robust reporting templates and the ability to create ad hoc reports for care management data

- Provider portal interface allowing providers to create, update and view information on medical necessity authorizations and determinations
- Clinically validated Care Gaps and electronic health records derived from claims and care management data

Jiva utilizes the Microsoft SSRS reporting tools for both standard data reporting and ad hoc reporting off of the analytical data structures. The Jiva reporting data repository is updated from the Jiva transactional production database with real-time MSSQL database replication where complex reporting can be done using the Microsoft SSRS tools. Reports can be created on a real time basis.

McKesson CERME

CERM(E), which stands for "CareEnhance® Review Manager Enterprise", is provided by McKesson. CERME is a decision support system used as an initial guideline for medical necessity. CERME is integrated into ZeOmega's Jiva application.

AutoCoder

AutoCoder is a third party product which provides cross reference lookups to IDC9/ICD10 diagnosis codes. AutoCoder is also integrated in Jiva's Care Management application.

E-Health Suite Technology

Our E-Health Suite leverages technology to connect providers and the heath plan to improve:

- Care Coordination
- Population Health
- Access to Care
- Quality
- Cost Control

The E-Health Suite is successfully utilized by our affiliate health plans at multiple client sites. The information technology infrastructure is flexible, extensible, and can be customized to meet unique affiliate needs. The E-Health Suite includes the following services:

Clinical Alert Services

This solution delivers the right information, on the right member, at the right time to the provider. Instead of waiting for a provider to "pull" relevant information on the member, this solution "pushes" information to the provider. The clinical alert service delivers information on care gaps to providers when they check eligibility on-line through NaviNet. The alert capability can be customized to deliver other types of clinical information and can be triggered by any transaction in NaviNet.

Clinical Reports

Providers are increasingly expected to manage the care of their patients from a population perspective, but few are equipped with electronic health records systems required for this. The AmeriHealth Mercy clinical reporting solution enables providers to easily obtain a list of members having certain clinical conditions such as asthma or diabetes. This information can be pulled as a print-ready report or downloaded in a MS Excel or csv file format.

Clinical Alert Reports

As the name implies, this tool combines the "push" capability of clinical alerts with aggregation capabilities of reports to alert the provider office to groups of members who have specific conditions or care needs. In addition to being available at the panel level, providers can pull a member-specific report for one member at a time.

Member Clinical Summary

The Member Clinical Summary offers the provider a broad view of the care the member has received across the continuum of providers. It includes a medication list, recent encounters, diagnoses, and care needs information. It is particularly useful when the member accesses an emergency room, is referred to a provider that has no prior information on the member or requires out of network care due to disaster area evacuations.

EPSDT Clinical Summary

Similar in format to the Member Clinical Summary, the EPSDT version of this document lists immunizations and EPSDT screening visits the member received from any provider in the network.

Continuity of Care Document (CCD)

AmeriHealth Mercy is a leader among managed care organizations in working with Health Information Exchange. We have developed a Continuity of Care Document (CCD) that includes current medications, a history of emergency room, inpatient and ambulatory visits, a problem list and gaps in care. This industry standard CCD was developed for the Kentucky HIE using a T12 query/response method and is secured with an x.509 certificate as per Kentucky's HIE specifications. The CCD can be integrated with any HIE that follows current standards and is also delivered for direct download to a provider's EHR through our Portal.

Ease of Access

E-Health services are delivered to our provider community via our Provider Portal. AmeriHealth Mercy uses NaviNet as its Provider Portal. NaviNet is the largest provider portal with over 700,000 providers nationally. A multi-payer portal (including Aetna, United Healthcare, and numerous Blue plans), it allows the provider to log in once to access information from multiple payers. AmeriHealth Mercy offers access to all of the standard transactions through NaviNet including eligibility and benefits inquiry, claim status and referral submission and update, as well as links to provider manuals, forms and other important administrative information. A single sign-on through the NaviNet Provider Portal provides seamless access to the Jiva application for submission of authorization requests, updates to clinical information and access to administrative member information supported by our Integrated Care Management platform.

Provider Network Management

AmeriHealth Mercy is transforming how we manage provider information and processes using Portico's integrated provider management system for full life cycle support of network and contract management.

Contract Manager (formerly Choreo) a Portico Product

The Portico product Contract Manager, formerly known as Choreo, consists of three components:

- Contract Manager
- Courier
- Negotiator

The Contract Manager suite is a single content source for provider contracting. It automates the way our contracts are created, negotiated, amended, viewed, analyzed, managed, distributed, and audited. Utilizing its components, we are able to streamline negotiations, manage provider demographics, and provide system-wide visibility into provider network information.

The Contract Manager component provides the information transparency and process automation necessary for our affiliates to effectively manage the end-to-end provider contracting process. Contract Manager automates the life cycle process of provider contracts, allowing us to track, report and update contracts that are expiring, have built in term changes or undergo renegotiation.

The built in workflow components streamline the automated amendment, notification, and review/approval processes for any contract changes. As part of the auditing functionality, Contract Manager safeguards ensure that the contracting staff uses pre-approved language and rates when creating contracts.

Courier enables our employees to securely send contracts and amendments electronically. Providers benefit from the fast and secure delivery of contract documents. Providers utilize an easy download process that has the functionality to allow them to sign contracts electronically. All contracts are distributed in Adobe PDF format. The electronic signature capability improves provider relations and reduces the cost of contract distribution. Courier also supports an internal eSignature process. Courier is a Web-based application that allows providers to access contracts from any internet connection, with no installation of software or a browser plug-in.

Negotiator provides our affiliates with the ability to have secure online contract negotiations between the affiliate and providers. The Negotiation Center walks all parties through the entire process and highlights comments from actual negotiation requests. As part of the process, Negotiator logs a complete history of the original and edited versions of the contract, resulting in end-to-end lifecycle tracking of the negotiation process. We track all negotiation requests, capture contract change intent, generate negotiation summary reports, and integrate negotiation requests with contract version control.

Figure 41: Negotiation Manager

Key points of the solution:

- A centralized repository for all provider contracts
- An automated end-to-end contracting process from creation to post signature
- Capable of electronic search and retrieval of provider contract information
- Audit and tracking facilities for all changes to contracts and related information
- Creates a library of standard clauses and contracting templates
- Includes functionality for standard and ad-hoc end user reporting

Credentialing

Visual CACTUS (CACTUS) is a Windows-based, desktop application, which maintains provider credentialing and re-credentialing information. Using electronic interfaces with web-based data repositories and primary verification sources, CACTUS allows us to electronically enter and update provider credentialing files. To ease the administrative burden associated with providing multiple plans with credentialing information, an interface exists between CACTUS and the Council for Affordable Quality Healthcare (CAQH). The CAQH Management Module downloads CAQH provider attestations and stores the complete attestation in a data repository. The repository maintains a history of all provider attestations downloaded and an intuitive viewer provides a side-by-side comparison of select CAQH and CACTUS data. Data currently imported includes: Provider demographics, Provider IDs, Institutions, Licenses, Affiliations, Insurance, Education, Specialties, Boards, Languages, Groups, and Addresses. The import program will also create a credentialing instance for the provider if they are due for credentialing and an instance does not already exist.

The Custom Delegate Importer module takes the data submitted from multiple delegates from a delimited text file containing the required data elements and populates them into CACTUS. The OIG Manager sweeps the Office of Inspector General and Medicaid sanction history against the practitioners in the CACTUS database and flags newly found matches.

The CACTUS ABMS Direct Connect Select module receives primary source verified data directly from the American Board of Medical Specialties (ABMS) database which contains board certification information, including effective and expiration dates, as well as historical board certification information.

The License Expiration Monitoring Module (LEMM) module monitors updates to providers' medical licensing information on the state and/or DEA level. This module incorporates officially published changes in the provider's licensing information into the CACTUS license record for the provider and posts each status change for us to review.

Provider Automation

The Provider Automation System was designed to improve the efficiency and integrity of information entered into the Facets system. A database rules engine ensures all provider information is accurate and complete. It also allows for the import of large provider files from sources such as hospitals and large provider groups, instead of manually keying each provider. Once imported, the system filters the providers through the automated business rules engine to ensure all data is accurate and complete before loading it into the provider tables in Facets. This improves the accuracy of information while improving the efficiency of this network department.

GeoAccess

GeoAccess GeoCoder, by Ingenix Suite®, is a desktop software application that provides the precise analysis and mapping of member access to network providers. Used to assist in the auto-assignment process for PCPs and to monitor network access standards, GeoAccess is also used to understand network disruption in the event of a known or threatened provider termination.

DirectoryExpert®

DirectoryExpert®, by Ingenix Suite®, is an easy to use Microsoft® Windows-based application that provides database publishing software. DirectoryExpert is used to produce comprehensive and customized provider directories.

Healthcare Benefits Administration

TriZetto Facets Application

TriZetto's Facets application is an industry-leading software solution for health plan administration. It features a powerful software engine that automates business processes, enhances efficiency and provides the flexibility to administer diverse plan designs, integrate with third party solutions, and adapt to the rapidly changing business and regulatory environments. AmeriHealth Mercy uses Facets as our enterprise-wide core eligibility and claims administration solution. Architected to maximize automation and provide expanded business functionality and integration, this highly scalable, state-of-the-art technology platform is the heart of our healthcare enterprise and claims processing and payment functions.

Facets offers a high degree of automation and data capture, achieving fast, accurate claims processing and high auto-adjudication rates. Medical, vision and hospital claims submitted via paper, online or electronic can be processed in an automated fashion, with full support for highly productive electronic adjudication. Facets' electronic commerce capabilities are designed to accept external claims submitted electronically from trading partners in the HIPAA compliant 837 transaction set standard format. Facets can also send remittance information to trading partners in the HIPAA compliant 835 transaction set standard format.

Facets permits configuration of complex benefit structures and pricing schedules. During the various stages of the adjudication process, Facets interacts with membership eligibility, product benefit parameters, provider pricing agreements, medical management requirements and clinical editing information to provide accurate and highly automated adjudication of claim and/or encounter submissions. Claim processing rules use diagnosis codes and procedure codes to read service-based rules, and include parameters for handling benefit limitations, deductibles, copays and coordination of benefits (COB) situations. The Facets system allows for generation of checks to individual providers or the combining of payments into one check at the group or IPA level. The Facets system also captures and reports 1099 tax information.

The claims processing applications within Facets are organized for efficiency and ease-of-use by both data entry staff and claims processors, while conforming to CMS 1500 and UB-04 formats which are the industry standards. Numerous edits alert our employees to any inconsistencies during entry, and predefined system warning messages facilitate increased accuracy and productivity. Claims can be entered online or electronically via a proprietary format or the industry standard ASC X12 Claims Submission (837 Transaction Set) format.

Facets' electronic auto adjudication allows us to process claims faster and more accurately than a paper claims process. AmeriHealth Mercy employees can adjudicate all medical and hospital claims that are submitted electronically in a batch mode. The batch mode capability allows us to automatically process a large amount of claims at one time. We can also adjudicate pended claims that have been mass-released for re-adjudication as a batch process. Online edits reduce errors prior to batch submission. Manual operations are substantially reduced and claim processors can focus their attention on claims that require experienced judgment.

All claims that are electronically adjudicated go through a detailed series of edits before processing to ensure that claims with data entry errors, or incorrect or missing information, are not processed in the batch cycle. The system indicates the nature of the submission error(s) and provides access to the claim on a line-item basis so that errors can be easily corrected. Once corrected, the claim can be resubmitted in the next batch for completion of the adjudication process.

The AmeriHealth Mercy Facets claim processing system offers full integration of member eligibility, including third party liability (TPL), provider network and prior authorization information to support accurate claim processing. The Facets system is the primary source of all member eligibility and provider

network information. This information is transmitted daily via interfaces to the Medical Management and Provider Management platforms and applications. Prior authorization and referral information is transmitted into the Facets claim processing system daily via interfaces.

Diagnostic Related Groups (DRG) Grouper

The DRG Grouper Calculator determines the appropriate DRG based on the principal diagnosis code. The calculator considers the first diagnosis code entered into the calculator as the principal diagnosis and determines the Major Diagnostic Codes (MDC). The grouper calculator does not change the principal diagnosis as entered into the calculator.

AmeriHealth Mercy supports multiple groupers and is capable of using different versions of a grouper for different affiliates:

- AP DRG (all patients)
- CMS DRG (Medicare)
- APR DRG (all patients refined)
- Any other generally accepted groupers

iHealth Technologies (*i*HT)

AmeriHealth Mercy utilizes *i*HT's system for enhanced clinical and business rule editing for claims. *i*HT's system applies a comprehensive, customized library of clinical coding edits to professional and outpatient hospital claims to ensure that they are coded correctly and paid accurately. In addition to generally-accepted clinical edits, each affiliate has its own library of customized Medicaid-specific medical policies. Using our years of Medicaid experience and our understanding of DHH coverage requirements, we will develop a custom library of edits for Louisiana.

A web based tool provides our Contact Center employees with the ability to access a detailed clinical description of edits and the reasons they were applied so that they can provide medically appropriate explanations to providers. These explanations are available for any claim processed within the iHealth process that had edits applied.

Enhanced Member Data Capture - REL Module

Cultural competency is a necessary component of a high quality health care system. To enhance our abilities in this area, we created a custom module, integrated with our Facets application. This module allows us to collect additional race, ethnicity and language (REL) information for our members without overwriting the information sent by the state Medicaid agency. Our custom-built REL module is fully integrated with our Healthcare Benefits Administration and Integrated Care Management systems, enabling our Contact Center and medical management employees to access and use the information. Additional information on our capabilities related to Culturally and Linguistically Appropriate Services (CLAS) capabilities, services and Multicultural Health Care Distinction can be found in Section L4.

Document Management

Top Down™

Top Down™ Client Letter® is a versatile letter writing utility that interfaces with numerous data sources / systems. It also allow easy integration with our Integrated Care Management solution, Jiva. It is extremely flexible, and can interact with all AmeriHealth Mercy data sources.

RightFax™

RightFax automates the flow of fax, paper, and electronic documents, which helps us deliver information securely and efficiently from virtually any application. We currently use Open Text RightFax version 9.3. as our desktop fax solution. RightFax has connections to several backend office systems including Exchange, Contact Center Express, EXP, and Self Service Integration. Toll-free and local fax numbers

can be terminated directly into the fax server and connected to Contact Center and Integrated Care Management employees via the internal network, eliminating the need to convert the faxed documents to paper.

Data Warehouse and Reporting

DataStage®

DataStage®, by IBM-Ascential Software Inc.™, provides an ETL (extract, transform, and load) function to populate business intelligence data into our data warehouse. Data is extracted from our business systems databases (such as Facets) and then loaded to our Oracle data warehouse. The enterprise leverages the following reporting tools against this data warehouse:

- SAP Business Objects Web Intelligence
- SAP Crystal Reports®
- Microsoft Access

SAP Crystal Reports®

SAP Crystal Reports® is a reporting tool that enables rapid development of flexible, versatile reports against a number of data sources and integrates them into Web and Windows applications. We use SAP Crystal Reports®, by Business Objects™, for reporting from the data warehouse, Facets and other sources. SAP Crystal Reports® is often used for medical management reporting on claims, membership, provider, authorizations, and care management data.

SPSS Statistical Reporting®

SPSS® is a statistical package for the social sciences. It provides data management, analysis, and presentation functions, including statistical analyses and graphical presentation of data. It is used to analyze survey data, utilization data, cost data, record sampling, and control group vs. test group outcomes.

HEDIS Reporting – Quality Spectrum®

Quality Spectrum® is a web-enabled service, provided by Catalyst. Source files are loaded monthly into a dedicated data repository used for HEDIS reporting, provider profiling and the generation of "care gap" intelligence. Catalyst is National Committee for Quality Assurance (NCQA)certified for HEDIS reporting.

Customer Contact

AmeriHealth Mercy provides multiple access channels for members and providers to easily interact with the plan. We provide toll free phone access to customer service representatives and Care Mangers and self-service access using an IVR and Internet portals.

Through our Voice Network Services (VNS) team, we ensure the highest level of support and availability of telephonic services for our members, providers and customers. Team members have a national voice in the Telecom field through membership of the local Avaya user's board, our telephony system vendor and PAETEC's customer advisory board, our local telecommunications provider. The VNS team has been quoted several times in *The Voice Report*, a national telecommunications newsletter and *Definitively Speaking*, the international Avaya users group publication. In addition, our team was chosen as a beta (test) for Avaya and other telecom services vendors. Members of the VNS group have also conducted briefing sessions at regional and national conferences for witness and Contact Center specific events.

Avaya™

The Avaya™ Communication Manager (r5.2) system is the backbone of AmeriHealth Mercy's Contact Center. It is configured with critical reliability architecture to ensure optimum performance and uptime of

all telephony systems and services needed to support our 24/7/365 Contact Center. The call vector program allows for a caller response within 4 rings. This is achieved by either the most-idle agent answering the call or with a greeting that is heard by the caller if no agents are in a readily available state.

The Avaya™ Call Management System (CMS) is the Contact Center reporting peripheral in use at AmeriHealth Mercy. CMS provides real-time and historical reporting for all Contact Centers, including Calls Offered, Calls Answered, Average Speed of Answer, Calls Abandoned and Average Abandon Time. These reports are available real-time (current 30 minute interval), intra-day, daily, weekly and monthly.

Avaya™ one-X Desktop Video Conferencing

The Avaya desktop video conference solution allows employees to participate in video conferences from their office, home office or while traveling with the use of a laptop. It has the capability to share computer content, enabling all participants to view the same information.

Automated Call Distribution (ACD)

Our Contact Center employs Automated Call Distribution (ACD) technology that supports call routing. Callers to the Contact Center are presented with a series of prompts beginning with language selection/assistance. The ACD accepts all calls and route them, depending upon the option selected, directly to a Contact Center Representative, the Nurse Call Line, the Rapid Response team or an IVR system. Our ACD system routes calls among hotline staff using a sophisticated routing system that ensures timely and accurate response to member inquiries.

NexTalk (NXI)

NexTalk (NXI) provides desktop capability to handle Telecommunication Device for the Deaf/Teletypewriter (TDD/TTY) calls. Contact Center representatives log into a TDD/TTY server, "sharing" central TTY modems over the network.

Verint® Quality Monitoring

Verint® Quality Monitoring software records a predetermined sample of phone contacts with images of the accompanying computer screen interactions using "screen scrape" technology. This provides our Quality Auditor staff with the ability to listen to what was said on the call, while watching the representatives actions in the system, providing invaluable information for best practice identification and performance improvement coaching.

IVR

AmeriHealth Mercy's Interactive Voice Response (IVR) system consists of two components- Eligibility\Benefits Information queries and Form Faxback technology. The system handles calls that are routed, by caller request, via our Contact Center Private Branch Exchange (PBX) prompting. The caller selects the appropriate option and is transferred to the IVR system to fulfill the request. We have the capability to add functionality to our IVR and will add a claim status option for Louisiana. The eligibility system provides access to member eligibility data via a real-time system interface to our Facets database. The Forms Faxback application provides doctor's offices access to prescription drug prior authorization forms via fax. This interface can also be modified for other forms, as needed.

Both applications run on the Avaya IR platform. The inquiry and fulfillment applications were designed by AmeriHealth Mercy and built by our programming vendor, Nuance Communications, Inc. The systems are available 24 hours a day, 7 days a week, 365 days a year except for scheduled maintenance.

IVR options for members include: ID Card request, Provider Directory request, and Member Handbook request. The goal of these applications is to remove the need to speak to a representative for these simple tasks and create more opportunities for efficiency among our Contact Center teams.

Provider and Member Web Portals

AmeriHealth Mercy delivers member and provider Web portals to each of its affiliates. Each Web portal is customized to the unique needs of the affiliate while leveraging our library of award-winning features. The websites use best practice designs to ensure members/providers can easily find, understand, and submit information, as well as access detailed member information through secure portals. The goal of each website is to ensure easy access to information and services, achieve outstanding levels of member/provider satisfaction and deliver on-line self-service tools that eliminate costly phone calls.

Our websites deliver all the standard features of health plan websites including detailed information on eligibility, benefits, claim status, searchable provider directory and others. Additionally, clients benefit from a best practice feature set including:

- Clinical information delivery including member clinical summaries and alerts for overdue health screens
- Member health resources and information tailored to the specific needs and comprehension levels of the our membership
- Provider report center that offers administrative and clinical reports in print and downloadable formats.
- Accessibility exceeding government standards and providing multi-lingual capabilities where appropriate

Each affiliate has its own public site that delivers up-to-date information on all aspects of our services to providers and members. This includes an NCQA-compliant searchable provider directory, provider and member handbooks, and a wealth of other information about our services and procedures. Our websites are optimized for easy access from Google and other external search engines as well as fully searchable from within the site. Information contained on the public web portal includes:

- Provider newsletters, handbooks and other communications
- Searchable provider directory
- Information on health management programs
- Health education materials (members) and Clinical Practice Guidelines (providers)

Web Member Portal

Our Member Portal is powered by Interwoven's TeamSite and LiveSite sophisticated content management and personalization system. This system allows each affiliate to update and control its content, eases the inclusion of multi-lingual capabilities, and allows for content targeting to specific member groups.

NaviNet Provider Portal

AmeriHealth Mercy uses NaviNet as its Provider Portal. The largest Provider Portal with over 700,000 providers nationally, NaviNet's multi-payer (including Aetna, United Healthcare, and numerous Blue plans) design allows the provider to log in once to access information from multiple payers. AmeriHealth Mercy offers access to all the standard transactions through NaviNet including eligibility and benefits, claim status and referrals submission and update, as well as links to providers manuals, forms and other important administrative information. Special features offered though NaviNet include a report query tool that allows providers to access reports that can vary by client and an encounters correction tool that can be accessed by providers to improve encounter submissions.

Searchable Provider Directory

Available from both the member and provider portal, AmeriHealth Mercy's searchable provider directory is designed to enable members to gain easy access to the right provider in the network. It offers a variety

of search features including detail and proximity ZIP code searches and returns detailed data including information on languages spoken, panel status and accreditation or board-certification status. The directory is fully integrated with our source provider data system (Facets) ensuring that it has the most up-to-date information available. Point-to-point directions are also offered for directory listings.

Secure Portal Services

Members and providers have access to secure areas of the Member Portal and Provider Portal, respectively, to access e-Health services (described above) and send/receive communications. Specific services are described in the table, below:

Table 16: Secure Portal Services

Secure Provider Portal Services	Secure Member Portal Services
• Eligibility/Benefit Inquiry • Care Gap Alerts • Claim Status Inquiry • Claim Correction • Referral Creation and/or Inquiry • Authorization Creation, Update or Inquiry • Clinical Reports and Clinical Alert Reports • Member Clinical Summary/EPSDT Summary • Continuity of Care Document	• PCP Information • Medication List • Care Gap Report • Member Clinical Summary • EPSDT Clinical Summary • Request an ID Card • Request a Handbook • Send secure email • Complete a Health Risk Assessment* *Available 1/1/2012

Web Accessibility

Web accessibility means that people with disabilities can perceive, understand, navigate, and interact with the Web, and that they can contribute to the Web. Web accessibility also benefits others, including older people with changing abilities due to aging. Web accessibility encompasses all disabilities that affect access to the Web, including visual, auditory, physical, speech, cognitive and neurological disabilities.

All AmeriHealth Mercy websites are in compliance with Section 508 of the US Rehabilitation Act. All AmeriHealth websites meet Web Content Accessibility Guidelines 1.0 Priority 2, making AmeriHealth Mercy WCAG Priority 2 (Double-A)-compliant exceeding the required Section 508 standard by two levels. Our Web development process leverages best in breed testing for Web content accessibility and colorblindness and infuses best practices for web usability as outlined by the United States Government's Usability.org web site.

Web 2.0 and Other Channels

Increasingly communication is moving from traditional Web applications to social networking sites, blogs and other mechanisms including text messaging. AmeriHealth Mercy has architected its solutions to integrate with these channels and is currently developing a number of pilot efforts to determine their effectiveness in communicating with members. Forays in this realm include the use of text messaging to alert members to Care Gaps and the use of a social media site, Mom2b, to communicate with and educate pregnant members.

Intranet Portal

iNSIGHT is our intranet portal. All employees have intranet access. This site is used to house and communicate departmental information throughout the company. It also provides links to commonly used vendor and internal applications. It is comprised of many interactive forms for requesting services or resources. It is also used to communicate annual goals, quality initiatives, departmental policies and other inter-departmental communications.

Corporate Systems

PeopleSoft

PeopleSoft is used to manage administrative functions including recruitment, benefit administration, position management, budgeting and financial reporting, general ledger, asset management and purchasing/requisition management functions. Utilizing these functions, self-service access points are available for employees to review and update data in order to ease system administration. In addition, an automated financial data interface from Facets, interfaces to benefits providers and a single source of associate data sets the foundation for a fully integrated back office system.

R.12: Information System (IS) Organization

R.12 Provide a profile of your current and proposed Information Systems (IS) organization.

The mission of the Information Systems (IS) department is to provide high quality information solutions which are responsive, proactive, stable and cost-effective. IS will deliver fully integrated and leveraged technology solutions and services to enable AmeriHealth Mercy and its affiliates to meet and exceed customer expectations.

AmeriHealth Mercy's IS organization is committed to supporting AmeriHealth Mercy through a strong alignment of the business and IS strategies, continuous customer collaboration, ongoing development of our employees and continued improvements in the effectiveness of our processes and technologies.

Our key operating goals are as follows:

- Technology Simplification
- Leverage Enterprise Technology Assets and Services
- Improve Decision Making thru Data, Information and Analytics
- Resource Optimization and Utilization
- Portfolio Rationalization and Demand Management
- Operational Efficiency and Excellence
- Data Quality, Security and Privacy

We create business value through standardized process and technology solutions that are adaptable and flexible. IS leverages institutional strength and technology platforms to adapt to the changing needs of publicly-funded health care programs. We deliver unrivaled technology service through a strong commitment to attract and retain top talent, develop and mature our skills and competencies and continuously evolve the organization to deliver maximum service in an efficient and cost effective manner.

This effort is led by an IS leadership team that has an average of 10 years of health care experience. The organizational chart of our team, the various technical domains (departments and teams) along with an explanation of their areas of responsibility are below.

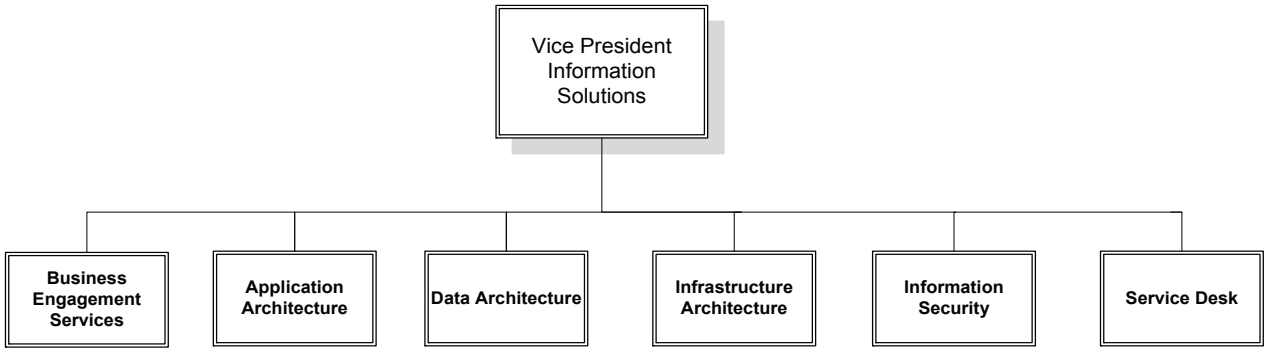

Figure 42: IS Organizational Chart

Business Engagement Services

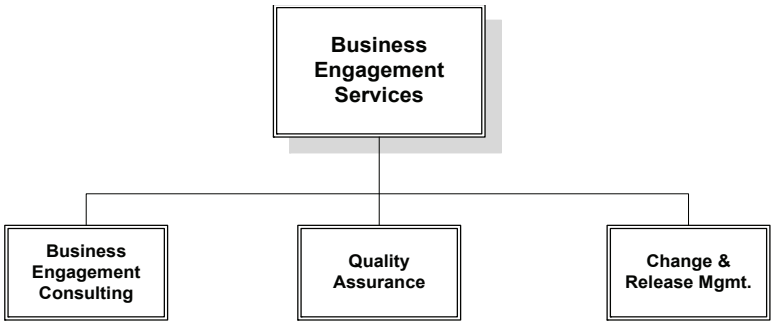

Figure 43: Business Engagement Services

Business Engagement Services (BES) is responsible for servicing and managing customer relations between operational areas and IS; in effect, they represent "face of IS." They coordinate all maintenance work requests, corporate projects and communications.

BES establishes the testing framework and quality assurance (QA) environment, and documents and conducts all system and integration testing activities including strategy, planning scheduling and results. They steward testing tools, methodologies and quality assurance best practices. All code changes into production from QA are coordinated with enterprise release plans and schedules.

BES provides horizontal services to each IS delivery domain for work intake, project methodology, quality assurance and release management.

Application Architecture

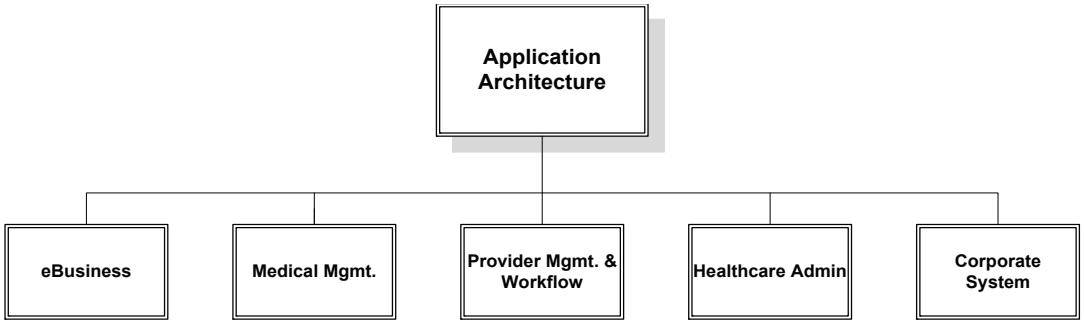

Figure 44: Application Architecture

Application Architecture provides the development and support of our core business applications. Application Architecture utilizes eBusiness to deliver real-time transaction processing for administrative and clinical transactions for members, providers and our internal systems. They provide critical online access via the Provider (NaviNet) and Member Portals.

Application Architecture supports the delivery of Medical Management functions (prior authorization, utilization management and integrated care management) through Jiva and Provider Management functions (contracting, credentialing, and information management) through Portico's Choreo application and Visual CACTUS. In addition, this domain delivers support for SunGard EXP workflow design and development.

The Corporate Systems team maintains all system development and support through the PeopleSoft Finance and HRMS applications.

The Health Care Administration team consists of Business Analysts and Developers who support the health care business services delivered via TriZetto's Facets application. Facets core business services include:

- Eligibility/Enrollment
- Claims (adjudication, adjustments, payments, clinical editing, recovery)
- Capitation (panel/capitation rosters, payments)
- Billing
- Provider
- Reporting (operational, informational, financial and statutory)
- Application/Data Integration (states, third party vendors, internal systems)

Data Architecture

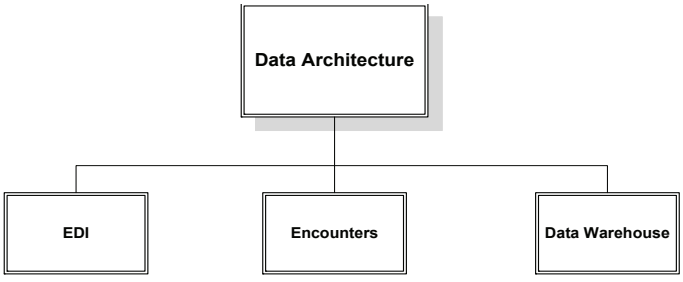

Figure 45: Data Architecture

Data Architecture delivers all HIPAA transactions exchanged with Providers and state clients including claims, remittances and enrollment through an EDI team.

The submission of encounters to all our state clients is managed by the Data Architecture Encounters group.

Data Architecture also supports the delivery of all consolidated reporting functions through an Enterprise Data Warehouse. Business Intelligence functions are delivered through a Business Objects suite of tools: SAS, SSRS and SQL Developer. The Data Warehouse team implements metadata dictionary and data stewardship and foundational support for data governance practices as well as the system delivery of data quality and data profiling functions.

Infrastructure Architecture

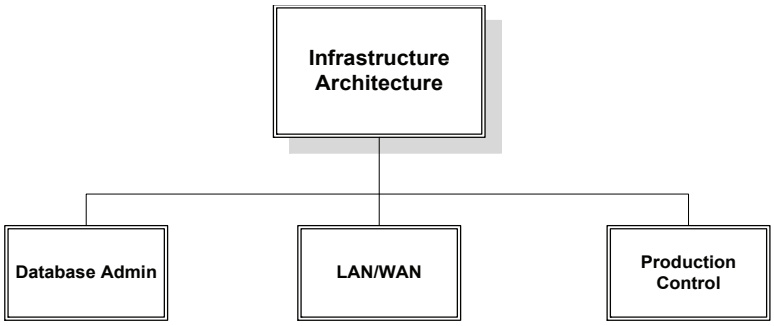

Figure 46: Infrastructure Architecture

Infrastructure Architecture designs, installs and maintains all network infrastructure hardware and software across AmeriHealth Mercy and our affiliates' local and wide area networks (400+ network nodes). This group manages the entire metropolitan and wide area network and circuits.

In addition, the Infrastructure Architecture team manages all Internet access, redundant Internet carriers, public Internet Protocol (IP) addresses and external Domain Name Systems (DNS). More than 1,300 remote VPN users and more than 90 site-to-site VPN tunnels with business partners are supported. Voice network services are supported with Gateways/IP Backbone, PBX and Telephony architecture, Contact Center applications, mobile services and conferencing services.

Infrastructure Architecture also administers hardware and software application servers and databases such as HP, Oracle, Sybase, MS SQL Server, EMC and HP-UX.

Production Control is a 24/7/365 operation that monitors all production batch processes and file transfers, including the monitoring and tracking of completed cycles and all standards using Information Technology Infrastructure Library (ITIL) standards. Our state-of-the art 18,000 sq. ft. Data Center is managed by this team and has full redundant services – all backed by disaster recovery and business continuity services.

Information Security

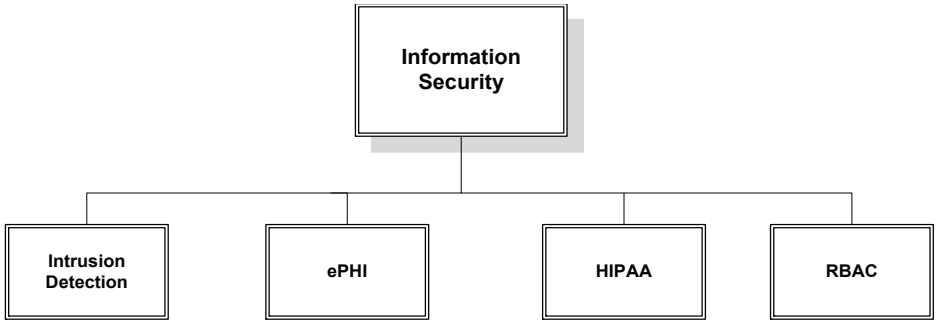

Figure 47: Information Security

Information Security coordinates the development, maintenance and enforcement of company policies, standards and procedures regarding information security. They provide risk and vulnerability assessments and security administration across the enterprise, including security for physical data access, electronic personal health information (ePHI) and unauthorized system access. .

Information Security acts in an oversight capacity to ensure the confidentiality, integrity and availability of electronic data and resources. The IS team is also responsible for the design, implementation and oversight of all Role-Based Access Controls (RBAC).

All AmeriHealth Mercy and affiliate employees are trained by Information Security on security awareness.

Service Desk

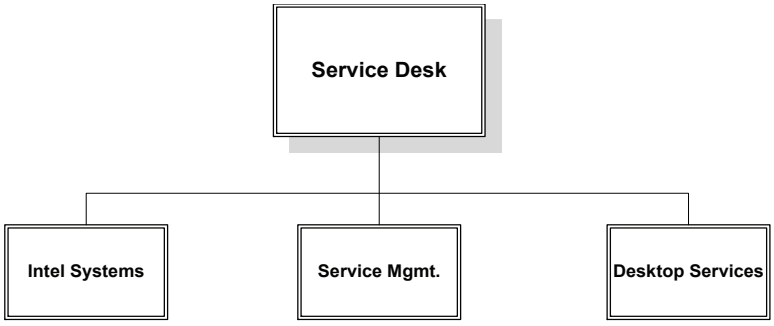

Figure 48: Service Desk

The Service Desk serves as a central point of contact between IS and all employees and external clients for reported incidents and/or requests (HEAT ticket recording system).

They establish desktop setups for new employees and handle any location changes (such as a change in office or cubicle). After setup, the Service Desk provides initial and ongoing problem management and incident reporting. They manage all desktop user technical environments: order, deploy, upgrade, and maintain desktop hardware and software with performance in mind.

The Service Desk implements, monitors, secures and maintains all key servers, services and applications across the enterprise and our affiliates: e-mail, backup and recovery, file and print, anti-virus and patch management as well as Citrix remote access and server virtualization.

R.13: Electronic Claims Submissions and Electronic Funds Transfers

R.13 Describe what you will do to promote and advance electronic claims submissions and assist providers to accept electronic funds transfers.

AmeriHealth Mercy continuously promotes the adoption of electronic data interchange (EDI) via a variety of programs and services. AmeriHealth Mercy will leverage several initiatives that have been successfully implemented by its affiliates to maximize electronic claims submission via EDI and encourage providers to utilize Electronic Funds Transfer (EFT) and adopt electronic remittance advice. Our track record speaks for itself with all current affiliates submitting over 80 percent of their claims electronically with some over 90 percent. EFT adoption has also been successful with some affiliates disbursing over 45% of payments (in dollars) through EFT.

Promotion of Electronic Claim Submission

Automated Clearinghouse (ACH)

A key part of our efforts will be to leverage our partnership with Emdeon, the largest and most comprehensive claims clearinghouse serving the industry today. Emdeon not only has a large footprint in provider offices, but also receives "pass-through" claims from virtually every other clearinghouse. As a result, providers who submit electronic claims today to virtually any payer will find it quick and easy to submit claims electronically to AmeriHealth Mercy.

Claim Correction, COB, Web Forms

We support the capability for providers to submit corrected claims and COB information electronically. Recognizing that some providers do not have practice management systems, AmeriHealth Mercy will offer a simple web form that any provider can use, free of charge, to submit claims electronically. In this way, even practices with minimal automation will be able to benefit from the speed and accuracy offered by electronic claims submission.

Promotion of Electronic Funds Transfers (EFT)

AmeriHealth Mercy will also make it easy and quick for providers to utilize our EFT capabilities. AmeriHealth Mercy will use Emdeon's ePayment multi-payer capability. With ePayment, a provider signs up once for EFT for multiple payers. This eliminates the time and effort needed to set up multiple EFT connections to the provider's bank. Some providers may already be signed up for this service.

AmeriHealth Mercy promotes EFT services to our provider community through our regular provider communication channels including links on the Provider Portal, the provider newsletter, inserts into the paper remittance advice and IVR messaging.

Electronic Data Interchange (EDI) Production Support

To assist providers in adopting EDI, AmeriHealth Mercy supports a wide range of transactions through our EDI Production Support which includes:

- An EDI Inbox which is checked daily and consists of questions from the provider community as well as internal inquiries from Provider Services and our Operations area.
- An EDI Hotline, which providers and software vendors can use to speak with a live person. These voicemails are checked daily with an expected response time of less than 24 hours.
- The phone numbers and EDI website information (including Q&A) for these areas is located in provider manuals and on the provider portal.

The table below shows the EDI transactions AmeriHealth Mercy supports.

Table 17: EDI Transaction Types Supported by AmeriHealth Mercy

X12 Transactions Batch	Type	Source	In/Out	Frequency
820	Premium Payments	State/FI	Inbound	Daily/Monthly
834	Enrollment	State/FI	Inbound	Daily/Weekly
835	Payment/Remittance	Health Plan	Outbound	Weekly
835	Inbound (Maternity Kick)	State/FI	Inbound	Weekly
837I	Institutional Claims	Emdeon	Inbound	Daily
837I	Institutional Claims	State/FI	Inbound	Daily
837P	Professional Claims	Emdeon	Inbound	Daily
837P	Professional Claims	State/FI	Inbound	Daily
837	Outbound (Maternity Kick)	State/FI	Inbound	Weekly

X12 Transactions Real Time	Type	Source	In/Out	Frequency
270	Eligibility Inquiry	Provider to NaviNet	Inbound	RT 24/7
271	Eligibility Response	Provider to NaviNet	Outbound	RT 24/7
276	Claims Status Inquiry	Provider to NaviNet	Inbound	RT 24/7
277	Claims Status Response	Provider to NaviNet	Outbound	RT 24/7
278	Referrals Submissions	Provider to NaviNet	In/Out	RT 24/7
278	Referral Inquiry	Provider to NaviNet	In/Out	RT 24/7
997	File level acknowledgement	Health Plan	Outbound	RT 24/7

We support the following clearinghouses: Emdeon, Zirmed, NaviNet, IBC Blue Exchange, and HDX.

AmeriHealth Mercy encourages overall adoption of EDI through the use of real-time, system to system eligibility checking. This capability allows the provider's practice management system to directly check eligibility without having to a staff person do it on-line. AmeriHealth Mercy also provides a fully HIPAA-compliant Electronic Remittance Advice (835) to deliver remittance information directly to the provider's practice management system for fully electronic posting.

Other key administrative transactions available through our NaviNet Provider Portal include:

- Electronic referrals
- Claim correction (corrections or submission of additional information to a previously submitted claim)
- Eligibility inquiry, including benefit verification
- Claim status inquiry

EDI successes by AmeriHealth Mercy

Our track record with EDI services speaks for itself:

- Processed over 12 million 837 institutional and professional claims for all affiliates in 2010
- Exceeded a record of over one million claims processed a month in 2010
- Average about 90,000 batch transactions daily
- Processed about 17 million real time transactions in 2010, including:
  - Over 7 million eligibility inquiry requests
  - Almost 2 million claim status requests

- Over 350,000 referral inquiries
- 250,000 referral submissions
- Transaction volume has increased to about 1.6 million real time transactions per month

R.14: Information System Software Version

R.14 Indicate how many years your IT organization or software vendor has supported the current or proposed information system software version you are currently operating. If your software is vendor supported, include vendor name(s), address, contact person and version(s) being used.

Table 18: Information Systems Software

Software Application(s) and Version	Vendor	Yrs	Contact	Contact Information
TeamSite 6.7.1	Autonomy Interwoven	4	Bob Clark Sr. Account Executive	One Market Plaza Spear Tower, Suite 1900 San Francisco, CA 94105 T:(415) 243-9955
Call Management System (CMS) 16.1 Automated Call Distribution Avaya Communication Manager 5.2.2	Avaya	11	Michael Fontanella Fontanella@avaya.com 610.908.3134	3015 Peacock Drive Audubon, PA
Tumbleweed Mail Gate 2010	Axway, Inc.	9	Basil Pais Account Executive T: (214) 636-3759 Andrew Hornbruch Account Development P: (650) 216-2536 F: (650) 216-2001 1600 Seaport Blvd., Ste 400, South Bldg Redwood City, CA 94063 ahornbruch@us.axway.com	6811 E. Mayo Boulevard, Suite 400 Phoenix, Arizona 85054 P: (480) 627-1800 http://www.axway.com
Blackberry Enterprise server 5.03	Blackberry	7	N/A	Research In Motion 295 Phillip Street Waterloo, Ontario Canada N2L 3W8 tel: (519) 888-7465

Software Application(s) and Version	Vendor	Yrs	Contact	Contact Information
Visual CACTUS 3.11	CACTUS	11	Bryan Robbins	CACTUS Software 4900 College Blvd Overland Park, KS 66211 (800) 776-2305
Quality Spectrum (HEDIS)	Med-Assurant	9	LaVonna Bowman (770) 982-8022 ext. 146	1559 Janmar Road Snellville, GA 30078 P: (770) 982-8022
Check Point v. 7.97.0Pointsec v. 6.13	Checkpoint	6	Validity1060 First Avenue, Suite 400King of Prussia, PA 19406Direct: 610-983-3592Cell: 484-744-0694Fax: 610-933-2663Email: tkauffman@validityinc.net	Check Point Software Technologies Inc. 800 Bridge ParkwayRedwood City, CA 94065
Presentation Server XenApp Access Gateways Edgesight	Citrix	13	Jeff Basciano Jeffrey.Basciano@citrix.com (610)213-1531	176 South Street Hopkinton , MA 01748 United States 866-438-3622
Heat 8.4	Front range Solutions	6	Cindy Riggs (800) 776-7889	FrontRange Solutions USA Inc. 1150 Kelly Johnson Blvd, Suite 100 Colorado Springs, CO 80920 P: (719) 531-5007

Software Application(s) and Version	Vendor	Yrs	Contact	Contact Information
EnCase v. 6.18	Guidance Software	4	David Moore	Guidance Software, Inc. 215 North Marengo Avenue, Suite 250 Pasadena, CA 91101 P: (626) 229-9191 (866) 973-6577
Dragon v.7.41 Squire v. 7.41	Enterasys	8	Kurt Skowronek kskowron@enterasys.com	50 Minuteman Road Andover, MA 01810
HP Quality Center 9.2 Tipping Point IPS v.3.2	HP	22	Troy Logan Genilogix (412) 444-0554 x300	Genilogix LLC 3846 South Water Street Pittsburgh, PA 15203
Rational Robot 7.0 Transformation Extender HIPAA Packs HIPAA Packs for 5010 DataStage 7.5.3 WebSphere Network Deployment WebSphere Express Guardian Application Firewall	IBM Corp	12	Don Williams djw@us.ibm.com Tel:919-854-4779 Cell: (919) 201-0298	IBM Corporation 1 New Orchard Road Armonk, New York 10504-1722 (914) 499-1900
GeoAccess 8.5GeoCoder 4.0ECM PRODirectory Expert 4.0	Ingenix Suite®	11	Barb AndersonDirector, Client ManagementINGENIX Office: (913) 904-5068Cell: (913) 481-3675 barbara.anderson@ingenix.com	12125 Technology DriveEden Prairie, MN 55344(800) 765-6034
CCNX 5.12 Streamline 5.13 Provider Automation 7.3	IntelliSource	7	Mark McAdoo (610) 992-0102	1012 W 8th Ave King Of Prussia, PA 19406-1313
WINUCS CarePlanner Web 5.0.3.10 CRIS iEXCHANGE 6.4 Autocoder 2011-A	MEDecision	11	Nina Reed Nina.Reed@MEDecision.com (610) 540-0202 ext. 1189	601 Lee Road Chesterbrook Corporate Center Wayne, PA 19087 P: (610) 540-0202 F: (610) 540-0270

Software Application(s) and Version	Vendor	Yrs	Contact	Contact Information
Desktop Operating Systems - Vista, Windows 2008 Enterprise Server Operating Systems Office 2010 Suite Forefront 1.596 SharePoint	Microsoft	22	Brian Benzel Microsoft Corporation Account Executive (215) 385-6968 bbenzel@microsoft.com	Microsoft Corporation 45 Liberty Boulevard, Suite 210 Malvern, PA 19355
CERMe 10.0	McKesson	8	Minaxi Rayjada	5 Country View Road Malvern, PA 19355 (800) 782-1334
Provider Portal	NaviNet (formerly NaviMedix)	4	Catherine Weston	179 Lincoln Street Boston, MA 02111 P: (800) 805-7569
TDD Software NexTalk v6.4	NXI	2	N/A	10757 River Front Parkway, Suite 290 South Jordan, UT 84095 (801) 274-6001
Oracle Enterprise Edition 10g PeopleSoft FS 8.9 PeopleSoft HR 8.9 PeopleSoft Hyperion 8.9	Oracle (includes PeopleSoft)	20	Rich Fellmann P: (781) 238-9414 rich.fellmenn@oracle.com	Oracle Corporation 500 Oracle Parkway Redwood Shores, CA 94065
Portico 9.0 Choreo Courier Negotiator	Portico	4	Scott McCulloughVice President Health Plan SalesP: (615) 661-5012Cell: (615) 594-6281David Magee, DMagee@porticosys.com	Portico Systems518 East Township Line Road, Suite 100Blue Bell, PA 19422P: (215) 358-3800F: (215) 358-3702
Business Objects Web Intelligence XI - 3.1 Crystal Reports 2008	SAP	7	Alison Yardley P: (604) 974-2722 F: (610) 707-9701 Alison.yardley@sap.com	3999 West Chester Pike Newtown Square, PA 19073 P: (610) 661-1000

Software Application(s) and Version	Vendor	Yrs	Contact	Contact Information
Orion (NPM) SolarWinds Orion Core 2011.1.0, APM 4.0.1, IPAM 2.0, IPSLAMGR 3.5.1, NPM 10.1.2, NTA 3.7, IVIM 1.1.0 Engineers Toolset Version 10	Solarwinds, Inc.	2	Matthew Preston Technical Sales / Account Exec - North East Territory O: (512) 682-9662 F: (800) 269-7365	3711 South MoPac Expressway Building Two Austin, Texas 78746 P: (866) 530-8100
EXP 3.3 Entrendx 7.3	SunGard/Macess	15	Michael Moore P: (205) 437-7500	104 Inverness Center Place Birmingham, AL 35242
Sybase ASE 15 Sybase Replication 15 EDI Tools Power Designer 10.5	Sybase	12	David Ginda P: (973) 896-8246 David.Ginda@sybase.com	One Sybase Drive Dublin, CA 94568 Phone: (925) 236-5000
BindView Enterprise Vault Backup Exec DLP	Symantec	4	Scott McFarland Enterprise Account Manager P (610) 832-3508 Cell: (215) 850-1383 Scott_McFarland@Symantec.com	350 Ellis Street Mountain View, CA 94043 (650) 527-8000
Tidal Enterprise Scheduler 5.3	Tidal Software (now a part of Cisco)	7	Jacob Lee Jacob.Lee@cisco.com P: (781) 535-1220 Cell: (781) 893-0296	170 West Tasman Dr. San Jose, CA 95134 (877) 558 – 4325
Client Letter 3.0.2103	TopDown Systems	3	Matt Ledderer P: (301) 417-9660 X174 matt@topdownsystems.com	Top Down Systems Corporation 9210 Corporate Blvd, Suite 401 Rockville, MD 20850 (800) 361-1211 (301) 417-9660
ScrewDrivers 4.6	Tri-Cerat	6	John CilibertoNorthEast Sales Manager800.582.5167 x1206P: (410)715-4226F: (410)715-3926Email: jciliberto@tricerat.com	10320 Little Patuxent Parkway, Suite 200 Columbia, MD 21044(800) 582-5167

Software Application(s) and Version	Vendor	Yrs	Contact	Contact Information
Facets 4.6 HIPAA Gateway Batch Server 4.6 NetworX	TriZetto	12	Peter Jeffries National Sales Executive The TriZetto Group, Inc. Cell: (717) 649.4727 P/F: (717) 932.5000 peter.jeffries@trizetto.com Norma Tatterfield Director, Client Services - BCBS Market The TriZetto Group P: (401) 218-2189 Norma.Tatterfield@TriZetto.com	The TriZetto Group Corporate Headquarters 6061 South Willow Drive, Suite 310 Greenwood Village, CO 80111 800-569-1222
VeraSMART eCas 8.1.152.04a	Veramark	6	Christopher Pratts P: (585) 383-6859	Check Point Software Technologies Inc. 800 Bridge Parkway Redwood City, CA 94065
Verint Quality Monitoring 7.8.2 Call Logger 10	Verint Americas Inc.	9	Jim Moretti	330 South Service Road Melville, NY 11747
V sphere Virtual Center Virtual Desktop	VMware	6	Scott Vandermeer P: (720) 457.8071 F: (415) 962.3243	3401 Hillview Ave Palo Alto, CA 94304 (877) 486-9273
Websense v7.5	Websense	5	Jose Andrews	10240 Sorrento Valley Rd San Diego, CA 92121 (858) 458.2940
Jiva 5.1.1	ZeOmega	1	Rakesh Naidu (Rocky) P: (214) 618-9880 ext:9004 D: (281) 668-8385 F: (214) 975-1258	ZeOmega LLC 3010 Gaylord Parkway, Suite 210 Frisco, TX 75034

R.15: Electronic Health Records

R.15 Describe your plans and ability to support network providers' "meaningful use" of Electronic Health Records (EHR) and current and future IT Federal mandates. Describe your plans to utilizing ICD-10 and 5010.

"Meaningful Use" of Electronic Health Records (EHR)

AmeriHealth Mercy has extensive experience in working with Health Information Exchanges (HIEs) and will be ready on day one to connect to the state's health information exchange and deliver a Continuity of Care Document (CCD) to providers. We will work with the provider network to both promote and support the adoption of electronic health records and qualification for HITECH incentive funding. We will promote the state Medicaid incentives and collaborate with the Louisiana Health Care Quality Forum, the state's regional extension center, to encourage use of those services by providers.

AmeriHealth Mercy has been working with the Kentucky Health Information Exchange (KHIE) over the past year to feed a fully standardized Continuity of Care Document (CCD) to KHIE on behalf of its Kentucky-based client. This information exchange with KHIE has passed quality assurance testing and is currently awaiting final legal approval from the Commonwealth to begin sending data. The AmeriHealth Mercy transaction meets all KHIE requirements. It uses WS security over a HTTP connection following the KHIE WSDL with an X.509 certificate as per KHIE specifications. It responds to a Query T-12 request with from KHIE that passes a KY Medicaid number. The response is provided by AmeriHealth Mercy in an encrypted DOC T12 containing a CCD (HITSP C32) that follows all KHIE nomenclature requirements (e.g. NDC, ICD-9, etc.) All of the above has been tested through to the KHIE portal.

It is also noteworthy that AmeriHealth Mercy's CCD payload includes a rich and timely set of clinical data on the member. This includes current dispensed medications, recent emergency room, inpatient and ambulatory visits, diagnoses, problem lists, and gaps in care for preventive health screenings and chronic disease management. A comprehensive set of data rules are in place to screen out prohibited data related to HIV, substance abuse, and mental health specific diagnoses, procedures and medications. AmeriHealth Mercy's transaction has gone through extensive testing with KHIE including connectivity, development, CCD compliance and end-to-end testing. The AmeriHealth Mercy transaction was demonstrated, with the support of KHIE, to the Office of National Coordinator of Healthcare Information Technology at the HIMSS 11 annual conference in February 2011. The AmeriHealth Mercy KHIE transaction is built on a flexible and extensible clinical information sharing technology infrastructure. As KHIE expands it document types, moves to later versions of HL7, considers a direct exchange model and evolves to say current with health care technology advances, AmeriHealth Mercy will continue to demonstrate its ability to keep pace with KHIE advancements to leverage technology to improve member access to quality care.

AmeriHealth Mercy is a founding member of the Southeastern Pennsylvania Health Information Exchange, which represents the Philadelphia area, one of the largest and most competitive health care market places in the country. This HIE will use the "direct" method for exchanging information focusing initially on hospital discharge information. These Health Information Exchange efforts are led by Joe Miller, FHIMSS. Mr. Miller is a recognized national leader in HIE, has authored a book on electronic health record (EHR) implementation, and is a frequent presenter to national conferences, government agencies, and other HIT events.

Current and future IT Federal mandates

AmeriHealth Mercy will work closely with its provider network to support them in meeting all federal IT mandates. AmeriHealth Mercy subject matter experts will bring with them the current industry

intelligence on the form and direction of Federal HIT initiatives. Joe Miller, Director of E-Business, regularly attends industry stakeholder meetings in Washington around 5010 and ICD-10 and has testified before the National Committee on Vital and Health Statistics on Federal IT initiatives. He speaks regularly in national and local forums to AmeriHealth Mercy's affiliate provider networks on HIT topics.

AmeriHealth Mercy, through Joe Miller, will offer appropriate HIT training and seminars on upcoming Federal IT mandates so that the network can effectively plan and prepare for changes such as 5010 and ICD-10.

Plans for Utilization and Compliance - HIPAA 5010

The Centers for Medicare and Medicaid (CMS) have mandated that all health organizations be compliant with HIPAA 5010 by 1/1/2012. AmeriHealth Mercy efforts toward remediating all 40101A X12 transactions started in September 2009, and we expect to implement all transactions in the 5010 format by the 1/1/2012 Level 2 Compliance date. We are currently testing the 837 and 270-271 transactions with our trading partners and expect to move our first transactions into production by the end of June 2011, well before the compliance deadline.

Plans for Utilization and Compliance - ICD-10 Compliance

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. AmeriHealth Mercy completed its impact assessment earlier this year and has begun detailed analysis of the changes required by ICD-10. We have already begun work on upgrading our two largest and most impacted applications. AmeriHealth Mercy's Health Care Benefit Administration system utilizes TriZetto's Facets product. Facets version 4.81 is ICD-10 certified and is currently scheduled for a second quarter 2012 implementation. AmeriHealth Mercy's medical management application is currently being replaced with an ICD-10 compliant version expected to be installed later this year. Detailed implementation plans for others systems are currently being worked on.

AmeriHealth Mercy's ICD-10 goals are:

- Ensure business continuity for our provider network, other trading partners and our health plan affiliates.
- 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.

AmeriHealth Mercy 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.

AmeriHealth Mercy 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.

R.16: Protecting Confidentiality

R.16 Describe the procedures that will be used to protect the confidentiality of records in DHH databases, including records in databases that may be transmitted electronically via e-mail or the Internet.

Protecting Confidentiality – Policies and Procedures

AmeriHealth Mercy will assure that medical records and any and all other health and enrollment information relating to members or potential members, which is provided to or obtained by or through the performance under this contract, whether verbal, written, electronic file, or otherwise, shall be considered as confidential information to the extent confidential treatment is provided under 45 CFR Parts 160 and 164 and other state and federal laws, DHH policies or this contract. AmeriHealth Mercy will not use any information so obtained in any manner except as necessary for the proper discharge of its obligations and securement of its rights under this contract.

All information is used, disseminated and stored following the AmeriHealth Mercy guidelines that ensure the security and confidentiality of such data and its proper usage.

All information as to personal facts and circumstances concerning members or potential members obtained by AmeriHealth Mercy will be treated as privileged communications, will be held confidential, and will not be divulged without the written consent of DHH or the member/potential member, provided that nothing stated herein shall prohibit the disclosure of information in summary, statistical, or other form which does not identify particular individuals. The use or disclosure of information concerning members/potential members shall be limited to purposes directly connected with the administration of this Contract.

AmeriHealth Mercy will protect the confidentiality of the records in DHH databases through the implementation of policies, procedures and technologies under the stewardship of the AmeriHealth Mercy Information Security organization in partnership with AmeriHealth Mercy Corporate Compliance organization. A policy matrix is included below:

Table 19: Confidentiality and Security Policy Matrix

POLICY	POLICY DESCRIPTION
145.001 Use of Automatic Password Protected Screen Saver	This policy describes the automatic timeout process for workstations and PC equipment used by all AmeriHealth Mercy employees. This process assists in the assurance that data cannot be viewed from a workstation while the user is away from the desk area.

POLICY	POLICY DESCRIPTION
145.002 Information Security	This policy describes the various functions, tools and processes of the Information Security organization within AmeriHealth Mercy. It details our safeguards and, which include the programs and policies for assuring the confidentiality, availability and integrity of all AmeriHealth Mercy managed data sets.
145.003 Portable Device Physical Security	The portable device physical security policy outlines acceptable usage of portable devices and the necessary safeguards, both programmatic and policy based, that are in place to protect the device and data stored within such devices.
145.005 Information Security Requirements for Third Parties	This policy details logical security requirements for any third party connection or vendor access into the AmeriHealth Mercy network and/or extranet areas of the organization.
145.007 Network and System Administration Policy	The Network and System Administration policy explains the various controls and technical mandates around the maintenance, creation and monitoring of administratively privileged accounts and processes.
145.009 UserID Standards and Maintenance	This policy dictates the specific requirements for user account creation standards, account lock-out, automatic disabling practices and back office controls designed to protect account and password information.
145.010 Remote Access and Teleworking	The Remote Access and Teleworking policy outlines the guidelines for any remote access requests, including teleworking relationships, and the requirements for secure and reliable communications to the corporate or remote offices.
145.012 Media Controls Policy	The Media Controls policy describes the various processes in place at AmeriHealth Mercy to control, audit and maintain security for all electronic media created or used by AmeriHealth Mercy employees.
145.016 email and Protected Health Information	This policy describes the processes in place to ensure all communication of electronic Protected Health Information (ePHI) is sent in secured and approved formats at all times.
145.017 Assignment of Access Privileges	Access Privileges are assigned as needed to perform specific roles within the organization. This policy outlines the available role based security designed for AmeriHealth Mercy employees, as well as the monitoring and enforcement capabilities that ensure compliance with the policy and best practices.
145.018 Termination or Modification of Access to PHI	This policy describes the processes implemented when existing access is modified or terminated within the logical network and associated applications in use by AmeriHealth Mercy employees.
145.019 Guidelines on workstation use and security	This policy explains the security rules and regulations with regard to workstations and both logical and physical security requirements for equipment used to facilitate secure connections and practices.
145.020 Security Policy Maintenance	This policy outlines the processes followed to ensure all Information Security policies are updated annually and the audit processes that reflect an ongoing commitment to ensure policy matches practice.

POLICY	POLICY DESCRIPTION
145.021 Security Incident Reporting and Response	This policy outlines the steps necessary to complete security-related investigations and alerts and details proper response and remediation steps for each suspected or actual incident.
145.022 Vulnerability Assessments	This policy explains the regular and scheduled vulnerability assessment processes, including the automated scanning of network assets for vulnerability data, patch levels of all electronic systems and remediation steps for any found or identified issues related to system vulnerabilities.
145.025 Password Management	This policy details specific password criteria across all electronic platforms and systems.
145.027 Temporary and Consultant Associate Login	This policy outlines the specific processes that contractor, consultant and temporary workers must comply with to ensure access to the AmeriHealth Mercy logical network and applications.
145.030 Citrix Timeout Process	This policy describes the timeout values programmatically configured for remote connections to the AmeriHealth Mercy network via Citrix sessions.
145.035 Access Controls	The Access Controls policy details the various components of role based security and access requirements for any user of the AmeriHealth Mercy network or applications and the security requirements for maintaining access and privileges to the logical network.
145.036 Device Controls	The Device Controls policy outlines the many methods employed to ensure all devices, both portable and otherwise, are properly secured and maintains standards for the assurance that any data stored on such devices is properly protected and monitored for compliance.
145.037 Security Awareness and Training to Safeguard ePHI	This policy explains the mandatory security awareness training available to all AmeriHealth Mercy employees.
145.038 Encryption Standards	This policy describes the approved connection methods to the AmeriHealth Mercy network as well as the approved methods for communicating in an encrypted format (including encryption algorithms, key lengths and processes).
145.039 Authentication of internal person or entity	This policy details the processes in place to verify employees and users of electronic assets are genuine and approved for access.
145.040 Integrity of ePHI	This policy explains the processes and policy for ensuring the integrity of electronic protected health information managed by AmeriHealth Mercy.
145.041 Electronic Transmission of ePHI	This policy details the prescribed and mandated steps for the secure transmission of ePHI both internally within AmeriHealth Mercy and externally.
145.042 Audit Controls	The Audit Controls policy explains that all electronic assets and datasets are monitored, by various means, to ensure a complete trail of data movement and access is created.
145.043 Activity Review of Information System Security	This policy explains proper system security reviews and auditing of log and other system data to ensure the security, confidentiality and availability of electronic assets and datasets
145.044 Wireless communication standards	This policy details the approved methods for wireless communication and associated security rules for such access.

POLICY	POLICY DESCRIPTION
145.045 Evaluation of the Security of ePHI	This policy outlines the steps taken to ensure ePHI is properly handled, classified and secured through out the lifecycle of data management.
145.046 Data Classification Policy	This policy maintains the current data classification systems and processes in use to ensure proper handling and access to ePHI.
145.047 Information Risk Management Program	This policy outlines AmeriHealth Mercy's commitment to ensuring the Information Security program is managing risk appropriately and is properly audited to ensure compliance with processes.
145.053 personal communication devices	This policy details specific rules and regulations on the proper usage of personal devices within the AmeriHealth Mercy logical network.

Protecting Confidentiality – Employee Training

Ensuring the confidentiality of member records is at the top of AmeriHealth Mercy's priorities. The policies and procedures surrounding the protection of confidentiality are strictly enforced. New employees are made aware of that from the first day of employment and all employees are constantly reminded to be vigilant on the issue. Annually, all employees of AmeriHealth Mercy will complete mandatory training in privacy and security principles, including HIPAA requirements and specific data steward policies.

Protecting Confidentiality – Tools

A key technology used to protect the confidentiality of electronic records is Symantec's Data Loss Prevention (DLP) product. This software is deployed throughout the organization to ensure all policies associated with the secure transfer and access of ePHI (electronic Protected Health Information) are maintained, enforced and audited. This toolset allows for the automatic encryption of data that meets ePHI requirements (or any confidential information data set); the automatic escalation of issues and events; and the systematic enforcement of policy decisions through end-user popup messages, tunneling of encryption options and escalation to management.

We have tools in place for intrusion detection and intrusion prevention (both host- and network-based) on all internal production network segments as well as any system that is Internet accessible. Additional technologies and processes in place to ensure the confidentiality of ePHI include:

- Thorough code review of any new application (as well as ethical hacking tests) performed by a trusted third party for any application that has the ability to connect to the public Internet
- Forced removable media encryption processes
- Malicious URL filtering and monitoring
- Robust enterprise anti-virus solutions
- Cisco firewalls
- Logical segmentation of user access by profile and group assignments
- Enterprise wide logging and alerting capabilities
- 24/7/365 incident response team

Databases are also protected by application firewalls that monitor and react to database events prior to event execution, maintain user and system access logs and enforce policy statements.

All tools and systems used to secure and maintain compliance with applicable policy are audited, both internally and externally, and are backed up to encrypted tapes and stored offsite nightly.

Protecting Confidentiality - Electronic Transmission

All electronic Protected Health Information (ePHI) is sent via secure methods. In the case of file transfers, AmeriHealth Mercy mandates the use of static VPN (Virtual Private Networks) and/or Secure Socket Layer (SSL) Secure File Transfer Protocol (SFTP) connections to ensure encrypted communication occurs throughout the file transmission.

AmeriHealth Mercy has a defined process that allows external entities to securely access our electronic environments in a manner that ensures security throughout the lifecycle of the connection. These sessions are fully auditable and are monitored on a 24/7/365 basis by the Information Security team.

Protecting Confidentiality - Electronic Messaging

AmeriHealth Mercy mandates the use of Tumbleweed as the standard for secure email communications. Tumbleweed requires unique user account information to login and retrieve (download) messages sent to a recipient and the file transfer occurs over an encrypted SSL session.

All email communication that includes ePHI, confidential or proprietary information is secured using our Tumbleweed Secure Email solution, which utilizes unique user credentials and SSL encryption to enforce standards of transmission.

Section S – Added Value to Louisiana

S.1 Provider Incentive Payments and Enhanced Payments

The "value added" from Provider Incentive Payments and Enhanced Payments (above the Medicaid rate floor) will be considered in the evaluation of Proposals. Responses to this section (which can be considered Proprietary) will be evaluated based solely on the quantified payment amounts reported herein, based on projected utilization for 75,000 members, and within the guidelines of the CCN program. Any health benefits or cost savings associated with any quality or incentive program shall not be included in this response and will not be considered in the evaluation of this factor. Pursuant to State Rules, the default payments between CCNs and providers are Louisiana Medicaid' rates and the CCN must contract at no less than Medicaid rate in effect on the date of service; for example the Medicaid physician fee schedule or Medicaid hospital per diem amounts or FQHC/RHC PPS amounts.

The AmeriHealth Mercy Family of Companies incent providers to improve the health of their members in many of their Medicaid managed care plans – and intend to have a similar program in Louisiana. We commit 1% of gross premiums to an incentive pool for certain providers who meet or exceed the pre-defined goals. The goals will focus on improvement in health outcomes, access to services and operational performance. The specific goals will be set based, in part, on DHH's performance measures. AmeriHealth Mercy will also solicit input from the Member Advisory Council and the Partnership Councils prior to finalizing the specific goals. We also commit to specific incentive plans for certain hospital systems, such as with the Franciscan Missionary of Our Lady Hospital System and Louisiana State University. Aligning incentives among providers and AmeriHealth Mercy enables all stakeholders to focus on improving the health of Louisiana's Medicaid members.

Primary Care Provider Incentive Plan

Primary care providers (PCPs) serving the AmeriHealth Mercy population are eligible for the PCP Incentive Plan. Using the PerformPlus methodology described in Section G, the PCP incentive plan will pay providers based on quality, access, and operational performance components that will be finalized by the Quality Assessment and Performance Improvement Committee after input from the Partnership Councils.

The Partnership Council will select a variety of performance metrics and targets that cover quality measures, severity of illness, medical cost management, operations and emergency room utilization. We create a true collaborative partnership that assists in getting other providers interested in participating with AmeriHealth Mercy by giving local providers the opportunity to offer input and guidance into the components of the incentive program.

AmeriHealth Mercy is initially committing 1 percent of premium revenue toward funding the incentive pool for the PCP Incentive Plan. This amount will be above the reimbursement providers earn through their provider contract, which will be set at a minimum of 100 percent of the Louisiana Medicaid fee schedule. To be eligible for the plan, the individual PCP or the PCP group will need a minimum assigned panel of 500 AmeriHealth Mercy members. The minimum membership requirements mitigate scenarios where a few high cost cases adversely affect the performance for the entire PCP panel and also ensure a deeper collaborative relationship between AmeriHealth Mercy and the practice.

While the local Partnership Council in each GSA will assist in identifying the exact components of the PCP Incentive Program, the following describes criteria found in similar programs of affiliated plans within the AmeriHealth Mercy Family of Companies, includes quality measures, medical cost management with adjustments for severity of illness, operational standards and emergency room utilization elements.

Quality Measures

AmeriHealth Mercy's incentive programs are designed to incent providers to deliver effective and efficient care. The programs are based on quality performance measures consistent with HEDIS® and other established clinical guidelines. Below is a list of potential measures which we have found to be effective in improving quality and providing attainable incentive payments to providers.

Table 1: Examples of Sample Quality Measurements

Quality Measure	Description
Adolescent Well-Care Visit	Adolescents age 12 through 21 who had at least one comprehensive well-care visit with a PCP or an OB/GYN provider during the applicable measurement year.
Use of Appropriate Medications for People with Asthma	Members age 5 to 50 identified as having persistent asthma and who were prescribed medications deemed acceptable by the National Heart, Lung and Blood Institute as primary therapy for long-term control of asthma (i.e., controller medications versus rescue medications) during the applicable measurement year and the year prior to the measurement year.
EPSDT Screening Rates	Number of screens performed for members under the age of 21 during the applicable measurement year.
EPSDT Participation Rates	Members under the age of 21 receiving at least one screen during the applicable measurement year.
Breast Cancer Screening	Women age 42 to 69 that had one or more mammograms during the applicable measurement year and the year prior to the measurement year.
Cervical Cancer Screening	Women age 24 to 64 that had one or more Pap Smear test(s) during the applicable measurement year.
Diabetes Care (HbA1C Test)	Members, ages 18 to 75, identified as a diabetic that had a HbA1C test performed during the applicable measurement year.
Diabetes Care (HbA1C Poor Control >9%)	Members, age 18 to 75, identified as a diabetic that had a HbA1C test performed during the applicable measurement year and the HbA1c result is >9 percent. (Lower scores are better for this measure)
Diabetes Care (LDL-C	Members, age 18 to 75, identified as a diabetic that had a LDL-C screening

Quality Measure	Description
Control <100 mg/dl)	test performed during the applicable measurement year and the LDL-C level is <100 mg/dl.
Patients with Cardiovascular Conditions (LDL-C Control <100 mg/dl)	Members, age 18 to 75, who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) from January 1 to November 1 of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) that had a LDL-C screening test performed during the applicable measurement year and the LDL-C level is <100 mg/dl.

Medical Cost Management

Another element of the incentive plan will be an evaluation of the providers' ability to adequately coordinate care and use cost-effective services to maintain medical costs. This measurement is largely based upon the PCP's ranking against peers in their ability to manage the overall cost of care for members. AmeriHealth Mercy works with PCPs to help avoid unnecessary hospital admissions and utilize clinical reporting to identify opportunities to manage complex patients in a more efficient manner.

Severity of Illness

Certain practices may treat patients with illnesses more severe than the average panel. Adjustments for practices that are treating higher-risk panels than their peers will be made to equalize the assessment of the provider's performance against their peers. AmeriHealth Mercy will evaluate all of the claims and encounters submitted by the practice and risk-adjust this information using an acceptable methodology similar to the Chronic Illness & Disability Payment System (CDPS) methodology developed by the University of California at San Diego (http://cdps.ucsd.edu). This adjustment helps create a leveling factor between different practices.

Operational Standards

Another common element of the incentive plan relates to operational standards. For example, we assess whether providers are meeting appointment and after-hour accessibility standards. Results from the After Hours Annual Survey and site visits from Provider Network Management staff are used to generate a provider score. In addition, elements such as the timely submission of claims data and utilization of assigned laboratory providers also have been included.

Emergency Room Utilization

Driving emergency room utilization down to benchmark levels will be a crucial success factor for AmeriHealth Mercy. The intent of this component will be to compensate practices for seeing patients with non-emergent diagnoses in an office-based setting as opposed to referring the member for an emergency room visit. AmeriHealth Mercy will work with PCP offices to identify frequent ER utilizers, and contact those members to encourage them to visit the PCP to develop a comprehensive care plan that

will help avoid further ER admissions. AmeriHealth Mercy will notify PCPs and their members of alternative care locations such as after-hours clinics to also support improvements in this measurement.

Other measurements may be added as recommended by the Partnership Council. However, developing a comprehensive PCP Incentive Program creates one of the most useful tools to change the way care is delivered for our members. As the PCP Incentive Program is finalized in Louisiana, details will be submitted to DHH for final approval.

Valuation of Physician Incentive Program

As requested in the RFP, below is the actuarial analyses and valuation of the PCP Incentive Program for 75,000 members in a GSA if all members were under PCPs participating in the PCP Incentive Program. The 1% of premium commitment to this payment above 100% of the Medicaid fee schedule equates to a $1.72 per member per month rate. For 75,000 members in one GSA, the total annual payment above 100% of the Medicaid fee schedule is $1,548,000.

LaCare (Amerihealth Mercy of Louisiana, Inc.)
Section S.1 Provider Incentive Payments and Enhanced Payments
Actuarial Certification of PMPM Value

I, Richard Pattinson, Vice President Actuarial Services, AmeriHealth Mercy Family of Companies, am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I have developed the valuation of LaCare's provider incentive payment as detailed in Section S.1 of the RFP proposal.

As indicated in LaCare's Section S.1 proposal, 1% of revenue will be committed to funding a primary care practitioner incentive plan.

The determination of the average PMPM cost of this program is simply one percent of the expected average revenue PMPM across the whole program (all regions and rate categories combined). Applying the FY09/10 deliveries and member mix by rate category to the revised revenue rates (6/15/2011 Mercer certification) produces an average Revenue PMPM across all regions of approximately $172.00. The expected payout of the incentive plan is one percent of this, or $1.72 PMPM.

Note that the allocation of this $1.72 PMPM across rate categories and regions was not varied in Appendix OO since rate category is not a determinant of the payout of this program.

In my opinion, the PMPM impact of the incentive plan, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the proposal.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Sincerely,

Richard Pattinson 6/23/2011

Richard Pattinson, A.S.A., MAAA
Vice President, Actuarial Services
AmeriHealth Mercy Family of Companies

Specialist Incentive Plan

Certain select specialists will be eligible for a Specialist Incentive Plan. As members are not traditionally assigned to a specialist, incentive programs for these providers tend to focus on a combination of quality metrics and reduction of unnecessary utilization rates. Again, the Specialist Incentive Plan will be defined and developed after consultation with the Partnership Council.

In Pennsylvania, a program for cardiologists has been piloted to support the quality of care delivered to members via this specialty group. The Pennsylvania incentive program includes nine industry-standard quality performance metrics specific to cardiology. These are based upon the American Medical Association (AMA) Physician Quality Reporting Initiative (PQRI) measures. The quality component contains the following PQRI-based performance metrics:

- ACE/ARB Therapy for Coronary Artery Disease
- Antiplatelet Therapy
- Event Cholesterol Test
- LDL Lowering Drug Therapy
- Lipid Test
- ACE/ARB Therapy for Heart Failure
- Beta Blocker Therapy for Systolic Heart Failure
- LVeF Assessment
- Warfarin and other approved anticoagulants

In early discussions with Woman's Hospital in Louisiana, we discussed a potential incentive program based upon reducing the NICU admission rate with selected OB/GYN/Pediatric providers. An incentive pool will be created by setting a target NICU admission rate for the pregnant members assigned to participating OB/GYN specialists. If this assigned population has a lower NICU admission rate than the target rate, a corresponding value will be funded in the incentive pool. Part of the pool will be paid out on the final realized NICU admission rate, and part of the pool will be paid out based upon relevant quality of care metrics defined by the Partnership Council. AmeriHealth Mercy intends to work with other potential specialists to develop incentive programs supporting initiatives defined by the Partnership Council and our clinical staff.

Partner Hospital System Incentive Plans

Louisiana State University Health System

Louisiana State University (LSU) Health System and AmeriHealth Mercy have various options for finalizing an incentive plan that would create a close working partnership. AmeriHealth Mercy has committed to paying 100 percent of the Medicaid fee schedule to LSU. We also have discussed an incentive plan catered to LSU's needs and abilities on top of those payments.

An incentive pool of 30 percent of savings would be funded if membership assigned to LSU PCPs had a lower than targeted medical loss ratio. Payment of 50 percent of the pool would be based upon the realized medical loss ratio, and the remaining amount would paid according to the results of quality and performance measurements mutually agreed upon between LSU leadership and AmeriHealth Mercy

clinical staff. Below is a chart estimating the incentive savings pool available to LSU for each one percent reduction in MLR from the target for a membership of 75,000 cared for by LSU PCPs.

Table 2: LSU Incentive Pool at MLR Ranges

Members	88%	87%	86%	85%
75,000	$0	$527,985	$1,055,969	$1,583,954

Franciscan Missionaries of Our Lady Health System

Also, we have had ongoing discussions with the Franciscan Missionaries of Our Lady Health System (FMOLHS) leadership team. In a similar fashion, we discussed various options in providing an incentive plan that would reflect FMOLHS's desire to be a significant partner with AmeriHealth Mercy in the CCN program.

An incentive pool of 50 percent of savings would be funded if the membership assigned to FMOLHS PCPs had a lower than targeted medical loss ratio. Payment of 50 percent of the pool would be based upon the realized medical loss ratio, and the remaining amount would be paid based on the results of quality and performance measurements mutually agreed upon between FMOLHS leadership and AmeriHealth Mercy clinical staff. The general terms of this incentive plan are outlined in a Memorandum of Understanding signed June 9, 2011, by both parties. Should AmeriHealth Mercy be awarded a contract as a participating CCN, both parties will work to conclude a definitive agreement finalizing the terms of the incentive plan.

Below is a chart estimating the incentive savings pool available to FMOLHS for each one percent reduction in MLR from the target for a membership of 75,000 cared for by FMOLHS PCPs.

Table 3: FMOLHS Incentive Pool at MLR Ranges

Members	88%	87%	86%	85%
75,000	$0	$879,975	$1,759,949	$2,639,924

CHRISTUS Health System

Finally, in discussions with CHRISTUS Health System's leadership, a similar incentive program was proposed. Again, AmeriHealth Mercy has committed to paying 100 percent of the Medicaid fee schedule to CHRISTUS and the incentive plan would be in addition to those payments.

An incentive pool of 25 percent of savings would be funded if membership assigned to CHRISTUS PCPs had a lower than targeted medical loss ratio. Payment of 50 percent of the pool would be based upon the realized medical loss ratio, and the remaining amount would be paid based on the results of quality and performance measurements mutually agreed upon between CHRISTUS leadership and AmeriHealth Mercy clinical staff. The allocation of the incentive payment would be at the discretion of the CHRISTUS leadership.

Below is a chart estimating the incentive savings pool available to CHRISTUS for each one percent reduction in MLR from the target for a membership of 75,000 cared for by CHRISTUS PCPs.

Table 4: CHRISTUS Incentive Pool at MLR Ranges

Members	88%	87%	86%	85%
75,000	$0	$439,987	$879,975	$1,319,962

S.2 Additional Benefits to Louisiana Members

S.2 Provide a listing, description, and conditions under which you will offer additional health benefits: 1) not included in the Louisiana Medicaid State Plan or 2) beyond the amount, duration and scope in the Louisiana Medicaid State Plan to members.

AmeriHealth Mercy will offer additional benefits that will serve to enhance current benefit offerings and complement AmeriHealth Mercy's medical management strategy to improve the health of our members. First, a summary of the expanded benefits is provided. A more detailed description of each expanded benefit follows the summary. Finally, an actuarial valuation of the benefit for 75,000 participating members is included at the end of the section.

Table 5: Expanded Benefits Summary

Benefit	Benefit Summary	Eligibility
Adult Vision	▪ $10 Copay - One routine eye exam every 24 months ▪ $0 Copay - $40 allowance toward the purchase of eyeglasses (frame and lenses) every 24 months	Adults 21 years and older
Enhanced Dental	▪ $0 Copay - One annual dental examination ▪ $0 Copay - One annual dental cleaning	Adults 21 years and older
24x7 Nurse Hotline	▪ Dedicated toll free Nurse Advice line ▪ 24 x 7 access to RNs for symptom counseling and health information	All members
Retail Over-the-Counter Rewards (tied to AmeriHealth Mercy quality initiatives)	▪ Dedicated toll free hotline ▪ Mail-order retail products provided and shipped free to membership	All members
WeeCare Over-the-Counter Rewards (tied to AmeriHealth Mercy's maternity program)	▪ Dedicated toll free hotline ▪ Mail-order retail maternity and newborn products provided and shipped free to qualifying members	All pregnant members meeting prenatal and post-partum care visit requirements
Hypertension Management Over-the-Counter Rewards	▪ Dedicated toll free hotline ▪ Mail-order retail products provided and shipped free to qualifying members	Members diagnosed with hypertension as defined by HEDIS who have a blood

Benefit	Benefit Summary	Eligibility
(tied to AmeriHealth Mercy's quality initiatives)		pressure result of less than 130/80 mmHg, measured by their physician (quarterly)
Well-Child Over-the-Counter Rewards (tied to AmeriHealth Mercy's quality initiatives)	▪ Dedicated toll free hotline ▪ Mail-order retail products provided and shipped free to qualifying members	Children age 3-18 after receiving annual pediatric check-up
Diabetes Over-the-Counter Rewards (tied to AmeriHealth Mercy's quality initiatives)	▪ Dedicated toll free hotline ▪ Mail-order retail products provided and shipped free to qualifying members	Diabetic members receiving annual diabetic screening and annual retinal exam
Reduced-Rate Cable Broadband	▪ $10 monthly cable broadband ▪ Discounts on person PCs	Members who are currently eligible for National School Lunch program

Detailed Benefits Explanation

Adult Vision

Benefit Description: This benefit will complement the State-mandated child benefit by providing a similar benefit to the adult population. We will use this annual benefit to proactively identify those members with more serious ophthalmological conditions such as glaucoma and cataracts. The standard welcome packet will be used to inform all adult members of this benefit.

Provider Coordination: Through the selected vision vendor, AmeriHealth Mercy will work closely with optometrist and ophthalmologist offices to ensure adequate access standards to administer this benefit. These standards will bear similarity to those applicable to physician office visits. We will also work with the vendor to outline a communication plan with providers to ensure they have the capacity to care for our membership. We will also work with the vendor to set-up regular data exchanges that will document utilization and more importantly, alert care managers of those members with more serious ophthalmological conditions.

Benefit Summary:

- $10 Copay- One routine eye exam every 24 months
- $0 Copay- $40 allowance toward the purchase of eyeglasses (frame and lenses) every 24 months

Enhanced Dental Benefit

Benefit Description: This benefit enhancement offers one annual exam and one annual cleaning for adults by a network dental provider at no cost. The welcome packet will provide members all of the relevant information related to this benefit.

Provider Coordination: AmeriHealth Mercy will utilize a dental management vendor to contract a network of dental providers and administer this benefit. Customer Service Representatives and Rapid Response Care Connectors will assist members to locate a network dental provider, as needed.

Benefit Summary:

- $0 Copay - One annual dental examination per year
- $0 Copay - One annual dental cleaning

24/7 Nurse Advice Line

Benefit Description: This benefit will provide increased access to symptom counseling and healthcare guidance to the entire membership. All members will have access to a 24/7 Nurse Advice Line, putting them in contact with registered nurses who can provide evidence-based guidance and instructions based on the member's stated symptoms. A summary of the interaction and the specific counseling and instructions provided are faxed to the PCP after the call. AmeriHealth Mercy's Rapid Response team will receive a daily report of all members using the service in the past 24-hours. Rapid Response Care Connectors will contact the member to assess for additional needs and assist the member to reconnect with the PCP. This telephonic nurse access provides an alternative access point for AmeriHealth Mercy members. Strong utilization of this benefit could lower wait times in partner hospital emergency rooms and provider offices, which in turn improves access for members with more urgent medical needs. In addition to the welcome packet, information on the Nurse Advice Line will be prominently featured in the Member Handbook, Member Portal and reinforced during all care management interactions.

Provider Coordination: AmeriHealth Mercy has contacted a vendor who will help administer this benefit. Provider Network Management Representative will explain this service and the post-call reports to providers during new provider orientation. Rapid Response Care Managers and Care Connectors will contact the physician's office to facilitate coordination of any follow-up care needed. The vendor will supply AmeriHealth Mercy with a standard reporting package that will show utilization.

Benefit Summary:

- Dedicated toll free nursing hotline
- 24/7 access to RNs for symptom counseling and health information

Retail Over-the-Counter Rewards

Benefit Description: This $25 annual benefit provides the membership with free over-the-counter (OTC) retail items commonly found in retail pharmacies delivered directly to their homes. The benefit, along with the toll-free number will be included in the member's welcome packet. Additionally, using email, text, mail, and phone, the vendor will separately communicate the benefit to each member regularly to encourage utilization. Below is a sample list of items that would be included in the benefit formulary.

Table 6: Sample Retail OTC Menu

OTC Item Categories	OTC ITEM
Allergy Prevention and Treatment	All Day Allergy Tablets 14 Tabs / 10mg / Generic for Zyrtec 24 Hr
Allergy Prevention and Treatment	Clearatadine Children's

OTC Item Categories	OTC ITEM
	10mg
Acne Treatment	Acne Gel 10 percent Benzoyl Peroxide 1oz tube/ Generic for Clean and Clear
Analgesics/Antipyretics	Acetaminaphen 00 Tabs / 325mg
Analgesics/Antipyretics	Children's Ibuprofen 100mg/5ml
Anticandial (Yeast)	Clotrimazole Vaginal Cream w/applicator *D 1 Kit / 6.4oz / Generic for Gyne-Lotrimin
Antihistamines	Dimaphen Childrens 1mg/5ml
Cough Suppressants or Expectorant	Guifenesen Cough Suppressant 60 Tabs / 200mg / Generic for Robitussin
First Aid Supplies	Alcohol Pads *D Box / 100
Minerals	Calcium 600 60 tabs / 600mg / Generic for Caltrate

Provider Coordination: AmeriHealth Mercy has contacted a vendor who will administer the benefit. The vendor has agreed to provide regular utilization reporting along with its standard reporting package.

Benefit Summary:

- Dedicated toll free hotline
- Mail-order retail products provided and shipped free to membership

Healthy Moms Over-the-Counter Program

Benefit Description: Based upon a successful program in South Carolina, this benefit provides the pregnant membership with free prenatal/maternity over-the-counter (OTC) items commonly found in retail pharmacies delivered directly to their homes by meeting specific prenatal and post-partum visit requirements. Claims reporting, supplemented with quality analytics, will identify eligible members completing the required prenatal and post-partum visits with a participating OB/GYN provider. AmeriHealth Mercy's vendor for this benefit will notify members when they have qualified for the reward by reaching the following milestones in their pregnancy:

- First prenatal visit during the first trimester or within 42 days of coming onto the plan
- Completion of more than 80% of expected prenatal visits (calculated using a combination of eligibility date, delivery date and gestational age)
- Upon completion of a postpartum visit within 45 days of the delivery

Each reward notice can be used to obtain $25 worth of over-the-counter maternity and newborn supplies from the reward catalogue.

Information on this benefit will be communicated through the Member Handbook, Member Portal and pregnancy-related educational materials and through prenatal care improvement initiatives coordinated by AmeriHealth Mercy's WeeCare (Maternity) program. The WeeCare employees will educate and

reinforce the benefit during their interactions with pregnant members. Additionally, AmeriHealth Mercy will conduct targeted communication campaigns (electronic, text, telephone, mail) to the pregnant population to inform them of the benefit. This benefit will also be prominently featured on our Mom2b social media site.

Focus group research completed in the past year identified items such as breast pumps and thermometers as desired reward items. Below is a sample list of items that will be included in the benefit:

- Thermometers
- Manual breast pump
- Lanolin
- Breast cream
- Baby powder

Provider Coordination*:* Provider Network Management Representatives will educate network OB/GYNs and Pediatricians about this benefit. AmeriHealth Mercy will contract with a vendor who will administer the benefit. The vendor will provide regular utilization reporting as part of its standard reporting package.

Benefit Summary:

- Dedicated toll free hotline (for selection of reward items and confirmation of mailing address)
- Customized maternity and newborn reward catalogue
- Mail-order retail maternity and newborn products provided and shipped free to qualifying members

Hypertension Management Over-the-Counter Program

Benefit Description: This benefit provides members who have been diagnosed with hypertension (as defined by HEDIS) the ability to receive free over-the-counter (OTC) items commonly found in retail pharmacies delivered directly to their homes. The benefit will be made eligible quarterly to members who have seen their physician; had their blood pressure measured; and have a blood pressure result lower than 130/80 mmHg. For each quarter the member meets this requirement, AmeriHealth Mercy's administrator will provide $25 worth of OTC items to the member.

Information on this benefit will be communicated through the Member Handbook, Member Portal and hypertension-related educational materials and through cardiac care improvement initiatives coordinated by the Integrated Care Management (ICM) program. ICM Care Managers and Care Connectors will educate and reinforce the benefit during their interactions with members. Additionally, AmeriHealth Mercy will conduct targeted communication campaigns (electronic, text, telephone, mail) to the hypertensive population to inform them of the benefit.

Below is a sample of list of items that will be included in the benefit:

- Aspirin
- Vitamins
- Minerals
- Smoking deterrents

Provider Coordination: Provider Network Management Representatives will educate network primary care physicians and cardiologists about the benefit. AmeriHealth Mercy will contract with a vendor to administer the benefit. The vendor will provide regular utilization reporting along with its standard

reporting package. AmeriHealth Mercy will set up regular data transfers with the vendor to alert the vendor to new qualifying members.

Benefit Summary:

- Dedicated toll free hotline (for selection of reward items and confirmation of mailing address)
- Customized health promotion reward catalogue
- Mail-order retail products that promote healthy lifestyle choices provided and shipped free to qualifying members

Well-Child Over-the-Counter Program

Benefit Description: In order to promote a coordinated benefit from infancy to adulthood, AmeriHealth Mercy will provide the parent/guardian of pediatric members, ages three to eighteen, the ability to receive free over-the-counter (OTC) items commonly found in retail pharmacies delivered directly to their homes. The $15 benefit is made available annually to eligible pediatric members who have completed their annual pediatric check-up.

Information on this benefit will be communicated through the Member Handbook, Member Portal and health promotion educational materials and through well child and adolescent visit improvement initiatives coordinated by the Integrated Care Management (ICM) program. ICM Care Managers and Care Connectors will educate and reinforce the benefit during outreach related to Early Periodic Screening Diagnosis and Treatment (EPSDT) initiatives. Additionally, AmeriHealth Mercy will conduct targeted communication campaigns (electronic, text, telephone, mail) to inform members of the benefit.

Below is a sample of list of items that will be included in the benefit:

- First Aid Creams and Ointments
- First Aid Supplies
- Orajel Baby/Topical Oral
- Cough and Cold Medicines

Provider Coordination: Provider Network Management Representatives will educate network pediatricians about the benefit. AmeriHealth Mercy will contract with a vendor who will administer the benefit. The vendor will provide regular utilization reporting along with its standard reporting package. AmeriHealth Mercy will set up regular data transfers with the vendor to alert the vendor to new qualifying members.

Benefit Summary:

- Dedicated toll-free hotline (for selection of reward items and confirmation of mailing address)
- Customized health promotion reward catalogue
- Mail-order retail products that promote healthy lifestyle choices provided and shipped free to qualifying members

Diabetes Over-the-Counter

Benefit Description: The intent of this benefit is to encourage diabetic members to proactively manage and monitor their diabetes by visiting their Primary Care Physician and eye-care provider for annual screenings. This benefit provides diabetic members the ability to receive free over-the-counter (OTC)

items commonly found in retail pharmacies delivered directly to their homes. Two separate benefits are made available annually:

- $25 OTC benefit available to diabetic members who receive an annual diabetic screening to include:
  - HBA1C testing
  - LDL testing
  - Foot examination
  - Blood pressure measurement
  - Nephropathy monitoring
- $25 OTC available to diabetic members who receive an annual dilated retinal exam

Information about this benefit will be communicated through the Member Handbook, Member Portal and diabetes-related educational materials and through diabetes improvement initiatives coordinated by the Integrated Care Management (ICM) program. ICM Care Managers and Care Connectors will educate and reinforce the benefit during their interactions with diabetic members. Additionally, AmeriHealth Mercy will conduct targeted communication campaigns (electronic, text, telephone, mail) to the diabetic population to inform them of the benefit.

Sample items in the reward catalogue could include:

- Diabetic skin care lotions
- Foot care items
- Diabetic socks

Provider Coordination: Provider Network Management Representatives will educate network primary care physicians and endocrinologists about the benefit. AmeriHealth Mercy will contract with a vendor to administer the benefit. The vendor will provide regular utilization reporting along with its standard reporting package. AmeriHealth Mercy will set up regular data transfers with the vendor to alert the vendor to new diabetic members.

Benefit Summary:

- Dedicated toll free hotline (for selection of reward items and confirmation of mailing address)
- Customized diabetic reward catalogue
- Mail-order retail products that help to promote healthy lifestyle choices for diabetics provided and shipped free to qualifying members

Reduced-Rate Cable Broadband

Benefit Description: The cable broadband benefit is designed to assist members to have access to the member portals through the internet, but is not included in the actuarial evaluation. AmeriHealth Mercy has registered with Comcast to be a community partner in their Comcast Internet Essentials program. The Comcast Internet Essentials program provides individuals with reduced-rate broadband cable internet and access as well as the ability to purchase a computer at a discounted rate. AmeriHealth Mercy believes it can leverage this access to provide eligible members with another avenue to communicate with their providers and with the health plan as they manage their health. Comcast Internet Essentials is offered in the following communities in Louisiana:

- Belcher Village

- Caddo Parish
- DeSoto Parish
- Gilliam Village
- Greenwood Town
- Hosston Village
- Lafourche Parish
- Monroe City (LA)
- Ouachita Parish
- Richwood Town
- Shreveport City
- St. John the Baptist Parish
- Stonewall Town
- Terrebonne Parish
- West Monroe City

Provider Coordination: AmeriHealth Mercy has partnered with Comcast to help promote and leverage this program to increase access for members to interact with AmeriHealth Mercy via online tools. The vendor will provide AmeriHealth Mercy with standard utilization reporting of this benefit.

Benefit Summary:

- Discounted monthly cable broadband ($9.95 per month)
- Discounts on personal computer ($149)

Actuarial Valuation of Enhanced Benefits

As requested, below is the actuarial valuation of enhanced benefits for 75,000 members in each GSA. The total value of all the benefits on a per member per month basis is $2.79. For 75,000 in one GSA, the annual benefit value is $2,511,000. The table below explains the calculation methodology for each of the enhanced benefits.

Table 7: Enhanced Benefits Valuation Calculations

Benefit Enhancement	Description	PMPM	Calculation Methodology		
Adult Vision	One routine eye exam (with $10 co-payment) and $40 allowance towards purchase of eyeglasses (frames and lenses) every 24 months for adults 21 years and over	$ .59	1	Eyewear Net Unit Cost = ($40 Allowance)	$40.00
			2	Eye Exam Average Unit Cost ($80 - 10 copay)	$70.00
			3	Expected Annual Utilization Per Adult Member	30%
			4	Vendor Admin PMPM Per Adult Member	$0.21
			5	Total Adult PMPM Cost = ([1] + [2])*[3] /12 + [4]	$2.96
			6	Adult Percentage of Enrollment	20%
			7	PMPM - Total Population	$0.59
Enhanced	One annual dental exam	$ .70	1	Average Unit Cost for	$98.36

Benefit Enhancement	Description	PMPM	Calculation Methodology		
Dental	and one annual cleaning for adults 21 years and older			Exam/Cleaning	
			2	Expected Annual Utilization Per Adult Member	40%
			3	Vendor Admin PMPM Per Adult Member	$0.21
			4	Total Adult PMPM Cost = ([1] * [2])/12 + [3]	$3.49
			5	Adult Percentage of Enrollment	20%
			6	PMPM - Total Population	$0.70
24x7 Nurse Hotline	Access to nurse advice line symptom counseling and health information for all members	$ .09	Management's expectation of vendor cost		
Retail Over-the-Counter Rewards	$25 annual benefit of mail order retail products shipped free of charge to all members	$ .63	1	Annual Allowance Per Member	$25.00
			2	Expected Annual Utilization Per Member	30%
			3	Total PMPM Cost = ([1] * [2])/12	$0.63
WeeCare Over-the-Counter Rewards	$25 OTC reward for pregnant members meeting each of the following requirements: one prenatal visit in the 1st trimester, attendance at 80% of all appointments and one postpartum visit within 3-6 weeks after delivery	$ .15	1	OTC Allowance (3 measures @ $25)	$75.00
			2	Expected Annual Utilization Per Pregnant Member	50%
			3	Total Expected Pregnant Member PMPM Cost = ([1] * [2])/12	$3.13
			4	Pregnant Member Percentage of Enrollment	4.7%
			5	PMPM - Total Population	$0.15
Hypertension Management Over-the-Counter Rewards	$25 OTC reward on a quarterly basis for members with hypertension meeting blood pressure screening requirement	$ .17	1	OTC Allowance (4 x per year @ $25)	$100.00
			2	Expected Annual Utilization Per Eligible Member	50%
			3	Total Expected Eligible Member PMPM Cost = ([1] * [2])/12	$4.17
			4	Eligible Member Percentage of Enrollment	4.0%
			5	PMPM - Total Population	$0.17
Well-Child Over-the-Counter Rewards	$15 annual OTC reward for children ages 3-18 receiving an annual well child visit	$ .40	1	OTC Allowance	$15.00
			2	Expected Annual Utilization Per Eligible Member	50%
			3	Total Expected Eligible Member PMPM Cost = ([1] * [2])/12	$0.63
			4	Eligible Member Percentage of	64.2%

Benefit Enhancement	Description	PMPM	Calculation Methodology		
				Enrollment	
			5	PMPM - Total Population	$0.40
Diabetes Over-the-Counter Rewards	$25 annual reward for diabetic members receiving the following services: annual HbA1C test, annual LDL-C screening, annual blood pressure check, foot check and neuropathy monitoring	$ .04	1	OTC Allowance	$25.00
			2	Expected Annual Utilization Per Eligible Member	81%
			3	Total Expected Eligible Member PMPM Cost = ([1] * [2])/12	$1.68
			4	Eligible Member Percentage of Enrollment	2.1%
			5	PMPM - Total Population	$0.04
	$25 annual reward for diabetic members receiving an annual retinal exam	$ .02	1	OTC Allowance	$25.00
			2	Expected Annual Utilization Per Eligible Member	40%
			3	Total Expected Eligible Member PMPM Cost = ([1] * [2])/12	$0.84
			4	Eligible Member Percentage of Enrollment	2.1%
			5	PMPM - Total Population	$0.02
Total		**$2.79**			

LaCare (Amerihealth Mercy of Louisiana, Inc.)
Section S.2 Additional Benefits to Louisiana Members
Actuarial Certification of Additional Benefits
PMPM Value

I, Richard Pattinson, Vice President Actuarial Services, AmeriHealth Mercy Family of Companies, am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I have developed the valuation of LaCare's additional benefits as detailed in Section S.2 of the RFP proposal.

The attached table describes each benefit and shows the development of the PMPM value.

In my opinion, the PMPM impact of each benefit, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the proposal.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

Sincerely,

Richard Pattinson 6/23/2011

Richard Pattinson, A.S.A., MAAA
Vice President, Actuarial Services
AmeriHealth Mercy Family of Companies